

Bills Digest  
Nos. 99-100 2003-04

Medical Indemnity Amendment Bill 2004

Medical Indemnity (IBNR Indemnity) Contribution  
Amendment Bill 2004

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Law and Bills Digest Group  
3 March 2004

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# Medical Indemnity Amendment Bill 2004

## Medical Indemnity (IBNR Indemnity) Contribution Amendment Bill 2004

**Date Introduced:** 19 February 2004

**House:** House of Representatives

**Portfolio:** Health and Ageing

**Commencement:** The Medical Indemnity Amendment Bill 2004 commences on the day after it receives the Royal Assent. Sections 1 to 3 of the Medical Indemnity (IBNR Indemnity) Contribution Amendment Bill 2004 commence on the day in which the Act receives Royal Assent. Schedule 1 of this Bill commences on the same day as the Medical Indemnity Amendment Bill 2004.

### Purpose

The purpose of these Bills is to put in place further measures to address the medical indemnity crisis. These Bills build on the measures put in place by the medical indemnity legislation that has been passed by Federal Parliament in 2002 and 2003.<sup>1</sup> In particular, the Bills put in place the new arrangements for the imposition of the 'IBNR levy' on medical practitioners. The Bills also make some changes to the way the premium subsidy scheme is operated.

### Background

Since 2002 there has been a medical indemnity crisis. Some of the key 'symptoms' of this crisis have been:

- the appointment of a provisional liquidation to the United Medical Protection group of companies (associated with this was the fact that medical defence organisation's (MDO's) have made insufficient provisioning for incurred but not reported claims (IBNR's)),<sup>2</sup> and
- large increases in the price paid by doctors for medical indemnity insurance.

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Since 2002 the Federal and State Governments have put in place a raft of measures designed to solve the medical indemnity crisis. At the Federal level, eight different medical indemnity related pieces of legislation have been passed by Federal Parliament to address the crisis. In October 2003, following his appointment as Health Minister, the Hon Tony Abbott announced the establishment of the Medical Indemnity Policy Review Panel (the Panel). The Panel was set up to develop further strategies to address key issues emerging from the crisis. On 10 December 2003, the Panel made a series of recommendations to address some of the outstanding medical indemnity issues. This Bill gives effect to some of the Panel's recommendations.

### United Medical Protection Limited/Australasian Medical Insurance Limited and the IBNR levy

In May 2002, a provisional liquidator was appointed to United Medical Protection Limited/Australasian Medical Insurance Limited (UMP/AMIL). At the time, UMP/AMIL provided insurance cover to approximately 60 per cent of medical practitioners in Australia.<sup>3</sup> The provisional liquidator, Mr David Lombe, identified three major factors contributing to the failure of UMP/AMIL:

- the lack of reserving for long term liabilities and consequently insufficient premium pricing and failure to account for incurred but not reported risk
- the lack of management experience within the organisation, and
- the adverse financial impact of the amalgamation which created the UMP Group.<sup>4</sup>

At the time the provisional liquidator was appointed, UMP/AMIL was in severe financial difficulties. UMP and AMIL had a deficiency of net assets of \$49.869 million and \$38.6 million respectively.<sup>5</sup> In addition to this, UMP/AMIL had an estimated IBNR liability of \$455 million.<sup>6</sup>

Following the appointment of the provisional liquidator, the State and Federal Governments implemented a series of measures to help re-establish the UMP Group. The scheme whereby the Federal Government agreed to pay for UMP/AMIL's unfunded IBNRs was one such measure. When established, the scheme was to be funded by imposing a levy (the 'IBNR levy') on doctors who were members of UMP/AMIL on 1 July 2000.<sup>7</sup>

Doctors became aware of the size of the IBNR levy when they received the levy notices in August 2003. Essentially doctors were required to pay 50% of the doctor's annual subscription to UMP/AMIL for the financial year that commenced on 1 July 2000. This is in addition to their normal insurance premiums. Once doctors were aware of the size of their liabilities under the scheme, they expressed strong opposition to the proposal. At a time when premium levels were already regarded as being unaffordable or nearing

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unaffordable levels for some parts of the medical profession, the doctors regarded the imposition of this levy as completely unsustainable.

