Medical Indemnity Act 2002

No. 132, 2002

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About this compilation

This compilation

This is a compilation of the *Medical Indemnity Act 2002* that shows the text of the law as amended and in force on 1 July 2020 (the ***compilation date***).

The notes at the end of this compilation (the ***endnotes***) include information about amending laws and the amendment history of provisions of the compiled law.

Uncommenced amendments

The effect of uncommenced amendments is not shown in the text of the compiled law. Any uncommenced amendments affecting the law are accessible on the Legislation Register (www.legislation.gov.au). The details of amendments made up to, but not commenced at, the compilation date are underlined in the endnotes. For more information on any uncommenced amendments, see the series page on the Legislation Register for the compiled law.

Application, saving and transitional provisions for provisions and amendments

If the operation of a provision or amendment of the compiled law is affected by an application, saving or transitional provision that is not included in this compilation, details are included in the endnotes.

Editorial changes

For more information about any editorial changes made in this compilation, see the endnotes.

Modifications

If the compiled law is modified by another law, the compiled law operates as modified but the modification does not amend the text of the law. Accordingly, this compilation does not show the text of the compiled law as modified. For more information on any modifications, see the series page on the Legislation Register for the compiled law.

Self-repealing provisions

If a provision of the compiled law has been repealed in accordance with a provision of the law, details are included in the endnotes.

Contents

An Act to make provision in relation to indemnities in relation to the practice of medical professions and vocations, and for related purposes

Part 1—Preliminary

1 Short title

This Act may be cited as the *Medical Indemnity Act 2002*.

2 Commencement

This Act commences, or is taken to have commenced, on 1 January 2003.

3 Objects of this Act and the medical indemnity payment legislation

Availability of medical services

(1) An object of this Act is to contribute towards the availability of medical services in Australia by providing Commonwealth assistance to support access by medical practitioners to arrangements that indemnify them for claims arising in relation to their practice of their medical professions.

(2) The Commonwealth provides that assistance under this Act by:

(a) meeting part of the costs of large settlements or awards paid by organisations that indemnify medical practitioners (but only for claims notified on or after 1 January 2003); and

(aa) meeting the amounts by which settlements and awards exceed insurance contract limits, if those contract limits meet the Commonwealth's threshold requirements; and

(ab) meeting the amounts payable in relation to certain claims (notified on or after 1 July 2004) against medical practitioners who are no longer in private medical practice; and

(b) providing for a subsidy scheme to help certain medical practitioners meet the cost of their indemnity arrangements; and

(c) meeting the cost associated with certain IBNR liabilities of organisations that indemnify medical practitioners to the extent to which those organisations had not made adequate provision for those liabilities as at 30 June 2002.

Note: The acronym "IBNR" is used in this Act for "incurred but not reported".

(3) The Commonwealth provides further assistance in relation to members and former members of UMP under a Medical Indemnity Agreement referred to in the *Medical Indemnity Agreement (Financial Assistance—Binding Commonwealth Obligations) Act 2002*.

(3A) This Act also supports access by medical practitioners to arrangements that indemnify them for claims arising in relation to their practice of their medical professions by limiting when medical indemnity insurers can refuse to provide medical indemnity cover.

(4) Another object of this Act (together with the medical indemnity payment legislation) is to allow the Commonwealth to recover the costs of providing the assistance referred to in paragraph (2)(ab) by requiring payments from medical indemnity insurers.

Availability of other health services

(5) Another object of this Act is to contribute towards the availability of certain health services in Australia by providing Commonwealth assistance to support access by persons who practise allied health professions to arrangements that indemnify them for claims arising in relation to their practices.

(6) The Commonwealth provides that assistance under this Act by:

(a) meeting part of the costs of large settlements or awards paid by organisations that indemnify persons who practise allied health professions; and

(b) meeting the amounts by which settlements and awards exceed insurance contract limits, if those contract limits meet the Commonwealth's threshold requirements.

4 Definitions

General

(1) In this Act, unless the contrary intention appears:

Actuary means the Australian Government Actuary.

administrative action has the meaning given by subsection 76A(4).

AFCA has the meaning given by section 761A of the *Corporations Act 2001*.

affected medical practitioner has the meaning given by section 34ZQ.

allied health exceptional claims indemnity means an allied health exceptional claims indemnity paid or payable under Division 2D of Part 2.

Note: Amounts payable under regulations made for the purposes of section 34ZZZD (allied health exceptional claims payments) are not covered by this definition.

allied health high cost claim indemnity means an allied health high cost claim indemnity paid or payable under Division 2C of Part 2.

Note: Amounts payable under regulations made for the purposes of section 34ZZG (allied health high cost claims payments) are not covered by this definition.

allied health high cost claim threshold has the meaning given by section 34ZZA.

allied health profession means a profession that is:

(a) a health profession within the meaning of the Health Practitioner Regulation National Law, other than the medical profession; or

(b) specified in the rules.

allied health termination date means the date, if any, set by rules under section 34ZZM.

Chapter 5 body corporate means:

(a) a body corporate that is a Chapter 5 body corporate within the meaning of the *Corporations Act 2001*; or

(b) a body corporate to which a provisional liquidator has been appointed.

Chief Executive Medicare has the same meaning as in the *Human Services (Medicare) Act 1973*.

claim:

(a) means a claim or demand of any kind (whether or not involving legal proceedings); and

(b) includes proceedings of any kind including:

(i) proceedings before an administrative tribunal or of an administrative nature; and

(ii) disciplinary proceedings (including disciplinary proceedings conducted by or on behalf of a professional body); and

(iii) an inquiry or investigation;

and ***claim*** against a person includes an inquiry into, or an investigation of, the person's conduct.

Note: Subsection (1A) extends the meaning of ***claim*** for the purposes of Division 2B of Part 2 (run-off cover indemnity scheme).

conducted appropriately: a defence of a claim against a person is ***conducted appropriately*** if, and only if:

(a) to the extent it is conducted on the person's behalf by an insurer, or by a legal practitioner engaged by an insurer—the defence is conducted to a standard that is consistent with the

insurer's usual standard for the conduct of the defence of claims; and

(b) to the extent it is conducted by the person, or by a legal practitioner engaged by the person—the defence is conducted prudently.

contribution year has the same meaning as in the *Medical Indemnity (Run-off Cover Support Payment) Act 2004*.

defence, of a claim against a person, includes any settlement negotiations on behalf of the person.

eligible insurer has the meaning given in section 34ZZ.

eligible MDO has the meaning given in section 34ZZ.

eligible midwife has the same meaning as in the *Midwife Professional Indemnity (Commonwealth Contribution) Scheme Act 2010*.

eligible related claims: see section 8A.

eligible run-off claim has the meaning given by section 34ZB.

exceptional claims indemnity means an exceptional claims indemnity paid or payable under Division 2A of Part 2.

Note: Amounts payable under regulations made for the purposes of section 34X (exceptional claims payments) are not covered by this definition.

exceptional claims termination date means the date, if any, set by rules under section 34G.

Federal Register of Legislation means the Federal Register of Legislation established under the *Legislation Act 2003*.

health care related vocation means a health care related vocation in relation to which there is at least one State or Territory under the law of which a person must be registered in order to practise.

Health Practitioner Regulation National Law means the Health Practitioner Regulation National Law set out in the Schedule to the *Health Practitioner Regulation National Law Act 2009* (Qld).

health service means any service, care, treatment, advice or goods provided in respect of the physical or mental health of a person.

high cost claim indemnity means a high cost claim indemnity paid or payable under Division 2 of Part 2.

Note: Amounts payable under regulations made for the purposes of section 34AA (high cost claims payments) are not covered by this definition.

high cost claim threshold has the meaning given by section 29.

IBNR exposure has the meaning given by section 8.

IBNR indemnity means an IBNR indemnity paid or payable under Division 1 of Part 2.

Note: Amounts payable under regulations made for the purposes of section 27A (IBNR claims payments) are not covered by this definition.

incident means any incident (including any act, omission or circumstance) that occurs, or that is claimed to have occurred, in the course of, or in connection with, the provision of a health service.

incident-occurring based cover has the meaning given by section 7.

indemnify has a meaning affected by subsection (2).

indemnity scheme payment means:

(a) an IBNR indemnity; or
(b) a high cost claim indemnity; or
(c) an exceptional claims indemnity; or
(d) a run-off cover indemnity; or
(e) an allied health high cost claim indemnity; or
(f) an allied health exceptional claims indemnity.

insurance business has the same meaning as in the *Insurance Act 1973*.

insurer means a person who carries on insurance business.

insurer-to-insurer payment means a payment that:

(a) is made by an MDO or insurer to an MDO or an insurer; and

(b) is not made by the MDO or insurer on behalf of another person.

invoice includes:

(a) any document issued by an MDO to a person (whether or not the person is already a member of the MDO) that contains a quote for the amount of subscription that is or would be payable by that person for membership of the MDO; and

(b) any document issued by a medical indemnity insurer to a person (whether or not the medical indemnity insurer already provides medical indemnity cover to the person) that contains a quote for the amount of premium that is or would be payable by that person for provision of such cover.

late payment penalty:

(a) in relation to an amount repayable under section 24—means a penalty payable under section 27; and

(aa) in relation to a debt owed under section 34T—means a penalty payable under section 34W; and

(ab) in relation to a debt owed under section 34ZJ—means a penalty payable under section 34ZM; and

(ac) in relation to a debt owed under section 34ZZZ—means a penalty payable under section 34ZZZC; and

(b) in relation to a run-off cover support payment—means a penalty payable under section 65.

legal practitioner means a person who is enrolled as a barrister, a solicitor, a barrister and solicitor, or a legal practitioner, of:

(a) a federal court; or

(b) a court of a State or Territory.

MDO has the meaning given by section 5.

medical indemnity cover: a contract of insurance provides medical indemnity cover for a person if:

(a) the person is specified or referred to in the contract, whether by name or otherwise, as a person to whom the insurance cover provided by the contract extends; and

(b) the insurance cover indemnifies the person (subject to the terms and conditions of the contract) in relation to claims that may be made against the person in relation to incidents that occur or occurred in the course of, or in connection with, the practice by the person of a medical profession.

Note: A single contract of insurance may provide medical indemnity cover for more than one person.

medical indemnity insurer means:

(a) a body corporate authorised under section 12 of the *Insurance Act 1973* that; or

(b) a Lloyd's underwriter within the meaning of that Act who;

in carrying on insurance business in Australia, enters into contracts of insurance providing medical indemnity cover for other persons.

medical indemnity payment legislation means the *Medical Indemnity (Run-off Cover Support Payment) Act 2004*.

medical practitioner means a person registered or licensed as a medical practitioner under a State or Territory law that provides for the registration or licensing of medical practitioners.

Note: Subsection (6) gives this definition an extended meaning in Division 2B or 4 of Part 2.

medical profession includes a health care related vocation.

medicare program has the same meaning as in the *Human Services (Medicare) Act 1973*.

member of an MDO has the meaning given by section 6.

participating MDO means UMP.

payment made in relation to a claim has (other than in Divisions 2A and 2D of Part 2) the meaning given by subsections (3) and (4).

practitioner's contract limit, in relation to a person for whom a contract of insurance provides medical indemnity cover, means the maximum amount payable, in aggregate, by the insurer under the contract in relation to claims against the person.

Note 1: If the contract provides medical indemnity cover for more than one person, there must be a separate contract limit for each of those persons.

Note 2: For how this definition applies if the contract provides for deductibles, see section 8B.

Note 3: For how this definition interacts with the high cost claim indemnity scheme and the allied health high cost claim indemnity scheme, see sections 34D and 34ZZJ.

private medical practice means practice as a medical practitioner, other than:

(a) practice consisting of treatment of public patients in a public hospital; or

(b) practice for which:

(i) the Commonwealth, a State or a Territory; or

(ii) a local governing body; or

(iii) an authority established under a law of the Commonwealth, a State or a Territory;

indemnifies medical practitioners from liability relating to compensation claims (within the meaning of the *Medical Indemnity (Prudential Supervision and Product Standards) Act 2003*); or

(c) practice conducted wholly outside both Australia and the external Territories; or

(d) practice of a kind specified in the rules.

professional indemnity cover: a contract of insurance with a medical practitioner provides ***professional indemnity cover*** if it provides medical indemnity cover for the practitioner in relation to the practitioner's private medical practice.

provable: an amount that an MDO or insurer is liable to pay is ***provable*** if:

(a) it is provable in the winding up of the MDO or insurer if the winding up of the MDO or insurer has commenced; or

(b) it would be provable in the winding up of the MDO or insurer if the MDO or insurer were to be wound up.

public hospital means a recognised hospital within the meaning of the *Health Insurance Act 1973*.

public patient has the same meaning as in the *Health Insurance Act 1973*.

qualifying allied health claim certificate means a certificate issued by the Chief Executive Medicare under section 34ZZK.

qualifying allied health liability, in relation to a claim, has the meaning given by section 34ZZS.

qualifying allied health payment: see subsection 34ZZB(4).

qualifying claim certificate means a certificate issued by the Chief Executive Medicare under section 34E.

qualifying liability, in relation to a claim, has the meaning given by section 34M.

qualifying payment: see subsection 30(2).

related body corporate has the same meaning as in the *Corporations Act 2001*.

relevant allied health threshold: see subsection 34ZZL(1).

relevant threshold: see subsection 34F(1).

risk surcharge has the meaning given by subsection 52C(1).

rules means the rules made under section 80.

run-off cover credit has the meaning given by subsection 34ZS(2).

run-off cover indemnity means a run-off cover indemnity paid or payable under Division 2B of Part 2.

Note: Amounts payable under regulations made for the purposes of section 34ZN (run-off claims payments) are not covered by this definition.

run-off cover support payment means a payment payable under Division 2 of Part 3.

Secretary means the Secretary of the Department.

subject to appeal: a judgment or order is ***subject to appeal*** until:

(a) any applicable time limits for lodging an appeal (however described) against the judgment or order have expired; and

(b) if there is such an appeal against the judgment or order—the appeal (and any subsequent appeals) have been finally disposed of.

total run-off cover credit has the meaning given by section 34ZS.

UMP means United Medical Protection Limited.

Notifications by practitioners may constitute claims

(1A) A reference in Division 2B of Part 2 to a claim includes a reference to a notification by or on behalf of a person of an incident, or a series of related incidents, if:

(a) at the time of the incident, or one or more of the incidents, the person was a medical practitioner; and

(b) the notification is to a medical indemnity insurer or an MDO; and

(c) at the time of the notification:

(i) a contract of insurance with the insurer provided the person with medical indemnity cover; or

(ii) an arrangement with the MDO provided medical indemnity cover (within the meaning of the *Medical Indemnity (Prudential Supervision and Product Standards) Act 2003*) for the person;

and the cover would have indemnified the person in relation to any claim relating to the incident, or series of incidents, if the claim had been made at the time of the notification.

The notification is taken, for the purposes of Division 2B of Part 2, to be a claim against the person.

Indemnifying

(2) To avoid doubt, a person may, for the purposes of this Act, ***indemnify*** someone else by either:

(a) making a payment; or

(b) agreeing to make a payment.

Note: A person may indemnify someone else by making a payment even if the payment was not preceded by an agreement to pay.

Payments in relation to claims

(3) For the purposes of this Act (other than Divisions 2A and 2D of Part 2):

(a) a payment is made ***in relation to a claim against a person*** if and only if the payment is made to:

(i) satisfy or settle the claim; or

(ii) meet legal and other expenses that are directly attributable to any negotiations, arbitration or proceedings in relation to the claim; and

(b) a payment is made ***in relation to a claim by a person*** if and only if the payment is made to meet legal and other expenses that are directly attributable to any negotiations, arbitration or proceedings in relation to the claim.

(4) A reference in this Act (other than Divisions 2A and 2D of Part 2) to a payment being made ***to satisfy or settle*** a claim against a person includes a reference to a payment that:

(a) is made to reimburse the person for a payment the person has made to satisfy or settle the claim; or

(b) is made to the person so that the person can make a payment to satisfy or settle the claim.

Changes in body corporate names

(5) A reference in this Act to a body corporate by a particular name is a reference to the body corporate that had that name on 30 June 2002.

Medical practitioners

(6) A reference in Division 2B or 4 of Part 2 to a medical practitioner includes a reference to a person who has been a medical practitioner.

5 Medical defence organisation (MDO)

(1) An ***MDO*** is a body corporate that is an MDO under subsection (2) or (3) or rules made for the purposes of subsection (4).

(2) Subject to rules made for the purposes of subsection (5), a body corporate is an ***MDO*** if:

(a) the body corporate is incorporated by or under a law of the Commonwealth, a State or a Territory; and

(b) the body corporate was in existence on 30 June 2002; and

(c) the body corporate, in the ordinary course of its business as at 30 June 2002, indemnified persons in relation to claims in relation to incidents that occurred in the course of, or in connection with, the practice of a medical profession by the persons; and

(d) did so only if the persons were one of the following:

(i) members or former members of the body corporate;

(ii) the legal personal representatives of members or former members of the body corporate.

This is so even if the indemnity is one that is provided at the body corporate's discretion.

(3) Subject to rules made for the purposes of subsection (5), each of the bodies corporate listed in the following table is an ***MDO***:

MDOs
Medical Defence Association of South Australia Limited
Medical Defence Association of Victoria Limited
Medical Defence Association of Western Australia (Incorporated)
Medical Indemnity Protection Society Limited
Medical Protection Society of Tasmania Inc.
Queensland Doctors Mutual Limited
United Medical Protection Limited

(4) The rules may provide that a body corporate specified in the rules is an ***MDO***.

(5) The rules may provide that a body corporate specified in the rules is not an MDO for the purposes of this Act.

6 Member of an MDO

(1) A person is a ***member*** of an MDO:

(a) at all times when the person is a member of the MDO according to the MDO's constitution; and

(b) no matter how the person's membership is described.

(2) Without limiting paragraph (1)(a), a person does not cease to be a ***member*** of an MDO merely because some or all of the person's rights and privileges as a member are suspended, have lapsed or have ceased.

(3) Without limiting paragraph (1)(b), a person is a ***member*** of an MDO even if the person is described by the MDO's constitution as:

(a) an associate member; or

(b) an honorary member; or

(c) a non-financial member; or

(d) a retired member; or

(e) a student member.

7 Incident-occurring based cover

(1) A person had ***incident-occurring based cover*** for an incident with an MDO on 30 June 2002 if:

(a) an arrangement between the MDO and the person, or between the MDO and someone else, existed on 30 June 2002; and

(b) under the arrangement, the MDO:

(i) would have been able to indemnify the person in relation to the incident if the person were to make a proper claim after 30 June 2002 in relation to the incident; and

(ii) would have been able, in the ordinary course of its business, to indemnify the person in relation to the incident even if the person had ceased to be a member of the MDO when the claim was made.

The person need not have been a member of the MDO on 30 June 2002 to have incident-occurring based cover for the incident.

Note: Subparagraph (b)(ii)—If the only cover the person had with the MDO was claims made cover, it would not be in the ordinary course of the MDO's business to indemnify the person if the claim was made after the person had ceased to be a member of the MDO.

(2) Subparagraph (1)(b)(i) is satisfied even if the MDO would be able to indemnify the person in relation to the incident only if the person were to make a claim during a limited period after 30 June 2002.

(2A) For the purposes of subparagraph 34ZB(1)(e)(ii), a person has ***incident-occurring based cover*** if, under an arrangement between an MDO and the person, the MDO:

(a) would be able to indemnify the person in relation to an incident if the person were to make a proper claim in relation to the incident; and

(b) would be able, in the ordinary course of its business, to indemnify the person in relation to the incident even if the person had ceased to be a member of the MDO when the claim was made.

(3) To avoid doubt, cover may be ***incident-occurring based cover*** even if it is called:

(a) claims incurred cover; or

(b) extended reporting benefit cover (ERB cover); or

(c) death, disability or retirement cover (DDR cover).

8 IBNR exposure of an MDO

(1) An MDO's ***IBNR exposure*** at a particular time is the total amount, at that time, of the payments that the MDO is likely to have to make after that time in relation to all claims that relate to incidents that satisfy subsection (2).

(2) An incident satisfies this subsection if:

(a) the incident occurred on or before 30 June 2002; and

(b) the incident occurred in the course of, or in connection with, the practice of a medical profession by a person; and

(c) on 30 June 2002, the person had incident-occurring based cover with the MDO for the incident; and

(d) the MDO:

(i) was not notified of the occurrence of the incident; and

(ii) was not notified of any claim against or by the person in relation to the incident;

before 1 July 2002.

8A Eligible related claims

(1) A claim or claims are ***eligible related claims*** in relation to a claim for which an application for a high cost claim indemnity or allied health high cost claim indemnity is made if:

(a) all the claims are made against the same person; and

(b) all the claims are made in relation to the same incident or series of related incidents; and

(c) either:

(i) all the claims are part of the same class action or representative proceeding; or

(ii) the incident, or series of related incidents, occurred in connection with a pregnancy or the birth of a child or children; and

(d) the application is the only application for a high cost claim indemnity or allied health high cost claim indemnity that has been made in relation to any of the claims; and

(e) none of the claims are eligible related claims in relation to another claim for which an application for a high cost claim indemnity or allied health high cost claim indemnity has been made.

(2) For the purposes of paragraphs (1)(d) and (e), disregard an application if it is withdrawn before payment is made in relation to the application.

8B Treatment of deductibles for the exceptional claims indemnity scheme and the allied health exceptional claims indemnity scheme

(1) This section applies if, under a contract of insurance that provides medical indemnity cover for a person (the ***practitioner***), the insurer is entitled to count an amount (the ***deductible amount***):

(a) incurred by the insurer in relation to a claim against the practitioner; or

(b) paid or payable by the practitioner or another person in relation to a claim against the practitioner;

towards the maximum amount payable, in aggregate, under the contract in relation to claims against the practitioner, even though the insurer has not paid, and is not liable to pay, the amount under the contract.

(2) For the purpose of the definition of ***practitioner's contract limit*** in subsection 4(1), the maximum amount payable, in aggregate, under the contract in relation to claims against the practitioner is as stated in the contract, even though the insurer (because of the deductible amount) may not actually be liable to pay the whole of that maximum amount.

(3) For the purpose of the references in paragraphs 34L(1)(e) and (f) and 34ZZR(1)(e) and (f) to an amount that an insurer has paid or is liable to pay under a contract of insurance, the deductible amount is to be counted as if it were an amount that the insurer has paid or is liable to pay under the contract.

(4) However, for the purpose of the references in paragraphs 34L(1)(e) and 34ZZR(1)(e) to an amount that an insurer would have been liable to pay under a contract of insurance, the deductible amount is not to be counted as if it were an amount that the insurer would have been liable to pay under the contract.

9 External Territories

This Act extends to every external Territory.

Part 2—Commonwealth payments

Division 1—IBNR (incurred but not reported) indemnity scheme

Subdivision A—Introduction

10 Guide to the IBNR indemnity provisions

(1) This Division provides that an IBNR indemnity may be paid to an MDO or insurer that makes, or is liable to make, a payment in relation to a claim against or by a person in relation to an incident that is covered by the IBNR indemnity scheme. The incident will only be covered by the scheme if, amongst other things, the person had incident-occurring based cover with the participating MDO for the incident on 30 June 2002.

(1A) This Division also provides for the regulations and rules to deal with other matters relating to incidents covered by the IBNR indemnity scheme.

(2) The following table tells you where to find the provisions dealing with various issues:

Where to find the provisions on various issues

Item	Issue	Provisions
1	which MDO is the participating MDO?	definition of ***participating MDO*** in subsection 4(1)
2	which incidents are covered by the scheme?	section 14
3	what conditions must be satisfied for an MDO or insurer to get the IBNR indemnity?	sections 15 to 19
4	what happens if the incidents	paragraph 19(a) and

Where to find the provisions on various issues		
Item	**Issue**	**Provisions**
	occurred during the treatment of a public patient in a public hospital?	section 20
5	how much is the IBNR indemnity?	section 21
6	in what circumstances can a payment to an MDO or insurer lead to a repayment of the IBNR indemnity?	sections 24 to 27
6A	what regulations can deal with	section 27A
7	how do MDOs and insurers apply for the IBNR indemnity?	section 36
8	when will the IBNR indemnity be paid?	section 37
9	what information has to be provided to the Chief Executive Medicare about IBNR indemnity matters?	sections 27C and 38
10	what records must MDOs and insurers keep?	sections 39 and 40
11	how are overpayments of the IBNR indemnity, and indemnity repayments, recovered?	sections 41 and 42

Subdivision C—Incidents covered by the IBNR indemnity scheme

14 Incidents covered by the IBNR indemnity scheme

The IBNR indemnity scheme covers an incident if:

(a) the incident occurred on or before 30 June 2002; and

(b) the incident occurred in the course of, or in connection with, the practice of a medical profession by a person; and

(c) on 30 June 2002, the person had incident-occurring based cover with an MDO for the incident; and

(d) the MDO:

(i) was not notified of the occurrence of the incident; and

(ii) was not notified of any claim against or by the person in relation to the incident;

before 1 July 2002; and

(e) the MDO is the participating MDO.

Subdivision D—IBNR indemnity

15 IBNR indemnity may be payable under either section 16 or 17

(1) An IBNR indemnity may be payable to an MDO or insurer under either section 16 or 17.

(2) To avoid doubt, an IBNR indemnity may be payable to an MDO or insurer under section 16 even if the MDO or insurer is a Chapter 5 body corporate.

(3) An IBNR indemnity is not payable to an MDO or insurer under section 16 in relation to a payment the MDO or insurer makes to discharge a liability in relation to a claim if an IBNR indemnity is paid to the MDO or insurer under section 17 in relation to the same liability.

16 IBNR indemnity for payment made by MDO or insurer

Basic payability rule

(1) An IBNR indemnity is payable to an MDO or insurer under this section if:

(a) the MDO or insurer makes a payment in relation to a claim against or by a person (the ***practitioner***); and

(b) the claim relates to:

(i) an incident that is covered by the IBNR indemnity scheme (see section 14); or

(ii) a series of related incidents that includes an incident that is covered by the scheme; and

(c) the practitioner had, on 30 June 2002, incident-occurring based cover with the participating MDO for the incident that is covered by the IBNR indemnity scheme; and

(d) if it is an MDO that makes the payment—the MDO makes the payment:
  (i) consistently with its constitution and the indemnity arrangement between the MDO and the practitioner; and
  (ii) in the ordinary course of its business; and
(e) if it is an insurer that makes the payment—the insurer makes the payment:
  (i) consistently with the terms of the insurance contract between the insurer and the practitioner; and
  (ii) in the ordinary course of its business; and
(f) the MDO or insurer applies to the Chief Executive Medicare for the IBNR indemnity in accordance with section 36.

(2) Subsection (1) has effect subject to:
(a) subsections (5) and (6) of this section; and
(b) subsection 15(3); and
(c) sections 19 and 20.

Basis on which payment made

(3) The IBNR indemnity is payable to the MDO or insurer regardless of the basis on which the payment is made by the MDO or insurer.

Note: If the criteria for the indemnity set out in subsection (1) are met, the indemnity may be payable to the MDO or insurer even if the MDO or insurer pays the practitioner on the basis of claims made cover the practitioner has with the MDO or insurer.

Payer need not be the participating MDO

(4) If the payment is made by an MDO, the MDO that makes the payment may be the participating MDO or may be a different MDO.

Payment by participating MDO

(5) If the payment is made by the participating MDO, the IBNR indemnity is payable only if the participating MDO:
(a) makes the payment; or

(b) could have made the payment;

in relation to the claim in relation to the incident covered by the IBNR indemnity scheme on the basis of incident-occurring based cover the practitioner had with the participating MDO for the incident on 30 June 2002.

Payment by someone else

(6) If the payment is not made by the participating MDO, the IBNR indemnity is payable only if the participating MDO could have made the payment in relation to the claim in relation to the incident covered by the IBNR indemnity scheme:

(a) consistently with its constitution and the indemnity arrangement between the MDO and the practitioner; and

(b) in the ordinary course of its business; and

(c) on the basis of incident-occurring based cover the practitioner had with the participating MDO on 30 June 2002;

if the practitioner made a proper claim in relation to the incident.

