

## **EXPLANATORY STATEMENT**

### **Issued by the Authority of the Minister for Health**

*Medical Indemnity Act 2002*

*Medical Indemnity Regulations 2020*

#### **Authority**

Section 79 of the *Medical Indemnity Act 2002* (the Act) provides that the Governor-General may make regulations prescribing matters which are required or permitted by the Act to be prescribed, or which are necessary or convenient to be prescribed, for carrying out or giving effect to the Act.

Under subsection 33(3) of the *Acts Interpretation Act 1901*, where an Act confers a power to make, grant or issue any instrument of a legislative or administrative character (including rules, regulations or by-laws), the power shall be construed as including a power exercisable in the like manner and subject to the like conditions (if any) to repeal, rescind, revoke, amend, or vary any such instrument.

#### **Purpose and operation**

The purpose of the *Medical Indemnity Regulations 2020* (the Regulations) is to consolidate the following three instruments into the one instrument prior to their sunset on 1 October 2021:

- *Medical Indemnity (IBNR Claims) Protocol 2006* (IBNR Protocol);
- *Medical Indemnity (Run-off Cover Claims and Administration) Protocol 2006 (No. 2)* (ROCS Protocol); and
- *Premium Support Scheme 2004* (2004 PSS).

The *Legislation Act 2003* provides that all legislative instruments, other than exempt instruments, are automatically repealed according to the progressive timetable set out in section 50 of that Act. Legislative instruments generally cease to have effect after a specific date unless further legislative action is taken to extend their operation, such as remaking the instrument.

The IBNR Protocol, ROCS Protocol and 2004 PSS (hereafter collectively referred to as the three instruments) were reviewed as part of the February 2018 *Thematic Review of Commonwealth Medical and Midwife Indemnity Legislation* (the Thematic Review) prepared for the Department of Health. The sunset date for the three instruments was adjusted to allow for the Thematic Review to be undertaken and then further deferred so that amendments to the Act could be legislated. These instruments will now sunset on 1 October 2021.

The Thematic Review examined 17 legislative instruments, including the three instruments, which collectively support the Medical Indemnity Insurance Fund (IIF). The IIF comprises seven related schemes that are collectively designed to promote the stability of the medical and midwife indemnity insurance industry and support the

availability of affordable indemnity insurance for medical practitioners, allied health professionals and eligible midwives.

The Thematic Review involved consultation with regulatory and other bodies managing or overseeing medical indemnity arrangements, relevant Departments and Government Agencies, the Law Council of Australia, medical indemnity insurers, and peak bodies representing insurers, medical practitioners and midwives. It also involved a review of reports including those of the Australian National Audit Office and the then Department of Human Services (now Services Australia) and a review of submissions made by stakeholders over the past three years.<sup>1</sup>

The Thematic Review found that the three instruments were, for the most part, still required in order to describe the conditions medical indemnity providers must meet in order to receive Commonwealth support relating to the Incurred But Not Reported (IBNR) indemnity scheme, run-off cover indemnity scheme and Premium Support Scheme. The Thematic Review also suggested that the three instruments should be remade as part of a consolidated instrument under the Act.

### IBNR indemnity scheme

The IBNR indemnity scheme provisions are set out in Part 2 of these Regulations and are substantially drawn from the IBNR Protocol. The IBNR indemnity scheme provisions allow the Chief Executive Medicare to make payments of claim handling fees to medical defence organisations (MDOs). They include provisions relating to:

- when a claims handling fee is payable to an MDO in respect of an IBNR claim, and
- the amount of claim handling fee that is payable in different circumstances.

The provisions also establish eligibility criteria for the payments and set out the process and timing of payments, including a provision to address the recovery of overpayments.

As for all application provisions in the Regulations, the MDO will be required to make a complying application for payment of the fee and to provide any additional information relating to the fee that the Chief Executive Medicare requests.

The term ‘complying application’ has been defined as an application to the Chief Executive Medicare that:

- is made in a form approved by the Chief Executive Medicare, and
- is accompanied by the documents and information (if any) required by the form.

This approach reflects the previous application process (provided for under section 7 of the IBNR Protocol) but draws on the term ‘complying application’, which has been defined to enable the term to be used wherever an application is required under these Regulations.

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<sup>1</sup> Department of Health, *Thematic Review of Commonwealth Medical and Midwife Indemnity Legislation*, February 2018  
[https://www1.health.gov.au/internet/main/publishing.nsf/Content/F923F31B70D61C37CA25815C00142243/\\$File/Thematic%20Review%20of%20Commonwealth%20Medical%20and%20Midwife%20Indemnity%20Legislation.pdf](https://www1.health.gov.au/internet/main/publishing.nsf/Content/F923F31B70D61C37CA25815C00142243/$File/Thematic%20Review%20of%20Commonwealth%20Medical%20and%20Midwife%20Indemnity%20Legislation.pdf) See pages 15-16 of the Thematic Review.

### Run-off cover indemnity scheme

The purpose of the run-off cover indemnity scheme provisions in the Regulations is to allow the Chief Executive Medicare to make payments:

- of claim handling fees to MDOs and medical indemnity insurers, and
- for certain costs incurred by medical indemnity insurers in respect of complying with their obligations under Division 2A, Part 3 of the *Medical Indemnity (Prudential Supervision and Product Standards) Act 2003* (the PPS Act).

The substance of Parts 1 to 4 of the ROCS Protocol is included in the Regulations. The ROCS Protocol enabled the payment of certain costs to medical indemnity insurers, including:

- when a claims handling fee is payable and the amount of claims handling fee that is payable (Part 2);
- when a payment in respect of ongoing administration is payable and the method for calculating the amount of such costs (Part 3); and
- applications for payment under the Protocol, payment dates and recovery of overpayments (Part 4).