Following significant medical opposition to the IBNR levy, the Government, on 3 October 2003, agreed to an eighteen month moratorium on IBNR levy payments in excess of \$1000. The *Medical Indemnity Amendment Act 2003* and the *Medical Indemnity (IBNR Indemnity) Contribution Amendment Act 2003* implemented the IBNR levy moratorium.

At the time that the moratorium was announced, the Government also stated that it would set up a policy review process to further consider the medical indemnity issues, such as the IBNR levy scheme.

The Medical Indemnity Policy Review Panel (the Panel) considered and reported on this issue. It noted the following:

Latest advice from the Australian Government Actuary suggests that while the aggregate IBNR for UMP as at 30 June 2003 is now \$482 million in net present value terms, the levy on doctors need only raise \$261 million. The balance is made up of Government funded payments under the High Cost Claims Scheme, subsidies and exemptions.

The Panel considers that is appropriate for UMP doctors to make a contribution towards the cost of the IBNR liability incurred by UMP.....

If the levy is to be retained, the Panel suggests that any contribution required from doctors should be set as a small percentage of their current income rather than the premium they paid in 2000-01. This would address the problems faced by doctors who have reduced their workload or even left practice since 2000-01.

The Panel also suggests that if the levy is to be retained the length of time a doctor should pay the levy should be linked to the period they belonged to UMP before 30 June 2000. Doctors who were members for only one year should only pay the levy for a year, those who were members for two years should pay for two years and so on up to a maximum period of six years.<sup>8</sup>

The Bill gives effect to this recommendation.

## High Premiums

The primary concern of doctors during the course of the medical indemnity crisis has been the high cost of acquiring medical indemnities. State, Territory and Federal Government's have worked towards bringing down the high cost of indemnities by addressing some of the cost drivers (namely frequency and size of damages payouts), through tort law reform.

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### Medical Indemnity Premium Subsidy Scheme

The Government has also looked to ease the pressure on some of the more high cost areas of the medical profession by putting in place a medical indemnity premium subsidy scheme. Under the scheme, the Commonwealth agreed to subsidise the cost of medical indemnity premiums for obstetricians, procedural general practitioners, neurosurgeons and GP registrars undertaking procedural training, who practise Medicare billable procedures in their area of specialty.

The Panel considered this medical indemnity subsidy scheme and stated that:

Under arrangements introduced in 2003 the Government subsidises premiums for doctors in particular high risk areas of practice as a proportion of the difference between costs in that area and costs in a comparator area of practice. However, many other doctors face very large indemnity costs relative to income (as shown in Table 1 above) and yet receive no assistance.

The Panel suggests that the Government should introduce a new medical indemnity Premium Support Scheme to provide assistance to insurers for them to support affordability across specialties.....The current subsidy scheme would be abolished, with funding folded into the new scheme. Special arrangements should ensure that no currently subsidised doctor receives less support under the new arrangements.

This assistance should be conditional on action by insurers to have more acceptable premium income bands within specialties, thus addressing the issue of affordability for low income part-time doctors.....

The benefit of this new Premium Support Scheme is that it is handled by the insurers, who reduce premiums payable by doctors before they have to make a payment. Doctors would not need to apply for subsidies.<sup>9</sup>

The Bills put in place necessary provisions so that these recommendations can be implemented.

### High Cost Claims Scheme

A further measure put in place by the Government to reduce cost pressures on MDO's has been the High Cost Claims Scheme. Under this scheme, the Commonwealth is to reimburse medical indemnity providers, on a per claim basis, 50 per cent of the insurance payout over \$500 000.<sup>10</sup>

It has been argued that this scheme will result in downward pressure on premiums by:

- lowering the amount Medical Defence Organisations have to pay out
- reducing the amount of reinsurance MDO's will need to buy to fund large claims, and

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- limiting MDO's exposure to large claims.