17 IBNR indemnity for MDO or insurer in external administration

Basic payability rule

(1) An IBNR indemnity is payable under this section to an MDO or insurer that is a Chapter 5 body corporate if:

(a) the MDO or insurer is liable to pay an amount in relation to a claim against or by a person (the ***practitioner***); and

(b) the claim relates to:

(i) an incident that is covered by the IBNR indemnity scheme (see section 14); or

(ii) a series of related incidents that includes an incident that is covered by the scheme; and

(c) the practitioner had, on 30 June 2002, incident-occurring based cover with the participating MDO for the incident that is covered by the IBNR indemnity scheme; and

(d) the amount that the MDO or insurer is liable to pay is provable; and

(e) if it is an MDO that is liable to pay the amount—the MDO could pay the amount:

(i) consistently with its constitution and the indemnity arrangement between the MDO and the practitioner; and

(ii) in the ordinary course of its business;

if it were not a Chapter 5 body corporate; and

(f) if it is an insurer that is liable to make the payment—the insurer could make the payment:

(i) consistently with the terms of the insurance contract between the insurer and the practitioner; and

(ii) in the ordinary course of its business;

if it were not a Chapter 5 body corporate; and

(g) the MDO or insurer applies to the Chief Executive Medicare for the IBNR indemnity in accordance with section 36.

(2) Subsection (1) has effect subject to:

(a) subsections (5) and (6) of this section; and

(b) sections 19 and 20.

Basis for liability to pay

(3) The IBNR indemnity is payable to the MDO or insurer regardless of the basis on which the amount is payable by the MDO or insurer.

Note: If the criteria for the indemnity set out in subsection (1) are met, the indemnity may be payable to the MDO or insurer even if the MDO or insurer is liable to pay on the basis of claims made cover the practitioner has with the MDO or insurer.

Person liable to pay need not be participating MDO

(4) If an MDO is liable to pay the amount, the MDO that is liable to pay the amount may be the participating MDO or may be a different MDO.

Participating MDO liable to pay

(5) If the amount is one that the participating MDO is liable to pay, the IBNR indemnity is payable only if the participating MDO could have paid the amount in relation to the claim in relation to the incident covered by the IBNR indemnity scheme on the basis of incident-occurring based cover the practitioner had with the participating MDO on 30 June 2002.

Someone else liable to pay

(6) If the amount is not one that the participating MDO is liable to pay, the IBNR indemnity is payable only if the participating MDO could have paid an amount in relation to the claim in relation to the incident covered by the IBNR indemnity scheme:

(a) consistently with its constitution and the indemnity arrangement between the participating MDO and the practitioner; and

(b) in the ordinary course of its business; and

(c) on the basis of incident-occurring based cover the practitioner had with the participating MDO on 30 June 2002;

if the practitioner made a proper claim in relation to the incident.

Indemnity to be paid on trust

(7) An IBNR indemnity paid to an MDO or insurer under this section is paid on trust for the benefit of the person to whom the MDO or insurer is liable to make the payment referred to in paragraph (1)(a).

18 Clarification of circumstances in which IBNR indemnity payable

An IBNR indemnity is payable to an MDO or insurer under section 16 or 17 in relation to a payment the MDO or insurer makes, or is liable to make, in relation to a claim even if:

(a) the MDO or insurer:

(i) has insured itself in relation to the payment; or

(ii) has already in fact been paid an amount by an insurer in relation to the payment; or

(b) the incident to which the claim relates occurred outside Australia; or

(c) the MDO or insurer made, or became liable to make, the payment before the commencement of this Act.

19 Exceptions

An IBNR indemnity is not payable to an MDO or insurer under section 16 or 17 in relation to a payment the MDO or insurer makes, or is liable to make, in relation to a claim against a person if:

(a) the incident, or all the incidents, to which the claim relates occurred in the course of the provision of treatment to a public patient in a public hospital; or

(c) the payment is an insurer-to-insurer payment; or

(ca) a run-off cover indemnity is payable to the MDO or insurer in relation to the same claim; or

(d) the payment is a payment specified in the rules for the purposes of this section.

20 Payment partly related to treatment of public patient in public hospital

(1) This section applies if:

(a) an MDO or insurer makes, or is liable to make, a payment in relation to a claim against a person in relation to a series of related incidents; and

(b) some, but not all, of the incidents occurred in the course of the provision of treatment to a public patient in a public hospital.

(2) For the purposes of this Subdivision:

(a) the payment is to be disregarded to the extent to which it relates to, or is reasonably attributable to, the incident or

incidents that occurred in the course of the provision of treatment to a public patient in a public hospital; and

(b) any amount that is paid or payable to the MDO or insurer in relation to the payment is to be disregarded to the extent to which it relates to, or is reasonably attributable to, the incident or incidents that occurred in the course of the provision of treatment to a public patient in a public hospital.

Note: Paragraph (b)—see subsection 21(2).

21 Amount of the IBNR indemnity

(1) The amount of the IBNR indemnity is the adjusted amount of the payment determined in accordance with subsection (2).

Note: In certain circumstances, an amount may be repayable under section 24.

(2) The adjusted amount of the payment is the amount obtained by deducting from the amount the MDO or insurer pays, or is liable to pay, the amount, or the sum of the amounts, that are:

(a) paid; or

(b) payable and liquidated at the time the amount of the IBNR indemnity is worked out;

to the MDO or insurer in relation to the payment the MDO or insurer makes or is liable to make.

(3) Without limiting subsection (2), the amounts to be deducted under that subsection include:

(a) any high cost claim indemnity that is paid or payable to the MDO or insurer in relation to the payment the MDO or insurer makes or is liable to make; and

(b) any amount that is paid or payable to the MDO or insurer because of a right to which the MDO or insurer is subrogated; and

(c) the amount of any payment specified in the rules.

(4) The following amounts are not to be deducted under subsection (2):

(a) any amount that is paid or payable to the MDO or insurer by way of an insurer-to-insurer payment;
(b) any amount that is paid or payable to the MDO or insurer by way of membership subscription or insurance premium;
(c) any amount that is payable under this Division;
(d) the amount of any payment specified in the rules.

Subdivision E—Recovery of amount paid to MDO or insurer after IBNR indemnity paid

24 Recovery if certain amounts paid to MDO or insurer after IBNR indemnity paid

(1) An MDO or insurer must repay an amount to the Commonwealth if:
(a) an IBNR indemnity has been paid to the MDO or insurer in relation to a claim against or by a person in relation to an incident; and
(b) an amount is paid to the MDO or insurer in relation to the payment the MDO or insurer made in relation to the incident; and
(c) that amount was not taken into account in calculating the amount of the IBNR indemnity paid to the MDO or insurer; and
(d) the amount is not an amount referred to in subsection 21(4); and
(e) the Chief Executive Medicare gives the MDO or insurer a notice in relation to the amount under section 26.

(2) The amount to be repaid is the amount referred to in paragraph (1)(b).

(4) The amount to be repaid is a debt due to the Commonwealth.

(5) The amount to be repaid may be recovered:
(a) by action by the Chief Executive Medicare against the MDO or insurer in a court of competent jurisdiction; or

(b) by deduction from the amount of an indemnity scheme payment payable to the MDO or insurer; or

(c) under section 42.

The total amount recovered must not exceed the amount to be repaid.

25 MDO or insurer to inform Chief Executive Medicare of certain amounts

(1) If:

(a) an IBNR indemnity is paid to an MDO or insurer in relation to a claim against or by a person in relation to an incident; and

(b) an amount to which section 24 applies is paid to the MDO or insurer;

the MDO or insurer must notify the Chief Executive Medicare that the amount has been paid to the MDO or insurer.

Note: Failure to notify is an offence (see section 46).

(2) The notification must:

(a) be in writing; and

(b) be given to the Chief Executive Medicare within 28 days after the day on which the amount is paid to the MDO or insurer.

26 Chief Executive Medicare to notify MDO or insurer of repayable amount

(1) If an amount to which section 24 applies is paid to an MDO or insurer, the Chief Executive Medicare may give the MDO or insurer a written notice that specifies:

(a) the amount that is repayable to the Commonwealth; and

(b) the day before which the amount must be repaid to the Commonwealth; and

(c) the effect of section 27.

The day specified under paragraph (b) must be at least 28 days after the day on which the notice is given.

(2) The amount becomes due and payable on the day specified under paragraph (1)(b).

27 Penalty imposed if an amount is repaid late

(1) If:

(a) an MDO or insurer must repay an amount to the Commonwealth under section 24; and

(b) the amount remains wholly or partly unpaid after it becomes due and payable;

the MDO or insurer is liable to pay a late payment penalty under this section.

(2) The late payment penalty is calculated:

(a) at the rate specified in the rules; and

(b) on the unpaid amount; and

(c) for the period:

(i) starting when the amount becomes due and payable; and

(ii) ending when the amount, and the penalty payable under this section in relation to the amount, have been paid in full.

(3) The Chief Executive Medicare may remit the whole or a part of an amount of late payment penalty if the Chief Executive Medicare considers that there are good reasons for doing so.

(4) An application may be made to the Administrative Appeals Tribunal for review of a decision of the Chief Executive Medicare not to remit, or to remit only part of, an amount of late payment penalty.

Note: Section 27A of the *Administrative Appeals Tribunal Act 1975* requires notification of a decision that is reviewable.

Subdivision F—Regulations may provide for payments

27A Regulations may provide for payments in relation to IBNR claims

(1) The regulations may provide in relation to:

(a) making payments to MDOs and insurers of claim handling fees; and

(b) making payments on account of legal, administrative or other costs incurred by MDOs and insurers (whether on their own behalf or otherwise);

in respect of claims relating to incidents covered by the IBNR indemnity scheme (see section 14).

(2) Without limiting subsection (1), the regulations may:

(a) make provision for:

(i) the conditions that must be satisfied for an amount to be payable to an MDO or insurer; and

(ii) the amount that is payable; and

(iii) the conditions that must be complied with by an MDO or insurer to which an amount is paid; and

(iv) other matters related to the making of payments, and the recovery of overpayments; and

(b) provide that this Division applies with specified modifications in relation to a liability that relates to costs in relation to which an amount has been paid under regulations made for the purposes of this section; and

(c) make provision for making payments on account of legal, administrative or other costs incurred by MDOs and insurers (whether on their own behalf or otherwise), in respect of incidents notified to MDOs and insurers that could give rise to claims in relation to which an IBNR indemnity could be payable.

(3) Paragraph (2)(b) does not allow the regulations to modify a provision that creates an offence, or that imposes an obligation which, if contravened, constitutes an offence.

(3A) It does not matter for the purposes of paragraph (2)(c) whether claims are subsequently made in relation to the incidents referred to in that paragraph.

27B The Chief Executive Medicare may request information

(1) If the Chief Executive Medicare believes that a person is capable of giving information that is relevant to determining:

(a) whether an MDO or insurer is entitled to a payment under regulations made for the purposes of section 27A; or

(b) the amount that is payable to an MDO or insurer under regulations made for the purposes of section 27A;

the Chief Executive Medicare may request the person to give the Chief Executive Medicare the information.

Note: Failure to comply with the request is an offence (see section 45).

(2) Without limiting subsection (1), any of the following persons may be requested to give information under that subsection:

(a) an MDO;

(b) an insurer;

(c) a member or former member of an MDO;

(d) a person who practises, or used to practise, a medical profession;

(e) a person who is acting, or has acted, on behalf of a person covered by paragraph (d);

(f) a legal personal representative of a person covered by paragraph (c), (d) or (e).

(3) Without limiting subsection (1), if the information sought by the Chief Executive Medicare is information relating to a matter in relation to which a person is required by section 39 to keep a record, the Chief Executive Medicare may request the person to give the information by giving the Chief Executive Medicare the record, or a copy of the record.

(4) The request:

(a) must be made in writing; and

(b) must state what information must be given to the Chief Executive Medicare; and

(c) may require the information to be verified by statutory declaration; and

(d) must specify a day on or before which the information must be given; and

(e) must contain a statement to the effect that a failure to comply with the request is an offence.

The day specified under paragraph (d) must be at least 28 days after the day on which the request was made.

Subdivision G—IBNR exposure

27C Process for annually reassessing IBNR exposure

Report by the Actuary

(1) For each financial year, the Actuary must give the Minister a written report that:

(a) states the Actuary's assessment of the participating MDO's IBNR exposure as at the end of the financial year; and

(b) sets out the reasons for the assessment.

(2) In preparing the report, the Actuary must take into account any information that the Chief Executive Medicare gives the Actuary in relation to the participating MDO under subsection (6).

Chief Executive Medicare's information gathering powers

(3) If the Chief Executive Medicare believes on reasonable grounds that the participating MDO is capable of giving information that is relevant to assessing the participating MDO's IBNR exposure as at the end of a financial year, the Chief Executive Medicare may request the participating MDO to give the Chief Executive Medicare the information.

Note: Failure to comply with the request is an offence (see section 45).

(4) Without limiting subsection (3), the kind of information that may be requested includes information in the form of:

(a) financial statements; and

(b) a report prepared by a suitably qualified actuary assessing the participating MDO's IBNR exposure as at the end of a financial year.

(5) The request:

(a) must be made in writing; and

(b) must state what information the participating MDO is to give to the Chief Executive Medicare; and

(c) may require the information to be verified by statutory declaration; and

(d) must specify the day on or before which the information must be given; and

(e) must contain a statement to the effect that a failure to comply with the request is an offence.

The day specified under paragraph (d) must be at least 28 days after the day on which the request is made.

(6) The Chief Executive Medicare must give any information that the participating MDO gives the Chief Executive Medicare to the Actuary for the purposes of preparing the report for the Minister under subsection (1).

Division 2—High cost claim indemnity scheme

Subdivision A—Introduction

28 Guide to the high cost claim indemnity provisions

(1) This Division provides that a high cost claim indemnity may be paid to an MDO or insurer that pays, or is liable to pay, more than a particular amount (referred to as the ***high cost claim threshold***) in relation to a claim against a person in relation to an incident that occurs in the course of, or in connection with, the person's practice as a medical practitioner.

(1A) This Division also provides for the regulations and rules to deal with other matters relating to incidents covered by the high cost claim indemnity scheme.

(2) The following table tells you where to find the provisions dealing with various issues:

Where to find the provisions on various issues

Item	Issue	Provisions
1	what is the high cost claim threshold?	section 29
2	what conditions must be satisfied for an MDO or insurer to get the high cost claim indemnity?	sections 30 to 32
3	what happens if the incidents occurred during the treatment of a public patient in a public hospital?	paragraph 32(a) and section 33
4	how much is the high cost claim indemnity?	section 34
4A	what regulations can deal with	section 34AA
5	how do MDOs and insurers apply for the high cost claim indemnity?	section 36

Where to find the provisions on various issues		
Item	**Issue**	**Provisions**
6	when will the high cost claim indemnity be paid?	section 37
7	what information has to be provided to the Chief Executive Medicare about high cost indemnity matters?	section 38
8	what records must MDOs and insurers keep?	section 39
9	how are overpayments of high cost claim indemnity recovered?	sections 41 and 42

29 High cost claim threshold

(1) The ***high cost claim threshold*** is:
  (a) $2 million; or
  (b) such other amount as is specified in the rules.

(2) Rules that specify an amount for the purposes of paragraph (1)(b) that increases the high cost claim threshold at the time the rules are registered on the Federal Register of Legislation must not commence earlier than 12 months after the day on which the rules are so registered.

Subdivision B—High cost claim indemnity

30 Circumstances in which high cost claim indemnity payable

Basic payability rule

(1) Subject to section 31, a high cost claim indemnity is payable to an MDO or insurer under this section if:
  (a) a claim is, or was, made against a person (the ***practitioner***); and
  (b) the claim relates to:
    (i) an incident that occurs or occurred; or

(ii) a series of related incidents that occur or occurred;

in the course of, or in connection with, the practitioner's practice as a medical practitioner; and

(c) either:

(i) the incident occurs or occurred; or

(ii) one or more of the incidents in the series occurs or occurred;

in Australia or in an external Territory; and

(d) the MDO or insurer is first notified of:

(i) the incident; or

(ii) the claim; or

(iii) an eligible related claim;

between 1 January 2003 and the date specified in the rules as the termination date for the high cost claim indemnity scheme; and

(e) the MDO or insurer has a qualifying payment in relation to the claim, or qualifying payments in relation to:

(i) the claim; or

(ii) the claim and one or more eligible related claims; and

(f) the amount of the qualifying payment, or the sum of the amounts of the qualifying payments, exceeds what was the high cost claim threshold at the earliest of the following times:

(i) when the MDO or insurer was first notified of the incident;

(ii) when the MDO or insurer was first notified of the claim;

(iii) when the MDO or insurer was first notified of an eligible related claim; and

(g) any other requirements (however described) that are specified in the rules have been met.

The claim referred to in paragraph (a) may be one that was made before, or is made after, the commencement of this Act and an incident referred to in paragraph (b) may be one that occurred before, or occurs after, the commencement of this Act.

(1A) Rules made for the purposes of paragraph (1)(g) do not apply in relation to an incident if the claim relating to the incident was made before the rules in question commence.

Qualifying payments

(2) The MDO or insurer has a ***qualifying payment*** in relation to a claim if:

(a) the MDO or insurer:

(i) pays an amount in relation to the claim; or

(ii) is liable to pay an amount in relation to a payment or payments that someone makes, or is liable to make, in relation to the claim under a written agreement between the parties to the claim; or

(iii) is liable to pay an amount in relation to a payment or payments that someone makes, or is liable to make, in relation to the claim under a judgment or order of a court that is not stayed and is not subject to appeal; or

(iv) is a Chapter 5 body corporate and is liable to pay a provable amount in relation to the claim; and

(b) the MDO or insurer pays, or is liable to pay, the amount under an insurance contract or other indemnity arrangement between the MDO or insurer and the practitioner; and

(c) the MDO or insurer:

(i) pays, or becomes liable to pay, the amount in the ordinary course of the MDO's or the insurer's business; or

(ii) is a Chapter 5 body corporate and would be able to pay the amount in the ordinary course of the MDO's or the insurer's business if it were not a Chapter 5 body corporate.

(3) The date specified in the rules for the purposes of paragraph (1)(d) must be at least 12 months after the day on which the rules in question are registered on the Federal Register of Legislation.

Indemnity to be paid on trust if MDO or insurer under external administration

(5) If a high cost claim indemnity is paid to an MDO or insurer that is a Chapter 5 body corporate, the indemnity is, to the extent to which it is attributable to an amount that the MDO or insurer is liable to pay to a person, paid on trust for the benefit of that person.

31 Aggregating amounts paid or payable by an MDO and insurer

(1) This section applies if:

(a) an MDO pays, or is liable to pay, an amount in relation to a claim that relates to an incident or a series of incidents; and

(b) an insurer also pays, or is also liable to pay, an amount (the ***insurer amount***) in relation to the same claim or in relation to an eligible related claim; and

(c) but for this section, a high cost claim indemnity in respect of the insurer amount:

(i) would be payable to the insurer under subsection 30(1); or

(ii) would be payable to the insurer under that subsection if paragraph 30(1)(f) were omitted; and

(d) the insurer elects in writing to have this section apply to the insurer amount.

(2) For the purposes of this Division (other than this section):

(a) the MDO is taken:

(i) to have paid, or to be liable to pay, the insurer amount in relation to the claim or eligible related claim; and

(ii) to satisfy paragraphs 30(1)(e) and (2)(a) to (c) in relation to the insurer amount; and

(iii) to have been notified of the incident, claim or eligible related claim when the insurer was first notified of the incident, claim or eligible related claim; and

(b) a high cost claim indemnity is not payable to the insurer in respect of the insurer amount.

32 Exceptions

A high cost claim indemnity is not payable to an MDO or insurer under section 30 in relation to a payment the MDO or insurer makes, or is liable to make, in relation to a claim against a person if:

(a) the incident, or all the incidents, to which the claim relates occurred in the course of the provision of treatment to a public patient in a public hospital; or

(b) the claim is specified in the rules; or

(c) the claim relates to an incident specified in the rules.

33 Payment partly related to treatment of public patient in public hospital

(1) This section applies if:

(a) an MDO or insurer makes, or is liable to make, a payment in relation to a claim against a person in relation to a series of related incidents; and

(b) some, but not all, of the incidents occurred in the course of the provision of treatment to a public patient in a public hospital.

(2) For the purposes of this Subdivision, the payment is to be disregarded to the extent to which it relates to, or is reasonably attributable to, the incident or incidents that occurred in the course of the provision of treatment to a public patient in a public hospital.

34 Amount of high cost claim indemnity

(1) The amount of a high cost claim indemnity is:

(a) 50%; or

(b) such other percentage as is specified in the rules;

of the amount by which the amount of the MDO's or insurer's qualifying payment, or the sum of the amounts of the MDO's or insurer's qualifying payments, exceeds the high cost claim threshold.

(2) Rules that specify for the purposes of paragraph (1)(b) a percentage that is less than the percentage in force at the time the rules are registered on the Federal Register of Legislation must not commence earlier than 12 months after the day on which the rules are so registered.

Subdivision C—Regulations may provide for payments

34AA Regulations may provide for payments in relation to high cost claims

(1) The regulations may provide in relation to:

(a) making payments to MDOs and insurers of claim handling fees; and

(b) making payments on account of legal, administrative or other costs incurred by MDOs and insurers (whether on their own behalf or otherwise);

in respect of claims relating to incidents in relation to which a high cost claim indemnity is payable (see section 30).

(2) Without limiting subsection (1), the regulations may:

(a) make provision for:

(i) the conditions that must be satisfied for an amount to be payable to an MDO or insurer; and

(ii) the amount that is payable; and

(iii) the conditions that must be complied with by an MDO or insurer to which an amount is paid; and

(iv) other matters related to the making of payments, and the recovery of overpayments; and

(b) provide that this Division applies with specified modifications in relation to a liability that relates to costs in relation to which an amount has been paid under regulations made for the purposes of this section; and

(c) make provision for making payments on account of legal, administrative or other costs incurred by MDOs and insurers (whether on their own behalf or otherwise), in respect of incidents notified to MDOs and insurers that could give rise

to claims in relation to which a high cost claim indemnity could be payable.

(3) Paragraph (2)(b) does not allow the regulations to modify a provision that creates an offence, or that imposes an obligation which, if contravened, constitutes an offence.

(4) It does not matter for the purposes of paragraph (2)(c) whether claims are subsequently made in relation to the incidents referred to in that paragraph.

34AB The Chief Executive Medicare may request information

(1) If the Chief Executive Medicare believes that a person is capable of giving information that is relevant to determining:

(a) whether an MDO or insurer is entitled to a payment under regulations made for the purposes of section 34AA; or

(b) the amount that is payable to an MDO or insurer under regulations made for the purposes of section 34AA;

the Chief Executive Medicare may request the person to give the Chief Executive Medicare the information.

Note: Failure to comply with the request is an offence (see section 45).

(2) Without limiting subsection (1), any of the following persons may be requested to give information under that subsection:

(a) an MDO;

(b) an insurer;

(c) a member or former member of an MDO;

(d) a person who practises, or used to practise, a medical profession;

(e) a person who is acting, or has acted, on behalf of a person covered by paragraph (d);

(f) a legal personal representative of a person covered by paragraph (c), (d) or (e).

(3) Without limiting subsection (1), if the information sought by the Chief Executive Medicare is information relating to a matter in relation to which a person is required by section 39 to keep a

record, the Chief Executive Medicare may request the person to give the information by giving the Chief Executive Medicare the record, or a copy of the record.

(4) The request:

(a) must be made in writing; and

(b) must state what information must be given to the Chief Executive Medicare; and

(c) may require the information to be verified by statutory declaration; and

(d) must specify a day on or before which the information must be given; and

(e) must contain a statement to the effect that a failure to comply with the request is an offence.

The day specified under paragraph (d) must be at least 28 days after the day on which the request was made.

Division 2A—Exceptional claims indemnity scheme

Subdivision A—Introduction

34A Guide to the exceptional claims indemnity provisions

(1) This Division provides that an exceptional claims indemnity may be paid in relation to a liability of a person if:

(a) the liability relates to a claim against the person in relation to an incident that occurs in the course of, or in connection with, the person's practice as a medical practitioner, being a claim that has been certified as a qualifying claim; and

(b) the liability exceeds the amount payable under an insurance contract that has a contract limit satisfying the relevant threshold.

(2) This Division also provides for the regulations and rules to deal with other matters relating to claims that have been certified as qualifying claims.

(3) The following table tells you where to find the provisions dealing with various issues:

Where to find the provisions on various issues

Item	Issue	Provisions
1	certification of claims that qualify for exceptional claims indemnity (including the threshold requirement for the insurance contract)	sections 34E to 34K
2	when is an exceptional claims indemnity payable in respect of a liability?	sections 34L and 34M
3	some liabilities are only partly covered	sections 34N and 34O
4	how much exceptional claims indemnity is payable?	section 34P

Where to find the provisions on various issues		
Item	**Issue**	**Provisions**
5	how must an exceptional claims indemnity be applied?	section 34Q
6	who is liable to repay an overpayment of exceptional claims indemnity?	section 34R
7	what if a payment is received that would have reduced the amount of an insurance payment?	sections 34S to 34W
8	what regulations can deal with	section 34X
9	modifications and exclusions by regulations	section 34Z
10	how does a person apply for an exceptional claims indemnity?	section 37A
11	when will an exceptional claims indemnity be paid?	section 37B
12	what information has to be provided to the Chief Executive Medicare about exceptional claims matters?	section 38
13	what records must be kept in relation to exceptional claims matters?	section 39
14	how are overpayments of exceptional claims indemnity recovered?	sections 41 and 42

34D Interaction with high cost claim indemnity scheme and run-off cover indemnity scheme

For the purposes of the definition of ***practitioner's contract limit*** in subsection 4(1), and of paragraphs 34L(1)(e) and (f), an amount that an insurer has paid or is liable to pay, or would have been liable to pay, under a contract of insurance is not to be reduced on account of a high cost claim indemnity, or a run-off cover indemnity, paid or payable, or that would have been payable, to the insurer.

Subdivision B—Certification of qualifying claims

34E When may the Chief Executive Medicare certify a claim as a qualifying claim?

Criteria for certification

(1) The Chief Executive Medicare may issue a certificate stating that a claim is a qualifying claim if the Chief Executive Medicare is satisfied that:

(a) the claim is a claim that is or was made against a person (the ***practitioner***); and

(b) the claim relates to:

(i) an incident that occurs or occurred; or

(ii) a series of related incidents that occur or occurred;

in the course of, or in connection with, the practitioner's practice as a medical practitioner; and

(c) except in the circumstances specified in rules made for the purposes of this paragraph, either:

(i) the incident occurs or occurred; or

(ii) one or more of the incidents in the series occurs or occurred;

in Australia or an external Territory; and

(d) the incident did not occur, or the incidents did not all occur, in the course of the provision of treatment to a public patient in a public hospital; and

(e) there is a contract of insurance in relation to which the following requirements are satisfied:

(i) the contract provides medical indemnity cover for the practitioner in relation to the claim, or would, but for the practitioner's contract limit, provide such cover for the practitioner in relation to the claim;

(ii) the practitioner's contract limit equals or exceeds the relevant threshold (see section 34F);

(iii) the insurer is a general insurer, within the meaning of the *Insurance Act 1973*;

(iv) the insurer entered into the contract in the ordinary course of the insurer's business; and

(f) the insurer was first notified of the claim, or of facts that might give rise to the claim, on or after 1 January 2003; and

(g) if a termination date for the exceptional claims indemnity scheme is set (see section 34G), the incident, or one or more of the incidents, to which the claim relates occurred before the exceptional claims termination date; and

(h) the claim is not a claim specified in rules made for the purposes of this paragraph; and

(i) the contract of insurance is not a contract specified in rules made for the purposes of this paragraph; and

(j) a person has applied for the certificate in accordance with section 34H.

Note 1: Paragraph (d)—for what happens if some, but not all, of the incidents in a series occur in the course of the provision of treatment to a public patient in a public hospital, see section 34N.

Note 2: Paragraph (g)—for what happens if some, but not all, of the incidents in a series occur after the exceptional claims termination date, see section 34O.

Certain eligible run-off claims may relate to treatment of public patients in public hospitals

(1A) Paragraph (1)(d) does not apply to an eligible run-off claim if:

(a) the claim relates to an incident that occurred, or a series of incidents that occurred, before 1 July 2003; and

(b) at the time the incident, or one or more of the incidents, occurred, there was an arrangement with an MDO under which the MDO would have been able to indemnify the practitioner in relation to the incident or series of incidents if the claim had been made while the arrangement had effect; and

(c) at the time the claim is made, a contract of insurance with a medical indemnity insurer provides medical indemnity cover for the practitioner; and

(d) the medical indemnity cover is provided under an arrangement of a kind referred to in paragraph 26B(1)(f) of the *Medical Indemnity (Prudential Supervision and Product Standards) Act 2003*; and

(e) the medical indemnity cover satisfies all of the requirements of subsection 26A(4) of that Act.

When a certificate is in force

(2) The certificate comes into force when it is issued and remains in force until it is revoked.

Matters to be identified or specified in certificate

(3) The certificate must:

(a) identify:

(i) the practitioner; and

(ii) the claim; and

(iii) the contract of insurance in relation to which paragraph (1)(e) is satisfied; and

(b) specify the relevant threshold.