The redrafting of Part 3 of the repealed ROCS Protocol as it now appears in Part 4 of the Regulations, provides for:

- the payment of ongoing administration costs (including to any new insurers entering the medical indemnity insurance market on or after 1 July 2007), and
- a one-off payment to Guild Insurance Limited and Berkshire Hathaway Specialty Insurance Company in respect of past run-off cover administration costs incurred in previous contribution years (where to date there has been no legal mechanism to make the relevant payments).

As identified in the Thematic Review, in remaking the provisions of the ROCS Protocol in the Regulations, a change was required to section 7 of the ROCS Protocol regarding the payment of ongoing administration costs. This change enables the payment of ROCS administration costs to insurers that have entered the medical indemnity insurance market since the instrument was made in 2006.

### Premium Support Scheme

The 2004 PSS established the Premium Support Scheme (PSS) on 1 July 2004. The objective of the PSS is to help ensure the continued availability of medical services in Australia by providing assistance to eligible medical practitioners, via their medical indemnity insurers, with the cost of obtaining appropriate medical indemnity cover.

Prior to 1 July 2020, the 'rules' relating to the PSS were spread across both legislation and contracts between medical indemnity insurers and the Commonwealth. The Commonwealth made subsidy payments to contracted medical indemnity providers on behalf of medical practitioners, where those providers had agreed to administer the PSS on behalf of the Commonwealth. The Commonwealth also made payment of an administration fee, now referred to as an administration payment, to contracted medical

indemnity providers to help meet the cost of administrating the PSS on behalf of the Commonwealth.

On 30 June 2020, the PSS contracts will expire and all matters relating to the PSS will be set out in the Regulations. The PSS provisions in the Regulations have been drawn from the 2004 PSS and the PSS contracts between the Commonwealth and providers. However, a number of changes have been made to:

- simplify provisions wherever possible;
- remove overly detailed or prescriptive provisions;
- remove definitions that are used broadly in Acts and delegated legislation; and
- make changes consistent with recommendations of the [First Principles Review](#) and [Thematic Review](#) including in relation to the definition of rural and remote practitioners, as well as changes to risk surcharge.

The term *professional indemnity cover*, used in relation to the universal cover provisions in the *Medical Indemnity Rules 2020*, has also been used for the purposes of this Part to simplify the drafting of the PSS provisions.

The inclusion of some of the provisions in these Regulations rely on authority set out in the *Medical and Midwife Indemnity Legislation Amendment Act 2019*, which commences on 1 July 2020, and provides for matters previously set out in individual Protocols to instead be consolidated in these Regulations. These Regulations are being made in advance of this commencement date. This is possible in accordance with section 4 of the *Acts Interpretation Act 1901*, which allows for the exercise of powers between enactment and commencement of an Act including, for example, the power to make Regulations.

Details of the Regulations are set out in [Attachment A](#).

The Regulations is a legislative instrument for the purposes of the *Legislation Act 2003* (Legislation Act).

The Regulations commence on 1 July 2020.

### **Regulation Impact Statement**

The Office of Best Practice Regulation has certified that the [First Principles Review](#) and [Thematic Review](#) of the Medical and Midwife Indemnity Schemes are equivalent to a Regulatory Impact Statement.

### **Consultation**

The Australian Government has worked collaboratively with the Australian Medical Association, relevant peak bodies, medical indemnity insurers and relevant government agencies.

Government has consulted extensively during the development of the medical and midwife indemnity reforms, including through the First Principles Review and Thematic Review, the development of the *Medical and Midwife Legislation Amendment Act 2019* and targeted stakeholder consultation on limited exposure drafts of the

legislative instruments. The final Regulations incorporates submissions received through the limited exposure draft consultation process in November 2019.

**Statement of Compatibility with human rights**

Subsection 9(1) of the *Human Rights (Parliamentary Scrutiny) Act 2011* requires the rule-maker in relation to a legislative instrument to which section 42 (disallowance) of the Legislation Act applies to cause a statement of compatibility to be prepared in respect of that legislative instrument. The Statement of Compatibility has been prepared to meet that requirement. The Statement of Compatibility is included at Attachment B.

## **Details of the *Medical Indemnity Regulations 2020***

### **Part 1—Preliminary**

#### **Section 1 – Name**

This section provides that the name of the Regulations is the *Medical Indemnity Regulations 2020* (Regulations).

#### **Section 2 – Commencement**

This section provides that the Regulations commence on 1 July 2020.

#### **Section 3 – Authority**

This section provides that the Regulations is made under *Medical Indemnity Act 2002* (the Act).

#### **Section 4 – Schedules**

This section provides that each instrument that is specified in a Schedule to this instrument is amended or repealed as set out in the applicable items in the Schedule concerned, and any other item in a Schedule to this instrument has effect according to its terms.

#### **Section 5 – Simplified outline of this instrument**

This section provides a simplified outline of the instrument, which summarises the content of the Regulations.

#### **Section 6 – Definitions**

This section provides that in the Regulations, Act means the *Medical Indemnity Act 2002*.

This section also defines other expressions in the Regulations, including: *advance subsidy, authorised reviewing officer, complying application, eligible medical practitioner, gross indemnity costs, GST, medical indemnity provider, membership fee, old scheme, original decision, practising in a rural area, premium period, premium year, private practice income, procedural general practitioner, retroactive cover, run-off cover, subsidised excess, subsidy, and substantial insurance costs*.

The definition of *general interest charge rate* and *GST* are consistent with terms used in other Commonwealth legislation (for example, the *Taxation Administration Act 1953* and *A New Tax System (Goods and Services Tax) Act 1999*).

The incorporation of the *general interest charge rate* by reference to section 8AAD of the *Taxation Administration Act 1953* is incorporated as varying from quarter to quarter. This variation in the rate is inherent in the definition being incorporated from that Act.

Section 14 of the *Legislation Act 2003* permits the incorporation by reference of material from an Act as in force from time to time. There are two definitions in the Regulations that rely on the authority in section 14.