The Panel considered the High Cost Claims Scheme and noted the following:

The Panel suggests that the Government should provide increased support to the industry generally by reducing the threshold at which the High Costs Claims Scheme begins to co-insure claims from \$500 000 to \$300 000.<sup>11</sup>

This measure has been implemented through regulations.

### Other recommendations by the Panel

The Panel has also recommended a number of other changes. One of the key changes is the creation of the Run-off Reinsurance Vehicle that will cover claims against doctors who have retired, left private practice for more than three years, or gone on maternity leave. The creation of this entity will be dealt with in separate legislation.<sup>12</sup>

### Cost of these measures

The second reading speech to the Bills states the following:

The Government will contribute a combined total of some \$620 million over the next four years to meet medical indemnity claims.<sup>13</sup>

### Position of significant interest groups/press commentary

Anecdotal evidence indicates that the medical profession and medical defence organisations support these amendments. There has been little media coverage on these amendments.

## Main Provisions

The Medical Indemnity Amendment Bill 2004 (MIAB) and the Medical Indemnity (IBNR Indemnity) Contribution Amendment Bill 2004 (MICA) put in place three key changes to the Federal Government's medical indemnity arrangements. The Bills:

- change the IBNR levy payment arrangements
- introduce a single billing arrangement for doctors, and
- put in place revised arrangements for the Premium Support Scheme.

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## UMP Support Payment Arrangements

The Bills change the IBNR levy payment arrangements. In particular the Bills change the name of 'IBNR levy' to 'UMP support payments' (primarily through **Schedule 3 MIAB**), change the method of calculating the amount of the UMP support payments, change the method of payment and collection and puts in place new exemptions.

### Calculating the amount of the UMP Support Payment

The proposed method used to calculate the amount of the UMP Support Payment is set out in the Medical Indemnity (IBNR Indemnity) Contribution Amendment Bill 2004. Importantly, the eighteen month moratorium that commenced on 1 July 2003 will continue to apply. Once this moratorium ends, a doctor's liabilities will be calculated using the following formula;

Doctors who were members of UMP at 30 June 2000 will pay whichever is the least of:

- (a) their original IBNR annual levy
- (b) 2 per cent of their gross Medicare billable income, or
- (c) \$5,000 (**item 23, Schedule 1, MICA**).

Essentially, under this new arrangement, the UMP support payment arrangements are linked directly to the doctor's current financial circumstances, thereby making payments more affordable for doctors. A key point regarding this new formula is that under the new arrangement the annual amount a practitioner will be required to pay will not exceed \$5000.

The Health Insurance Commission (HIC) will continue to be responsible for calculating the amount that each practitioner is liable to pay each year.

### Exemptions

The *Medical Indemnity Act 2002* and associated regulations set out circumstances where a practitioner may be exempt from having to pay the UMP support payment. This Bill amends the current list of exemptions in the *Medical Indemnity Act 2000* so that doctors whose Medicare billable income is less than \$5000 and health professionals whose medical income is less than \$5000 will be exempt from paying the annual levy during that income period (**item 4, Schedule 1, MIAB**).

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## Payment timeframes

The Bill reduces the maximum number of years that a doctor will be required to make support payments from ten years to six years (**item 5, Schedule 1, MIAB**). Doctors who were members of UMP for less than six years before 2000 will only be required to make payments for the number of years that are equal to the number of years they were members of UMP (**item 5, Schedule 1, MIAB**).