The certificate may also contain other material.

AAT review of decision to refuse

(4) An application may be made to the Administrative Appeals Tribunal for review of a decision of the Chief Executive Medicare to refuse to issue a qualifying claim certificate.

Note: Section 27A of the *Administrative Appeals Tribunal Act 1975* requires notification of a decision that is reviewable.

Chief Executive Medicare to give applicant copy of certificate

(5) If the Chief Executive Medicare decides to issue a qualifying claim certificate, the Chief Executive Medicare must, within 28 days of making his or her decision, give the applicant a copy of the certificate. However, a failure to comply does not affect the validity of the decision.

34F What is the relevant threshold?

The relevant threshold

(1) The ***relevant threshold*** is:

(a) if the insurer was first notified of the claim, or of facts that might give rise to the claim, on or after 1 January 2003 and before 1 July 2003—$15 million; or

(b) if the insurer is or was first notified of the claim, or of facts that might give rise to the claim, on or after 1 July 2003—$20 million, or such other amount as is specified in the rules as the threshold.

Threshold specified in rules only applies to contracts entered into after the rules commence

(2) A rule specifying an amount as the threshold (or changing the amount previously so specified) only applies in relation to contracts of insurance entered into after the rule commences.

When rules reducing the threshold commence

(3) A rule reducing the threshold (which could be the threshold originally applicable under subsection (1), or that threshold as already changed by rules) commences on the date specified in the rules, which must be the date on which the rules are registered on the Federal Register of Legislation or a later day.

When rules increasing the threshold commence

(4) A rule increasing the threshold (which could be the threshold originally applicable under subsection (1), or that threshold as already changed by rules), commences on the date specified in the rules, which must be at least 3 months after the date on which the rules are registered on the Federal Register of Legislation.

34G Setting the exceptional claims termination date

(1) The rules may set a termination date for the exceptional claims indemnity scheme.

Note: The scheme does not cover incidents that occur after the exceptional claims termination date (see paragraph 34E(1)(g) and section 34O).

(2) The termination date cannot be before the date on which the rules are registered on the Federal Register of Legislation.

34H Application for a qualifying claim certificate

(1) An application for the issue of a qualifying claim certificate in relation to a claim may be made by the person against whom the claim is or was made, or by a person acting on that person's behalf.

(2) The application must:
(a) be made in writing using a form approved by the Chief Executive Medicare; and
(b) be accompanied by the documents and other information required by the form approved by the Chief Executive Medicare.

34I Time by which an application must be decided

(1) Subject to subsections (2) and (3), the Chief Executive Medicare is to decide an application for the issue of a qualifying claim certificate on or before the 21st day after the day on which the application is received by the Chief Executive Medicare.

(2) If the Chief Executive Medicare requests a person to give information under section 38 in relation to the application, the Chief Executive Medicare does not have to decide the application until the 21st day after the day on which the person gives the information to the Chief Executive Medicare.

(3) The Chief Executive Medicare may treat an application as having been withdrawn if:

(a) the Chief Executive Medicare requests the person who applied for the certificate to give information under section 38 in relation to the application; and

(b) the person does not give the information to the Chief Executive Medicare by the end of the day specified in the request.

(4) The Chief Executive Medicare must notify the person who applied for the certificate if the Chief Executive Medicare treats the application as having been withdrawn.

34J Obligation to notify the Chief Executive Medicare if information is incorrect or incomplete

(1) If:

(a) a qualifying claim certificate is in force in relation to a claim; and

(b) a person becomes aware that the information provided to the Chief Executive Medicare in connection with the application for the certificate was incorrect or incomplete, or is no longer correct or complete; and

(c) the person is:

(i) the person who applied for the certificate; or

(ii) another person who has applied for a payment of exceptional claims indemnity, or for a payment under regulations made for the purposes of section 34X (exceptional claims payments), in relation to the claim;

the person must notify the Chief Executive Medicare of the respect in which the information was incorrect or incomplete, or is no longer correct or complete.

Note: Failure to notify is an offence (see section 46).

(2) The notification must:

(a) be made in writing; and

(b) be given to the Chief Executive Medicare within 28 days after the person becomes aware as mentioned in subsection (1).

34K Revocation and variation of qualifying claim certificates

Revocation

(1) The Chief Executive Medicare may revoke a qualifying claim certificate if the Chief Executive Medicare is no longer satisfied as mentioned in subsection 34E(1) in relation to the claim.

(2) To avoid doubt, in considering whether he or she is still satisfied as mentioned in subsection 34E(1) in relation to the claim, the Chief Executive Medicare may have regard to matters that have occurred since the decision to issue the qualifying claim certificate was made, including for example:

(a) the making of rules for the purpose of paragraph 34E(1)(h) or (i); or

(b) changes to the terms and conditions of the contract of insurance identified in the certificate.

Variation

(3) If the Chief Executive Medicare is satisfied that a matter is not correctly identified or specified in a qualifying claim certificate, the Chief Executive Medicare may vary the certificate so that it correctly identifies or specifies the matter.

Effect of revocation

(4) If:

(a) the Chief Executive Medicare revokes a qualifying claim certificate; and

(b) an amount of exceptional claims indemnity has already been paid in relation to the claim;

the amount is an amount overpaid to which section 41 applies.

Effect of variation

(5) If:

(a) the Chief Executive Medicare varies a qualifying claim certificate; and

(b) an amount of exceptional claims indemnity has already been paid in relation to the claim, and that amount exceeds the amount that would have been paid if the amount of indemnity had been determined having regard to the certificate as varied;

the amount of the excess is an amount overpaid to which section 41 applies.

AAT review of decision to revoke or vary

(6) An application may be made to the Administrative Appeals Tribunal for review of a decision of the Chief Executive Medicare to revoke or vary a qualifying claim certificate.

Note: Section 27A of the *Administrative Appeals Tribunal Act 1975* requires notification of a decision that is reviewable.

Chief Executive Medicare to give applicant copy of varied certificate

(7) If the Chief Executive Medicare decides to vary a qualifying claim certificate, the Chief Executive Medicare must, within 28 days of making his or her decision, give the applicant a copy of the varied certificate. However, a failure to comply does not affect the validity of the decision.

Subdivision C—Exceptional claims indemnity

34L When is an exceptional claims indemnity payable?

Criteria for payment of indemnity

(1) The Chief Executive Medicare may decide that an exceptional claims indemnity is payable in relation to a liability of a person (the ***practitioner***) if:

(a) a claim for compensation or damages (the ***current claim***) is, or was, made against the practitioner by another person; and

(b) a qualifying claim certificate is in force in relation to the current claim; and

(c) the liability is a qualifying liability of the practitioner in relation to the current claim (see section 34M); and

(d) because of the practitioner's contract limit in relation to the contract of insurance identified in the qualifying claim certificate, the contract does not cover, or does not fully cover, the liability; and

(e) the amount that, if the practitioner's contract limit had been high enough to cover the whole of the liability, the insurer would (subject to the other terms and conditions of the contract) have been liable to pay under the contract of insurance in relation to the liability exceeds the actual amount (if any) that the insurer has paid or is liable to pay under the contract in relation to the liability; and

(f) the aggregate of:

(i) the amount (if any) the insurer has paid, or is liable to pay, in relation to the liability under the contract of insurance; and

(ii) the other amounts (if any) that the insurer has already paid, or has already become liable to pay, under the contract in relation to the current claim; and

(iii) the amounts (if any) that the insurer has already paid, or has already become liable to pay, under the contract in relation to other claims against the practitioner (being other claims that were first notified to the insurer no later than the time the current claim was notified to the insurer);

equals or exceeds the relevant threshold identified in the qualifying claim certificate; and

(g) a person has applied for the indemnity in accordance with section 37A.

Note 1: For how paragraphs (e) and (f) apply:

(a) if there are deductibles—see section 8B; or

(b) if a high cost claim indemnity or a run-off cover indemnity is paid or payable—see section 34D; or

(c) if the insurer is a Chapter 5 body corporate—see subsection (4); or

(d) if the claim relates to a series of incidents some, but not all, of which occurred in the course of the provision of treatment to a public patient in a public hospital—see section 34N; or

(e) if the claim relates to a series of incidents some, but not all, of which occurred after the exceptional claims termination date—see section 34O.

Note 2: For the purpose of subparagraphs (f)(i) and (ii), payments and liabilities to pay must meet the ordinary course of business requirement set out in subsection (3).

Who the indemnity is payable to

(2) The indemnity is to be paid to the person who applies for it.

Note: For who can apply, see section 37A.

Ordinary course of business test for insurance payments

(3) An amount that an insurer has paid, or is liable to pay, under a contract of insurance does not count for the purpose of subparagraph (1)(f)(i) or (ii) unless it is an amount that the insurer paid, or is liable to pay, in the ordinary course of the insurer's business.

What if the insurer is a Chapter 5 body corporate?

(4) If an insurer is a Chapter 5 body corporate:

(a) a reference in paragraphs (1)(e) and (f) to an amount that the insurer is liable to pay under a contract of insurance is a reference to an amount that the insurer is liable to pay under the contract and that is a provable amount; and

(b) a reference in subsection (3) to an amount that an insurer is liable to pay in the ordinary course of the insurer's business is a reference to an amount that the insurer is liable to pay, and would be able to pay in the ordinary course of the insurer's business if it were not a Chapter 5 body corporate.

AAT review of decision to refuse, or to pay a particular amount of indemnity

(5) An application may be made to the Administrative Appeals Tribunal for review of a decision of the Chief Executive Medicare to refuse an application for exceptional claims indemnity, or a decision of the Chief Executive Medicare to pay a particular amount of exceptional claims indemnity.

Note: Section 27A of the *Administrative Appeals Tribunal Act 1975* requires notification of a decision that is reviewable.

34M Qualifying liabilities

A person (the ***practitioner***) has a ***qualifying liability*** in relation to a claim made against the person if:

(a) one of the following applies:
  (i) the liability is under a judgment or order of a court in relation to the claim, being a judgment or order that is not stayed and is not subject to appeal;
  (ii) the liability is under a settlement of the claim that takes the form of a written agreement between the parties to the claim;
  (iii) the liability is some other kind of liability of the practitioner (for example, a liability to legal costs) that relates to the claim; and

(b) the defence of the claim against the practitioner was conducted appropriately up to the time when:
  (i) if the liability is under a judgment or order of a court—the date on which the judgment or order became a judgment or order that is not stayed and is not subject to appeal; or
  (ii) if the liability is under a settlement of the claim—the date on which the settlement agreement was entered into; or
  (iii) if the liability is some other kind of liability—the date on which the liability was incurred; and

(c) if the liability is under a settlement of the claim, or is under a consent order made by a court—a legal practitioner has given a statutory declaration certifying that the amount of the liability is reasonable.

Note: For paragraph (b), see the definitions of ***defence*** and ***conducted appropriately*** in subsection 4(1).

34N Treatment of a claim that partly relates to a public patient in a public hospital

If:

(a) a claim against a person relates to a series of incidents; and

(b) some, but not all, of the incidents occurred in the course of the provision of treatment to a public patient in a public hospital;

then, for the purposes of applying paragraph 34L(1)(e) and subparagraphs 34L(1)(f)(i) and (ii) in relation to the claim, an amount that an insurer has paid or is liable to pay, or would have been liable to pay, in relation to the claim, is to be reduced by the extent (if any) to which the amount relates or would relate to, or is or would be reasonably attributable to, the incident or incidents that occurred in the course of the provision of treatment to a public patient in a public hospital.

34O Treatment of a claim that relates to a series of incidents some of which occurred after the exceptional claims termination date

If:

(a) a claim against a person relates to a series of incidents; and

(b) some, but not all, of the incidents occurred after the exceptional claims termination date;

then, for the purposes of applying paragraph 34L(1)(e) and subparagraphs 34L(1)(f)(i) and (ii) in relation to the claim, an amount that an insurer has paid or is liable to pay, or would have been liable to pay, in relation to the claim, is to be reduced by the extent (if any) to which the amount relates or would relate to, or is

or would be reasonably attributable to, the incident or incidents that occurred after the exceptional claims termination date.

34P The amount of exceptional claims indemnity that is payable

The amount of exceptional claims indemnity that is payable in relation to a particular qualifying liability is the amount of the excess referred to in paragraph 34L(1)(e).

Note: It is only liabilities that exceed the practitioner's contract limit that will be covered by an exceptional claims indemnity (even if the relevant threshold is less than that limit).

34Q How exceptional claims indemnity is to be applied

(1) This section applies if an exceptional claims indemnity is paid to a person (the ***recipient***) in relation to a liability of a person (the ***practitioner***).

Note: The recipient will either be the practitioner himself or herself, or a person acting on behalf of the practitioner.

Chief Executive Medicare to give recipient of payment a notice identifying the liability to be discharged

(2) The Chief Executive Medicare must give the recipient a written notice (the ***payment notice***) identifying the liability in relation to which the indemnity is paid, and advising the recipient how this section requires the indemnity to be dealt with.

Recipient's obligation if the amount of the indemnity equals or is less than the liability

(3) If the amount of the indemnity equals or is less than the undischarged amount of the liability identified in the payment notice, the recipient must apply the whole of the indemnity towards the discharge of the liability.

Recipient's obligation if the amount of the indemnity exceeds the liability

(4) If the amount of the indemnity is greater than the undischarged amount of the liability identified in the payment notice, the recipient must:

(a) apply so much of the indemnity as equals the undischarged amount of the liability towards the discharge of the liability; and

(b) if the recipient is not the practitioner—deal with the balance of the indemnity in accordance with the directions of the practitioner.

Time by which recipient must comply with obligation

(5) The recipient must comply with whichever of subsections (3) and (4) applies:

(a) by the time specified in a written direction (whether contained in the payment notice or otherwise) given to the recipient by the Chief Executive Medicare; or

(b) if no such direction is given to the recipient—as soon as practicable after the indemnity is received by the recipient.

To avoid doubt, the Chief Executive Medicare may vary a direction under paragraph (a) to specify a different time.

Debt to Commonwealth if recipient does not comply with obligation on time

(6) If the recipient does not comply with whichever of subsections (3) and (4) applies by the time required by subsection (5), the amount of the indemnity is a debt due to the Commonwealth.

(7) The debt may be recovered:

(a) by action by the Chief Executive Medicare against the recipient in a court of competent jurisdiction; or

(b) under section 42.

(8) If the amount of the indemnity is recoverable, or has been recovered, as mentioned in subsection (7), no amount is recoverable under section 34T or section 41 in relation to the same payment of exceptional claims indemnity.

34R Who is liable to repay an overpayment of exceptional claims indemnity?

(1) This section applies if, in relation to an exceptional claims indemnity that has been paid, there is an amount overpaid as described in subsection 34T(2) or 41(2).

(2) The ***liable person***, in relation to the amount overpaid, is:

(a) if the indemnity has not yet been dealt with in accordance with whichever of subsections 34Q(3) and (4) applies—the recipient referred to in subsection 34Q(1); or

(b) if the indemnity has been dealt with in accordance with whichever of those subsections applies—the practitioner referred to in subsection 34Q(1).

Note: The recipient and the practitioner will be the same person if the indemnity was paid to the practitioner.

(3) If:

(a) the recipient and the practitioner referred to in subsection 34Q(1) are not the same person; and

(b) when the overpayment is recovered as a debt, the liable person is the recipient;

the fact that the recipient may later deal with the remainder of the indemnity in accordance with subsection 34Q(3) or (4) does not mean that the overpayment should instead have been recovered from the practitioner.

Subdivision D—Payments that would have reduced the amount paid out under the contract of insurance

34S Amounts paid before payment of exceptional claims indemnity

(1) If:

(a) an amount (the ***insurance payment***) has been paid under a contract of insurance that provides medical indemnity cover for a person (the ***practitioner***) in relation to a liability of the practitioner; and

(b) another amount (not being an amount referred to in subsection (2)) has been paid to the practitioner, the insurer or another person in relation to the incident or incidents to which the liability relates; and

(c) the other amount was not taken into account in working out the amount of the insurance payment; and

(d) if the other amount had been taken into account in working out the amount of the insurance payment, a lesser amount would have been paid under the contract of insurance in relation to the liability;

then, for the purpose of calculating the amount of exceptional claims indemnity (if any) that is payable in relation to a liability of the practitioner, the lesser amount is taken to have been the amount of the insurance payment.

(2) This section does not apply to any of the following:

(a) an amount paid to an insurer by another insurer under a right of contribution;

(b) a payment of high cost claim indemnity;

(ba) a payment of run-off cover indemnity;

(c) an amount of a kind specified in the rules for the purposes of this paragraph.

34T Amounts paid after payment of exceptional claims indemnity

(1) This section applies if:

(a) an amount (the ***actual indemnity amount***) of exceptional claims indemnity has been paid in relation to a qualifying liability that relates to a claim made against a person (the ***practitioner***); and

(b) another amount (not being an amount referred to in subsection (5)) is paid to the practitioner, an insurer or another person in relation to the incident or incidents to

which the claim relates, or in relation to one or more other incidents; and

(c) the other amount was not taken into account in calculating the actual indemnity amount; and

(d) if the other amount had been so taken into account, a lesser amount (the ***reduced indemnity amount***, which could be zero) of exceptional claims indemnity would have been paid in relation to the liability.

(2) The ***amount overpaid*** is the amount by which the actual indemnity amount exceeds the reduced indemnity amount.

(3) If the Chief Executive Medicare has given the liable person (see subsection 34R(2)) a notice under subsection 34V(1) in relation to the amount overpaid, the amount is a debt owed to the Commonwealth by the liable person.

Note 1: If the indemnity is or was not dealt with in accordance with whichever of subsections 34Q(3) and (4) applies by the time required by subsection 34Q(5), the whole amount of the indemnity is a debt owed by the recipient, and no amount is recoverable under this section (see subsections 34Q(6) to (8)).

Note 2: If:

(a) the recipient and the practitioner referred to in subsection 34Q(1) are not the same person; and

(b) the practitioner becomes the liable person;

then (subject to subsection 34R(3)), the recipient ceases to be the liable person, and the amount overpaid must instead be recovered from the practitioner.

(4) The amount overpaid may be recovered:

(a) by action by the Chief Executive Medicare against the liable person in a court of competent jurisdiction; or

(b) under section 42.

(5) This section does not apply to any of the following:

(a) an amount paid to an insurer by another insurer under a right of contribution;

(b) a payment of high cost claim indemnity;

(ba) a payment of run-off cover indemnity;

(c) an amount of a kind specified in the rules for the purposes of this paragraph.

34U Obligation to notify the Chief Executive Medicare that amount has been paid

(1) If:

(a) an amount of exceptional claims indemnity has been paid in relation to a qualifying liability that relates to a claim made against a person (the ***practitioner***); and

(b) the person (the ***applicant***) who applied for the exceptional claims indemnity becomes aware that another amount has been paid to the practitioner, an insurer or another person in relation to the incident or incidents to which the claim relates, or in relation to one or more other incidents; and

(c) because of the payment of the other amount, there is an amount overpaid as described in subsection 34T(2);

the applicant must notify the Chief Executive Medicare that the other amount has been paid.

Note: Failure to notify is an offence (see section 46).

(2) The notification must:

(a) be in writing; and

(b) be given to the Chief Executive Medicare within 28 days after the applicant becomes aware that the other amount has been paid.

34V The Chief Executive Medicare to notify of amount of debt due

(1) If:

(a) an amount of exceptional claims indemnity has been paid in relation to a qualifying liability that relates to a claim made against a person (the ***practitioner***); and

(b) another amount is paid to the practitioner, an insurer or another person in relation to the incident or incidents to which the claim relates, or in relation to one or more other incidents; and

(c) because of the payment of the other amount, there is an amount overpaid as described in subsection 34T(2);

the Chief Executive Medicare may give the liable person (see subsection 34R(2)) a written notice that specifies:

(d) the amount overpaid, and that it is a debt owed to the Commonwealth under subsection 34T(3); and

(e) the day before which the amount must be paid to the Commonwealth; and

(f) the effect of section 34W.

The day specified under paragraph (e) must be at least 28 days after the day on which the notice is given.

(2) The debt becomes due and payable on the day specified under paragraph (1)(e).

34W Penalty imposed if an amount is repaid late

(1) If:

(a) a person owes a debt to the Commonwealth under subsection 34T(3); and

(b) the debt remains wholly or partly unpaid after it becomes due and payable;

the person is liable to pay a late payment penalty under this section.

(2) The late payment penalty is calculated:

(a) at the rate specified in the rules for the purposes of this paragraph; and

(b) on the unpaid amount; and

(c) for the period:

(i) starting when the amount becomes due and payable; and

(ii) ending when the amount, and the penalty payable under this section in relation to the amount, have been paid in full.

(3) The Chief Executive Medicare may remit the whole or a part of an amount of late payment penalty if the Chief Executive Medicare considers that there are good reasons for doing so.

(4) An application may be made to the Administrative Appeals Tribunal for review of a decision of the Chief Executive Medicare not to remit, or to remit only part of, an amount of late payment penalty.

Note: Section 27A of the *Administrative Appeals Tribunal Act 1975* requires notification of a decision that is reviewable.

(5) If:

(a) the recipient and the practitioner referred to in subsection 34Q(1) are not the same person; and

(b) the practitioner becomes the liable person; and

(c) the recipient has or had a liability under this section to pay late payment penalty;

the recipient's liability to the late payment penalty is not affected by the fact that the recipient is no longer the person who owes the debt to the Commonwealth under subsection 34T(3), except that the period referred to in paragraph (2)(c) ends when the practitioner becomes the liable person.

Subdivision E—Regulations may provide for payments

34X Regulations may provide for payments in relation to exceptional claims

(1) The regulations may provide in relation to making payments to insurers of claim handling fees, and payments on account of legal, administrative or other costs incurred by insurers (whether on their own behalf or otherwise), in respect of claims in relation to which qualifying claim certificates have been issued.

(2) Without limiting subsection (1), the regulations may:

(a) make provision for:

(i) the conditions that must be satisfied for an amount to be payable to an insurer; and

(ii) the amount that is payable; and
(iii) the conditions that must be complied with by an insurer to which an amount is paid; and
(iv) other matters related to the making of payments, and the recovery of overpayments; and

(b) provide that this Division applies with specified modifications in relation to a liability that relates to costs in relation to which an amount has been paid under regulations made for the purposes of this section; and

(c) make provision for making payments on account of legal, administrative or other costs incurred by insurers (whether on their own behalf or otherwise), in respect of incidents notified to insurers that could give rise to claims in relation to which an exceptional claims indemnity could be payable.

(3) Paragraph (2)(b) does not allow the regulations to modify a provision that creates an offence, or that imposes an obligation which, if contravened, constitutes an offence.

(3A) It does not matter for the purposes of paragraph (2)(c) whether claims are subsequently made in relation to the incidents referred to in that paragraph.

34Y The Chief Executive Medicare may request information

(1) If the Chief Executive Medicare believes that a person is capable of giving information that is relevant to determining:

(a) whether an insurer is entitled to a payment under regulations made for the purposes of section 34X; or

(b) the amount that is payable to an insurer under regulations made for the purposes of section 34X;

the Chief Executive Medicare may request the person to give the Chief Executive Medicare the information.

Note: Failure to comply with the request is an offence (see section 45).

(2) Without limiting subsection (1), any of the following persons may be requested to give information under that subsection:

(a) an MDO;
(b) an insurer;
(c) a member, or former member of an MDO;
(d) a person who practises, or used to practise, a medical profession;
(e) a person who is acting, or has acted, on behalf of a person covered by paragraph (d);
(f) a legal personal representative of a person covered by paragraph (c), (d) or (e).

(3) Without limiting subsection (1), if the information sought by the Chief Executive Medicare is information relating to a matter in relation to which a person is required by section 39 to keep a record, the Chief Executive Medicare may request the person to give the information by giving the Chief Executive Medicare the record, or a copy of the record.

(4) The request:
(a) must be made in writing; and
(b) must state what information must be given to the Chief Executive Medicare; and
(c) may require the information to be verified by statutory declaration; and
(d) must specify a day on or before which the information must be given; and
(e) must contain a statement to the effect that a failure to comply with the request is an offence.

The day specified under paragraph (d) must be at least 28 days after the day on which the request was made.

Subdivision F—Miscellaneous

34Z Modifications and exclusions

(1) The regulations may provide that this Division applies with specified modifications in relation to:
(a) a specified class of claims; or

(b) a specified class of contracts of insurance; or

(c) a specified class of situations in which a liability is, whether wholly or partly, covered by more than one contract of insurance.

Note: For the capacity for rules to exclude claims and contracts of insurance, see paragraphs 34E(1)(h) and (i).

(2) The regulations may provide that this Division does not apply, or applies with specified modifications, in relation to a specified class of liabilities or payments.

(3) Without limiting subsection (2), the regulations may specify modifications regarding how this Division applies in relation to a liability under an order of a court requiring an amount to be paid pending the outcome of an appeal, including modifications:

(a) to count the liability as a qualifying liability (even though subparagraph 34M(a)(i) may not be satisfied in relation to the order); and

(b) to deal with what happens if, as a result of the appeal or another appeal, the amount paid later becomes wholly or partly repayable; and

(c) to deal with what happens if the amount paid is later applied towards a liability that is confirmed as a result of the appeal or another appeal.

(4) This section does not allow the regulations to modify a provision that creates an offence, or that imposes an obligation which, if contravened, constitutes an offence.

Division 2B—Run-off cover indemnity scheme

Subdivision A—Introduction

34ZA Guide to the run-off cover indemnity provisions

(1) This Division provides that a run-off cover indemnity may be paid in relation to a liability of a medical practitioner if the liability relates to an eligible run-off claim.

(2) This Division also provides for the regulations and rules to deal with other matters relating to eligible run-off claims.

(3) The following table tells you where to find the provisions dealing with various issues:

Where to find the provisions on various issues

Item	Issue	Provisions
1	what is an eligible run-off claim?	section 34ZB
2	when is a run-off cover indemnity payable in respect of a liability?	sections 34ZC to 34ZG
3	how much run-off cover indemnity is payable?	section 34ZH
4	what if a payment is received that would have reduced the amount of an insurance payment?	sections 34ZI to 34ZM
5	what regulations can deal with	section 34ZN
6	what is the effect of terminating the run-off cover indemnity scheme?	sections 34ZP to 34ZT
7	notifying the Chief Executive Medicare if a person ceases to be covered by the run-off cover indemnity scheme	section 34ZU
8	invoices for medical indemnity cover	section 34ZV
9	reports on the run-off cover	section 34ZW

Where to find the provisions on various issues		
Item	**Issue**	**Provisions**
	indemnity scheme	
10	modifications and exclusions by regulations	section 34ZX
11	how does a person apply for a run-off cover indemnity?	section 36
12	when will a run-off cover indemnity be paid?	section 37
13	what information has to be provided to the Chief Executive Medicare about run-off cover indemnity matters?	section 38
14	what records must be kept in relation to run-off cover indemnity matters?	section 39
15	how are overpayments of a run-off cover indemnity recovered?	sections 41 and 42

Note: Division 2A of Part 3 of the *Medical Indemnity (Prudential Supervision and Product Standards) Act 2003* requires medical indemnity insurers to provide "run-off cover" for medical practitioners in certain circumstances covered by the run-off cover indemnity scheme.

34ZB Eligible run-off claims

(1) A claim is an ***eligible run-off claim*** if:

(a) it is a claim made against a person who, at the time the claim is made, is a person to whom subsection (2) applies; and

(b) it relates to an incident, or a series of related incidents, that occurred in the course of, or in connection with, the person's practice as a medical practitioner; and

(d) if a termination date for the run-off cover indemnity scheme has been set (see subsection (3)), the person:

(i) was, immediately before the termination date, a person to whom subsection (2) applies; and

(ii) continued to be such a person for the whole of the period between the termination date and the time when an MDO or insurer was first notified of the claim, or of facts that might give rise to the claim; and

(e) the person has medical indemnity cover that indemnifies the person in relation to the claim, being cover that:

(i) is required to be provided under Division 2A of Part 3 of the *Medical Indemnity (Prudential Supervision and Product Standards) Act 2003*; or

(ii) is incident-occurring based cover provided by an MDO.

Note: For the meaning of incident-occurring based cover, see subsections 7(2A) and (3).

(2) This subsection applies to a person who is one or more of the following:

(a) a person who has retired permanently from private medical practice;

(b) a person who has not engaged in private medical practice at any time during the preceding period of 3 years;

(c) a person who has ceased (temporarily or permanently) the person's practice as a medical practitioner because of maternity (see subsection (4A));

(d) a person who has ceased the person's practice as a medical practitioner because of permanent disability (see subsection (4B));

(e) a person who is the legal personal representative of a deceased person who had been a medical practitioner;

(f) a person who is included in a class of persons that the rules specify as persons to whom this subsection applies.