- Incorporation of the Premium Support Scheme 2004 within the definition of the **old scheme** as in force immediately before 1 July 2020, and
- The reference to 26A of the Medical Indemnity (Prudential Supervision and Product Standards) Act 2003 within the definition of **run-off cover** is to that section as in force from time to time.

Section 6 also notes that a number of expressions used in the Regulations are defined in the Act including the expressions ‘Chief Executive Medicare’, ‘claim’, ‘MDO’, ‘medical indemnity insurer’, and ‘medical practitioner’.

The term ‘complying application’ has been defined to mean an application to the Chief Executive Medicare that:

- is made in a form approved by the Chief Executive Medicare, and
- is accompanied by the documents and information (if any) required by the form.

The term ‘complying application’ has been defined to enable the term to be used wherever an application is required under the Regulations.

## **Part 2—Claim handling fees for claims for which IBNR indemnity payable**

### **Section 7 – Simplified outline of this Part**

This section provides an outline of what is included in Part 2. Part 2 deals with the payment of the claim handling fees for IBNR claims.

### **Section 8 – Authority for this Part**

This section provides that Part 2 is made for the purposes of paragraphs 27A(1)(a) and (2)(a) of the Act.

### **Section 9 – When claim handling fee is payable for claim for which IBNR indemnity payable**

This section sets out when a claim handling fee, of the amount calculated under section 10 of the Regulations, is payable to an MDO in respect of an IBNR claim. This includes that the MDO has made a complying application for payment of the claim handling fee, and that the MDO has complied with any requests for information regarding the fee from the Chief Executive Medicare under section 27B of the Act.

Legislative notes under section 9 explain that the underlying payment referred to in paragraph 9(a) may be for legal and other expenses directly attributable to the negotiations, arbitration or proceedings relating to the claim.

The costs incurred in complying with a request from the Chief Executive Medicare under sections 27B, 38 or 71 of the Act are not underlying payments or taken into account in working out the amount of the IBNR indemnity because they are not covered by subsection 4(3) of the Act.

### **Section 10 – Amount of claim handling fee**

This section provides that the amount of the claim handling fee is 5% of the IBNR indemnity. However, subsection 10(2) sets out a different amount of claim handling fee if the IBNR indemnity has been paid to the MDO in relation to a qualifying payment under high cost claim indemnity scheme. In this case the claim handling fee is 5% of the IBNR indemnity and the amount by which the IBNR indemnity was less than it would have been had a high cost claim indemnity not been payable because of a qualifying payment.

This calculation is consistent with section 6 of the repealed IBNR Protocol but has been expressed more simply in the redrafting of the provision.

## **Part 3—Claim handling fees for eligible run-off claims**

### **Section 11 – Simplified outline of this Part**

This section provides an outline of what is included in Part 3. Part 3 deals with the payment of the claim handling fees for eligible run-off cover claims.

### **Section 12 – Authority for this Part**

This section provides that Part 3 is made for the purposes of paragraphs 34ZN(1)(a) and (2)(a) of the Act.

### **Section 13 – When claim handling fee is payable for eligible run-off claim**

This section sets out when a claim handling fee is payable. This includes the requirement for the medical indemnity provider to make a complying application for payment of the fee and to provide any additional information relating to the fee that the Chief Executive Medicare requests.

### **Section 14 – Amount of claim handling fee for eligible run-off claim**

Section 14 of the Regulations reduces the drafting complexity in section 6 of the ROCS Protocol, while specifying the same amount of claim handling fee. That is, that the amount of the claim handling fee is 5% of the run-off cover indemnity unless the run-off cover indemnity has been paid to the MDO in relation to a qualifying payment under high cost claim indemnity scheme, in which case the amount of the claim handling fee is 5% of the sum of:

- the run-off cover indemnity, and
- the amount by which the run-off cover indemnity was reduced by a high cost claim indemnity payable in respect of the qualifying payment.



## **Part 4—Compulsory run-off cover administration payments**

### **Section 15 – Simplified outline of this Part**

This section provides an outline of what is included in Part 4. Part 4 deals with run-off cover administration payments.

### **Section 16 – Authority for this Part**

This section provides that Part 4 is made for the purposes of paragraphs 34ZN(1)(a) and (2)(a) of the Act.

### **Section 17 – When compulsory run-off cover administration payment is payable**

This section sets out when a compulsory run-off administration payment, of the amount calculated under section 18 of the Regulations, is payable to a medical indemnity provider for a contribution year starting on or after 1 July 2020.

### **Section 18 – Amount of compulsory run-off cover administration payment**

Subsection 18(1) sets out that the method for calculating the amount of the payment for a contribution year is by multiplying the amount for the year in the table in subsection 18(2) by:

- the number of medical practitioners for whom the medical indemnity insurer provided medical indemnity cover by contracts of insurance during the period for which premiums were paid to the insurer by reference to which the amount of run-off cover support payment payable by the insurer; or
- if that number is less than 1,000—1,000.

The effect of this provision is that medical indemnity insurers that entered the market after 2006, or that enter the market in future, will be able to make application for the run-off cover administration payment by reference to the number of practitioners for whom a run-off cover support payment was payable by the insurer, or, if that number is less than 1,000 – by multiplying the relevant contribution year by 1,000.

Subsection 18(2) specifies applicable amounts of compulsory run-off cover administration payments for up to 10 contribution years. Projecting the amounts for a 10-year period aligns with the Government’s requirements for sunset provisions (whereby all legislative instruments will be automatically repealed after 10 years unless action is taken to preserve them).

### **Section 19 – One-off payments to particular insurers for past costs**

Subsection 19(1) specifies one-off payments to be made to two medical indemnity insurers in recognition of past costs that have not been able to be paid under the existing instrument (because Guild Insurance Limited and Berkshire Hathaway Specialty Insurance Company entered the medical indemnity insurance market after the commencement of the ROCS Protocol in 2006).

Subsection 19(2) provides that the time for making the one-off payment set out in subsection 19(1) is within 30 days of the insurer making a written application for the payment.

