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# Medical Indemnity Legislation Amendment Bill 2005

Susan Dudley
Law and Bills Digest Section

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# Medical Indemnity Legislation Amendment Bill 2005

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**House:** House of Representatives

**Portfolio:** Health and Ageing

**Commencement:** Varied commencement dates. Refer to the table for detailed provision by provision commencement dates

## Purpose

The purpose of this Bill is to make a small number of changes to the operation of the medical indemnity support scheme that was put in place by the Government in response to the medical indemnity crisis.

## Background

Issues associated with the provision of medical indemnities reached crisis point in 2002 when United Medical Protection Limited (UMP) and its wholly owned subsidiary Australian Medical Protection Limited (AMIL) went into provisional liquidation. At the time of the crisis doctors were experiencing substantial increases in the cost of their indemnity premiums and the entire medical indemnity regime was under threat of collapse. This was due to the very real prospect of UMP/AMIL, which provided indemnities to approximately 60% of Australian doctors, going into liquidation.

In response to this crisis the Government rolled out a series of measures to alleviate the upward pressure on insurance premiums and the unsustainable operating environment that existed for some medical indemnity providers. The measures included the Run-off Cover Indemnity Scheme, the High Cost Claims Scheme, the Exceptional Claims Scheme and the Medical Indemnity Premium Subsidy Scheme

### Run-off Cover Indemnity Scheme

In 2004 the Government set up the Run-off Cover Indemnity Scheme (ROCS). This followed a period of lobbying by doctors regarding the sustainability of the run-off cover arrangements that were in place at the time.

#### The run-off cover issue

Run-off cover became a substantial issue for doctors once the Government made changes to the regulatory regime that applied to medical indemnity providers. Under the new

regulatory regime, medical indemnity providers became subject to the *Insurance Act 1973.* As a result of this they have become required to supply 'claims made' rather than 'claims incurred' cover. Prior to the regulatory changes, many doctors held claims incurred policies.

The difference between claims incurred and claims made cover is significant. Under claims incurred cover, if a doctor pays a premium for a year, the doctor knows that the policy covers him or her for claims that are lodged at any time, if they relate to an incident that occurs in that year. Under claims made cover, if a doctor pays a premium for a year, they will only be covered for claims that are made in that year and which relate to an incident that occurs in that year. Claims made in other years for an incident that occurs in that policy year will not be covered by a claims made policy.

If a doctor with a claims made policy wishes to leave practice for a period of time or retire altogether, they must take out an additional insurance policy (known as 'run-off cover'), if they wish to have insurance cover for claims made in those non-practising/retirement years.

In 2003, and as a result of the forced move across to claims made policies, doctors concerns about run-off were heightened. They particularly had two key concerns. Firstly they were worried about the availability of cover and secondly they were concerned about its affordability.[1] Further background relating to the issue of run-off cover can be located in Bills Digests Nos 157-158 for 2003-04[2]

## Legislative response

In response to these concerns and through an iterative process, the Government has implemented a number of measures to regulate and provide a more stable run-off cover arrangement for doctors. Initially, the Government legislated so that providers of medical indemnity insurance were required to provide run-off cover to retiring doctors for a period of six years with the cover to be provided at a reasonable rate.[3] These legislative measures were supplemented by the changes implemented by the *Medical Indemnity Legislation Amendment (Run-off Cover Indemnity and Other Measures) Act 2004* and the associated *Medical Indemnity (Run-off cover Support Payment) Act 2004* which implemented the recommendations made by the Government's Medical Indemnity Policy Review.