However, a person is not a person to whom this subsection applies if the person is included in a class of persons that the rules specify as a class of persons to whom this subsection does not apply.

(3) The rules may set a termination date for the run-off cover indemnity scheme.

(4) The termination date cannot be a date occurring before the end of the period of 12 months after the day on which the rules in question are registered on the Federal Register of Legislation.

(4A) A person is taken, for the purposes of paragraph (2)(c), to have ceased the person's practice as a medical practitioner because of maternity if and only if:

(a) the person:

(i) is pregnant; or

(ii) has given birth; or

(iii) is recovering from a pregnancy (including a miscarriage or a stillbirth); and

(b) another person who is a medical practitioner has certified, in the form approved by the Chief Executive Medicare, that the person is pregnant, has given birth or is recovering from a pregnancy, as the case requires; and

(c) the person has ceased all practice as a medical practitioner:

(i) because she is pregnant; or

(ii) in order to care for one or more children to whom she has given birth; or

(iii) in order to recover from the pregnancy; and

(d) any other requirements specified in the rules have been met.

(4B) A person is taken, for the purposes of paragraph (2)(d), to have ceased the person's practice as a medical practitioner because of permanent disability if and only if:

(a) the person has incurred an injury, or suffers from an illness, that is permanent, or is likely to be permanent; and

(b) as a result of the injury or illness, the person can no longer practise in the area of medicine in which he or she had (at the time of the injury or illness) chosen to practise and been qualified to practise; and

(c) another person who is a medical practitioner has certified, in the form approved by the Chief Executive Medicare, that the person:

(i) has incurred an injury, or suffers from an illness, that is permanent, or is likely to be permanent; and

(ii) can no longer practise in that area of medicine; and

(d) the person has permanently ceased all practice as a medical practitioner.

(4C) For the purposes of paragraph (4B)(b), if registration in respect of that area of medicine is required in order to practise in that area of medicine in the place where the person would have practised, the person is not taken to be qualified in that area of medicine unless he or she is so registered.

Subdivision B—Run-off cover indemnities

34ZC Circumstances in which run-off cover indemnities are payable

(1) A run-off cover indemnity is payable to an MDO or a medical indemnity insurer under this section if:

(a) an eligible run-off claim is made that relates to an incident, or a series of related incidents, that occurred in the course of, or in connection with, a person's practice as a medical practitioner; and

(ab) at the time the claim is first notified to the MDO or medical indemnity insurer, the person is a person to whom subsection 34ZB(2) applies; and

(b) in the case of an MDO—the MDO makes, or is able to make, a payment in relation to the claim:

(i) under an arrangement, with the MDO or someone else, under which the MDO is able to indemnify the person in relation to claims made by or against the person while he or she is a person to whom subsection 34ZB(2) applies; and

(ii) in the ordinary course of the MDO's business; and

(c) in the case of a medical indemnity insurer—the insurer makes, or is liable to make, a payment in relation to the claim under a contract of insurance under which the insurer is liable to indemnify the person in relation to claims made by or

against the person while he or she is a person to whom subsection 34ZB(2) applies; and

(d) the MDO or medical indemnity insurer was first notified of the claim, or of facts that might give rise to the claim on or after 1 July 2004; and

(e) the MDO or medical indemnity insurer applies to the Chief Executive Medicare for the run-off cover indemnity in accordance with section 36.

(2) Paragraph (1)(c) does not apply to a payment that a medical indemnity insurer makes or is liable to make unless the payment is or would be made:

(a) in relation to a claim made in relation to medical indemnity cover that section 26A or 26C of the *Medical Indemnity (Prudential Supervision and Product Standards) Act 2003* requires the insurer to provide for the person; and

(b) in the insurer's ordinary course of business.

34ZD MDOs and medical indemnity insurers that are Chapter 5 bodies corporate

(1) If an MDO is a Chapter 5 body corporate:

(a) the reference in paragraph 34ZC(1)(b) to a payment that the MDO is able to make under an arrangement to indemnify a person is a reference to an amount that:

(i) the MDO is liable to make under the arrangement to indemnify the person; and

(ii) is a provable amount; and

(b) the reference in that paragraph to a payment that the MDO is able to make in the ordinary course of the MDO's business is a reference to an amount that the MDO:

(i) is liable to pay; and

(ii) would be able to pay in the ordinary course of the MDO's business if it were not a Chapter 5 body corporate.

(2) If a medical indemnity insurer is a Chapter 5 body corporate, the reference in paragraph 34ZC(1)(c) to a payment that the medical indemnity insurer makes or is liable to make under a contract of insurance to indemnify a person is a reference to an amount that:

(a) the medical indemnity insurer pays or is liable to pay under the contract to indemnify the person; and

(b) is a provable amount.

(3) If a run-off cover indemnity is paid to an MDO or medical indemnity insurer that is a Chapter 5 body corporate, the indemnity is, to the extent to which it is attributable to an amount that the MDO or medical indemnity insurer is liable to pay to a person, paid on trust for the benefit of that person.

34ZE Aggregating amounts paid or payable by an MDO and medical indemnity insurer

(1) This section applies if:

(a) an MDO pays, or is liable to pay, an amount in relation to a claim; and

(b) a medical indemnity insurer also pays, or is also liable to pay, an amount in relation to the same claim (the ***insurer amount***); and

(c) but for this section, a run-off cover indemnity in respect of the insurer amount would be payable to the insurer under section 34ZC; and

(d) the medical indemnity insurer elects in writing to have this section apply to the insurer amount.

(2) For the purposes of this Division (other than this section):

(a) the MDO is taken:

(i) to have paid, or to be liable to pay, the insurer amount in relation to the claim; and

(ii) to satisfy paragraphs 34ZC(1)(a) to (e) in relation to the insurer amount; and

(b) a run-off cover indemnity is not payable to the medical indemnity insurer in respect of the insurer amount.

34ZF Clarification of circumstances in which run-off cover indemnities are payable

A run-off cover indemnity is payable to an MDO or a medical indemnity insurer under section 34ZC in relation to a payment the MDO makes or is able to make, or the medical indemnity insurer makes or is liable to make, in relation to a claim even if:

(a) the MDO or medical indemnity insurer:

(i) has insured itself in relation to the payment; or

(ii) has already in fact been paid an amount by an insurer in relation to the payment; or

(b) the incident to which the claim relates occurred outside Australia and the external Territories.

34ZG Exceptions

A run-off cover indemnity is not payable to an MDO or a medical indemnity insurer under section 34ZC in relation to a payment the MDO makes or is able to make, or the medical indemnity insurer makes or is liable to make, in relation to a claim if:

(a) the payment is an insurer-to-insurer payment; or

(b) the payment is a payment specified in the rules for the purposes of this section.

34ZH Amount of run-off cover indemnities

(1) The amount of a run-off cover indemnity is:

(a) if it is payable to an MDO—the amount of the payment referred to in paragraph 34ZC(1)(b); or

(b) if it is payable to a medical indemnity insurer—the amount of the payment referred to in paragraph 34ZC(1)(c), but only to the extent that the payment is or would be made:

(i) in relation to a claim made in relation to medical indemnity cover that section 26A or 26C of the *Medical Indemnity (Prudential Supervision and Product Standards) Act 2003* requires the insurer to provide for a person; and

(ii) in the insurer's ordinary course of business.

(2) However, if a high cost claim indemnity is payable in respect of that payment, the amount of the run-off cover indemnity is reduced by the amount of the high cost claim indemnity.

Subdivision C—Payments that would have reduced the amount of run-off cover indemnity

34ZI Amounts paid before run-off cover indemnity

(1) If:

(a) an amount (the ***indemnity payment***) has been paid, in relation to a liability of a medical practitioner, under:

(i) an arrangement with an MDO for indemnifying the practitioner in relation to claims that may be made against the practitioner in relation to incidents that occur or occurred in the course of, or in connection with, the practice of the practitioner's profession; or

(ii) a contract of insurance with a medical indemnity insurer that provides medical indemnity cover for the practitioner; and

(b) another amount (not being an amount referred to in subsection (2)) has been paid to the practitioner, MDO, medical indemnity insurer or another person in relation to the incident or incidents to which the liability relates; and

(c) the other amount was not taken into account in working out the amount of the indemnity payment; and

(d) if the other amount had been taken into account in working out the amount of the indemnity payment, a lesser amount would have been paid under the arrangement with the MDO, or under the contract of insurance, in relation to the liability;

then, for the purpose of calculating the amount of run-off cover indemnity (if any) that is payable in relation to a liability of the practitioner, the lesser amount is taken to have been the amount of the indemnity payment.

(2) This section does not apply to any of the following:
  (a) an amount paid to a medical indemnity insurer by another insurer under a right of contribution;
  (b) a payment of high cost claim indemnity;
  (c) a payment of exceptional claims indemnity;
  (d) an amount of a kind specified in the rules for the purposes of this paragraph.

34ZJ Amounts paid after payment of run-off cover indemnity

(1) This section applies if:
  (a) an amount (the ***actual run-off cover amount***) of run-off cover indemnity has been paid in relation to an eligible run-off claim made against a medical practitioner; and
  (b) another amount (not being an amount referred to in subsection (5)) is paid to the practitioner, an MDO, a medical indemnity insurer or another person in relation to the incident or incidents to which the claim relates, or in relation to one or more other incidents; and
  (c) the other amount was not taken into account in calculating the actual run-off cover amount; and
  (d) if the other amount had been so taken into account, a lesser amount (the ***reduced run-off cover amount***, which could be zero) of run-off cover indemnity would have been paid in relation to the liability.

(2) The ***amount overpaid*** is the amount by which the actual run-off cover amount exceeds the reduced run-off cover amount.

(3) If the Chief Executive Medicare has given an MDO or a medical indemnity insurer a notice under subsection 34ZL(1) in relation to the amount overpaid, the amount is a debt owed to the Commonwealth by the MDO or insurer.

(4) The amount overpaid may be recovered:
  (a) by action by the Chief Executive Medicare against the MDO or insurer in a court of competent jurisdiction; or

(b) under section 42.

(5) This section does not apply to any of the following:
(a) an amount paid to an insurer by another insurer under a right of contribution;
(b) a payment of high cost claim indemnity;
(c) a payment of exceptional claims indemnity;
(d) an amount of a kind specified in the rules for the purposes of this paragraph.

34ZK Obligation to notify the Chief Executive Medicare that amount has been paid

(1) If:
(a) a run-off cover indemnity has been paid to an MDO or medical indemnity insurer in relation to a liability that relates to a claim made against a medical practitioner; and
(b) the MDO or medical indemnity insurer becomes aware that another amount has been paid to the practitioner, MDO, medical indemnity insurer or another person in relation to the incident or incidents to which the claim relates, or in relation to one or more other incidents; and
(c) because of the payment of the other amount, there is an amount overpaid as described in subsection 34ZJ(2);
the MDO or medical indemnity insurer must notify the Chief Executive Medicare that the other amount has been paid.

Note: Failure to notify is an offence (see section 46).

(2) The notification must:
(a) be in writing; and
(b) be given to the Chief Executive Medicare within 28 days after the applicant becomes aware that the other amount has been paid.

34ZL The Chief Executive Medicare to notify of amount of debt due

(1) If:

(a) a run-off cover indemnity has been paid to an MDO or medical indemnity insurer in relation to a liability that relates to a claim made against a medical practitioner; and

(b) another amount is paid to the practitioner, MDO, medical indemnity insurer or another person in relation to the incident or incidents to which the claim relates, or in relation to one or more other incidents; and

(c) because of the payment of the other amount, there is an amount overpaid as described in subsection 34ZJ(2);

the Chief Executive Medicare may give the MDO or medical indemnity insurer a written notice that specifies:

(d) the amount overpaid, and that it is a debt owed to the Commonwealth under subsection 34ZJ(3); and

(e) the day before which the amount must be paid to the Commonwealth; and

(f) the effect of section 34ZM.

The day specified under paragraph (e) must be at least 28 days after the day on which the notice is given.

(2) The debt becomes due and payable on the day specified under paragraph (1)(e).

34ZM Penalty imposed if an amount is repaid late

(1) If:

(a) a person owes a debt to the Commonwealth under subsection 34ZJ(3); and

(b) the debt remains wholly or partly unpaid after it becomes due and payable;

the person is liable to pay a late payment penalty under this section.

(2) The late payment penalty is calculated:

(a) at the rate specified in the rules for the purposes of this paragraph; and

(b) on the unpaid amount; and

(c) for the period:

(i) starting when the amount becomes due and payable; and

(ii) ending when the amount, and the penalty payable under this section in relation to the amount, have been paid in full.

(3) The Chief Executive Medicare may remit the whole or a part of an amount of late payment penalty if the Chief Executive Medicare considers that there are good reasons for doing so.

(4) An application may be made to the Administrative Appeals Tribunal for review of a decision of the Chief Executive Medicare not to remit, or to remit only part of, an amount of late payment penalty.

Note: Section 27A of the *Administrative Appeals Tribunal Act 1975* requires notification of a decision that is reviewable.

Subdivision D—Regulations may provide for payments

34ZN Regulations may provide for payments in relation to run-off claims

(1) The regulations may provide in relation to:

(a) making payments to MDOs and medical indemnity insurers of claim handling fees in respect of eligible run-off claims; and

(b) making payments on account of legal, administrative or other costs incurred by MDOs and medical indemnity insurers (whether on their own behalf or otherwise) in respect of eligible run-off claims; and

(c) making payments on account of legal, administrative or other costs incurred by medical indemnity insurers (whether on their own behalf or otherwise) in respect of complying with Division 2A of Part 3 of the *Medical Indemnity (Prudential Supervision and Product Standards) Act 2003*.

(2) Without limiting subsection (1), the regulations may:

(a) make provision for:

(i) the conditions that must be satisfied for an amount to be payable to an MDO or medical indemnity insurer; and

(ii) the amount that is payable; and

(iii) the conditions that must be complied with by an MDO or medical indemnity insurer to which an amount is paid; and

(iv) other matters related to the making of payments, and the recovery of overpayments; and

(b) provide that this Division applies with specified modifications in relation to a liability that relates to costs in relation to which an amount has been paid under regulations made for the purposes of this section.

(3) Paragraph (2)(b) does not allow the regulations to modify a provision that creates an offence, or that imposes an obligation which, if contravened, constitutes an offence.

34ZO The Chief Executive Medicare may request information

(1) If the Chief Executive Medicare believes that a person is capable of giving information that is relevant to determining:

(a) whether an MDO or medical indemnity insurer is entitled to a payment under regulations made for the purposes of section 34ZN; or

(b) the amount that is payable to an MDO or medical indemnity insurer under regulations made for the purposes of section 34ZN;

the Chief Executive Medicare may request the person to give the Chief Executive Medicare the information.

Note: Failure to comply with the request is an offence (see section 45).

(2) Without limiting subsection (1), any of the following persons may be requested to give information under that subsection:

(a) an MDO;

(b) an insurer;

(c) a member or former member of an MDO;

(d) a person who practises, or used to practise, a medical profession;

(e) a person who is acting, or has acted, on behalf of a person covered by paragraph (d);

(f) a legal personal representative of a person covered by paragraph (c), (d) or (e).

(3) Without limiting subsection (1), if the information sought by the Chief Executive Medicare is information relating to a matter in relation to which a person is required by section 39 to keep a record, the Chief Executive Medicare may request the person to give the information by giving the Chief Executive Medicare the record, or a copy of the record.

(4) The request:

(a) must be made in writing; and

(b) must state what information must be given to the Chief Executive Medicare; and

(c) may require the information to be verified by statutory declaration; and

(d) must specify a day on or before which the information must be given; and

(e) must contain a statement to the effect that a failure to comply with the request is an offence.

The day specified under paragraph (d) must be at least 28 days after the day on which the request was made.

Subdivision E—Effect of terminating the run-off cover indemnity scheme

34ZP Commonwealth's obligations on termination of the run-off cover indemnity scheme

(1) If a termination date for the run-off cover indemnity scheme has been set (see subsection 34ZB(3)), the Commonwealth is liable to pay an amount in accordance with this Subdivision in relation to each affected medical practitioner.

(2) However, this section does not apply if:

(a) the rules provide that alternative arrangements for providing medical cover for medical practitioners in relation to eligible run-off claims will apply on and from the termination date; and

(b) the rules made for the purposes of paragraph (a) commence on or before the termination date.

34ZQ Affected medical practitioners

A medical practitioner is an ***affected medical practitioner*** if:

(a) a termination date for the run-off cover indemnity scheme has been set (see subsection 34ZB(3)); and

(b) prior to the termination date, one or more premiums have been paid for medical indemnity cover, for the medical practitioner, in relation to one or more periods totalling at least 12 months; and

(c) immediately before the termination date, the medical practitioner was not a person to whom subsection 34ZB(2) applies.

34ZR Payments in relation to affected medical practitioners

(1) A payment that the Commonwealth is liable to make in relation to an affected medical practitioner:

(a) must be paid to a person who:

(i) is nominated by the practitioner; and

(ii) has, on or after the termination date, provided medical indemnity cover for the practitioner under a contract of insurance; and

(b) must be paid as all or part of the premium payable for the provision of that cover; and

(c) must be paid within 12 months after the termination date; and

(d) must not exceed the practitioner's total run-off cover credit.

(2) Amounts payable by the Commonwealth under this Subdivision are payable out of the Consolidated Revenue Fund, which is appropriated accordingly.

34ZS Total run-off cover credits

(1) This is how to work out an affected practitioner's total run-off cover credit:

Method statement

Step 1. For the first financial year after 30 June 2004 in which a medical indemnity insurer provided medical indemnity cover for the practitioner under a contract of insurance, multiply:

(a) the practitioner's run-off cover credit for the financial year; by

(b) the interest rate adjustment for the financial year (see subsection (4)).

Step 2. For each subsequent financial year (if any) until the financial year in which the termination date occurs, multiply:

(a) the sum of the practitioner's run-off cover credit for the financial year and the amount worked out, under Step 1 or this Step, for the immediately preceding financial year; by

(b) the interest rate adjustment for the financial year (see subsection (4)).

Step 3. Add together:

(a) the practitioner's run-off cover credit for the financial year in which the termination date occurs; and

(b) the last of the amounts worked out under Step 1 or Step 2.

The result is the practitioner's ***total run-off cover credit***.

(2) The practitioner's ***run-off cover credit*** for a financial year is the sum of all run-off cover support payments paid or payable to the extent that they are attributable, under subsection (3), to the practitioner in relation to the financial year.

(3) Run-off cover support payments are ***attributable*** to the practitioner in relation to the financial year to the extent that they relate to premiums paid during the financial year to a medical indemnity insurer for medical indemnity cover provided for the practitioner by one or more contracts of insurance with the insurer.

(4) The ***interest rate adjustment*** for a financial year is the number worked out as follows:

1 + Applicable interest rate

where:

applicable interest rate is the rate of interest, for the financial year, specified in the rules for the purposes of this subsection.

34ZT Medical indemnity insurers must provide information attributing run-off cover support payments

(1) A medical indemnity insurer must, in relation to each run-off cover support payment that the medical indemnity insurer is liable to make to the Chief Executive Medicare, notify the Chief Executive Medicare of:

(a) each medical practitioner to whom the payment is attributable; and

(b) for each such practitioner, each financial year in relation to which the payment is attributable; and

(c) for each such practitioner and financial year, the extent to which the payment is attributable to the practitioner in relation to the financial year.

Note: Failure to notify is an offence (see section 46).

(2) The notification must:

(a) be made in writing; and

(b) be given to the Chief Executive Medicare on or before the day on which the run-off cover support payment becomes due and payable under section 61.

Subdivision F—Miscellaneous

34ZU Chief Executive Medicare must be notified of a person ceasing to be covered by the run-off cover indemnity scheme

(1) If:

(a) a person ceases to be a person to whom subsection 34ZB(2) applies; and

(b) immediately before the cessation, an MDO or medical indemnity insurer was providing medical indemnity cover (within the meaning of the *Medical Indemnity (Prudential Supervision and Product Standards) Act 2003*) to the person;

the MDO or medical indemnity insurer must notify the Chief Executive Medicare of the cessation.

Note: Failure to notify is an offence (see section 46).

(2) The notification must:

(a) be in writing; and

(b) set out details of the cessation; and

(c) be given to the Chief Executive Medicare within a period, starting on the day after the day on which the person becomes aware of the cessation, of:

(i) 61 days; or

(ii) such greater number of days specified in the rules.

34ZV Invoices for medical indemnity cover

(1) If:

(a) a medical indemnity insurer gives to a person an invoice stating the premium that is or will be payable for medical indemnity cover provided by a contract of insurance with the medical indemnity insurer; and

(b) payment of the premium would increase the medical indemnity insurer's liability to pay run-off cover support payment;

the medical indemnity insurer must ensure that the invoice states:

(c) the amount of the medical indemnity insurer's premium income, for the contribution year in question, that represents the premium that is or will be payable for medical indemnity cover provided by the contract of insurance; and

(d) the applicable percentage relating to that contribution year; and

(e) the amount of the run-off cover support payment imposed on the medical indemnity insurer, for that contribution year, that relates to the premium that is or will be payable for medical indemnity cover provided by the contract of insurance.

Note: Failure to comply with this section is an offence (see section 47A).

(2) In this section:

applicable percentage has the same meaning as in subsection 6(2) of the *Medical Indemnity (Run-off Cover Support Payment) Act 2004*.

premium income has the same meaning as in the *Medical Indemnity (Run-off Cover Support Payment) Act 2004*.

34ZW Reports on the run-off cover indemnity scheme

(1) After the end of each financial year, the Actuary must give the Secretary a report on the operation of this Division.

(2) Without limiting the matters that may be included in a report under subsection (1), the report must include:

(a) a statement of the number of persons who were, at the end of the financial year, persons to whom subsection 34ZB(2) applies; and

(b) a statement of the total of all the amounts of run-off cover indemnity, and amounts payable under regulations made for the purposes of section 34ZN (run-off claims payments), paid by the Commonwealth during the financial year; and

(c) a statement of the total of all the amounts of run-off cover support payments paid to the Commonwealth during the financial year; and

(d) estimates by the Actuary of the Commonwealth's liabilities under this Division in future financial years.

(2A) The Secretary must publish the report on the Department's website within 30 days after receiving the report.

(3) If a termination date for the run-off cover indemnity scheme has been set (see subsection 34ZB(3)), this section does not apply in relation to a financial year starting after the end of the financial year in which the termination date occurs.

34ZX Modifications and exclusions

(1) The regulations may provide that this Division applies with specified modifications in relation to:

(a) a specified class of claims; or

(b) a specified class of arrangements with MDOs or contracts of insurance; or

(c) a specified class of situations in which a liability is, whether wholly or partly, covered by more than one contract of insurance.

(2) The regulations may provide that this Division does not apply, or applies with specified modifications, in relation to a specified class of liabilities or payments.

(3) Without limiting subsection (2), the regulations may specify modifications regarding how this Division applies in relation to a liability under an order of a court requiring an amount to be paid pending the outcome of an appeal, including modifications:

(a) to deal with what happens if, as a result of the appeal or another appeal, the amount paid later becomes wholly or partly repayable; and

(b) to deal with what happens if the amount paid is later applied towards a liability that is confirmed as a result of the appeal or another appeal.

(4) This section does not allow the regulations to modify a provision that creates an offence, or that imposes an obligation which, if contravened, constitutes an offence.

Division 2C—Allied health high cost claim indemnity scheme

Subdivision A—Introduction

34ZY Guide to the allied health high cost claim indemnity provisions

(1) This Division provides that an allied health high cost claim indemnity may be paid to an eligible MDO or eligible insurer that pays, or is liable to pay, more than a particular amount (referred to as the ***allied health high cost claim threshold***) in relation to a claim against a person in relation to an incident that occurs in the course of, or in connection with, the practice by the person of an allied health profession.

(2) This Division also provides for the regulations and rules to deal with other matters relating to incidents covered by the allied health high cost claim indemnity scheme.

(3) The following table tells you where to find the provisions dealing with various issues:

Where to find the provisions on various issues

Item	Issue	Provisions
1	which MDOs and insurers are eligible?	section 34ZZ
2	what is the allied health high cost claim threshold?	section 34ZZA
3	what conditions must be satisfied for an MDO or insurer to get the allied health high cost claim indemnity?	sections 34ZZB to 34ZZD
4	what happens if the incidents occurred during treatment of a public patient in a public hospital?	paragraph 34ZZD(a) and section 34ZZE

Where to find the provisions on various issues		
Item	**Issue**	**Provisions**
5	how much is the allied health high cost claim indemnity?	section 34ZZF
6	what regulations can deal with	section 34ZZG
7	how do MDOs and insurers apply for the allied health high cost claim indemnity?	section 36
8	when will the allied health high cost claim indemnity be paid?	section 37
9	what information has to be provided to the Chief Executive Medicare about allied health high cost indemnity matters?	section 38
10	what records must MDOs and insurers keep?	section 39
11	how are overpayments of allied health high cost claim indemnity recovered?	sections 41 and 42

34ZZ Eligible MDOs and eligible insurers

An MDO is an ***eligible MDO***, or a medical indemnity insurer is an ***eligible insurer***, if:

(a) it is specified in the rules; and

(b) it is party to contracts of insurance that provide medical indemnity cover for medical practitioners; and

(c) it is party to contracts of insurance that provide medical indemnity cover for persons who practise an allied health profession.

34ZZA Allied health high cost claim threshold

(1) The ***allied health high cost claim threshold*** is:

(a) $2 million; or

(b) such other amount as is specified in the rules.

(2) Rules that specify an amount for the purposes of paragraph (1)(b) that increases the allied health high cost claim threshold at the time the rules are registered on the Federal Register of Legislation must not commence earlier than 12 months after the day on which the rules are so registered.

Subdivision B—Allied health high cost claim indemnity

34ZZB Circumstances in which allied health high cost claim indemnity payable

Basic payability rule

(1) Subject to section 34ZZC, an allied health high cost claim indemnity is payable to an eligible MDO or eligible insurer under this section if:

(a) a claim is, or was, made against a person (the ***practitioner***); and

(b) the claim relates to:

(i) an incident that occurs or occurred; or

(ii) a series of related incidents that occur or occurred;

in the course of, or in connection with, the practice by the practitioner of an allied health profession; and

(c) if the allied health profession is midwifery:

(i) the incident occurs or occurred; or

(ii) all of the incidents in the series occur or occurred;

in the course of, or in connection with, practice of a kind in relation to which eligible midwives are ordinarily, or could reasonably be expected in the ordinary course of business to be, engaged as employees (and therefore indemnified from liability by their employer); and

(d) either:

(i) the incident occurs or occurred; or

(ii) one or more of the incidents in the series occurs or occurred;

in Australia or in an external Territory; and

(e) either:
  (i) the incident occurs or occurred; or
  (ii) all of the incidents in the series occur or occurred;
on or after 1 July 2020; and

(f) the MDO or insurer is first notified of:
  (i) the incident; or
  (ii) the claim; or
  (iii) an eligible related claim;
on or before the date specified in the rules as the termination date for the allied health high cost claim indemnity scheme; and

(g) the MDO or insurer has a qualifying allied health payment in relation to the claim, or qualifying allied health payments in relation to:
  (i) the claim; or
  (ii) the claim and one or more eligible related claims; and

(h) the amount of the qualifying allied health payment, or the sum of the amounts of the qualifying allied health payments, exceeds what was the allied health high cost claim threshold at the earliest of the following times:
  (i) when the MDO or insurer was first notified of the incident;
  (ii) when the MDO or insurer was first notified of the claim;
  (iii) when the MDO or insurer was first notified of an eligible related claim; and

(i) a high cost claim indemnity is not payable in relation to the claim; and

(j) any other requirements (however described) that are specified in the rules have been met.

(2) Any rules made for the purposes of subsection 11(3A) of the *Midwife Professional Indemnity (Commonwealth Contribution) Scheme Act 2010* apply for the purposes of determining whether practice is of a kind mentioned in paragraph (1)(c).

(3) Rules made for the purposes of paragraph (1)(j) do not apply in relation to an incident if the claim relating to the incident was made before the rules in question commence.

Qualifying allied health payments

(4) The MDO or insurer has a ***qualifying allied health payment*** in relation to a claim if:

(a) the MDO or insurer:

(i) pays an amount in relation to the claim; or

(ii) is liable to pay an amount in relation to a payment or payments that someone makes, or is liable to make, in relation to the claim under a written agreement between the parties to the claim; or

(iii) is liable to pay an amount in relation to a payment or payments that someone makes, or is liable to make, in relation to the claim under a judgment or order of a court that is not stayed and is not subject to appeal; or

(iv) is a Chapter 5 body corporate and is liable to pay a provable amount in relation to the claim; and

(b) the MDO or insurer pays, or is liable to pay, the amount under an insurance contract or other indemnity arrangement between the MDO or insurer and the practitioner; and

(c) the MDO or insurer:

(i) pays, or becomes liable to pay, the amount in the ordinary course of the MDO's or the insurer's business; or

(ii) is a Chapter 5 body corporate and would be able to pay the amount in the ordinary course of the MDO's or the insurer's business if it were not a Chapter 5 body corporate.