## **Part 5—Payment of claim handling fees and some compulsory run-off cover administration payments**

### **Section 20 – Simplified outline of this Part**

This section provides an outline of what is included in Part 5. Part 5 sets out the time in which an IBNR claim handling fee, ROCS claim handling fee and a ROCS administration payment must be paid by the Chief Executive Medicare.

### **Section 21 – Authority for this Part**

This section provides that Part 5 is made for the purposes of paragraphs 27A(1)(a) and (2)(a) and 34ZN(1)(a) and (c) and (2)(a) of the Act.

### **Section 22 – Time of payment**

Consistent with previous arrangements, this section provides that these payments must be paid before the end of the next calendar month after which the complying application for the payment is made. However, if a request for information is made regarding the amount payable, payments will be due after the calendar month in which the request for information is complied with.

## **Part 6—Premium support scheme**

### **Division 1—Introduction**

#### **Section 23 – Simplified outline of this Part**

This section provides an outline of what is included in Part 6.

Part 6 sets out provisions relating to the PSS for payment of subsidies to medical indemnity insurers on behalf of medical practitioners. Part 6 also:

- describes:
  - the eligibility requirements for subsidy to be paid to medical indemnity insurers on behalf of medical practitioners,
  - the method by which the amount of subsidy is calculated,
  - the circumstances in which advance subsidy is payable,
- sets out the conditions that must be met by insurers for subsidy to be payable;
- provides for an administration payment to medical indemnity insurers to help meet the cost of administering the PSS; and
- provides for review of decisions made under PSS and for other administrative matters.

## **Section 24 – Authority for this Part**

This section provides that Part 5 is made for the purposes of paragraphs 43(1)(a) and (2)(a) to (e) of the Act.

## **Section 25 – Object of this Part**

This section states that the main object of Part 6 is to provide for payments to medical indemnity insurers on behalf of eligible medical practitioners to help those practitioners meet the cost of purchasing medical indemnity.

## **Division 2—Eligibility for payment**

### **Section 26 – General conditions**

This section sets out the general conditions that must be met in order for an amount of subsidy to be paid to a medical indemnity insurer on behalf of a medical practitioner for a premium year.

Subsection 26(1) sets out the basic rules for an amount of premium support subsidy to be paid to an insurer in respect of a medical practitioner for a premium year. Rules are also set out in subsection 26(2) in relation to advance payments of subsidy based on an estimate of private practice income.

Note that the “complying application” condition (in paragraph 26(1)(e)) may also be used by the Chief Executive Medicare to require the application for subsidy to be accompanied by the practitioner’s statutory declaration of income (see the definition of complying application in section 6).

## **Division 3—When is a medical practitioner an eligible medical practitioner for a premium period?**

### **Subdivision A—General**

#### **Sections 27, 28, 29 and 30**

For subsidy to be payable, the medical practitioner must have been an eligible practitioner for a premium period. Section 27 establishes that a practitioner is eligible if there is a contract of insurance between the practitioner and the insurer providing professional indemnity cover in relation to the period; and the practitioner:

- is a procedural general practitioner practising in a rural area for the whole period, or
- has gross indemnity costs (for the cover) more than 7.5% of the practitioner’s private practice income, or
- if the premium year is the year after 1 July 2020—the practitioner would have been a member with a MISS entitlement for the period under the old scheme.

The categories of eligible medical practitioner described in paragraph 27(1)(b) are further described in Subdivisions B, C and D of Division 3.

The rules in section 27 are subject to the matters in sections 28, 29 and 30, which describe certain circumstances when a practitioner will not be an eligible medical practitioner. These circumstances include:

- Practitioner with no or low private income for a premium period (refer to section 28). This provision states that a medical practitioner will not be eligible for subsidy for a premium period if:
  - The practitioner’s private practice income is nil: unless the practitioner’s only practice in the premium period is the provision of health services through an organisation whose primary function is to provide health services at no charge; and the practitioner’s professional indemnity cover provides for retroactive and/or run-off cover only in relation to incidents in the course of prior private medical practice from which the practitioner received income.
  - The practitioner’s private practice income for the premium year is less than \$1000; the practitioner mainly treated public patients in a public hospital; and the practitioner is not indemnified in relation to the practitioner’s private medical practice under an agreement with one or more of those public hospitals that allows the practitioner to carry on private medical practice during that premium year.
  
- Practitioner practising wholly outside Australia and external Territories (refer to section 29).
  - A medical practitioner is not an eligible medical practitioner for a premium year (or any period in it) if the practitioner has practised outside Australia (and the external Territories) for a least 6 months of that year.
  - Subsection 29(2) clarifies how this provision intersects with practice in the circumstances prescribed for the purposes of exceptional claims (i.e. when incidents that are connected with medical practice and occur outside Australia are treated like incidents occurring in Australia).
  
- Practitioner who has not paid the insurer for subsidy that the insurer must repay (refer to section 30).
  - This provision prevents a practitioner from being eligible for subsidy if an insurer has requested that some or all the subsidy paid to the medical practitioner be repaid to the insurer (on the basis it is a debt due to the Commonwealth). This rule also applies where the practitioner moves insurers – such that amounts owing to any insurer preclude the practitioner from being eligible for subsidy. It also includes reference to the old scheme, such that any subsidy repayable under that scheme is also relevant for the purposes of determining eligibility for subsidy under the new scheme.

## **Subdivision B—Procedural general practitioners practising in rural areas**

### **Section 31 – Who is a *procedural general practitioner*?**

Section 31 provides that a general practitioner (within the meaning of the *Health Insurance Act 1973*) is a ***procedural general practitioner*** for a period if:

- the practitioner paid, or is liable to pay, a premium for a contract of insurance that provides professional indemnity cover for the practitioner in relation to the period; and
- the practitioner's practice in the period includes any of the following activities that are covered by subsection 31(2):
  - administration of anaesthetic;
  - a surgical procedure for which hospital facilities are, or would normally be, required;
  - an obstetric procedure;
  - accident and emergency medicine;
  - an invasive medical procedure except the administration of Implanon.