The 2004 legislation created the Run-off Cover Indemnity Scheme (ROCS). Under the scheme, eligible doctors (such as retirees, doctors on maternity leave and doctors who have suffered a permanent disability[4]) are able to access run-off cover free of charge. Claims made under the scheme are paid by the Commonwealth. The Commonwealth also reimburses the medical indemnity insurers for the costs of managing the run-off cover scheme. The cost of the scheme is funded by a tax on medical indemnity insurers.[5] For the first four years of the scheme's operation, the cost of the scheme is 8.5% of the medical indemnity provider's annual premium income except for AMIL.[6] AMIL pays 9.5626% of

their annual premium income.[7] Medical indemnity providers pay for the tax by passing the cost onto doctors in the form of higher premiums.

The legislative arrangements for the ROCS is set out in Part 2 Division 2B of the *Medical Indemnity Act 2002,* the *Medical Indemnity (Run-off Cover support Payment) Act 2004* and associated regulations. For further information on the arrangements, reference should be made to Bills Digest No. 157-158, 2003-2004.[8]

## High Cost Claims Scheme

Under the High Cost Claims Scheme, the Commonwealth will reimburse the medical indemnity providers on a per claims basis, 50 per cent of any insurance payout that is over $300 000.[9]

The legislative arrangements for the high cost claims scheme is set out in Part 2 Division 2 of the *Medical Indemnity Act 2002* and associated regulations.

## Exceptional Claims Scheme

The Exceptional Claims Scheme was put in place in 2003 to address doctors concerns that in some circumstances they could be personally liable for a certain amount of claims against them.

As noted above, medical indemnity providers are now subject to the *Insurance Act 1973*. As a result of this, medical indemnity cover that is provided to doctors now contains a cap (normally of either $20million or $25milion) on the amount of damages that may be paid under the policy. Formerly medical indemnities were uncapped. In response to this change, doctors expressed concern that they may be at financial risk in the situation where claims against them were in excess of that capped amount.

To respond to these concerns, the Government implemented the Exceptional Claims Scheme in 2003. Under the scheme the Commonwealth will assume liability for 100% of the damages that are payable that exceed the doctor's insurance cap that is set down in their policy.

The legislative arrangements for the exceptional claims scheme is set out in Part 2 Division 2A of the *Medical Indemnity Act 2002* and associated regulations.

## IBNR (incurred but not reported) indemnity scheme

In May 2002, a provisional liquidator was appointed to United Medical Protection Limited/Australasian Medical Insurance Limited (UMP/AMIL). 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.[10] In addition to this, UMP/AMIL had an estimated IBNR liability of $455 million.[11]

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.[12]

This scheme has been somewhat revised since it was established in 2002. The Government has now agreed to fund three quarters of UMP's liability, with the remaining quarter to be met by from doctors who were members of UMP at 30 June 2000. [13]

The legislative arrangements for the IBNR scheme are set out in Part 2 Division 1 of the *Medical Indemnity Act 2002*.

## Medical Indemnity Premium Subsidy Scheme

Under the medical indemnity premium subsidy scheme, premium subsidies are paid directly to medical indemnity providers. Doctors receive premium subsidies automatically through reduced premiums from the medical indemnity provider.

Under the scheme, where a doctor's gross medical indemnity costs exceed 7.5% of his or her gross private medical income, he or she will only be required to pay twenty cents in the dollar for the cost of the premium beyond the threshold limit.[14]

Premium subsidies will also apply to procedural general practitioners working in rural areas. Under the scheme, premium subsidies will cover 75% of the difference between premiums for these doctors and those for non-procedural GPs in similar circumstances (ie same location, same income, same insurer). Rural GPs will be eligible for the premium subsidy scheme regardless of whether they meet other criteria.[15]

There is scope in the legislation to deem other groups of doctors eligible for the scheme.

The legislative arrangements for the premium subsidy scheme are set out in Part 2 Division 4 of the *Medical Indemnity Act 2002*.

## Main Provisions

### Schedule 1 amendments

**Schedule 1** of the Bill contains amendments to the Run-off Cover Indemnity Scheme (ROCS). Unless otherwise specified, the discussion of amendments in this Schedule relate to amendments to the *Medical Indemnity Act 2002*.