(5) The date specified in the rules for the purposes of paragraph (1)(f) must be at least 12 months after the day on which the rules in question are registered on the Federal Register of Legislation.

Indemnity to be paid on trust if MDO or insurer under external administration

(6) If an allied health high cost claim indemnity is paid to an MDO or insurer that is a Chapter 5 body corporate, the indemnity is, to the extent to which it is attributable to an amount that the MDO or insurer is liable to pay to a person, paid on trust for the benefit of that person.

34ZZC Aggregating amounts paid or payable by an MDO and insurer

(1) This section applies if:

(a) an eligible MDO pays, or is liable to pay, an amount in relation to a claim that relates to an incident or a series of incidents; and

(b) an eligible insurer also pays, or is also liable to pay, an amount (the ***insurer amount***) in relation to the same claim or in relation to an eligible related claim; and

(c) but for this section, an allied health high cost claim indemnity in respect of the insurer amount:

(i) would be payable to the insurer under subsection 34ZZB(1); or

(ii) would be payable to the insurer under that subsection if paragraph 34ZZB(1)(h) were omitted; and

(d) the insurer elects in writing to have this section apply to the insurer amount.

(2) For the purposes of this Division (other than this section):

(a) the MDO is taken:

(i) to have paid, or to be liable to pay, the insurer amount in relation to the claim or eligible related claim; and

(ii) to satisfy paragraphs 34ZZB(1)(g) and (4)(a) to (c) in relation to the insurer amount; and

(iii) to have been notified of the incident, claim or eligible related claim when the insurer was first notified of the incident, claim or eligible related claim; and

(b) an allied health high cost claim indemnity is not payable to the insurer in respect of the insurer amount.

34ZZD Exceptions

An allied health high cost claim indemnity is not payable to an MDO or insurer under section 34ZZB in relation to a payment the MDO or insurer makes, or is liable to make, in relation to a claim against a person if:

(a) the incident, or all the incidents, to which the claim relates occurred in the course of the provision of treatment to a public patient in a public hospital; or

(b) the claim is specified in the rules; or

(c) the claim relates to an incident specified in the rules.

34ZZE Payment partly related to treatment of public patient in public hospital

(1) This section applies if:

(a) an MDO or insurer makes, or is liable to make, a payment in relation to a claim against a person in relation to a series of related incidents; and

(b) some, but not all, of the incidents occurred in the course of the provision of treatment to a public patient in a public hospital.

(2) For the purposes of this Subdivision, the payment is to be disregarded to the extent to which it relates to, or is reasonably attributable to, the incident or incidents that occurred in the course of the provision of treatment to a public patient in a public hospital.

34ZZF Amount of allied health high cost claim indemnity

(1) The amount of an allied health high cost claim indemnity is:

(a) 50%; or

(b) such other percentage as is specified in the rules;

of the amount by which the amount of the MDO's or insurer's qualifying allied health payment, or the sum of the amounts of the MDO's or insurer's qualifying allied health payments, exceeds the allied health high cost claim threshold.

(2) Rules that specify for the purposes of paragraph (1)(b) a percentage that is less than the percentage in force at the time the rules are registered on the Federal Register of Legislation must not commence earlier than 12 months after the day on which the rules are so registered.

Subdivision C—Regulations may provide for payments

34ZZG Regulations may provide for payments in relation to allied health high cost claims

(1) The regulations may provide in relation to:

(a) making payments to eligible MDOs and eligible insurers of claim handling fees; and

(b) making payments on account of legal, administrative or other costs incurred by eligible MDOs and eligible insurers (whether on their own behalf or otherwise);

in respect of claims relating to incidents in relation to which an allied health high cost claim indemnity is payable (see section 34ZZB).

(2) Without limiting subsection (1), the regulations may:

(a) make provision for:

(i) the conditions that must be satisfied for an amount to be payable to an eligible MDO or eligible insurer; and

(ii) the amount that is payable; and

(iii) the conditions that must be complied with by an eligible MDO or eligible insurer to which an amount is paid; and

(iv) other matters related to the making of payments, and the recovery of overpayments; and

(b) provide that this Division applies with specified modifications in relation to a liability that relates to costs in relation to which an amount has been paid under regulations made for the purposes of this section; and

(c) make provision for making payments on account of legal, administrative or other costs incurred by eligible MDOs and eligible insurers (whether on their own behalf or otherwise), in respect of incidents notified to eligible MDOs and eligible insurers that could give rise to claims in relation to which an allied health high cost claim indemnity could be payable.

(3) Paragraph (2)(b) does not allow the regulations to modify a provision that creates an offence, or that imposes an obligation which, if contravened, constitutes an offence.

(4) It does not matter for the purposes of paragraph (2)(c) whether claims are subsequently made in relation to the incidents referred to in that paragraph.

34ZZH The Chief Executive Medicare may request information

(1) If the Chief Executive Medicare believes that a person is capable of giving information that is relevant to determining:

(a) whether an MDO or insurer is entitled to a payment under regulations made for the purposes of section 34ZZG; or

(b) the amount that is payable to an MDO or insurer under regulations made for the purposes of section 34ZZG;

the Chief Executive Medicare may request the person to give the Chief Executive Medicare the information.

Note: Failure to comply with the request is an offence (see section 45).

(2) Without limiting subsection (1), any of the following persons may be requested to give information under that subsection:

(a) an eligible MDO;

(b) an eligible insurer;

(c) a member or former member of an eligible MDO;

(d) a person who practises, or used to practise, an allied health profession;

(e) a person who is acting, or has acted, on behalf of a person covered by paragraph (d);

(f) a legal personal representative of a person covered by paragraph (c), (d) or (e).

(3) Without limiting subsection (1), if the information sought by the Chief Executive Medicare is information relating to a matter in relation to which a person is required by section 39 to keep a record, the Chief Executive Medicare may request the person to give the information by giving the Chief Executive Medicare the record, or a copy of the record.

(4) The request:

(a) must be made in writing; and

(b) must state what information must be given to the Chief Executive Medicare; and

(c) may require the information to be verified by statutory declaration; and

(d) must specify a day on or before which the information must be given; and

(e) must contain a statement to the effect that a failure to comply with the request is an offence.

The day specified under paragraph (d) must be at least 28 days after the day on which the request was made.

Division 2D—Allied health exceptional claims indemnity scheme

Subdivision A—Introduction

34ZZI Guide to the allied health exceptional claims indemnity provisions

(1) This Division provides that an allied health exceptional claims indemnity may be paid in relation to a liability of a person if:

(a) the liability relates to a claim against the person in relation to an incident that occurs in the course of, or in connection with, the practice by the person of an allied health profession, being a claim that has been certified as a qualifying allied health claim; and

(b) the liability exceeds the amount payable under an insurance contract with an eligible insurer that has a contract limit satisfying the relevant allied health threshold.

(2) This Division also provides for the regulations and rules to deal with other matters relating to claims that have been certified as qualifying allied health claims.

(3) The following table tells you where to find the provisions dealing with various issues:

Where to find the provisions on various issues

Item	Issue	Provisions
1	which insurers are eligible insurers?	section 34ZZ
2	certification of claims that qualify for allied health exceptional claims indemnity (including the threshold requirement for the insurance contract)	sections 34ZZK to 34ZZQ
3	when is an allied health exceptional claims indemnity payable in respect	sections 34ZZR and 34ZZS

Where to find the provisions on various issues		
Item	**Issue**	**Provisions**
	of a liability?	
4	some liabilities are only partly covered	sections 34ZZT and 34ZZU
5	how much allied health exceptional claims indemnity is payable?	section 34ZZV
6	how must an allied health exceptional claims indemnity be applied?	section 34ZZW
7	who is liable to repay an overpayment of allied health exceptional claims indemnity?	section 34ZZX
8	what if a payment is received that would have reduced the amount of an insurance payment?	sections 34ZZY to 34ZZZC
9	what regulations can deal with	section 34ZZZD
10	modifications and exclusions by regulations	section 34ZZZF
11	how does a person apply for an allied health exceptional claims indemnity?	section 37A
12	when will an allied health exceptional claims indemnity be paid?	section 37B
13	what information has to be provided to the Chief Executive Medicare about allied health exceptional claims matters?	section 38
14	what records must be kept in relation to allied health exceptional claims matters?	section 39
15	how are overpayments of allied health exceptional claims indemnity recovered?	sections 41 and 42

34ZZJ Interaction with allied health high cost claim indemnity scheme

For the purposes of the definition of ***practitioner's contract limit*** in subsection 4(1), and of paragraphs 34ZZR(1)(e) and (f), an amount that an insurer has paid or is liable to pay, or would have been liable to pay, under a contract of insurance is not to be reduced on account of an allied health high cost claim indemnity paid or payable, or that would have been payable, to the insurer.

Subdivision B—Certification of qualifying allied health claims

34ZZK When may the Chief Executive Medicare certify a claim as a qualifying allied health claim?

Criteria for certification

(1) The Chief Executive Medicare may issue a certificate stating that a claim is a qualifying allied health claim if the Chief Executive Medicare is satisfied that:

(a) the claim is a claim that is or was made against a person (the ***practitioner***); and

(b) the claim relates to:

(i) an incident that occurs or occurred; or

(ii) a series of related incidents that occur or occurred;

in the course of, or in connection with, the practice by the practitioner of an allied health profession; and

(c) if the allied health profession is midwifery:

(i) the incident occurs or occurred; or

(ii) all of the incidents in the series occur or occurred;

in the course of, or in connection with, practice of a kind in relation to which eligible midwives are ordinarily, or could reasonably be expected in the ordinary course of business to be, engaged as employees (and therefore indemnified from liability by their employer); and

(d) except in the circumstances specified in rules made for the purposes of this paragraph, either:

(i) the incident occurs or occurred; or

(ii) one or more of the incidents in the series occurs or occurred;

in Australia or an external Territory; and

(e) either:

(i) the incident occurs or occurred; or

(ii) all of the incidents in the series occur or occurred;

on or after 1 July 2020; and

(f) the incident did not occur, or the incidents did not all occur, in the course of the provision of treatment to a public patient in a public hospital; and

(g) there is a contract of insurance in relation to which the following requirements are satisfied:

(i) the contract provides medical indemnity cover for the practitioner in relation to the claim, or would, but for the practitioner's contract limit, provide such cover for the practitioner in relation to the claim;

(ii) the practitioner's contract limit equals or exceeds the relevant allied health threshold (see section 34ZZL);

(iii) the insurer is an eligible insurer;

(iv) the insurer entered into the contract in the ordinary course of the insurer's business; and

(h) if a termination date for the allied health exceptional claims indemnity scheme is set (see section 34ZZM), the incident, or one or more of the incidents, to which the claim relates occurred before the allied health termination date; and

(i) the claim is not a claim specified in rules made for the purposes of this paragraph; and

(j) the contract of insurance is not a contract specified in rules made for the purposes of this paragraph; and

(k) a person has applied for the certificate in accordance with section 34ZZN; and

(l) the Chief Executive Medicare could not issue a qualifying claim certificate in relation to the claim if an application for the certificate were made in accordance with section 34H.

Note 1: Paragraph (f)—for what happens if some, but not all, of the incidents in a series occur in the course of the provision of treatment to a public patient in a public hospital, see section 34ZZT.

Note 2: Paragraph (h)—for what happens if some, but not all, of the incidents in a series occur after the allied health termination date, see section 34ZZU.

(2) Any rules made for the purposes of subsection 11(3A) of the *Midwife Professional Indemnity (Commonwealth Contribution) Scheme Act 2010* apply for the purposes of determining whether practice is of a kind mentioned in paragraph (1)(c).

When a certificate is in force

(3) The certificate comes into force when it is issued and remains in force until it is revoked.

Matters to be identified or specified in certificate

(4) The certificate must:

(a) identify:

(i) the practitioner; and

(ii) the claim; and

(iii) the contract of insurance in relation to which paragraph (1)(g) is satisfied; and

(b) specify the relevant allied health threshold.

The certificate may also contain other material.

AAT review of decision to refuse

(5) Applications may be made to the Administrative Appeals Tribunal for review of decisions of the Chief Executive Medicare to refuse to issue a qualifying allied health claim certificate.

Note: Section 27A of the *Administrative Appeals Tribunal Act 1975* requires notification of a decision that is reviewable.

Chief Executive Medicare to give applicant copy of certificate

(6) If the Chief Executive Medicare decides to issue a qualifying allied health claim certificate, the Chief Executive Medicare must, within 28 days of making the decision, give the applicant a copy of the certificate. However, a failure to comply does not affect the validity of the decision.

34ZZL What is the relevant allied health threshold?

The relevant allied health threshold

(1) The ***relevant allied health threshold*** is $20 million, or such other amount as is specified in the rules as the threshold.

Threshold specified in rules only applies to contracts entered into after the rules commence

(2) A rule specifying an amount as the threshold (or changing the amount previously so specified) only applies in relation to contracts of insurance entered into after the rule commences.

When rules reducing the threshold commence

(3) A rule reducing the threshold (which could be the threshold originally applicable under subsection (1), or that threshold as already changed by rules) commences on the date specified in the rules, which must be the date on which the rules are registered on the Federal Register of Legislation or a later day.

When rules increasing the threshold commence

(4) A rule increasing the threshold (which could be the threshold originally applicable under subsection (1), or that threshold as already changed by rules), commences on the date specified in the rules, which must be at least 3 months after the date on which the rules are registered on the Federal Register of Legislation.

34ZZM Setting the allied health termination date

(1) The rules may set a termination date for the allied health exceptional claims indemnity scheme.

Note: The scheme does not cover incidents that occur after the allied health termination date (see paragraph 34ZZK(1)(h) and section 34ZZU).

(2) The termination date cannot be before the date on which the rules are registered on the Federal Register of Legislation.

34ZZN Application for a qualifying allied health claim certificate

(1) An application for the issue of a qualifying allied health claim certificate in relation to a claim may be made by the person against whom the claim is or was made, or by a person acting on that person's behalf.

(2) The application must:
(a) be made in writing using a form approved by the Chief Executive Medicare; and
(b) be accompanied by the documents and other information required by the form approved by the Chief Executive Medicare.

34ZZO Time by which an application must be decided

(1) Subject to subsections (2) and (3), the Chief Executive Medicare is to decide an application for the issue of a qualifying allied health claim certificate on or before the 21st day after the day on which the application is received by the Chief Executive Medicare.

(2) If the Chief Executive Medicare requests a person to give information under section 38 in relation to the application, the Chief Executive Medicare does not have to decide the application until the 21st day after the day on which the person gives the information to the Chief Executive Medicare.

(3) The Chief Executive Medicare may treat an application as having been withdrawn if:

(a) the Chief Executive Medicare requests the person who applied for the certificate to give information under section 38 in relation to the application; and

(b) the person does not give the information to the Chief Executive Medicare by the end of the day specified in the request.

(4) The Chief Executive Medicare must notify the person who applied for the certificate if the Chief Executive Medicare treats the application as having been withdrawn.

34ZZP Obligation to notify the Chief Executive Medicare if information is incorrect or incomplete

(1) If:

(a) a qualifying allied health claim certificate is in force in relation to a claim; and

(b) a person becomes aware that the information provided to the Chief Executive Medicare in connection with the application for the certificate was incorrect or incomplete, or is no longer correct or complete; and

(c) the person is:

(i) the person who applied for the certificate; or

(ii) another person who has applied for a payment of allied health exceptional claims indemnity, or for a payment under regulations made for the purposes of section 34ZZZD (allied health exceptional claims payments), in relation to the claim;

the person must notify the Chief Executive Medicare of the respect in which the information was incorrect or incomplete, or is no longer correct or complete.

Note: Failure to notify is an offence (see section 46).

(2) The notification must:

(a) be made in writing; and

(b) be given to the Chief Executive Medicare within 28 days after the person becomes aware as mentioned in subsection (1).

34ZZQ Revocation and variation of qualifying allied health claim certificates

Revocation

(1) The Chief Executive Medicare may revoke a qualifying allied health claim certificate if the Chief Executive Medicare is no longer satisfied as mentioned in subsection 34ZZK(1) in relation to the claim.

(2) To avoid doubt, in considering whether the Chief Executive Medicare is still satisfied as mentioned in subsection 34ZZK(1) in relation to the claim, the Chief Executive Medicare may have regard to matters that have occurred since the decision to issue the qualifying allied health claim certificate was made, including for example:

(a) the making of rules for the purpose of paragraph 34ZZK(1)(i) or (j); or

(b) changes to the terms and conditions of the contract of insurance identified in the certificate.

Variation

(3) If the Chief Executive Medicare is satisfied that a matter is not correctly identified or specified in a qualifying allied health claim certificate, the Chief Executive Medicare may vary the certificate so that it correctly identifies or specifies the matter.

Effect of revocation

(4) If:

(a) the Chief Executive Medicare revokes a qualifying allied health claim certificate; and

(b) an amount of allied health exceptional claims indemnity has already been paid in relation to the claim;

the amount is an amount overpaid to which section 41 applies.

Effect of variation

(5) If:

(a) the Chief Executive Medicare varies a qualifying allied health claim certificate; and

(b) an amount of allied health exceptional claims indemnity has already been paid in relation to the claim, and that amount exceeds the amount that would have been paid if the amount of indemnity had been determined having regard to the certificate as varied;

the amount of the excess is an amount overpaid to which section 41 applies.

AAT review of decision to revoke or vary

(6) Applications may be made to the Administrative Appeals Tribunal for review of decisions of the Chief Executive Medicare to revoke or vary a qualifying allied health claim certificate.

Note: Section 27A of the *Administrative Appeals Tribunal Act 1975* requires notification of a decision that is reviewable.

Chief Executive Medicare to give applicant copy of varied certificate

(7) If the Chief Executive Medicare decides to vary a qualifying allied health claim certificate, the Chief Executive Medicare must, within 28 days of making the decision, give the applicant a copy of the varied certificate. However, a failure to comply does not affect the validity of the decision.

Subdivision C—Allied health exceptional claims indemnity

34ZZR When is an allied health exceptional claims indemnity payable?

Criteria for payment of indemnity

(1) The Chief Executive Medicare may decide that an allied health exceptional claims indemnity is payable in relation to a liability of a person (the ***practitioner***) if:

(a) a claim for compensation or damages (the ***current claim***) is, or was, made against the practitioner by another person; and

(b) a qualifying allied health claim certificate is in force in relation to the current claim; and

(c) the liability is a qualifying allied health liability of the practitioner in relation to the current claim (see section 34ZZS); and

(d) because of the practitioner's contract limit in relation to the contract of insurance identified in the qualifying allied health claim certificate, the contract does not cover, or does not fully cover, the liability; and

(e) the amount that, if the practitioner's contract limit had been high enough to cover the whole of the liability, the insurer would (subject to the other terms and conditions of the contract) have been liable to pay under the contract of insurance in relation to the liability exceeds the actual amount (if any) that the insurer has paid or is liable to pay under the contract in relation to the liability; and

(f) the aggregate of:

(i) the amount (if any) the insurer has paid, or is liable to pay, in relation to the liability under the contract of insurance; and

(ii) the other amounts (if any) that the insurer has already paid, or has already become liable to pay, under the contract in relation to the current claim; and

(iii) the amounts (if any) that the insurer has already paid, or has already become liable to pay, under the contract in relation to any other claim against the practitioner that relates to an incident, or series of related incidents, covered by subsection (2) (being other claims that were first notified to the insurer no later than the time the current claim was notified to the insurer);

equals or exceeds the relevant allied health threshold identified in the qualifying allied health claim certificate; and

(g) a person has applied for the indemnity in accordance with section 37A.

Note 1: For how paragraphs (e) and (f) apply:

(a) if there are deductibles—see section 8B; or

(b) if an allied health high cost claim indemnity is paid or payable—see section 34ZZJ; or

(c) if the insurer is a Chapter 5 body corporate—see subsection (6); or

(d) if the claim relates to a series of incidents some, but not all, of which occurred in the course of the provision of treatment to a public patient in a public hospital—see section 34ZZT; or

(e) if the claim relates to a series of incidents some, but not all, of which occurred after the allied health termination date—see section 34ZZU.

Note 2: For the purpose of subparagraphs (f)(i) and (ii), payments and liabilities to pay must meet the ordinary course of business requirement set out in subsection (5).

(2) For the purposes of subparagraph (1)(f)(iii), an incident or series of related incidents is covered by this subsection if the incident occurs or occurred, or the series of related incidents all occur or occur:

(a) on or after 1 July 2020; and

(b) in the course of, or in connection with:

(i) practice by the practitioner of an allied health profession other than midwifery; or

(ii) practice by the practitioner of midwifery, if the practice is of a kind in relation to which eligible midwives are ordinarily, or could reasonably be expected in the ordinary course of business to be, engaged as employees

(and therefore indemnified from liability by their employer).

(3) Any rules made for the purposes of subsection 11(3A) of the *Midwife Professional Indemnity (Commonwealth Contribution) Scheme Act 2010* apply for the purposes of determining whether practice is of a kind mentioned in subparagraph (2)(b)(ii).

Who the indemnity is payable to

(4) The indemnity is to be paid to the person who applies for it.

Note: For who can apply, see section 37A.

Ordinary course of business test for insurance payments

(5) An amount that an insurer has paid, or is liable to pay, under a contract of insurance does not count for the purpose of subparagraph (1)(f)(i) or (ii) unless it is an amount that the insurer paid, or is liable to pay, in the ordinary course of the insurer's business.

What if the insurer is a Chapter 5 body corporate?

(6) If an insurer is a Chapter 5 body corporate:

(a) a reference in paragraphs (1)(e) and (f) to an amount that the insurer is liable to pay under a contract of insurance is a reference to an amount that the insurer is liable to pay under the contract and that is a provable amount; and

(b) a reference in subsection (5) to an amount that an insurer is liable to pay in the ordinary course of the insurer's business is a reference to an amount that the insurer is liable to pay, and would be able to pay in the ordinary course of the insurer's business if it were not a Chapter 5 body corporate.

AAT review of decision to refuse, or to pay a particular amount of indemnity

(7) Applications may be made to the Administrative Appeals Tribunal for review of the following decisions of the Chief Executive Medicare:

(a) a decision to refuse an application for allied health exceptional claims indemnity;

(b) a decision to pay a particular amount of allied health exceptional claims indemnity.

Note: Section 27A of the *Administrative Appeals Tribunal Act 1975* requires notification of a decision that is reviewable.

34ZZS Qualifying allied health liabilities

A person (the ***practitioner***) has a ***qualifying allied health liability*** in relation to a claim made against the person if:

(a) one of the following applies:

(i) the liability is under a judgment or order of a court in relation to the claim, being a judgment or order that is not stayed and is not subject to appeal;

(ii) the liability is under a settlement of the claim that takes the form of a written agreement between the parties to the claim;

(iii) the liability is some other kind of liability of the practitioner (for example, a liability to legal costs) that relates to the claim; and

(b) the defence of the claim against the practitioner was conducted appropriately up to the time when:

(i) if the liability is under a judgment or order of a court—the date on which the judgment or order became a judgment or order that is not stayed and is not subject to appeal; or

(ii) if the liability is under a settlement of the claim—the date on which the settlement agreement was entered into; or

(iii) if the liability is some other kind of liability—the date on which the liability was incurred; and

(c) if the liability is under a settlement of the claim, or is under a consent order made by a court—a legal practitioner has given a statutory declaration certifying that the amount of the liability is reasonable.

Note: For paragraph (b), see the definitions of ***defence*** and ***conducted appropriately*** in subsection 4(1).

34ZZT Treatment of a claim that partly relates to a public patient in a public hospital

If:

(a) a claim against a person relates to a series of incidents; and

(b) some, but not all, of the incidents occurred in the course of the provision of treatment to a public patient in a public hospital;

then, for the purposes of applying paragraph 34ZZR(1)(e) and subparagraphs 34ZZR(1)(f)(i) and (ii) in relation to the claim, an amount that an insurer has paid or is liable to pay, or would have been liable to pay, in relation to the claim, is to be reduced by the extent (if any) to which the amount relates or would relate to, or is or would be reasonably attributable to, the incident or incidents that occurred in the course of the provision of treatment to a public patient in a public hospital.

34ZZU Treatment of a claim that relates to a series of incidents some of which occurred after the allied health termination date

If:

(a) a claim against a person relates to a series of incidents; and

(b) some, but not all, of the incidents occurred after the allied health termination date;

then, for the purposes of applying paragraph 34ZZR(1)(e) and subparagraphs 34ZZR(1)(f)(i) and (ii) in relation to the claim, an amount that an insurer has paid or is liable to pay, or would have

been liable to pay, in relation to the claim, is to be reduced by the extent (if any) to which the amount relates or would relate to, or is or would be reasonably attributable to, the incident or incidents that occurred after the allied health termination date.

34ZZV The amount of allied health exceptional claims indemnity that is payable

The amount of allied health exceptional claims indemnity that is payable in relation to a particular qualifying allied health liability is the amount of the excess referred to in paragraph 34ZZR(1)(e).

Note: It is only liabilities that exceed the practitioner's contract limit that will be covered by an allied health exceptional claims indemnity (even if the relevant allied health threshold is less than that limit).

34ZZW How allied health exceptional claims indemnity is to be applied

(1) This section applies if an allied health exceptional claims indemnity is paid to a person (the ***recipient***) in relation to a liability of a person (the ***practitioner***).

Note: The recipient will either be the practitioner, or a person acting on behalf of the practitioner.

Chief Executive Medicare to give recipient of payment a notice identifying the liability to be discharged

(2) The Chief Executive Medicare must give the recipient a written notice (the ***payment notice***) identifying the liability in relation to which the indemnity is paid, and advising the recipient how this section requires the indemnity to be dealt with.

Recipient's obligation if the amount of the indemnity equals or is less than the liability

(3) If the amount of the indemnity equals or is less than the undischarged amount of the liability identified in the payment notice, the recipient must apply the whole of the indemnity towards the discharge of the liability.

Recipient's obligation if the amount of the indemnity exceeds the liability

(4) If the amount of the indemnity is greater than the undischarged amount of the liability identified in the payment notice, the recipient must:

(a) apply so much of the indemnity as equals the undischarged amount of the liability towards the discharge of the liability; and

(b) if the recipient is not the practitioner—deal with the balance of the indemnity in accordance with the directions of the practitioner.

Time by which recipient must comply with obligation

(5) The recipient must comply with whichever of subsections (3) and (4) applies:

(a) by the time specified in a written direction (whether contained in the payment notice or otherwise) given to the recipient by the Chief Executive Medicare; or

(b) if no such direction is given to the recipient—as soon as practicable after the indemnity is received by the recipient.

To avoid doubt, the Chief Executive Medicare may vary a direction under paragraph (a) to specify a different time.

Debt to Commonwealth if recipient does not comply with obligation on time

(6) If the recipient does not comply with whichever of subsections (3) and (4) applies by the time required by subsection (5), the amount of the indemnity is a debt due to the Commonwealth.

(7) The debt may be recovered:

(a) by action by the Chief Executive Medicare against the recipient in a court of competent jurisdiction; or

(b) under section 42.

(8) If the amount of the indemnity is recoverable, or has been recovered, as mentioned in subsection (7), no amount is recoverable under section 34ZZZ or section 41 in relation to the same payment of allied health exceptional claims indemnity.

34ZZX Who is liable to repay an overpayment of allied health exceptional claims indemnity?

(1) This section applies if, in relation to an allied health exceptional claims indemnity that has been paid, there is an amount overpaid as described in subsection 34ZZZ(2) or 41(2).

(2) The ***liable person***, in relation to the amount overpaid, is:

(a) if the indemnity has not yet been dealt with in accordance with whichever of subsections 34ZZW(3) and (4) applies—the recipient referred to in subsection 34ZZW(1); or

(b) if the indemnity has been dealt with in accordance with whichever of those subsections applies—the practitioner referred to in subsection 34ZZW(1).

Note: The recipient and the practitioner will be the same person if the indemnity was paid to the practitioner.

(3) If:

(a) the recipient and the practitioner referred to in subsection 34ZZW(1) are not the same person; and

(b) when the overpayment is recovered as a debt, the liable person is the recipient;

the fact that the recipient may later deal with the remainder of the indemnity in accordance with subsection 34ZZW(3) or (4) does not mean that the overpayment should instead have been recovered from the practitioner.