Subsection 31(2) provides that the activities must be covered by:

- the non-referred provision of a medical service described in the general medical services table under the *Health Insurance Act 1973*;
- the provision of a health service specified in a determination under subsection 3C(1) of that Act.

A legislative note clarifies that a general practitioner is not a procedural general practitioner if the practitioner's practice in the period includes any of the activities described above but none of them are covered by subsection 31(2) (for example, because they relate to procedures that are cosmetic and not therapeutic).

As permitted by section 14 of the *Legislation Act 2003* the incorporation by reference of the definition of **general practitioner** from the *Health Insurance Act 1973* is incorporated as in force from time to time.

### **Section 32 – When is a procedural general practitioner *practising in a rural area*?**

Section 32 sets out when a procedural general practitioner is practising in a rural area by reference to the [Modified Monash Model](#) (MMM), which is used to define whether a location is a city, rural, remote or very remote. The model measures remoteness and population size on a scale of Modified Monash areas 1 to 7. Modified Monash 1 area being a major city and Modified Monash 7 area being very remote.

A procedural general practitioner practises in a rural area if the majority of their Medicare eligible services in a financial year are conducted within Modified Monash 3 area to Modified Monash 7 area (inclusive).

Paragraph 32(b) provides for a savings component to the definition of *practising in a rural area*. This ensures practitioners who, before the reforms, were receiving subsidy because they were practicing in a rural area under the Rural, Remote and Metropolitan Area (RRMA), continue to receive the subsidy under the new scheme. This will occur even if the area in which they are practicing is no longer classified as rural/remote under the new MMM classification. While the practitioner continues to practice in that same rural area, they will continue to be eligible for a subsidy.

The definitions of **Modified Monash 3 area**, **Modified Monash 4 area**, **Modified Monash 5 area**, **Modified Monash 6 area**, and **Modified Monash 7 area** are as in force from time to time, as permitted by section 14 of the *Legislation Act 2003* because the

*Health Insurance (General Medical Services Table) Regulations* (as enforced from time to time) is a disallowable legislative instrument.

### **Subdivision C—Medical practitioners with substantial insurance costs**

#### **Section 33 – When does a medical practitioner have *substantial insurance costs*?**

Section 33 provides that a medical practitioner has *substantial insurance costs* for a premium period if the practitioner's gross indemnity costs for the period exceed 7.5% of the practitioner's private practice income (if any) for the period.

The term 'substantial insurance costs' is used in the Regulations as a short-hand way to describe the class of practitioners' whose gross indemnity costs for the period exceed 7.5% of the practitioners private practice income.

#### **Section 34 – What are *gross indemnity costs*?**

Subsection 34(1) defines gross indemnity costs as the total of the following for which a medical practitioner is charged:

- the premium for the contract, excluding any risk surcharge;
- the membership fee (if any); and
- costs payable by the practitioner for retroactive cover or run-off cover.

Subsection 34(2) provides that the following amounts are excluded from gross indemnity costs:

- GST relating to the contract;
- stamp duty on the contract;
- a capital contribution required of the practitioner under rules (however described) of an MDO;
- payment of an excess or deductible;
- costs for earlier premium periods;
- charges imposed by the insurer for late payment of any of the amounts described in subsection (1); and
- late payment penalty.

Subsection 34(3) provides that a premium for a contract of insurance that primarily covers employees of the practitioner or an entity, other than the practitioner, that runs the practitioner's medical practice is not included in gross indemnity costs of the practitioner. Examples of entities include companies and partnerships.

#### **Section 35 – What is *private practice income*?**

Section 35 defines private practice income as the total gross income received in the premium period by the practitioner from the practitioner's private medical practice for which either a contract of insurance provides professional indemnity cover for the practitioner, or the practitioner is personally liable.

The words “from the practitioner’s private medical practice” in the definition of *private practice income* are not intended to refer to income received by the practitioner through the profits of a partnership. Rather the intent is to refer to income received as a result of the practitioner’s own private medical practice.

The term ‘billings’, as it was used in the previous PSS instrument, has not been used in these Regulations as it was not sufficiently clear what was intended, specifically, whether billings included amounts invoiced in a premium period but not paid, or amounts paid during the period.

## **Division 4—Applications for subsidies**

### **Subdivision A—Application for advance subsidy**

#### **Section 36 – Application for advance subsidy may be made before, or within 14 months after, start of premium period**

This section provides for applications for advance subsidy, where an application can be made based on an estimate of the practitioner’s private practice income. Applications for advance subsidy can be made before, or within 14 months after, the start of the premium year.

This section also provides that an insurer may not make an application under this section if the insurer has already made an application under section 37 for a subsidy to be paid to the insurer on behalf of the practitioner for the year.

### **Subdivision B—Final application for subsidy**

#### **Section 37 – Final application to be made within 13 months after end of premium year**

Subsection 37(1) provides that section 37 applies if a medical indemnity insurer has a contract of insurance with a medical practitioner that provides professional indemnity cover for the practitioner in relation to a premium period in a premium year and either:

- the insurer is satisfied that, if the insurer makes a complying application under this section for a subsidy to be paid to the insurer on behalf of the practitioner for the year, an amount of subsidy will be payable to the insurer under subsection 26(1) on behalf of the practitioner for the year; or
- the insurer has been paid an amount of advance subsidy on behalf of the practitioner for the premium year.

Subsection 37(2) provides that the insurer:

- may make a complying application within 13 months after the end of the premium year for the subsidy to be paid to the insurer on behalf of the practitioner; and
- must do so if the insurer has been paid advance subsidy on behalf of the practitioner for the premium year, unless:

- the insurer made a complying application under section 53 for adjustment of the advance subsidy; and
- the Chief Executive Medicare determined under section 39 that the advance subsidy was not payable; and
- the insurer has not made a later application under section 36 to be paid subsidy on behalf of the practitioner for the premium year.