**Items 1 and 2** amend the definition of 'claim' that is contained within section 4 of the Act. Currently the term 'claim' is defined as including a 'claim or demand of any kind' and includes 'proceedings of any kind'. The Bill expands the definition of claim to include the 'notification of an incident…[to a]...medical indemnity insurer or an MDO…[if their contract of insurance]…'would have indemnified the person in relation to any claim relating to the incident.'

The amendment allows Government payment practices under the ROCS scheme to align with current business practices of medical indemnity providers.

**Items 4 and 5** expand the criteria for determining whether a claim under a run-off cover scheme is entitled to be reimbursed by the Commonwealth. The Bill removes the current paragraph 34ZB(1)(c) which makes it a requirement that at the time of the incident the insurance contract held by the doctor would have indemnified the doctor in relation to the claim if the claims had been made at that time.

Removing this paragraph aligns the reimbursement available to medical indemnity providers under the ROCS with the medical indemnity provider's obligations to their run-off cover policy holders.

As a result of the changes in **items 1, 2, 4 and 5**, the providers of the run-off cover will be able to receive compensation from the Commonwealth for all claims that are made against them under the run-off cover contract.

**Item 6** makes some adjustments to the arrangements for those persons who will be entitled to be covered by ROCS. In particular, it changes the arrangements for persons on maternity leave and persons who have ceased worked because of a permanent disability.

In relation to persons on maternity leave; proof of the pregnancy in the form of a signed certificate will need to be supplied to the Health Insurance Commission. The person will need to have ceased all practice as a medical practitioner because of the pregnancy, provision of care for the children or recovery from the pregnancy (proposed subsection 34ZB(4)).

In relation to persons who have ceased practice because of a permanent disability; it needs to be shown that:

- the injury/illness has resulted or is likely to result in a permanent disability
- as a result of the injury/illness the person can no longer practice in the area of medicine that the person was practising in at the time of the injury. These facts need to be certified by another medical practitioner, and
- the person has permanently ceased all practice as a medical practitioner (proposed subsection 34ZB(4)).

These amendments also make it clear through the use of the words 'ceased the person's practice as a medical practitioner', that for doctors on maternity leave or suffering from a permanent injury/illness, they must have ceased practising medicine altogether, not just ceased private medical practice, to be covered by the run-off cover scheme.

**Items 10-12** improve the disclosure regime for the ROCS, so that medical indemnity providers will be required to show to policy holders:

- the amount a doctor will need to pay which effectively covers his/her risk
- the rate of tax applied to the particular medical indemnity provider under the run-off cover support payment legislation, and
- the amount of the doctor's premium which will contribute to the medical indemnity provider's run-off cover support payment.

**Item 15** amends the definition of 'medial practice period' in the *Medical Indemnity (Prudential Supervision and Product Standards) Act 2003* so that doctors who have practised in the public sector can be covered by the ROCS.

**Item 16** amends the notification requirements in the *Medical Indemnity (Prudential Supervision and Product Standards) Act 2003* so that the medical indemnity provider must notify the Health Insurance Commission within 28 days of providing run-off cover to a doctor.

## Claims Protocols - Schedule 2 amendments

Schedule 2 contains amendments to the *Medical Indemnity Act 2002* relating to Claims Protocols. Claims protocols are procedures that have been drawn up by the Commonwealth, and which set out the details of how the payment arrangements for the different medical indemnity subsidy schemes work.

Currently the *Medical Indemnity Act 2002* provides the legislative basis for claims protocols for the Incurred But Not Reported Scheme and the Exceptional Claims Scheme.

The Bill in **items 1, 2, 7 and 8** amend the *Medical Indemnity Act 2002* to put in place legislative provisions so that a High Cost Claims Protocol can be drawn up.