Subdivision D—Payments that would have reduced the amount paid out under the contract of insurance

34ZZY Amounts paid before payment of allied health exceptional claims indemnity

(1) If:

(a) an amount (the ***insurance payment***) has been paid under a contract of insurance that provides medical indemnity cover for a person (the ***practitioner***) in relation to a liability of the practitioner; and

(b) another amount (not being an amount referred to in subsection (2)) has been paid to the practitioner, the insurer or another person in relation to the incident or incidents to which the liability relates; and

(c) the other amount was not taken into account in working out the amount of the insurance payment; and

(d) if the other amount had been taken into account in working out the amount of the insurance payment, a lesser amount would have been paid under the contract of insurance in relation to the liability;

then, for the purpose of calculating the amount of allied health exceptional claims indemnity (if any) that is payable in relation to a liability of the practitioner, the lesser amount is taken to have been the amount of the insurance payment.

(2) This section does not apply to any of the following:

(a) an amount paid to an insurer by another insurer under a right of contribution;

(b) a payment of allied health high cost claim indemnity;

(c) an amount of a kind specified in the rules for the purposes of this paragraph.

34ZZZ Amounts paid after payment of allied health exceptional claims indemnity

(1) This section applies if:

(a) an amount (the ***actual indemnity amount***) of allied health exceptional claims indemnity has been paid in relation to a qualifying allied health liability that relates to a claim made against a person (the ***practitioner***); and

(b) another amount (not being an amount referred to in subsection (5)) is paid to the practitioner, an insurer or another person in relation to the incident or incidents to which the claim relates, or in relation to one or more other incidents; and

(c) the other amount was not taken into account in calculating the actual indemnity amount; and

(d) if the other amount had been so taken into account, a lesser amount (the ***reduced indemnity amount***, which could be zero) of allied health exceptional claims indemnity would have been paid in relation to the liability.

(2) The ***amount overpaid*** is the amount by which the actual indemnity amount exceeds the reduced indemnity amount.

(3) If the Chief Executive Medicare has given the liable person (see subsection 34ZZX(2)) a notice under subsection 34ZZZB(1) in relation to the amount overpaid, the amount is a debt owed to the Commonwealth by the liable person.

Note 1: If the indemnity is or was not dealt with in accordance with whichever of subsections 34ZZW(3) and (4) applies by the time required by subsection 34ZZW(5), the whole amount of the indemnity is a debt owed by the recipient, and no amount is recoverable under this section (see subsections 34ZZW(6) to (8)).

Note 2: If:

(a) the recipient and the practitioner referred to in subsection 34ZZW(1) are not the same person; and

(b) the practitioner becomes the liable person;

then (subject to subsection 34ZZX(3)), the recipient ceases to be the liable person, and the amount overpaid must instead be recovered from the practitioner.

(4) The amount overpaid may be recovered:

(a) by action by the Chief Executive Medicare against the liable person in a court of competent jurisdiction; or

(b) under section 42.

(5) This section does not apply to any of the following:
(a) an amount paid to an insurer by another insurer under a right of contribution;
(b) a payment of allied health high cost claim indemnity;
(c) an amount of a kind specified in the rules for the purposes of this paragraph.

34ZZZA Obligation to notify the Chief Executive Medicare that amount has been paid

(1) If:
(a) an amount of allied health exceptional claims indemnity has been paid in relation to a qualifying allied health liability that relates to a claim made against a person (the ***practitioner***); and
(b) the person (the ***applicant***) who applied for the allied health exceptional claims indemnity becomes aware that another amount has been paid to the practitioner, an insurer or another person in relation to the incident or incidents to which the claim relates, or in relation to one or more other incidents; and
(c) because of the payment of the other amount, there is an amount overpaid as described in subsection 34ZZZ(2);

the applicant must notify the Chief Executive Medicare that the other amount has been paid.

Note: Failure to notify is an offence (see section 46).

(2) The notification must:
(a) be in writing; and
(b) be given to the Chief Executive Medicare within 28 days after the applicant becomes aware that the other amount has been paid.

34ZZZB The Chief Executive Medicare to notify of amount of debt due

(1) If:

(a) an amount of allied health exceptional claims indemnity has been paid in relation to a qualifying allied health liability that relates to a claim made against a person (the ***practitioner***); and

(b) another amount is paid to the practitioner, an insurer or another person in relation to the incident or incidents to which the claim relates, or in relation to one or more other incidents; and

(c) because of the payment of the other amount, there is an amount overpaid as described in subsection 34ZZZ(2);

the Chief Executive Medicare may give the liable person (see subsection 34ZZX(2)) a written notice that specifies:

(d) the amount overpaid, and that it is a debt owed to the Commonwealth under subsection 34ZZZ(3); and

(e) the day before which the amount must be paid to the Commonwealth; and

(f) the effect of section 34ZZZC.

The day specified under paragraph (e) must be at least 28 days after the day on which the notice is given.

(2) The debt becomes due and payable on the day specified under paragraph (1)(e).

34ZZZC Penalty imposed if an amount is repaid late

(1) If:

(a) a person owes a debt to the Commonwealth under subsection 34ZZZ(3); and

(b) the debt remains wholly or partly unpaid after it becomes due and payable;

the person is liable to pay a late payment penalty under this section.

(2) The late payment penalty is calculated:
  (a) at the rate specified in the rules for the purposes of this paragraph; and
  (b) on the unpaid amount; and
  (c) for the period:
    (i) starting when the amount becomes due and payable; and
    (ii) ending when the amount, and the penalty payable under this section in relation to the amount, have been paid in full.

(3) The Chief Executive Medicare may remit the whole or a part of an amount of late payment penalty if the Chief Executive Medicare considers that there are good reasons for doing so.

(4) Applications may be made to the Administrative Appeals Tribunal for review of decisions of the Chief Executive Medicare not to remit, or to remit only part of, an amount of late payment penalty.

Note: Section 27A of the *Administrative Appeals Tribunal Act 1975* requires notification of a decision that is reviewable.

(5) If:
  (a) the recipient and the practitioner referred to in subsection 34ZZW(1) are not the same person; and
  (b) the practitioner becomes the liable person; and
  (c) the recipient has or had a liability under this section to pay late payment penalty;

the recipient's liability to the late payment penalty is not affected by the fact that the recipient is no longer the person who owes the debt to the Commonwealth under subsection 34ZZZ(3), except that the period referred to in paragraph (2)(c) of this section ends when the practitioner becomes the liable person.

Subdivision E—Regulations may provide for payments

34ZZZD Regulations may provide for payments in relation to allied health exceptional claims

(1) The regulations may provide in relation to making payments to eligible insurers of claim handling fees, and payments on account of legal, administrative or other costs incurred by eligible insurers (whether on their own behalf or otherwise), in respect of claims in relation to which qualifying allied health claim certificates have been issued.

(2) Without limiting subsection (1), the regulations may:

(a) make provision for:

(i) the conditions that must be satisfied for an amount to be payable to an eligible insurer; and

(ii) the amount that is payable; and

(iii) the conditions that must be complied with by an eligible insurer to which an amount is paid; and

(iv) other matters related to the making of payments, and the recovery of overpayments; and

(b) provide that this Division applies with specified modifications in relation to a liability that relates to costs in relation to which an amount has been paid under regulations made for the purposes of this section; and

(c) make provision for making payments on account of legal, administrative or other costs incurred by eligible insurers (whether on their own behalf or otherwise), in respect of incidents notified to eligible insurers that could give rise to claims in relation to which an allied health exceptional claims indemnity could be payable.

(3) Paragraph (2)(b) does not allow the regulations to modify a provision that creates an offence, or that imposes an obligation which, if contravened, constitutes an offence.

(4) It does not matter for the purposes of paragraph (2)(c) whether claims are subsequently made in relation to the incidents referred to in that paragraph.

34ZZZE The Chief Executive Medicare may request information

(1) If the Chief Executive Medicare believes that a person is capable of giving information that is relevant to determining:

(a) whether an insurer is entitled to a payment under regulations made for the purposes of section 34ZZZD; or

(b) the amount that is payable to an insurer under regulations made for the purposes of section 34ZZZD;

the Chief Executive Medicare may request the person to give the Chief Executive Medicare the information.

Note: Failure to comply with the request is an offence (see section 45).

(2) Without limiting subsection (1), any of the following persons may be requested to give information under that subsection:

(a) an MDO;

(b) an eligible insurer;

(c) a member or former member of an MDO;

(d) a person who practises, or used to practise, an allied health profession;

(e) a person who is acting, or has acted, on behalf of a person covered by paragraph (d);

(f) a legal personal representative of a person covered by paragraph (c), (d) or (e).

(3) Without limiting subsection (1), if the information sought by the Chief Executive Medicare is information relating to a matter in relation to which a person is required by section 39 to keep a record, the Chief Executive Medicare may request the person to give the information by giving the Chief Executive Medicare the record, or a copy of the record.

(4) The request:

(a) must be made in writing; and

(b) must state what information must be given to the Chief Executive Medicare; and

(c) may require the information to be verified by statutory declaration; and

(d) must specify a day on or before which the information must be given; and

(e) must contain a statement to the effect that a failure to comply with the request is an offence.

The day specified under paragraph (d) must be at least 28 days after the day on which the request was made.

Subdivision F—Miscellaneous

34ZZZF Modifications and exclusions

(1) The regulations may provide that this Division applies with specified modifications in relation to:

(a) a specified class of claims; or

(b) a specified class of contracts of insurance; or

(c) a specified class of situations in which a liability is, whether wholly or partly, covered by more than one contract of insurance.

Note: For the capacity for rules to exclude claims and contracts of insurance, see paragraphs 34ZZK(1)(i) and (j).

(2) The regulations may provide that this Division does not apply, or applies with specified modifications, in relation to a specified class of liabilities or payments.

(3) Without limiting subsection (2), the regulations may specify modifications regarding how this Division applies in relation to a liability under an order of a court requiring an amount to be paid pending the outcome of an appeal, including modifications:

(a) to count the liability as a qualifying allied health liability (even though subparagraph 34ZZS(a)(i) may not be satisfied in relation to the order); and

(b) to deal with what happens if, as a result of the appeal or another appeal, the amount paid later becomes wholly or partly repayable; and

(c) to deal with what happens if the amount paid is later applied towards a liability that is confirmed as a result of the appeal or another appeal.

(4) This section does not allow the regulations to modify a provision that creates an offence, or that imposes an obligation which, if contravened, constitutes an offence.

Division 3—Administration of the indemnity schemes

Subdivision A—Introduction

35 Guide to this Division

(1) This Division makes provision for the administration of the IBNR indemnity scheme, the high cost claim indemnity scheme, the exceptional claims indemnity scheme, the run-off cover indemnity scheme, the allied health high cost claim indemnity scheme and the allied health exceptional claims indemnity scheme.

(2) The following table tells you where to find the provisions dealing with various issues:

Where to find the provisions on various issues

Item	Issue	Provisions
1	how do people apply for the indemnities?	sections 36 and 37A
2	when will the indemnities be paid?	sections 37 and 37B
3	what information has to be provided to the Chief Executive Medicare about indemnity matters?	section 38
4	what records must be kept?	sections 39 and 40
5	how are overpayments of the indemnities, and indemnity repayments, recovered?	sections 41 and 42

Subdivision B—Applications for, and payment of, indemnity scheme payments

36 Application for IBNR indemnity, high cost claim indemnity, run-off cover indemnity or allied health high cost claim indemnity

An application by an MDO or insurer for an IBNR indemnity, a high cost claim indemnity, a run-off cover indemnity or an allied health high cost claim indemnity must:

(a) be made in writing using a form approved by the Chief Executive Medicare; and

(b) be accompanied by the documents and other information required by the form approved by the Chief Executive Medicare.

37 Payment date for IBNR indemnity, high cost claim indemnity, run-off cover indemnity or allied health high cost claim indemnity

(1) Subject to subsections (2) and (2A), the Chief Executive Medicare must pay an IBNR indemnity, a high cost claim indemnity, a run-off cover indemnity or an allied health high cost claim indemnity that is payable to an MDO or insurer before the end of the month that immediately follows the month in which the MDO or insurer applies for the indemnity.

Payment will not be made until requested information is given

(2) Subject to subsection (2A), if:

(a) an MDO or insurer applies for an IBNR indemnity, a high cost claim indemnity, a run-off cover indemnity or an allied health high cost claim indemnity; and

(b) the Chief Executive Medicare requests a person to give information under section 38 in relation to the application; and

(c) the person does not give the Chief Executive Medicare the information requested before the end of the month that immediately follows the month in which the MDO or insurer applies for the indemnity; and

(d) an IBNR indemnity, a high cost claim indemnity, a run-off cover indemnity or an allied health high cost claim indemnity is payable to the MDO or insurer;

the Chief Executive Medicare must pay the IBNR indemnity, the high cost claim indemnity, the run-off cover indemnity or the allied health high cost claim indemnity to the MDO or insurer before the end of the month that immediately follows the month in which the person gives the Chief Executive Medicare the requested information.

Application may be treated as withdrawn if requested information is not given

(2A) The Chief Executive Medicare may treat an application as having been withdrawn if:

(a) the Chief Executive Medicare requests the MDO or insurer who made the application to give information under section 38 in relation to the application; and

(b) the MDO or insurer does not give the information to the Chief Executive Medicare by the end of the day specified in the request.

(2B) The Chief Executive Medicare must notify the MDO or insurer if the Chief Executive Medicare treats the application as having been withdrawn.

Definitions

(3) In this section:

month means one of the 12 months of the year.

37A Application for exceptional claims indemnity or allied health exceptional claims indemnity

(1) An application for an exceptional claims indemnity in relation to a qualifying liability that relates to a claim may be made by the person against whom the claim is or was made, or by a person acting on that person's behalf.

(1A) An application for an allied health exceptional claims indemnity in relation to a qualifying allied health liability that relates to a claim may be made by the person against whom the claim is or was made, or by a person acting on that person's behalf.

(2) An application under subsection (1) or (1A) must:
  (a) be made in writing using a form approved by the Chief Executive Medicare; and
  (b) be accompanied by the documents and other information required by the form approved by the Chief Executive Medicare.

(3) Subject to subsection (5), the application cannot be made more than 28 days after:
  (a) if the liability is under a judgment or order of a court—the date on which the judgment or order became or becomes a judgment or order that is not stayed and is not subject to appeal; or
  (b) if the liability is under a settlement of the claim—the date on which the settlement agreement was entered into; or
  (c) if the liability is some other kind of liability—the date on which the liability was incurred.

(5) The Chief Executive Medicare may accept a late application if the Chief Executive Medicare considers that there are good reasons for doing so.

(6) An application may be made to the Administrative Appeals Tribunal for review of a decision of the Chief Executive Medicare not to accept a late application.

Note: Section 27A of the *Administrative Appeals Tribunal Act 1975* requires notification of a decision that is reviewable.

37B Payment date for exceptional claims indemnity or allied health exceptional claims indemnity

Time by which application must be decided

(1) Subject to subsections (2) and (3), the Chief Executive Medicare is to decide an application for an exceptional claims indemnity or an allied health exceptional claims indemnity on or before the end of the 21st day after the day on which the application is received by the Chief Executive Medicare.

(2) If the Chief Executive Medicare requests a person to give information under section 38 in relation to an application for an exceptional claims indemnity or an allied health exceptional claims indemnity, the Chief Executive Medicare does not have to decide the application until the 21st day after the day on which the person gives the information to the Chief Executive Medicare.

(3) If the Chief Executive Medicare has received, but not yet decided:
   (a) an application (the ***certificate application***) for the issue of a qualifying claim certificate or a qualifying allied health claim certificate in relation to a claim; and
   (b) an application (the ***indemnity application***) for an exceptional claims indemnity or allied health exceptional claims indemnity in relation to the same claim;

   the Chief Executive Medicare does not have to decide the indemnity application until the Chief Executive Medicare has decided the certificate application.

Time by which payment must be made

(4) If the Chief Executive Medicare decides to grant an application for an exceptional claims indemnity or an allied health exceptional claims indemnity, the Chief Executive Medicare must pay the indemnity to the applicant as soon as practicable after making that decision.

Subdivision C—Information gathering and record keeping

38 Chief Executive Medicare may request information

(1) If the Chief Executive Medicare believes on reasonable grounds that a person is capable of giving information that is relevant to determining:

(a) whether an indemnity scheme payment is payable; or

(b) the amount of the indemnity scheme payment that is payable; or

(c) whether a qualifying claim certificate or qualifying allied health claim certificate should be issued, varied or revoked; or

(d) the Commonwealth's possible future liability to make indemnity scheme payments, or a particular kind of indemnity scheme payment;

the Chief Executive Medicare may request the person to give the Chief Executive Medicare the information.

Note 1: Failure to comply with the request is an offence (see section 45).

Note 2: Failure to comply may affect certain indemnity scheme payments: see sections 34I, 34ZZO and 37.

(2) Without limiting subsection (1), any of the following persons may be requested to give information under that subsection:

(a) an MDO;

(b) an insurer;

(c) a member, or former member, of an MDO;

(ca) a person who practises, or used to practise, a medical profession;

(cb) a person who is acting, or has acted, on behalf of a person covered by paragraph (ca);

(d) the legal personal representative of a person covered by paragraph (c), (ca) or (cb).

(3) Without limiting subsection (1), if the information sought by the Chief Executive Medicare is information relating to a matter in

relation to which a person is required by section 39 or 40 to keep a record, the Chief Executive Medicare may request the person to give the information by giving the Chief Executive Medicare the record, or a copy of the record.

(3A) Without limiting paragraph (1)(d), the Chief Executive Medicare may request an MDO or insurer to give information under that paragraph on a periodic basis.

(4) The request:

(a) must be made in writing; and

(b) must state what information must be given to the Chief Executive Medicare; and

(c) may require the information to be verified by statutory declaration; and

(d) must specify the day on or before which the information must be given; and

(e) must contain a statement to the effect that a failure to comply with the request is an offence.

The day specified under paragraph (d) must be at least 28 days after the day on which the request is made.

39 Main record keeping obligations

Records to be kept by person who applies for payment

(1) A person who applies for an indemnity scheme payment, or a payment under regulations made for the purposes of section 27A (IBNR claims payments), 34AA (high cost claims payments), 34X (exceptional claims payments), 34ZN (run-off claims payments), 34ZZG (allied health high cost claims payments) or 34ZZZD (allied health exceptional claims payments), must keep records relevant to the following matters:

(a) the payability of the payment;

(b) the amount of the payment payable;

(c) any amount paid to the person that results in a person being liable to pay an amount under section 24, 34T, 34ZJ or 34ZZZ;

(d) any other matter specified in the rules.

Note: Failure to keep the records is an offence (see section 47).

Records to be kept by person who applies for a qualifying claim certificate or qualifying allied health claim certificate

(1A) A person who applies for the issue of a qualifying claim certificate or a qualifying allied health claim certificate in relation to a claim must keep records that are relevant to the following:

(a) matters related to whether the criteria specified in subsection 34E(1) or 34ZZK(1) are satisfied in relation to the claim;

(b) any other matter specified in the rules.

Note: Failure to keep the records is an offence (see section 47).

Records to be retained for certain period

(2) The records must be retained for a period of 5 years (or any other period specified in the rules) starting on the day on which the records were created.

Note: Failure to retain the records is an offence (see section 47).

Rules regarding additional matters

(3) Rules made for the purposes of paragraph (1)(d) or (1A)(b) must not commence earlier than 14 days after the day on which the rules are registered on the Federal Register of Legislation.

40 Certain insurers and MDOs to keep additional records

Records to be kept

(1) An insurer or MDO that applies for an IBNR indemnity must keep records that are relevant to the following matters:

(d) determining its IBNR exposure as at the end of a financial year;
(e) any other matter specified in the rules.

Note: Failure to keep the records is an offence (see section 47).

Records to be retained for certain period

(2) The records must be retained for a period of 5 years (or any other period specified in the rules) starting on the day on which the records were created.

Note: Failure to retain the records is an offence (see section 47).

Rules regarding additional matters

(3) Rules made for the purposes of paragraph (1)(e) must not commence earlier than 14 days after the day on which the rules are registered on the Federal Register of Legislation.

Subdivision D—Overpayments of the indemnities

41 Recovery of overpayments

(1) This section applies if an amount is paid by way of an indemnity scheme payment and:
(a) the amount of indemnity scheme payment is not payable; or
(b) the amount paid is greater than the amount of the indemnity scheme payment that was payable.

(2) The ***amount overpaid*** is:
(a) the whole of the amount paid if paragraph (1)(a) applies; or
(b) the difference between the amount that was paid and the amount that was payable if paragraph (1)(b) applies.

(3) The amount overpaid is a debt due to the Commonwealth by the liable person. For this purpose the ***liable person*** is:
(a) if the indemnity scheme payment was an IBNR indemnity, a high cost claim indemnity, a run-off cover indemnity or an

allied health high cost claim indemnity—the MDO or insurer to which the payment was made; or

(b) if the indemnity scheme payment was an exceptional claims indemnity—the person who is the liable person under subsection 34R(2); or

(c) if the indemnity scheme payment was an allied health exceptional claims indemnity—the person who is the liable person under subsection 34ZZX(2).

Note 1: For paragraphs (b) and (c), if the exceptional claims indemnity or allied health exceptional claims indemnity is not dealt with as required by section 34Q or 34ZZW, the whole amount of the indemnity is a debt owed by the recipient, and no amount is recoverable under this section (see subsections 34Q(6) to (8) and 34ZZW(6) to (8)).

Note 2: For paragraphs (b) and (c), if:

(a) the recipient and the practitioner are not the same person; and

(b) the practitioner becomes the liable person;

then (subject to subsections 34R(3) and 34ZZX(3)), the recipient ceases to be the liable person, and the amount overpaid must instead be recovered from the practitioner.

(4) The amount overpaid may be recovered:

(a) by action by the Chief Executive Medicare against the liable person in a court of competent jurisdiction; or

(b) by deduction from the amount of an IBNR indemnity, a high cost claim indemnity, a run-off cover indemnity or an allied health high cost claim indemnity payable to the liable person; or

(c) under section 42.

The total amount recovered must not exceed the amount overpaid.

Subdivision E—Recovery of repayment or overpayment debt

42 Chief Executive Medicare may collect money from a person who owes money to a person

What this section does

(1) This section allows the Chief Executive Medicare to collect money from a person who owes money to a person (the ***liable person***) who has a debt to the Commonwealth under subsection 24(4), 34Q(6), 34T(3), 34ZJ(3), 34ZZW(6), 34ZZZ(3) or 41(3) (the ***repayment or overpayment debt***).

The Chief Executive Medicare may give direction

(2) The Chief Executive Medicare may direct a person (the ***third party***) who owes, or may later owe, money (the ***available money***) to the liable person to pay some or all of the available money to the Chief Executive Medicare in accordance with the direction. The Chief Executive Medicare must give a copy of the direction to the liable person.

Limit on directions

(3) The direction must:
  (a) not require an amount to be paid to the Chief Executive Medicare at a time before it becomes owing by the third party to the liable person; and
  (b) specify a period of not less than 14 days within which the third party must comply with the direction.

(3A) If:
  (a) the repayment or overpayment debt relates to an exceptional claims indemnity or an allied health exceptional claims indemnity; and
  (b) the recipient and the practitioner referred to in subsection 34Q(1) or 34ZZW(1) are not the same person; and
  (c) the practitioner becomes the liable person; and

(d) the direction was given to the recipient;

the direction ceases to have effect when the practitioner becomes the liable person.

Third party to comply

(4) The third party commits an offence if the third party fails to comply with the direction.

Penalty: 20 penalty units.

(5) The third party does not commit an offence against subsection (4) if the third party complies with the direction so far as the third party is able to do so.

Note: A defendant bears an evidential burden in relation to the matter in this subsection (see subsection 13.3(3) of the *Criminal Code*).

(6) An offence against subsection (4) is an offence of strict liability.

Note: For ***strict liability***, see section 6.1 of the *Criminal Code*.

Court orders

(7) If a person is convicted of an offence in relation to a failure of the third party to comply with subsection (4), the court may (in addition to imposing a penalty on the convicted person) order the convicted person to pay to the Commonwealth an amount up to the amount involved in the failure of the third party.

Indemnity

(8) Any payment made by the third party under this section is taken to have been made with the authority of the liable person and of all other persons concerned and the third party is indemnified for the payment.

Notice

(9) If the whole of the repayment or overpayment debt of the liable person is discharged before any payment is made by the third

party, the Chief Executive Medicare must immediately give notice to the third party of that fact.

(10) If a part of the repayment or overpayment debt of the liable person is discharged before any payment is made by the third party, the Chief Executive Medicare must:

(a) immediately give notice to the third party of that fact; and

(b) make an appropriate variation to the direction; and

(c) give a copy of the varied direction to the liable person.

When third party is taken to owe money

(11) The third party is taken to owe money to the liable person if:

(a) money is due or accruing by the third party to the liable person; or

(b) the third party holds money for or on account of the liable person; or

(c) the third party holds money on account of some other person for payment to the liable person; or

(d) the third party has authority from some other person to pay money to the liable person;

whether or not the payment of the money to the liable person is dependent on a pre-condition that has not been fulfilled.

Division 4—Medical indemnity premium subsidy scheme

43 Regulations may provide for subsidy scheme

(1) The regulations may provide for one or more schemes for one or more of the following:

(a) making payments to:

(i) medical practitioners; or

(ii) medical indemnity insurers on behalf of medical practitioners;

to help those medical practitioners meet the cost of purchasing medical indemnity (whether such costs are incurred by way of MDO membership subscriptions, insurance premiums or otherwise);

(aa) making payments to:

(i) medical practitioners; or

(ii) medical indemnity insurers on behalf of medical practitioners;

to help those medical practitioners meet the cost of paying run-off cover support payments;

(b) making payments to medical indemnity insurers to help the medical indemnity insurers meet the cost of administering schemes provided for under paragraph (a).

(2) Without limiting subsection (1), a scheme may make provision for:

(a) the conditions that must be satisfied for a subsidy to be payable; and

(b) the amount of a subsidy; and

(c) the conditions that must be complied with by persons to whom a subsidy is paid; and

(d) payments to medical indemnity insurers to reduce the costs of medical indemnity for medical practitioners; and

(e) any amount payable to the Commonwealth to be recovered as a debt.

(3) Without limiting paragraph (2)(a), a scheme may provide that a subsidy is to be paid only:
   (a) to medical practitioners working in particular areas of medical practice; or
   (b) for the purchase of particular kinds of medical indemnity.

44 Chief Executive Medicare may request information

(1) If the Chief Executive Medicare believes on reasonable grounds that a person is capable of giving information that is relevant to determining:
   (a) whether a subsidy is payable to a person under a scheme provided for under subsection 43(1); or
   (b) the amount of a subsidy that is payable to a person under a scheme provided for under subsection 43(1);

   the Chief Executive Medicare may request the person to give the Chief Executive Medicare the information.

   Note: Failure to comply with the request is an offence (see section 45).

(2) The request:
   (a) must be made in writing; and
   (b) must state what information must be given to the Chief Executive Medicare; and
   (c) may require the information to be verified by statutory declaration; and
   (d) must specify a day on or before which the information must be given; and
   (e) must contain a statement to the effect that a failure to comply with the request is an offence.

   The day specified under paragraph (d) must be at least 28 days after the day on which the request is made.

44B Chief Executive Medicare may notify run-off cover credits

The Chief Executive Medicare may notify a medical practitioner of:

(a) the practitioner's run-off cover credit for a financial year; or
(b) the amount worked out in relation to the practitioner under Step 2 of the Method Statement in subsection 34ZS(1) for a financial year; or
(c) if a termination date for the run-off cover indemnity scheme has been set (see subsection 34ZB(3))—the practitioner's total run-off cover credit.

Division 5—Offences

45 Failing to give information

(1) This section applies if a person is given a request for information under:

(a) subsection 27B(1); or

(b) subsection 27C(3); or

(bab) subsection 34AB(1); or

(ba) subsection 34Y(1); or

(bb) subsection 34ZO(1); or

(bc) subsection 34ZZH(1); or

(bd) subsection 34ZZZE(1); or

(c) subsection 38(1); or

(d) subsection 44(1).

(2) The person commits an offence if the person fails to comply with the request.

Penalty: 30 penalty units.

(3) An individual is excused from complying with the request if the giving of the information might tend to incriminate the individual or expose the individual to a penalty.

(4) An offence against subsection (2) is an offence of strict liability.

Note: For ***strict liability***, see section 6.1 of the *Criminal Code*.

46 Failing to notify

(1) This section applies if section 25, 34J, 34U, 34ZK, 34ZT, 34ZU, 34ZZP or 34ZZZA requires a person to notify the Chief Executive Medicare of a matter within a particular period.

(2) The person commits an offence if the person fails to notify the Chief Executive Medicare of the matter within that period.

Penalty: 30 penalty units.