Subsection 37(2) notes that if the insurer does not comply with paragraph 37(2)(b), the insurer must repay the advance subsidy to the Commonwealth: see section 51. If the insurer is not required by paragraph (b) to make an application under this section because the circumstances described above apply (i.e. the Chief Executive Medicare determined that no advance subsidy was payable and no further application for advance subsidy was made), the insurer must repay the advance subsidy that was paid: see section 49.

### **Subdivision C— Determining applications for subsidy and applications for adjustment of advance subsidy**

#### **Section 38 – Chief Executive Medicare to determine applications for subsidy**

This section deals with matters regarding the determination of applications for subsidy by the Chief Executive Medicare. This section provides that complying applications for subsidy must be decided as soon as practicable after they are received, including whether any subsidy is payable and, if so, the amount payable.

#### **Section 39 – Chief Executive Medicare to determine applications for adjustment of advance subsidy**

Subsection 39(1) provides that as soon as practicable after receiving a complying application made under section 53 for adjustment of advance subsidy paid to a medical indemnity insurer on behalf of a medical practitioner for a premium year, the Chief Executive Medicare must, on the basis of the information in that application:

- determine whether any advance subsidy is payable; and
- if it is determined that advance subsidy is payable—determine the amount payable.

Subsection 39(2) provides that the Chief Executive Medicare must not make a determination under subsection 39(1) after the insurer makes an application under section 37 (i.e. a final application) for subsidy to be paid to the insurer on behalf of the practitioner for the premium year.

### **Division 5—Amount of subsidy**

#### **Sections 40, 41, 42, 43, 44 and 45**

Division 5 sets out matters regarding the amount of subsidy that is payable. The amount payable generally depends on the practitioner's circumstances and private practice income for the year concerned. Division 5 addresses five matters regarding the amount of subsidy, including:



- Procedural general practitioners practising in rural areas.
  - Section 40 states that, for a procedural general practitioner (*subsidised practitioner*) practising in a rural area (as defined in section 32), the subsidy is 75% of the difference between:
    - the amount of the premium, excluding any risk surcharge, attributable to the period for the contract of insurance providing professional indemnity cover for the subsidised practitioner; and
    - the lowest amount of premium, excluding any risk surcharge, for the period of a general practitioner (*comparison practitioner*) who: is not a procedural general practitioner for the period; and who has professional indemnity cover with the same medical indemnity insurer in relation to the period; and is practising in the same State or Territory; and has private practice income for the period in the same range as the subsidised practitioner.

As permitted by section 14 of the *Legislation Act 2003*, the references to the general medical services table and determinations under section 3C of the *Health Insurance Act 1973* are to that table and those determinations as in force from time to time as the general medical services table and those determinations are disallowable legislative instruments.

- Practitioners with substantial insurance costs.
  - Under section 41, the amount of subsidy payable for a practitioner with substantial insurance costs for the premium period is 60% of the subsidised excess of the practitioner for the period (refer to Subdivision C of Division 3 of Part 6 for details about when a medical practitioner has substantial insurance costs).
- Practitioners with Medical Indemnity Subsidy Scheme (MISS) entitlements under the old scheme (i.e. the PSS as it existed before 1 July 2020).
  - Section 42 provides that if the medical practitioner would have been a PSS member with a MISS entitlement (as defined in section 12 of the old scheme) then they will be eligible from 1 July 2020 until 30 June 2021 for the amount payable as it would have been under the old scheme had it not ceased to be in force. In essence, medical practitioners with a MISS entitlement will be grandfathered until 1 July 2021.
- Eligible medical practitioners with multiple or varying eligibility.
  - Sections 43 and 44 deal with two eligibility scenarios:
    - If a practitioner is eligible on different grounds for the same period – the amount of subsidy is the greatest of the amounts that apply in relation to the practitioner for the period.

- If a practitioner is eligible on different grounds for different periods in the premium year because of one or more contracts of insurance with the insurer – the amount of subsidy is the sum of the amounts of subsidy for the premium periods.
- Reconciling advance subsidy and subsidy.
  - Section 45 provides for the reconciliation of advance subsidy (if paid) and the final amount of subsidy that is payable. The amount payable on the basis of the practitioner’s actual private practice income for the year is reduced by any amount paid on the basis of an estimate of that income. If the final amount is less than the advance amount, the insurer must repay the Commonwealth the difference between the amounts (as per section 50).

## **Division 6—Conditions to be complied with by insurers**

### **Sections 46, 47, 48, 49, 50, 51, 52, 53 and 54**

Section 46 provides an outline of what is included in Division 6 of Part 6.

Division 6 establishes the conditions to be complied with by insurers for a subsidy to be payable to the insurer on behalf of a medical practitioner, and requirements to be met after subsidy has been paid.

The conditions relate to the following matters:

- Asking medical practitioners about participating in the subsidy scheme before entering a contract of insurance to provide professional indemnity cover for a premium period (refer to section 47).
  - Insurers should provide the following information in their Product Disclosure Statement (or equivalent document) to each medical practitioner for whom it is proposed professional indemnity cover may be provided in relation to a premium period:
    - asking (if eligible) whether the practitioner is willing for a subsidy to be paid to the insurer on behalf of the practitioner,
    - stating that for subsidy to be paid the practitioner will need to give necessary information to the insurer and that this information will need to be given to the Chief Executive Medicare, and
    - stating that overpayments of subsidy made to the insurer must be repaid by the practitioner.
- The contents that must be included in invoices given to eligible medical practitioners relating to the contract of insurance between the insurer and the practitioner for the premium period (refer to section 48).