## Payment and collection

**Item 25 Schedule 2, MIAB** sets out the arrangements for collection of the UMP support payments. Under the Bill it is proposed that the medical indemnity insurer or the MDO for the medical practitioner be the 'collection body' for the UMP support payment (previously it was the HIC). Under the Bill, where the medical indemnity insurer or MDO issues the invoice for payment of a premium for medical indemnity cover, they will also be required to include in that invoice a request for payment of the UMP support payment. The medical practitioner will be required to pay their UMP support payment to the medical indemnity insurer or the MDO. The collection body will then remit this money to the HIC. If the collection body does not remit the money to the HIC in the time specified, the collection body will be required to pay a late payment penalty.

## Medical Indemnity Premium Subsidy Scheme

**Schedule 4 MIAB** makes amendments to the medical indemnity premium subsidy scheme arrangements. The amendments allow premium subsidies to be paid directly to medical indemnity insurers or MDO's. This will mean that doctors will be able to receive their premium subsidies automatically through reduced premiums from the medical indemnity insurer or MDO, rather than by applying to the HIC for a premium subsidy payment.

The Government has indicated that it intends to expand the range of practice areas within the medical profession that will be entitled to the premium subsidy.

## Concluding Comments

These Bills put in place legislative arrangements to change the operation of some of the Federal Government's measures for addressing the medical indemnity crisis. In particular the Bills make changes to the IBNR levy scheme (renamed UMP support payment) and the premium subsidy scheme.

These amendments reduce the size of the UMP support payments and will facilitate the more direct payment of premium subsidies to doctors.

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## Endnotes

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- 1 Included in this legislative package have been the following Acts; *Medical Indemnity Act 2002*, *Medical Indemnity (Enhanced UMP Indemnity) Contribution Act 2002*, *Medical Indemnity (Consequential Amendments) Act 2002*, *Medical Indemnity Agreement (Financial Assistance-Binding Commonwealth Obligations) Act 2002*, *Medical Indemnity (IBNR Indemnity) Contribution Amendment Act 2003*, *Medical Indemnity Amendment Act 2003*, *Medical Indemnity (Prudential Supervision and Product Standards) Act 2003*, *Medical Indemnity (Prudential Supervision and Product Standards) (Consequential Amendments) Act 2003*.
- 2 Historically, MDOs provided their members with ‘claims incurred’ cover. Under a ‘claims incurred’ policy, doctors were insured against injuries to patient brought about through conduct which took place during the term of the policy. The patient’s claim could be notified to the MDO at any time; ie during the term of the policy or once the policy has lapsed (for example, five years after the policy has lapsed).  
  
Incidents which occur during the term of the policy, giving rise to a claim that is reported to the MDO after the policy has lapsed are referred to as ‘incurred but not reported’ claims.
- 3 Gillian Harrex, Karen Johnston and Estelle Pearson, *Medical Indemnity in Australia; Presented to the Institute of Actuaries in Australia; XIII General Insurance Seminar*, Trowbridge Consulting, November 2001, p. 9.
- 4 *United Medical Protection & Ors* [2003] NSWSC 1031, p. 21. Further analysis of the collapse of UMP/AMIL can be found in this judgement where Justice Austin considers the termination of the appointment of the provisional liquidator and discontinuance of the winding up proceedings for the UMP Group.
- 5 *ibid.*, p. 14.
- 6 *ibid.*, p. 19.
- 7 The legislation that put this scheme into place was the Medical Indemnity Act 2002 and the Medical Indemnity (Enhanced UMP Indemnity) Contribution Act 2002.
- 8 Medical Indemnity Policy Review Panel, *Affordable, Secure and Fair: Report to the Prime Minister*, 10 December 2003, Canberra, p. 16–17.
- 9 *ibid.*, p. 14–15.
- 10 Note the initial level was \$2 million and this amount was revised down to \$500,000 in October 2003.
- 11 Medical Indemnity Policy Review Panel, *op. cit.*, p. 15.
- 12 Second Reading Speech, Medical Indemnity Amendment Bill 2004, Medical Indemnity (IBNR Indemnity) Contribution Amendment Bill 2004.
- 13 *ibid.*

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