(3) An offence against subsection (2) is an offence of strict liability. However, strict liability does not apply to the physical element described in paragraph 34J(1)(b), 34U(1)(b), 34ZK(1)(b), 34ZZP(1)(b) or 34ZZZA(1)(b).

Note: For ***strict liability***, see section 6.1 of the *Criminal Code*.

47 Failing to keep and retain records

(1) This section applies if section 39 or 40 requires a person to keep records or to retain records for a particular period.

(2) The person commits an offence if the person fails to keep the records or fails to retain the records for that period.

Penalty: 30 penalty units.

(3) An offence against subsection (2) is an offence of strict liability.

Note: For ***strict liability***, see section 6.1 of the *Criminal Code*.

47A Failing to include required information in invoices

(1) This section applies if section 34ZV applies to an invoice that a medical indemnity insurer gives to a person.

(2) A person commits an offence if:
(a) the person is a medical indemnity insurer; and
(b) the person gives such an invoice to another person; and
(c) the invoice does not state the matters required by section 34ZV.

Penalty: 30 penalty units.

(3) An offence against subsection (2) is an offence of strict liability.

Note: For ***strict liability***, see section 6.1 of the *Criminal Code*.

(4) To avoid doubt, subsection 4B(3) of the *Crimes Act 1914* applies to any offence against this section committed by a body corporate, as

if an offence against that provision could be committed by a natural person.

(5) Subsection (4) does not affect the meaning of any other offence against this Act.

Division 6—Finance

48 Appropriation

The Consolidated Revenue Fund is appropriated for the purposes of paying:

(a) IBNR indemnities; and

(b) high cost claim indemnities; and

(ba) exceptional claims indemnities; and

(bc) run-off cover indemnities; and

(bd) allied health high cost claim indemnities; and

(be) allied health exceptional claims indemnities; and

(bf) amounts payable under regulations made for the purposes of section 27A (IBNR claims payments), 34AA (high cost claims payments), 34X (exceptional claims payments), 34ZN (run-off claims payments), 34ZZG (allied health high cost claims payments) or 34ZZZD (allied health exceptional claims payments); and

(c) subsidies payable under a scheme provided for under subsection 43(1).

Division 7—Reinsurance contracts

49 Indemnity scheme payments disregarded for purposes of reinsurance contracts

(1) If:

(a) a contract is a contract of insurance:

(i) between 2 insurers; or

(ii) between an insurer and an MDO that are not related bodies corporate; and

(b) the contract is governed by the laws of a State or Territory;

the contract has effect as if the contract provided, and had at all times provided, that:

(c) indemnity scheme payments; and

(d) MDOs' and insurers' rights to indemnity scheme payments;

were to be disregarded for all purposes and, without limiting this, were to have no effect on the amounts payable under the contract by the insurer providing the insurance.

(2) By force of this subsection, subsection (1) applies to a contract if it is entered into on or after the commencement of this Act.

(3) By force of this subsection, subsection (1) applies to a contract if it was entered into before the commencement of this Act.

Division 8—Monitoring

50 Insurers may be required to provide information

The rules may require a medical indemnity insurer to provide to the Secretary information about any of the following:

(a) premium costs for medical indemnity cover provided by contracts of insurance with the insurer;

(b) the income of medical practitioners, or persons who practise an allied health profession, for whom contracts of insurance with the insurer provide medical indemnity cover;

(c) the profitability of the insurer;

(d) the insurer's reinsurance arrangements and costs.

Part 2A—Universal cover obligation

Division 1—Introduction

51 Guide to the universal cover obligation provisions

(1) This Part prevents medical indemnity insurers from refusing to provide medical indemnity cover for medical practitioners in relation to private medical practice, except in certain circumstances.

(2) This Part also specifies when a medical indemnity insurer may require a medical practitioner to pay a risk surcharge.

(3) Medical indemnity insurers must keep records and provide information in relation to these requirements.

51A Winding up of medical indemnity insurer

This Part has effect subject to section 116 of the *Insurance Act 1973*.

Note: Under that section, a general insurer must not carry on insurance business after it starts to be wound up. A general insurer will not contravene this Part by refusing to enter into an insurance contract if the winding up of the insurer has started.

Division 2—Requirements in relation to providing professional indemnity cover

52 Division applies for the purposes of the AFCA scheme

A medical indemnity insurer is not required to comply with this Division other than for the purposes of the AFCA scheme (within the meaning of the *Corporations Act 2001*).

Note: A medical practitioner can make a complaint to AFCA about certain issues relating to medical indemnity insurance.

52A Universal cover obligation

A medical indemnity insurer must not refuse to enter into a contract of insurance with a medical practitioner to provide professional indemnity cover unless:

(a) in relation to a contract of insurance between the practitioner and the insurer to provide professional indemnity cover, the practitioner:

(i) failed to comply with the duty of the utmost good faith (within the meaning of the *Insurance Contracts Act 1984*); or

(ii) failed to comply with the duty of disclosure (within the meaning of that Act); or

(iii) made a misrepresentation to the insurer during the negotiations for the contract but before it was entered into; or

(iv) failed to comply with a provision of the contract, including a provision with respect to payment of the premium; or

(v) made a fraudulent claim under the contract; or

(b) the practitioner places the public at risk of substantial harm in the practitioner's private medical practice because the practitioner has an impairment (within the meaning of the Health Practitioner Regulation National Law); or

(c) the practitioner's private medical practice poses an unreasonable risk of substantial harm to the public or patients; or

(d) the practitioner poses an unreasonable risk of harm to members of the insurer's staff because of persistent threatening or abusive behaviour towards members of the insurer's staff; or

(e) the practitioner has persistently failed to comply with reasonable risk management requirements of the insurer; or

(f) the circumstances specified in the rules apply.

52B Medical indemnity insurer to notify of refusal

(1) If a medical indemnity insurer refuses to enter into a contract of insurance with a medical practitioner to provide professional indemnity cover, the insurer must notify the practitioner in writing in accordance with any requirements specified in the rules.

(2) Without limiting subsection (1), the rules may specify:

(a) the information that must be included in the notification; and

(b) a time within which the insurer must notify.

52C Risk surcharge requirements

(1) Subject to subsections (3) and (4), a medical indemnity insurer may require a medical practitioner (the ***practitioner***) to pay, as part of the amount payable for professional indemnity cover provided by a contract of insurance with the practitioner, an amount (the ***risk surcharge***):

(a) to reflect that, because the practitioner engages, or has engaged, in conduct that deviates from good medical practice, the practitioner's private medical practice is likely to pose a higher risk to patients than similar practices (see subsection (2)); or

(b) in circumstances specified in the rules.

(2) The private medical practice of another medical practitioner (the ***comparison practitioner***) is a similar practice if the insurer

reasonably considers that the practitioner and the comparison practitioner have similar practice profiles for the purposes of calculating premiums for professional indemnity cover, except that the comparison practitioner does not engage, and has not engaged, in conduct that deviates from good medical practice.

(3) The risk surcharge must not exceed the amount:
  (a) specified in the rules; or
  (b) worked out in accordance with a method specified in the rules.

(4) The offer to enter into the contract of insurance to provide the professional indemnity cover must:
  (a) identify the amount of the risk surcharge; and
  (b) state the reason for requiring payment of the risk surcharge;

in accordance with any requirements specified in the rules.

52D Medical indemnity insurer may be required to offer interim cover until complaint is finalised

(1) A medical indemnity insurer must offer to enter into a contract of insurance with a medical practitioner to provide professional indemnity cover if:
  (a) a contract of insurance between the insurer and the practitioner provides professional indemnity cover (the ***initial cover***); and
  (b) the insurer refuses to enter into a contract of insurance with the practitioner to provide professional indemnity cover (the ***subsequent cover***) starting after the initial cover ceases; and
  (c) the practitioner makes a complaint to AFCA in relation to the refusal; and
  (d) the initial cover, or professional indemnity cover provided as a result of an offer made for the purposes of this section, ceases before the complaint finalisation date.

(2) The offer must comply with any requirements specified in the rules.

(3) However, the insurer is not required to offer to enter into a contract of insurance that provides professional indemnity cover after the complaint finalisation date.

(4) In this section:

complaint finalisation date means the earlier of:

(a) the day the subsequent cover starts; and

(b) the day 60 days after the complaint is finalised.

finalised: a complaint is finalised when:

(a) the complaint is resolved by agreement between the insurer and the practitioner; or

(b) the complaint is withdrawn; or

(c) AFCA closes the complaint because:

(i) it has excluded the complaint, or decided not to continue to consider the complaint, and the timeframe in which the practitioner may object to the decision has expired; or

(ii) it has made a preliminary assessment in relation to the complaint and the timeframe for requesting a determination of the complaint has expired; or

(iii) it has determined the complaint; or

(d) the complaint otherwise ceases to be dealt with by AFCA.

Division 3—Records, reporting and information

53 Records

(1) The rules may require a medical indemnity insurer to keep records relating to the following:

(a) a refusal by the insurer to enter into a contract of insurance with a medical practitioner to provide professional indemnity cover;

(b) a requirement by the insurer that a medical practitioner pay a risk surcharge.

Note: Failure to keep the records is an offence (see section 53A).

(2) Records required by the rules must be retained for a period of 5 years (or any other period specified in the rules) starting on the day on which the records were created.

Note: Failure to retain the records is an offence (see section 53A).

53A Failing to keep and retain records

(1) This section applies if section 53 or rules made for the purposes of that section require a person to keep records or to retain records for a particular period.

(2) The person commits an offence if the person fails to keep the records or fails to retain the records for that period.

Penalty: 30 penalty units.

(3) An offence against subsection (2) is an offence of strict liability.

53B Medical indemnity insurer must report annually

(1) If, in a financial year, a medical indemnity insurer refuses to enter into a contract of insurance with a medical practitioner to provide professional indemnity cover, the insurer must notify the Secretary within 2 months after the end of the financial year of:

(a) the number of times in the financial year the insurer refused to enter into a contract of insurance with a medical practitioner to provide professional indemnity cover; and

(b) any other matter that relates to the insurer's obligations under Division 2 and that is specified in the rules.

Note: Failure to notify is an offence (see section 53C).

(2) If, in a financial year, a medical indemnity insurer requires a medical practitioner to pay a risk surcharge, the insurer must notify the Secretary within 2 months after the end of the financial year of:

(a) the number of times in the financial year the insurer required a medical practitioner to pay a risk surcharge; and

(b) any other matter that relates to the insurer's obligations under Division 2 and that is specified in the rules.

Note: Failure to notify is an offence (see section 53C).

(3) The Secretary may, by notifiable instrument, approve a form for the purposes of notification under subsection (1) or (2).

(4) If the Secretary does so, the notification must be in the approved form.

(5) Within 3 months after the end of the financial year, the Secretary must publish on the Department's website any information notified under paragraph (1)(a) or (2)(a) in relation to the financial year.

53C Failing to report

(1) This section applies if section 53B requires a person to notify the Secretary of a matter within a particular period.

(2) The person commits an offence if:

(a) if the Secretary has approved a form for the purposes of the notification—the person fails to notify the Secretary of the matter in the approved form within that period; or

(b) otherwise—the person fails to notify the Secretary of the matter within that period.

Penalty: 30 penalty units.

(3) An offence against subsection (2) is an offence of strict liability.

53D Secretary may request information

(1) The Secretary may request a medical indemnity insurer to give the Secretary the following information, in the form requested by the Secretary:

(a) the number of times in a period the insurer refused to enter into a contract of insurance with a medical practitioner to provide professional indemnity cover;

(b) the number of times in a period the insurer required a medical practitioner to pay a risk surcharge;

(c) any other information that relates to the insurer's obligations under Division 2 and that is specified in the rules.

Note: Failure to comply with the request is an offence (see section 53E).

(2) The request:

(a) must be made in writing; and

(b) may require the information to be verified by statutory declaration; and

(c) must specify the day on or before which the information must be given; and

(d) must contain a statement to the effect that a failure to comply with the request is an offence.

The day specified under paragraph (c) must be at least 28 days after the day on which the request is made.

53E Failing to give information

(1) This section applies if a person is given a request for information under section 53D.

(2) The person commits an offence if the person fails to comply with the request.

Penalty: 30 penalty units.

(3) An offence against subsection (2) is an offence of strict liability.

Part 3—Payments towards the cost of providing indemnities

Division 2—Run-off cover support payment

Subdivision A—Introduction

57 Guide to the run-off cover support payment provisions

(1) Division 2B of Part 2 provides for the payment of run-off cover indemnities.

(2) The *Medical Indemnity (Run-off Cover Support Payment) Act 2004* (the ***Payment Act***):

(a) imposes payments on medical indemnity insurers for contribution years; and

(b) specifies the amount of those payments (by reference to an insurer's premium income for the contribution year).

This Division contains further provisions relating to the payment.

(3) The following table tells you where to find the provisions dealing with various issues:

Where to find the provisions on various issues

Item	Issue	Provisions
1	which years are contribution years?	section 5 of the Payment Act
2	who must pay the run-off cover support payment?	section 58 of this Act
3	who is exempt from the run-off cover support payment?	section 59 of this Act
4	what is the amount of the run-off cover support payment?	section 6 of the Payment Act
5	what is the time for paying the	section 61 of this Act

Where to find the provisions on various issues		
Item	**Issue**	**Provisions**
	run-off cover support payment?	
6	when is late payment penalty payable?	section 65 of this Act
7	what method should be used to pay the run-off cover support payment?	section 66 of this Act
8	what happens if an amount of run-off cover support payment is overpaid?	section 67 of this Act
9	how are run-off cover support payments and late payment penalties recovered?	sections 68 to 70 of this Act
10	what information has to be provided to the Chief Executive Medicare about run-off cover support payment matters?	sections 71 and 72 of this Act

Subdivision B—Who pays run-off cover support payment

58 Who is liable to pay the run-off cover support payment

A person is liable to pay a run-off cover support payment for a financial year if:

(a) the person is a medical indemnity insurer; and

(b) the financial year is a contribution year; and

(c) the person is not exempt from the payment under section 59.

59 Exemptions

(1) The rules may provide that a person is exempt from run-off cover support payment in the circumstances specified in the rules.

(2) Rules made for the purposes of subsection (1) may provide that a person is exempt from run-off cover support payment either generally or for a particular contribution year.

Division 3—Administration of the run-off cover support payments

Subdivision A—Introduction

60 Guide to this Division

(1) This Division makes provision for the administration of the run-off cover support payments.

(2) The following table tells you where to find the provisions dealing with various issues:

Where to find the provisions on various issues

Item	Issue	Provisions
1	what is the time for paying run-off cover support payments?	section 61
2	when is late payment penalty payable?	section 65
3	what method should be used to pay run-off cover support payments?	section 66
4	what happens if run-off cover support payments are overpaid?	section 67
5	how are run-off cover support payments and late payment penalties recovered?	sections 68 to 70
6	what information has to be provided to the Chief Executive Medicare about run-off cover support payment matters?	sections 71 and 72

Subdivision B—Payment and collection of run-off cover support payments

61 When run-off cover support payment must be paid

A run-off cover support payment that a person is liable to pay for a contribution year becomes due and payable on:

(a) 30 June in the contribution year; or

(b) such other day as is specified in the rules as the payment day for the contribution year either generally for all people, for the class of people that includes the person or for the person, as the case may be.

65 Late payment penalty

(1) If:

(a) a person is liable to pay a run-off cover support payment; and

(b) the payment remains wholly or partly unpaid after it becomes due and payable;

the person is liable to pay a late payment penalty under this section.

(2) The late payment penalty is calculated:

(a) at the rate specified in the rules; and

(b) on the unpaid amount of payment; and

(c) for the period:

(i) starting when the payment becomes due and payable; and

(ii) ending when the payment, and the penalty payable under this section in relation to the payment, have been paid in full.

Paragraph (c) has effect subject to subsection (3).

(3) The person is not liable to pay a late payment penalty under subsection (1) for any period after the person's death.

(4) The Chief Executive Medicare may remit the whole or a part of an amount of late payment penalty if the Chief Executive Medicare considers that there are good reasons for doing so.

(5) An application may be made to the Administrative Appeals Tribunal for review of a decision of the Chief Executive Medicare not to remit, or to remit only part of, an amount of late payment penalty.

Note: Section 27A of the *Administrative Appeals Tribunal Act 1975* requires notification of a decision that is reviewable.

66 Method of paying certain amounts

(1) A run-off cover support payment must be paid to the Chief Executive Medicare.

(3) A late payment penalty payable under section 65 must be paid to the Chief Executive Medicare.

(4) The rules may specify methods for paying an amount referred to in subsection (1) or (3).

Subdivision C—Refunds

67 Refund of overpaid amounts

Refund of overpaid run-off cover support payment and late payment penalty

(1) If a person overpays:

(a) a run-off cover support payment for a contribution year; or

(b) a late payment penalty in relation to a run-off cover support payment for a contribution year;

the amount overpaid must be refunded to the person unless the amount has been previously repaid to the person in accordance with an authorisation under section 65 of the *Public Governance, Performance and Accountability Act 2013* (which deals with act of grace payments by the Commonwealth).

Appropriation

(4) The Consolidated Revenue Fund is appropriated for the purpose of providing refunds under this section.

Subdivision D—Recovery of payment debt

68 Recovery of payment debt

(1) A run-off cover support payment is a debt due to the Commonwealth.

(3) A late payment penalty payable under section 65 is a debt due to the Commonwealth.

(4) The Chief Executive Medicare may recover an amount referred to in subsection (1) or (3) as a debt by action in a court of competent jurisdiction.

69 Chief Executive Medicare may collect money from a person who owes money to a person

What this section does

(1) This section allows the Chief Executive Medicare to collect money from a person who owes money to a person (the ***payment debtor***) who has a debt to the Commonwealth under section 68 (a ***payment debt***).

The Chief Executive Medicare may give direction

(2) The Chief Executive Medicare may direct a person (the ***third party***) who owes, or may later owe, money (the ***available money***) to the payment debtor to pay some or all of the available money to the Chief Executive Medicare in accordance with the direction. The Chief Executive Medicare must give a copy of the direction to the payment debtor.

Limit on directions

(3) The direction must:

(a) not require an amount to be paid to the Chief Executive Medicare at a time before it becomes owing by the third party to the payment debtor; and

(b) specify a period of not less than 14 days within which the third party must comply with the direction.

Third party to comply

(4) The third party commits an offence if the third party fails to comply with the direction.

Penalty: 20 penalty units.

(5) The third party does not commit an offence against subsection (4) if the third party complies with the direction so far as the third party is able to do so.

Note: A defendant bears an evidential burden in relation to the matter in this subsection (see subsection 13.3(3) of the *Criminal Code*).

(6) An offence against subsection (4) is an offence of strict liability.

Note: For ***strict liability***, see section 6.1 of the *Criminal Code*.

Court orders

(7) If a person is convicted of an offence in relation to a failure of the third party to comply with subsection (4), the court may (in addition to imposing a penalty on the convicted person) order the convicted person to pay to the Chief Executive Medicare an amount up to the amount involved in the failure of the third party.

Indemnity

(8) Any payment made by the third party under this section is taken to have been made with the authority of the payment debtor and of all other persons concerned and the third party is indemnified for the payment.

Notice

(9) If the whole of the payment debt of the payment debtor is discharged before any payment is made by the third party, the Chief Executive Medicare must immediately give notice to the third party of that fact.

(10) If a part of the payment debt of the payment debtor is discharged before any payment is made by the third party, the Chief Executive Medicare must:
  (a) immediately give notice to the third party of that fact; and
  (b) make an appropriate variation to the direction; and
  (c) give a copy of the varied direction to the payment debtor.

When third party is taken to owe money

(11) The third party is taken to owe money to the payment debtor if:
  (a) money is due or accruing by the third party to the payment debtor; or
  (b) the third party holds money for or on account of the payment debtor; or
  (c) the third party holds money on account of some other person for payment to the payment debtor; or
  (d) the third party has authority from some other person to pay money to the payment debtor;

whether or not the payment of the money to the payment debtor is dependent on a pre-condition that has not been fulfilled.

70 Evidentiary certificates

(1) The Chief Executive Medicare may issue a written certificate:
  (a) stating that a person is liable to pay:
    (i) a run-off cover support payment; or
    (ii) a late payment penalty in relation to a run-off cover support payment; and
  (b) setting out particulars of the liability.

(2) In any civil proceedings under, or arising out of, this Act or the medical indemnity payment legislation, a certificate under subsection (1) is prima facie evidence of the matters in the certificate.

(3) A document purporting to be a certificate under subsection (1) must, unless the contrary is established, be taken to be such a certificate and to have been properly issued.

(4) The Chief Executive Medicare may certify that a document is a copy of a certificate issued under subsection (1).

(5) This section applies to the certified copy as if it were the original.

Subdivision E—Information gathering processes

71 Chief Executive Medicare may request information

(1) If the Chief Executive Medicare believes on reasonable grounds that a person is capable of giving information that is relevant to determining:

(a) whether a person is liable to pay a run-off cover support payment; or

(b) the amount of the run-off cover support payment a person is liable to pay; or

(c) whether a person has medical indemnity cover provided by a contract of insurance with a particular medical indemnity insurer; or

(d) whether a person is a member of a particular MDO;

the Chief Executive Medicare may request the person to give the Chief Executive Medicare the information.

Note: Failure to comply with the request is an offence (see section 73).

(2) Without limiting subsection (1), any of the following persons may be requested to provide information under that subsection:

(a) an MDO;

(b) an insurer;

(c) a member, or former member, of an MDO;

(d) the legal personal representative of a person mentioned in paragraph (c).

(3) The request:

(a) must be made in writing; and

(b) must state what information must be given to the Chief Executive Medicare; and

(c) may require the information to be verified by statutory declaration; and

(d) must specify the day on or before which the information must be given; and

(e) must contain a statement to the effect that a failure to comply with the request is an offence.

The day specified under paragraph (d) must be at least 28 days after the day on which the request is made.

72 Chief Executive Medicare must be notified of a change in circumstances etc.

(1) A person who:

(a) is exempt from a run-off cover support payment; and

(b) ceases to be exempt from the payment because:

(i) the person's circumstances change before the start of, or during, a contribution year; or

(ii) the person fails to satisfy a condition on which the exemption from the payment depends;

must notify the Chief Executive Medicare of that change in circumstances or that failure, as the case may be.

Note: Failure to notify is an offence (see section 74).

(2) The notification must:

(a) be in writing; and

(b) set out details of the change in circumstances or failure of which the person is required to notify the Chief Executive Medicare under subsection (1); and

(c) be given to the Chief Executive Medicare within 28 days after the day on which the person becomes aware of the change in circumstances or failure, as the case may be.

Division 4—Offences

73 Failing to give information

(1) This section applies if a person is given a request for information under subsection 71(1).

(2) The person commits an offence if the person fails to comply with the request.

Penalty: 30 penalty units.

(3) An individual is excused from complying with the request if the giving of the information might tend to incriminate the individual or expose the individual to a penalty.

(4) An offence against subsection (2) is an offence of strict liability.

Note: For ***strict liability***, see section 6.1 of the *Criminal Code*.

74 Failing to notify

(1) This section applies if section 72 requires a person to notify the Chief Executive Medicare, within a particular period, of a matter.

(2) The person commits an offence if the person fails to notify the Chief Executive Medicare of that matter within that period.

Penalty: 30 penalty units.

(3) An offence against subsection (2) is an offence of strict liability.

Note: For ***strict liability***, see section 6.1 of the *Criminal Code*.

Part 4—Miscellaneous

75 General administration of this Act and medical indemnity payment legislation

The Chief Executive Medicare has the general administration of this Act and the medical indemnity payment legislation.

76 Additional functions of the Chief Executive Medicare

In addition to the functions of the Chief Executive Medicare under the *Human Services (Medicare) Act 1973*, the Chief Executive Medicare has such additional functions as are conferred on the Chief Executive Medicare under this Act and the medical indemnity payment legislation.

76A Chief Executive Medicare may use computer programs to take administrative action

(1) The Chief Executive Medicare may arrange for the use, under the Chief Executive Medicare's control, of computer programs for any purposes for which the Chief Executive Medicare may or must take administrative action under this Act or a legislative instrument made under this Act.

(2) Administrative action taken by the operation of a computer program under such an arrangement is, for the purposes of this Act, taken to be administrative action taken by the Chief Executive Medicare.

(3) The Chief Executive Medicare may substitute a decision for a decision the Chief Executive Medicare is taken to have made under subsection (2) if the Chief Executive Medicare is satisfied that the decision made by the operation of the computer program is incorrect.

(4) In this Act:

administrative action means any of the following:

(a) making a decision;

(b) exercising any power or complying with any obligation;

(c) doing anything else that relates to making a decision or exercising a power or complying with an obligation.

76B Delegation by Secretary

(1) The Secretary may, in writing, delegate all or any of the functions or powers of the Secretary under this Act or a legislative instrument made under this Act to any of the following persons:

(a) the Chief Executive Medicare;

(b) an SES employee, or an acting SES employee, in the Department or the Department administered by the Minister administering the *Human Services (Centrelink) Act 1997*.

Note: Sections 34AA to 34A of the *Acts Interpretation Act 1901* contain provisions relating to delegations.

(2) In performing a delegated function or exercising a delegated power, the delegate must comply with any written directions of the Secretary.

77 Officers to observe secrecy

Definitions

(1) In this section:

medical indemnity legislation means:

(a) this Act; or

(b) the medical indemnity payment legislation; or

(c) the repealed *Medical Indemnity (Competitive Advantage Payment) Act 2005*; or

(d) the repealed *Medical Indemnity (UMP Support Payment) Act 2002*.

officer means a person performing duties, or exercising powers or functions, under or in relation to, the medical indemnity legislation.

person to whom this section applies means a person who is or was an officer.

protected document means a document that:

(a) is obtained or made by a person to whom this section applies in the course of, or because of, the person's functions, powers or duties under or in relation to the medical indemnity legislation; and

(b) contains information relating to a person's affairs.

protected information means information that:

(a) is disclosed to, or obtained by, a person to whom this section applies in the course of, or because of, the person's functions, powers or duties under or in relation to the medical indemnity legislation; and

(b) relates to a person's affairs.

Offence

(2) A person to whom this section applies commits an offence if:

(a) the person:

(i) makes a copy or other record of any protected information or of all or part of any protected document; or

(ii) discloses any protected information to another person; or

(iii) produces all or part of a protected document to another person; and

(b) in doing so, is not acting in the performance of his or her duties, or in the exercise of his or her powers or functions, under the medical indemnity legislation; and

(c) in doing so, is not acting for the purpose of enabling a person to perform functions under:

(i) the medical indemnity legislation; or

(ii) the *Health Insurance Act 1973*; or

(iii) a medicare program; or

(iv) the *National Health Act 1953*; or

(v) the *Private Health Insurance Act 2007*.

Penalty: Imprisonment for 2 years.

Circumstances in which protected information and protected documents may be copied, recorded or divulged

(2A) Despite subsection (2), any of the following persons may make a copy or record of, or divulge to any other of the following persons, protected information or a protected document, for the purposes of monitoring, assessing or reviewing the operation of the medical indemnity legislation:

(a) the Secretary;

(b) the Chief Executive Medicare;

(c) the Actuary;

(d) the Australian Prudential Regulation Authority;

(e) the Australian Securities and Investments Commission.

Note: A defendant bears an evidential burden in relation to the matter in this subsection (see subsection 13.3(3) of the *Criminal Code*).

(2B) Despite subsection (2), any of the following persons may make a copy or record of, or divulge to any other of the following persons, protected information or a protected document, for the purposes of conducting, or assisting a person to conduct, the evaluation mentioned in section 78A:

(a) a person mentioned in subsection (2A) of this section;

(b) a person conducting the evaluation;

(c) a person assisting a person to conduct the evaluation.

Note: A defendant bears an evidential burden in relation to the matter in this subsection (see subsection 13.3(3) of the *Criminal Code*).

(3) Despite subsection (2), the Secretary or the Chief Executive Medicare may:

(a) if the Minister certifies, in writing, that it is necessary in the public interest that any protected information should be divulged, divulge that information to such person as the Minister directs; or

(b) divulge any protected information to a person who, in the opinion of the Minister, is expressly or impliedly authorised by the person to whom the information relates to obtain it.

Note: A defendant bears an evidential burden in relation to the matter in this subsection (see subsection 13.3(3) of the *Criminal Code*).

(4) Despite subsection (2), the Secretary or the Chief Executive Medicare may divulge any protected information to an authority or person if:

(a) the authority or person is specified in rules made for the purposes of this subsection; and

(b) the information is information of a kind that may, in accordance with the rules, be provided to the authority or person.

Note: A defendant bears an evidential burden in relation to the matter in this subsection (see subsection 13.3(3) of the *Criminal Code*).