- Repaying overpayments of subsidy (refer to the three scenarios outlined in sections 49, 50 and 51).
- Records relating to subsidies must be kept for a period of 5 years after the record was created (refer to section 52). This is consistent with the record keeping requirements for other schemes in the Act.
- Reporting between making an application for advance subsidy and making final application for subsidy (refer to section 53).
  - The requirement in section 54 replaces the previous requirements in relation to monthly reporting to instead reflect arrangements consistent with the system requirements: that changes in information regarding an eligible medical practitioner or relevant to the calculation of a subsidy for a medical practitioner be reported to the Chief Executive Medicare. This may include information that was accurate when reported, but subsequently changes, or information that was inaccurate at the time of reporting and therefore needs to be amended.
- Reporting to the Chief Executive Medicare on information in the application for subsidy that was not correct or is no longer correct in respect of whom applications for payment of subsidy have been made (refer to section 54).

## **Division 7—Review of decisions relevant to subsidies**

### **Sections 55, 56, 57 and 58**

In accordance with Division 7 of Part 6, practitioners and insurers may apply for review of decisions about whether an amount is payable and how much is payable. Provisions in Division 7 provide for:

- the Chief Executive Medicare to authorise an Australian Public Service employee in the Department administered by the Minister administering the *Human Services (Medicare) Act 1973* to be an authorised reviewing officer if a review of a decision is sought in accordance with section 55. The reviewing officer must have a higher classification than the original decision maker;
- applications may be made by medical practitioners or medical indemnity insurers for review of a determination as to whether PSS subsidy is payable, and how much subsidy is payable (refer to section 56);
- an authorised reviewing officer to affirm or to set aside the original decision and substitute a new decision, and to give written reasons for that decision (refer to section 57); and
- applications to be made to the Administrative Appeals Tribunal in relation to decisions that are made on review, specifically, decisions of an authorised reviewing officer under section 58.

## **Part 7—Payments for administrating premium support scheme**

### **Sections 59, 60, 61, 62 and 63**

Section 59 provides an outline of what is included in Part 7. Part 7 provides for the PSS administration payments.

Consistent with the current scheme, this is an amount payable to a medical indemnity insurer in respect of a financial year for incurring costs related to the administration of the PSS.

As for other administration payments under Part 6, the insurer must make a complying application for the payment and have complied with any request for additional information relating to the payment.

The amount of the PSS administration payment is calculated in accordance with section 62, which sets out the applicable amount for a financial year (starting from 1 July 2020) and provides for that amount to be multiplied by:

- the number of medical practitioners which whom the medical indemnity insurer has contracts providing professional indemnity cover for all or part of the preceding financial year, or
- 1,000 (where the number of medical practitioners described is less than 1,000).

This simplified approach of drawing on the number of insured practitioners for the preceding financial year enables the administration payments to continue to be paid in advance, while avoiding the more complex process whereby insurers are required to estimate the number of practitioners that are likely to be insured in the relevant financial year, which later has to be reconciled after the end of that financial year based on actual numbers.

The table at subsection 62(2) specifies applicable amounts of premium support scheme administration payments over 10 financial years, where 1 July 202 is the first financial year. Projecting the amounts for a 10-year period aligns with the Government's requirements for sunset provisions (whereby all legislative instruments will be automatically repealed after 10 years unless action is taken to preserve them).

Consistent with the Government decision, the amount specified for the first financial year following the commencement of the reforms is \$5.00 per insured medical practitioner. Amounts for subsequent financial years have been forecast using the consumer price inflation (CPI) rate current at the time of drafting (that is, 1.7%).

Section 63 provides for a one-off payment of \$250,000 to be made to each of the four medical indemnity insurers that currently participate in the PSS.

Payment of the specified amount must be made within 30 days of the insurer making a written application to the Chief Executive Medicare.

## **Part 8—Recovery of overpayments and amounts required to be repaid**

### **Section 64 – Simplified outline of this Part**

This section provides an outline of what is included in Part 8.

### **Section 65 – Authority for this Part**

This section provides that Part 8 is made for the purposes of paragraphs 27A(2)(a), 34ZN(2)(a) and 43(2)(e) of the Act.

### **Section 66 – Recovery of overpayments and amounts required to be repaid**

Subsection 66(1) sets out the requirements for the recovery of overpayments if a medical indemnity provider is paid more than it is entitled to under Part 2, 3, 4, 6 or 7 or section 69 of the Regulations (whether no initial payment should have been made, or if the amount paid was greater than the amount that should have been paid).

Debts created by the *old scheme* before it ceased to be in force on 1 July 2020 because of the repeal and substitution of subsection 43(1) of the Act will not be affected by that scheme ceasing to be in force (see *section 7 of the Acts Interpretation Act 1901*, as applying because of section 13 of the *Legislation Act 2003*). Action to recover such debts can therefore still be taken under the general law after 1 July 2020.

Subsection 66(2) describes an amount overpaid. Subsection 66(3) provides that an amount overpaid is a debt due to the Commonwealth by the medical indemnity provider.

Subsection 66(4) provides for the amount to be recovered through court action or by deduction from another amount that is payable to the medical indemnity provider under the Regulations.

## **Part 9—Application, saving and transitional provisions**

### **Division 1—Provisions for this instrument as originally made**

#### **Section 67 – Application of Part 6**

##### *Contracts of insurance made on or after 1 July 2020*

Subsection 67(1) provides that Part 6 (regarding the Premium Support Scheme) applies in relation to contracts of insurance made on or after 1 July 2020 for the provision of professional indemnity cover for medical practitioners in relation to premium periods starting on or after that day.

##### *Contracts of insurance made before 1 July 2020 for premium periods starting on or after 1 July 2020*

Subsection 67(2) provides that Part 6 (except section 47 regarding invoices to be given to PSS eligible medical practitioners) also applies in relation to contracts of insurance that were made before 1 July 2020 by medical indemnity insurers that were parties to

PSS contracts within the meaning of the old scheme, so far as those contracts of insurance are for the provision of professional indemnity cover for medical practitioners in relation to premium periods:

- starting on or after 1 July 2020; and
- forming the whole or part of premium years starting on or after 1 July 2020.

For premium periods that started before 1 July 2020, section 69 continues to apply the old scheme in relation to contracts of insurance made before 1 July 2020 by insurers that were party to PSS contracts within the meaning of the old scheme.