The High Cost Claims Protocol will give the Minister for Health and Ageing the capacity to determine arrangements for payment of:

- claims handling fees
- costs associated with legal, administrative or other costs incurred by medical indemnity providers in relation to the High Cost Claims Scheme and
- costs associated with incidents notified to doctors, which may or may not give rise to a claim under the High Cost Claims Scheme.

The Bill also amends the legislative arrangements for the Incurred But Not Report Claims Protocol and the Exceptional Claims Protocol so that the protocol can put in place arrangements for claims that have been notified (but not yet made) to the medical indemnity providers. The current legislative provisions do not make provision for this (**item 4 and item 9**). This is in accordance with general business practices of the medical indemnity providers.

### Schedule 3 amendments

The amendments contained within schedule 3 of the Bill are a series of miscellaneous amendments to the *Medical Indemnity Act 2002* relating to the schemes discussed in the 'Background' section above.

In particular the Bill makes amendments which implement the changes made by the *Legislative Instruments Act 2003* so that matters which were formally notified in the Commonwealth Gazette are now notified under the Federal Register of Legislative Instruments (**item 1, 4, 10, 13, and 14)**.

Most of the other amendments contained within schedule 3 are minor fix ups to terminology used in the *Medical Indemnity Act 2002*.

## Concluding Comments

The Medical Indemnity Legislation Amendment Bill 2005 is the twelfth in a series of bills to put in place arrangements to address the medical indemnity crisis. The measures in this Bill are uncontroversial as they make small changes to the operational nature of the current medical indemnity arrangements.

## Endnotes

1 Medical Indemnity Policy Review Panel, *affordable, secure and fair; Report to the Prime Minister*, 10 December 2003, p. 12.

2 *Medical Indemnity Legislation Amendment (Run-off Cover Indemnity and Other Measures) Act 2004*.

3 Section 26A Medical Indemnity (Prudential Supervision and Product Standards) Act 2003.

4 Section 34ZB *Medical Indemnity Act 2002.*

5 Section 4, *Medical Indemnity (Run-off Cover Support Payment) Act 2004.*

6 Medical Indemnity (Run-off Cover Support Payment) Regulations 2004, regulation 5.

7 Medical Indemnity (Run-off Cover Support Payment) Regulations 2004, regulation 6.

8 Susan Dudley, 'Medical Indemnity Legislation Amendment (Run-off Cover Indemnity and other Measures) Bill 2004 and Medical Indemnity (Run-off Cover Support Payment) Bill 2004' Bills Digest No, 157-158 2003-4, Department of the Parliamentary Library.

9 When the scheme was initially set up, the proposal was to provide assistance once the claim exceeded 2 million dollars. This amount was revised down to $500 000 in October 2003 and then changed by regulation in 2004 to the current amount of $300 000.

10 ibid., Gillian Harrex, Karen Johnston and Estelle Pearson, *Medical Indemnity in Australia*; *Presented to the Institute of Actuaries in Australia; XIII General Insurance Seminar,* Trowbrindge Consulting, November 2001, p. 14.

11 ibid., p. 19.

12 The legislation that put this scheme into place was the *Medical Indemnity Act 2002* and the *Medical Indemnity (Enhanced UMP Indemnity) Contribution Act 2002*.

13 Department of Health website, *Medical Indemnity Frequently Asked Questions*, UMP Support Payment, [http://www.health.gov.au/internet/wcms/publishing.nsf/Content/health-medicalindemnity-umpsp.htm, 4 March 2005.

14 Department of Health website, *Medical Indemnity Frequently Asked Questions*, Premium Support Scheme, [http://www.health.gov.au/internet/wcms/publishing.nsf/Content/health-medicalindemnity-faq-pss.htm], 3 March 2005.

15 Department of Health website, *Medical Indemnity Frequently Asked Questions*, Premium Support Scheme, also refer to section, http://www.health.gov.au/internet/wcms/publishing.nsf/Content/health-medicalindemnity-faq-pss.htm, 3 March 2005.

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