(5) If protected information is divulged to an authority or person under subsection (2A), (2B), (3) or (4):

(a) the authority or person; and

(b) any person or employee under the control of the authority or person;

is, in respect of that information, subject to the same rights, privileges, obligations and liabilities under subsection (2) as if he or she were a person performing duties under the medical indemnity legislation and had acquired the information in the performance of those duties.

(5A) Despite subsection (2), an officer may make a record of information with the express or implied authorisation of the person to whom the information relates.

(6) This section does not prohibit the divulging or communicating to a person of information that relates to the person.

Note: A defendant bears an evidential burden in relation to the matter in this subsection (see subsection 13.3(3) of the *Criminal Code*).

78 Act not to apply in relation to State insurance within a State

If, but for this section, a provision of this Act:

(a) would have a particular application; and

(b) by virtue of having that application, would be a law with respect to State insurance not extending beyond the limits of the State concerned;

the provision is not to have that application.

78A Evaluation of medical indemnity market

(1) The Minister must cause to be conducted an actuarial evaluation of:

(a) the stability of the medical indemnity insurance industry; and

(b) the affordability of medical indemnity insurance.

(2) The Minister must cause to be prepared a report of an evaluation under subsection (1).

(3) The Minister must cause a copy of the report to be tabled in each House of the Parliament by 28 February 2021.

79 Regulations

(1) The Governor-General may make regulations prescribing matters:

(a) required or permitted by this Act to be prescribed; or

(b) necessary or convenient to be prescribed for carrying out or giving effect to this Act;

and, in particular, prescribing penalties, not exceeding 10 penalty units, for offences against the regulations.

(2) Without limiting subsection (1), the regulations may make provision for the qualifications of actuaries preparing reports for the purposes of this Act.

80 Rules

(1) The Minister may, by legislative instrument, make rules prescribing matters:

(a) required or permitted by this Act to be prescribed by the rules; or

(b) necessary or convenient to be prescribed for carrying out or giving effect to this Act.

(2) To avoid doubt, the rules may not do the following:

(a) create an offence or civil penalty;

(b) provide powers of:

(i) arrest or detention; or

(ii) entry, search or seizure;

(c) impose a tax;

(d) set an amount to be appropriated from the Consolidated Revenue Fund under an appropriation in this Act;

(e) directly amend the text of this Act.

(3) Rules that are inconsistent with the regulations have no effect to the extent of the inconsistency, but rules are taken to be consistent with the regulations to the extent that the rules are capable of operating concurrently with the regulations.

Endnotes

Endnote 1—About the endnotes

The endnotes provide information about this compilation and the compiled law.

The following endnotes are included in every compilation:

Endnote 1—About the endnotes
Endnote 2—Abbreviation key
Endnote 3—Legislation history
Endnote 4—Amendment history

Abbreviation key—Endnote 2
The abbreviation key sets out abbreviations that may be used in the endnotes.

Legislation history and amendment history—Endnotes 3 and 4
Amending laws are annotated in the legislation history and amendment history.

The legislation history in endnote 3 provides information about each law that has amended (or will amend) the compiled law. The information includes commencement details for amending laws and details of any application, saving or transitional provisions that are not included in this compilation.

The amendment history in endnote 4 provides information about amendments at the provision (generally section or equivalent) level. It also includes information about any provision of the compiled law that has been repealed in accordance with a provision of the law.

Editorial changes
The *Legislation Act 2003* authorises First Parliamentary Counsel to make editorial and presentational changes to a compiled law in preparing a compilation of the law for registration. The changes must not change the effect of the law. Editorial changes take effect from the compilation registration date.

If the compilation includes editorial changes, the endnotes include a brief outline of the changes in general terms. Full details of any changes can be obtained from the Office of Parliamentary Counsel.

Misdescribed amendments
A misdescribed amendment is an amendment that does not accurately describe the amendment to be made. If, despite the misdescription, the amendment can

be given effect as intended, the amendment is incorporated into the compiled law and the abbreviation "(md)" added to the details of the amendment included in the amendment history.

If a misdescribed amendment cannot be given effect as intended, the abbreviation "(md not incorp)" is added to the details of the amendment included in the amendment history.

Endnote 2—Abbreviation key

ad = added or inserted

am = amended

amdt = amendment

c = clause(s)

C[x] = Compilation No. x

Ch = Chapter(s)

def = definition(s)

Dict = Dictionary

disallowed = disallowed by Parliament

Div = Division(s)

ed = editorial change

exp = expires/expired or ceases/ceased to have effect

F = Federal Register of Legislation

gaz = gazette

LA = *Legislation Act 2003*

LIA = *Legislative Instruments Act 2003*

(md) = misdescribed amendment can be given effect

(md not incorp) = misdescribed amendment cannot be given effect

mod = modified/modification

No. = Number(s)

o = order(s)

Ord = Ordinance

orig = original

par = paragraph(s)/subparagraph(s) /sub-subparagraph(s)

pres = present

prev = previous

(prev…) = previously

Pt = Part(s)

r = regulation(s)/rule(s)

reloc = relocated

renum = renumbered

rep = repealed

rs = repealed and substituted

s = section(s)/subsection(s)

Sch = Schedule(s)

Sdiv = Subdivision(s)

SLI = Select Legislative Instrument

SR = Statutory Rules

Sub-Ch = Sub-Chapter(s)

SubPt = Subpart(s)

underlining = whole or part not commenced or to be commenced

Endnote 3—Legislation history

Act	Number and year	Assent	Commencement	Application, saving and transitional provisions
Medical Indemnity Act 2002	132, 2002	19 Dec 2002	1 Jan 2003 (s 2)	—
Medical Indemnity Amendment Act 2003	121, 2003	5 Dec 2003	s 1–3, Sch 1 (items 3, 5–8, 12, 13, 18, 21–26) and Sch 2: 5 Dec 2003 (s 2(1) items 1, 3, 5, 7, 9, 11, 12) Remainder: 1 July 2003 (s 2(1) items 2, 4, 6, 8, 10)	Sch 1 (items 24–26) and Sch 2 (item 33)
Medical Indemnity Amendment Act 2004	17, 2004	23 Mar 2004	24 Mar 2004 (s 2)	Sch 4 (item 7)
Medical Indemnity Legislation Amendment (Run-off Cover Indemnity and Other Measures) Act 2004	77, 2004	23 June 2004	Sch 1 (items 1–35) and Sch 2 (items 3–15): 1 July 2004 (s 2(1) items 2–7) Sch 4 (items 1–5, 9) and Sch 6 (items 3–6): 23 June 2004 (s 2(1) items 9, 11, 15) Sch 4 (items 6–8): 24 June 2004 (s 2(1) item 10) Sch 6 (item 1): 24 Mar 2004 (s 2(1) item 13) Sch 6 (item 1A): 1 Jan 2003 (s 2(1) item 13A) Sch 6 (item 2): 5 Dec 2003 (s 2(1) item 14)	Sch 1 (item 19) and Sch 2 (item 15)

Endnote 3—Legislation history

Act	Number and year	Assent	Commencement	Application, saving and transitional provisions
Medical Indemnity Legislation Amendment Act 2005	25, 2005	21 Mar 2005	Sch 1 (items 1–5, 9, 13, 14): 1 July 2004 (s 2(1) items 2, 6, 8) Sch 1 (items 6, 8), Sch 2 (items 1–10, 14) and Sch 3 (items 2, 3, 8, 9, 12, 17–21): 21 Mar 2005 (s 2(1) items 3, 5, 11, 13, 15, 18, 20, 23) Sch 1 (item 7) and Sch 3 (items 1, 4, 10, 11, 13, 14): 1 Jan 2005 (s 2(1) items 4, 14, 16, 19, 21) Sch 1 (items 10–12) and Sch 2 (items 11–13): 22 Mar 2005 (s 2(1) items 7, 12) Sch 3 (items 5–7): 1 Jan 2003 (s 2(1) item 17) Sch 3 (items 15, 16): 5 Dec 2003 (s 2(1) item 22)	Sch 1 (item 3) and Sch 3 (item 21)
Human Services Legislation Amendment Act 2005	111, 2005	6 Sept 2005	Sch 2 (items 399–549): 1 Oct 2005 (s 2(1) item 7)	—
Medical Indemnity Legislation Amendment (Competitive Neutrality) Act 2005	126, 2005	19 Oct 2005	Sch 1 (items 3–13) and Sch 2 (items 1–5): 1 July 2005 (s 2(1) item 2) Sch 3: 1 July 2004 (s 2(1) item 3)	—
Health Legislation Amendment Act 2005	155, 2005	19 Dec 2005	Sch 4: 1 Oct 2005 (s 2(1) item 9)	—

Act	Number and year	Assent	Commencement	Application, saving and transitional provisions
Medical Indemnity Legislation Amendment Act 2006	116, 2006	4 Nov 2006	Sch 1 (item 1): 1 July 2004 (s 2(1) item 2) Sch 1 (items 2–10) and Sch 2 (items 1–14): 4 Nov 2006 (s 2(1) items 3, 6)	—
Private Health Insurance (Transitional Provisions and Consequential Amendments) Act 2007	32, 2007	30 Mar 2007	Sch 2 (item 74): 1 Apr 2007 (s 2(1) item 7)	—
Health Legislation Amendment (Midwives and Nurse Practitioners) Act 2010	29, 2010	12 Apr 2010	Sch 2 (items 4–8): 1 July 2010 (s 2(1) item 3)	—
Human Services Legislation Amendment Act 2011	32, 2011	25 May 2011	Sch 4 (items 286–357A): 1 July 2011 (s 2(1) item 3)	—
Acts Interpretation Amendment Act 2011	46, 2011	27 June 2011	Sch 2 (item 760) and Sch 3 (items 10, 11): 27 Dec 2011 (s 2(1) items 5, 12)	Sch 3 (items 10, 11)
Public Governance, Performance and Accountability (Consequential and Transitional Provisions) Act 2014	62, 2014	30 June 2014	Sch 10 (item 6) and Sch 14: 1 July 2014 (s 2(1) items 6, 14)	Sch 14
as amended by				
Public Governance and Resources Legislation Amendment Act (No. 1) 2015	36, 2015	13 Apr 2015	Sch 2 (items 7–9) and Sch 7: 14 Apr 2015 (s 2)	Sch 7

Endnote 3—Legislation history

Act	Number and year	Assent	Commencement	Application, saving and transitional provisions
as amended by				
Acts and Instruments (Framework Reform) (Consequential Provisions) Act 2015	126, 2015	10 Sept 2015	Sch 1 (item 486): 5 Mar 2016 (s 2(1) item 2)	—
Acts and Instruments (Framework Reform) (Consequential Provisions) Act 2015	126, 2015	10 Sept 2015	Sch 1 (item 495): 5 Mar 2016 (s 2(1) item 2)	—
Acts and Instruments (Framework Reform) (Consequential Provisions) Act 2015	126, 2015	10 Sept 2015	Sch 1 (items 364–371): 5 Mar 2016 (s 2(1) item 2)	—
Insolvency Law Reform Act 2016	11, 2016	29 Feb 2016	Sch 2 (items 287–298): 1 Mar 2017 (s 2(1) item 5)	—
Medical and Midwife Indemnity Legislation Amendment Act 2019	105, 2019	28 Nov 2019	Sch 1 (items 8–52, 54), Sch 2 (items 1–16, 18–20, 23, 24, 27), Sch 3 (items 1–20, 31), Sch 4 (items 1–138, 148–153), Sch 5 (items 1–4, 6) and Sch 6 (items 1–57, 59): 1 July 2020 (s 2(1) items 2, 3)	Sch 1 (item 54), Sch 2 (items 10, 16, 20, 27), Sch 3 (item 31), Sch 4 (items 148–153), Sch 5 (item 6) and Sch 6 (item 59)

Endnote 4—Amendment history

Provision affected	How affected
Part 1	
s 3	am No 121, 2003; No 17, 2004; No 77, 2004; No 126, 2005; No 105, 2019
s 4	am No 121, 2003; No 17, 2004; No 77, 2004; No 25, 2005; No 111, 2005; No 126, 2005; No 29, 2010; No 32, 2011; No 126, 2015; No 11, 2016; No 105, 2019
s 5	am No 105, 2019
s. 7	am. No. 77, 2004
s. 8	am. No. 25, 2005
s 8A	ad No 126, 2005
	rs No 105, 2019
s 8B	ad No 105, 2019
Part 2	
Division 1	
Subdivision A	
s 10	am No 77, 2004; No 25, 2005; No 111, 2005; No 32, 2011; No 105, 2019
Subdivision B	rep No 105, 2019
s 11	rep No 105, 2019
s 12	am No 116, 2006
	rep No 105, 2019
s 13	am No 111, 2005; No 32, 2011
	rep No 105, 2019
Subdivision C	
s 14	am No 25, 2005; No 105, 2019
Subdivision D	
s 15	am No 11, 2016
s 16	am No 111, 2005; No 32, 2011; No 105, 2019
s 17	am No 111, 2005; No 32, 2011; No 11, 2016; No 105, 2019
s 19	am No 77, 2004; No 111, 2005; No 32, 2011; No 105, 2019

Endnote 4—Amendment history

Provision affected	How affected
s 21	am No 105, 2019
s 22	am No 116, 2006
	rep No 105, 2019
s 23	am No 111, 2005; No 32, 2011
	rep No 105, 2019
Subdivision E	
s 24	am No 111, 2005; No 32, 2011; No 105, 2019
s. 25	am. No. 111, 2005; No. 32, 2011
s 26	am No 111, 2005; No 32, 2011
s 27	am No 111, 2005; No 32, 2011; No 105, 2019
Subdivision F	
Subdivision F heading	rs No 105, 2019
Subdivision F	ad. No. 77, 2004
s 27A	ad No 77, 2004
	am No 25, 2005; No 116, 2006; No 105, 2019
s 27B	ad No 77, 2004
	am No 111, 2005; No 32, 2011; No 105, 2019
Subdivision G	
Subdivision G	ad No 105, 2019
s 27C	ad No 105, 2019
Division 2	
Subdivision A	
s 28	am No 25, 2005; No 111, 2005; No 29, 2010; No 32, 2011; No 105, 2019
s 29	am No 25, 2005; No 126, 2015; No 105, 2019
Subdivision B	
s 30	am No 121, 2003; No 77, 2004; No 25, 2005; No 29, 2010; No 126, 2015; No 11, 2016; No 105, 2019
s 31	am No 105, 2019
s 32	am No 105, 2019
s 34	am No 25, 2005; No 126, 2015; No 105, 2019
Subdivision C	

Provision affected	How affected
Subdivision C heading	rs No 105, 2019
Subdivision C	ad. No. 25, 2005
s 34AA	ad No 25, 2005
	am No 105, 2019
s 34AB	ad No 25, 2005
	am No 111, 2005; No 32, 2011; No 105, 2019
Division 2A	
Division 2A	ad. No. 121, 2003
Subdivision A	
s 34A	ad No 121, 2003
	am No 111, 2005; No 29, 2010; No 32, 2011; No 105, 2019
s 34B	ad No 121, 2003
	rep No 105, 2019
s 34C	ad No 121, 2003
	rep No 105, 2019
s 34D	ad No 121, 2003
	am No 77, 2004; No 105, 2019
Subdivision B	
s 34E	ad No 121, 2003
	am No 77, 2004; No 25, 2005; No 111, 2005; No 29, 2010; No 32, 2011; No 105, 2019
s 34F	ad No 121, 2003
	am No 25, 2005; No 46, 2011; No 126, 2015; No 105, 2019
s 34G	ad No 121, 2003
	am No 25, 2005; No 126, 2015; No 105, 2019
s 34H	ad No 121, 2003
	am No 111, 2005; No 32, 2011
s 34I	ad No 121, 2003
	am No 111, 2005; No 32, 2011; No 105, 2019
s 34J	ad No 121, 2003
	am No 111, 2005; No 32, 2011; No 105, 2019

Endnote 4—Amendment history

Provision affected	How affected
s 34K	ad No 121, 2003
	am No 111, 2005; No 32, 2011; No 105, 2019
Subdivision C	
s 34L	ad No 121, 2003
	am No 25, 2005; No 111, 2005; No 32, 2011; No 11, 2016; No 105, 2019
s 34M	ad No 121, 2003
	am No 105, 2019
s 34N	ad No 121, 2003
s 34O	ad No 121, 2003
	am No 105, 2019
s 34P	ad No 121, 2003
s. 34Q	ad. No. 121, 2003
	am. No. 111, 2005; No. 32, 2011
s. 34R	ad. No. 121, 2003
Subdivision D	
s 34S	ad No 121, 2003
	am No 77, 2004; No 105, 2019
s 34T	ad No 121, 2003
	am No 77, 2004; No 111, 2005; No 32, 2011; No 105, 2019
s. 34U	ad. No. 121, 2003
	am. No. 111, 2005; No. 32, 2011
s. 34V	ad. No. 121, 2003
	am. No. 111, 2005; No. 32, 2011
s 34W	ad No 121, 2003
	am No 111, 2005; No 32, 2011; No 105, 2019
Subdivision E	
Subdivision E heading	rs No 105, 2019
s 34X	ad No 121, 2003
	am No 25, 2005; No 116, 2006; No 105, 2019
s 34Y	ad No 121, 2003
	am No 111, 2005; No 32, 2011; No 105, 2019

Provision affected	How affected
Subdivision F	
s 34Z	ad No 121, 2003
	am No 105, 2019
Division 2B	
Division 2B	ad. No. 77, 2004
Subdivision A	
s 34ZA	ad No 77, 2004
	am No 111, 2005; No 32, 2011; No 105, 2019
s 34ZB	ad No 77, 2004
	am No 25, 2005; No 111, 2005; No 116, 2006; No 32, 2011; No 126, 2015; No 105, 2019
Subdivision B	
s. 34ZC	ad. No. 77, 2004
	am. No. 111, 2005; No. 116, 2006; No. 32, 2011
s 34ZD	ad No 77, 2004
	am No 116, 2006; No 11, 2016
s 34ZE	ad No 77, 2004
	am No 116, 2006
s 34ZF	ad No 77, 2004
s 34ZG	ad No 77, 2004
	am No 105, 2019
s. 34ZH	ad. No. 77, 2004
	am. No. 116, 2006
Subdivision C	
s 34ZI	ad No 77, 2004
	am No 105, 2019
s 34ZJ	ad No 77, 2004
	am No 111, 2005; No 32, 2011; No 105, 2019
s. 34ZK	ad. No. 77, 2004
	am. No. 111, 2005; No. 32, 2011
s 34ZL	ad No 77, 2004

Endnote 4—Amendment history

Provision affected	How affected
	am No 111, 2005; No 32, 2011
s 34ZM	ad No 77, 2004
	am No 111, 2005; No 32, 2011; No 105, 2019
Subdivision D	
Subdivision D heading	rs No 105, 2019
s 34ZN	ad No 77, 2004
	am No 116, 2006; No 105, 2019
s 34ZO	ad No 77, 2004
	am No 111, 2005; No 32, 2011; No 105, 2019
Subdivision E	
s 34ZP	ad No 77, 2004
	am No 116, 2006; No 105, 2019
s 34ZQ	ad No 77, 2004
s 34ZR	ad No 77, 2004
s 34ZS	ad No 77, 2004
	am No 105, 2019
s 34ZT	ad. No. 77, 2004
	am No 111, 2005; No 32, 2011; No 105, 2019
Subdivision F	
s 34ZU	ad No 77, 2004
	am No 111, 2005; No 116, 2006; No 32, 2011; No 105, 2019
s 34ZV	ad. No. 77, 2004
	am No 25, 2005; No 105, 2019
s 34ZW	ad No 77, 2004
	am No 105, 2019
s 34ZX	ad No 77, 2004
Division 2C	
Division 2C	ad No 105, 2019
Subdivision A	
s 34ZY	ad No 105, 2019
s 34ZZ	ad No 105, 2019

Provision affected	How affected
s 34ZZA	ad No 105, 2019
Subdivision B	
s 34ZZB	ad No 105, 2019
s 34ZZC	ad No 105, 2019
s 34ZZD	ad No 105, 2019
s 34ZZE	ad No 105, 2019
s 34ZZF	ad No 105, 2019
Subdivision C	
s 34ZZG	ad No 105, 2019
s 34ZZH	ad No 105, 2019
Division 2D	
Division 2D	ad No 105, 2019
Subdivision A	
s 34ZZI	ad No 105, 2019
s 34ZZJ	ad No 105, 2019
Subdivision B	
s 34ZZK	ad No 105, 2019
s 34ZZL	ad No 105, 2019
s 34ZZM	ad No 105, 2019
s 34ZZN	ad No 105, 2019
s 34ZZO	ad No 105, 2019
s 34ZZP	ad No 105, 2019
s 34ZZQ	ad No 105, 2019
Subdivision C	
s 34ZZR	ad No 105, 2019
s 34ZZS	ad No 105, 2019
s 34ZZT	ad No 105, 2019
s 34ZZU	ad No 105, 2019
s 34ZZV	ad No 105, 2019
s 34ZZW	ad No 105, 2019
s 34ZZX	ad No 105, 2019

Endnote 4—Amendment history

Provision affected	How affected
Subdivision D	
s 34ZZY	ad No 105, 2019
s 34ZZZ	ad No 105, 2019
s 34ZZZA	ad No 105, 2019
s 34ZZZB	ad No 105, 2019
s 34ZZZC	ad No 105, 2019
Subdivision E	
s 34ZZZD	ad No 105, 2019
s 34ZZZE	ad No 105, 2019
Subdivision F	
s 34ZZZF	ad No 105, 2019
Division 3	
Subdivision A	
s 35	am No 121, 2003; No 77, 2004; No 111, 2005; No 32, 2011; No 105, 2019
Subdivision B	
s 36	am No 121, 2003; No 77, 2004; No 111, 2005; No 32, 2011; No 105, 2019
s 37	am No 121, 2003; No 77, 2004; No 111, 2005; No 32, 2011; No 105, 2019
s 37A	ad No 121, 2003
	am No 111, 2005; No 32, 2011; No 105, 2019
s 37B	ad No 121, 2003
	am No 111, 2005; No 32, 2011; No 105, 2019
Subdivision C	
s 38	am No 121, 2003; No 111, 2005; No 32, 2011; No 105, 2019
s 39	am No 121, 2003; No 77, 2004; No 25, 2005; No 111, 2005; No 32, 2011; No 105, 2019
s 40	am No 111, 2005; No 126, 2005; No 116, 2006; No 32, 2011; No 105, 2019
Subdivision D	

Endnote 4—Amendment history

Provision affected	How affected
s 41	am No 121, 2003; No 77, 2004; No 111, 2005; No 32, 2011; No 105, 2019
Subdivision E	
s 42	am No 121, 2003; No 77, 2004; No 111, 2005; No 32, 2011; No 105, 2019
Division 4	
s 43	am No 17, 2004; No 77, 2004; No 25, 2005; No 116, 2006; No 105, 2019
s 44	am No 111, 2005; No 32, 2011; No 105, 2019
s 44A	ad No 17, 2004
	am No 111, 2005; No 32, 2011
	rep No 105, 2019
s. 44B	ad. No. 77, 2004
	am. No 25, 2005; No 111, 2005; No. 32, 2011
Division 5	
s 45	am No 121, 2003; No 77, 2004; No 25, 2005; No 105, 2019
s 46	am No 121, 2003; No 77, 2004; No 111, 2005; No 32, 2011; No 105, 2019
s. 47A	ad. No. 77, 2004
Division 6	
s 48	am No 121, 2003; No 17, 2004; No 77, 2004; No 25, 2005; No 105, 2019
Division 8	
Division 8	ad No 105, 2019
s 50	ad No 105, 2019
Part 2A	
Part 2A	ad No 105, 2019
Division 1	
s 51	ad No 105, 2019
s 51A	ad No 105, 2019
Division 2	
s 52	ad No 105, 2019
s 52A	ad No 105, 2019

Endnote 4—Amendment history

Provision affected	How affected
s 52B	ad No 105, 2019
s 52C	ad No 105, 2019
s 52D	ad No 105, 2019
Division 3	
s 53	ad No 105, 2019
s 53A	ad No 105, 2019
s 53B	ad No 105, 2019
s 53C	ad No 105, 2019
s 53D	ad No 105, 2019
s 53E	ad No 105, 2019
Part 3	
Part 3 heading	rs. No. 17, 2004
Division 1 heading	rs. No. 17, 2004
	rep 105, 2019
Division 1	rep No 105, 2019
Subdivision A	rep No 105, 2019
s 50	am No 17, 2004; No 111, 2005; No 32, 2011
	rep No 105, 2019
Subdivision B heading	rs. No. 17, 2004
	rep No 105, 2019
Subdivision B	rep No 105, 2019
s 51	am No 17, 2004
	rep No 105, 2019
s 52	am No 121, 2003; No 17, 2004; No 111, 2005; No 126, 2005; No 32, 2011
	rep No 105, 2019
s 53	am No 17, 2004; No 111, 2005; No 32, 2011
	rep No 105, 2019
Subdivision C heading	rs. No. 17, 2004
	rep No 105, 2019
Subdivision C	rep No 105, 2019

Endnote 4—Amendment history

Provision affected	How affected
s 54	am No 17, 2004
	rep No 105, 2019
Subdivision D	rep No 105, 2019
s 55	am No 17, 2004
	rep No 105, 2019
s 56	am No 111, 2005; No 32, 2011
	rep No 105, 2019
Division 2	
Division 2	rs. No. 77, 2004
Subdivision A	
s 57	rs No 77, 2004
	am No 111, 2005; No 32, 2011; No 105, 2019
Subdivision B	
s. 58	rs. No. 77, 2004
	am. No. 126, 2005
s 59	am No 121, 2003
	rs No 77, 2004
	am No 105, 2019
Division 2A	ad No 126, 2005
	rep No 105, 2019
Subdivision A	rep No 105, 2019
s 59A	ad No 126, 2005
	am No 155, 2005; No 32, 2011
	rep No 105, 2019
Subdivision B	rep No 105, 2019
s 59B	ad No 126, 2005
	rep No 105, 2019
s 59C	ad No 126, 2005
	rep No 105, 2019
Subdivision C	rep No 105, 2019
s 59D	ad No 126, 2005

Endnote 4—Amendment history

Provision affected	How affected
	rep No 105, 2019
s 59E	ad No 126, 2005
	am No 155, 2005; No 32, 2011
	rep No 105, 2019
Division 3	
Division 3 heading	rs No 17, 2004
	am No 105, 2019
Subdivision A	
s 60	am No 17, 2004; No 77, 2004; No 111, 2005; No 126, 2005; No 32, 2011; No 105, 2019
Subdivision B	
Subdivision B heading	rs No 17, 2004
	am No 105, 2019
s 61	am No 121, 2003; No 17, 2004; No 77, 2004; No 126, 2005
	rs No 105, 2019
s 62	am No 121, 2003; No 17, 2004; No 77, 2004; No 111, 2005; No 32, 2011
	rep No 105, 2019
ss. 63, 64	am. No. 121, 2003
	rep. No. 17, 2004
s 65	am No 17, 2004; No 111, 2005; No 32, 2011; No 105, 2019
s 66	am No 17, 2004; No 111, 2005; No 32, 2011; No 105, 2019
s 66A	ad No 17, 2004
	am No 77, 2004; No 111, 2005; No 32, 2011
	rep No 105, 2019
s. 66B	ad No 17, 2004
	am No 111, 2005; No 32, 2011
	rep No 105, 2019
Subdivision C	
s 67	am No 121, 2003; No 17, 2004; No 111, 2005; No 32, 2011; No 62, 2014; No 105, 2019
Subdivision D	

Provision affected	How affected
Subdivision D heading	rs. No. 17, 2004
s 68	am No 17, 2004; No 111, 2005; No 32, 2011; No 105, 2019
s 69	am No 17, 2004; No 111, 2005; No 32, 2011
s 70	am No 17, 2004; No 111, 2005; No 32, 2011; No 105, 2019
Subdivision E	
s 71	am No 17, 2004; No 111, 2005; No 32, 2011; No 105, 2019
s 72	rs No 121, 2003
	am No 17, 2004; No 111, 2005; No 32, 2011; No 105, 2019
Division 4	
s 73	am No 126, 2005; No 105, 2019
s. 74	am. No. 121, 2003; No. 111, 2005; No. 32, 2011
s 74A	ad No 17, 2004
	rep No 105, 2019
Part 4	
s. 75	am. No. 17, 2004; No. 111, 2005; No. 32, 2011
s. 76	am. No. 17, 2004; No. 111, 2005; No. 32, 2011
s 76A	ad No 105, 2019
s 76B	ad No 105, 2019
s 77	am No 17, 2004; No 111, 2005; No 32, 2007; No 32, 2011; No 105, 2019
s 78A	ad No 105, 2019
s 80	ad No 105, 2019