Subsection 67(3) provides that a medical indemnity insurer that was not a party to a PSS contract within the meaning of the old scheme may choose, by written notice given to the Chief Executive Medicare, that Part 6 apply in relation to a specified contract of insurance that:

- was made by the insurer and a specified medical practitioner before 1 July 2020; and
- is (at least partly) for the provision of professional indemnity cover for the medical practitioner in relation to one or more premium periods starting on or after 1 July 2020;

so far as that contract is for the provision of professional indemnity cover for the medical practitioner in relation to those premium periods.

Subsection 67(4) provides that the choice made in accordance to subsection 67(3), to choose to apply the PSS in respect of a specified contract, cannot be revoked or changed.

Subsection 67(5) provides that if the medical indemnity insurer has chosen that Part 6 apply in relation to the contract, that Part, except sections 47 and 48, applies in relation to the contract so far as it is for the provision of professional indemnity cover for the medical practitioner in relation to one or more premium periods starting on or after 1 July 2020.

### **Section 68 – Transitional—agreement to payment of subsidy to insurer**

This section provides that the reference in subparagraph 26(1)(c)(i) to agreement to payment of subsidy to the insurer includes a reference to consent to the insurer receiving payments under the old scheme. This ensures that agreement to participate in the old scheme, and have payments of subsidy made the insurer on behalf of the practitioner, continue to apply in respect of the new scheme.

### **Section 69 – Saving—old scheme**

Subsection 69(1) provides that the old scheme (as in force immediately before 1 July 2020) continues to apply in relation to premium periods (within the meaning of the old scheme) that started before 1 July 2020.

Subsection 69(2) provides that the old scheme continues to apply as if PSS contracts (within the meaning of the old scheme) that were in force immediately before 1 July 2020 continued in force so far as they related to the old scheme.

Subsection 69(3) provides that subsections (1) and (2) do not continue to apply:

- Part 8 of the old scheme; or
- a provision of the old scheme so far as the provision relates to that Part; or
- PSS contracts so far as they relate to that Part.

This saving provision is required so that contracts of insurance that are in effect before 1 July 2020 where a medical practitioner has agreed to participate in the PSS can be managed in accordance with the old scheme until the end of that premium period. Matters that are not saved under the old scheme include the PSS administration payment (referred to as PSS administration fee under the old scheme).

The incorporation by reference of the old scheme and PSS contracts is permitted by section 14 of the *Legislation Act 2003* because they are incorporated as in force immediately before the commencement of this section.

### **Section 70 – Transitional—premium support scheme administration payment for financial years starting on 1 July 2020 and 1 July 2021**

#### *Payment for financial year starting on 1 July 2020*

Subsection 70(1) provides that for the purposes of calculating the amount of a payment under Part 7 for the financial year starting on 1 July 2020, paragraph 62(1)(a) has effect as if the reference in that paragraph to subsidy or advance subsidy having been payable, or potentially being payable if application were made, to the insurer for a premium year were a reference to subsidy under the old scheme having been payable to the insurer for a premium period (within the meaning of the old scheme).

#### *Payment for financial year starting on 1 July 2021*

Subsection 70(2) provides that for the purposes of calculating the amount of a payment under Part 7 for the financial year starting on 1 July 2021, paragraph 62(1)(a) has effect as if the reference in that paragraph to subsidy or advance subsidy having been payable, or potentially being payable if application were made, to the insurer for a premium year included a reference to subsidy under the old scheme having been payable under section 69 to the insurer for a premium period (within the meaning of the old scheme).

### **Schedule 1—Repeals**

Item 1 of schedule 1 to the Regulations repeals the *Medical Indemnity Regulations 2003*.

## Statement of Compatibility with Human Rights

*Prepared in accordance with Part 3 of the Human Rights (Parliamentary Scrutiny) Act 2011*

### ***Medical Indemnity Regulations 2020***

This Legislative Instrument is compatible with the human rights and freedoms recognised or declared in the international instruments listed in section 3 of the *Human Rights (Parliamentary Scrutiny) Act 2011*.

#### **Overview of the Legislative Instrument**

The purpose of the *Medical Indemnity Regulations 2020* (the Regulations) is to consolidate the following three instruments into the one instrument prior to their sunsetting on 1 October 2021:

- *Medical Indemnity (IBNR Claims) Protocol 2006* (IBNR Protocol);
- *Medical Indemnity (Run-off Cover Claims and Administration) Protocol 2006 (No. 2)* (ROCS Protocol); and
- *Premium Support Scheme 2004* (2004 PSS).

The *Legislation Act 2003* provides that all legislative instruments, other than exempt instruments, are automatically repealed according to the progressive timetable set out in section 50 of that Act. Legislative instruments generally cease to have effect after a specific date unless further legislative action is taken to extend their operation, such as remaking the instrument.

The IBNR Protocol, ROCS Protocol and 2004 PSS (hereafter collectively referred to as the three instruments) were reviewed as part of the February 2018 *Thematic Review of Commonwealth Medical and Midwife Indemnity Legislation* (the Thematic Review) prepared for the Department of Health. The sunsetting date for the three instruments was adjusted to allow for the Thematic Review to be undertaken and then further deferred so that amendments to the Act could be legislated. These instruments will now sunset on 1 October 2021.

The Thematic Review examined 17 legislative instruments, including the three instruments, which collectively support the Medical Indemnity Insurance Fund (IIF). The IIF comprises seven related schemes that are collectively designed to promote the stability of the medical and midwife indemnity insurance industry and support the availability of affordable indemnity insurance for medical practitioners, allied health professionals and eligible midwives.

The Thematic Review involved consultation with regulatory and other bodies managing or overseeing medical indemnity arrangements, relevant Departments and Government Agencies, the Law Council of Australia, medical indemnity insurers, and peak bodies representing insurers, medical practitioners and midwives. It also involved a review of reports including those of the Australian National Audit Office and the then Department



of Human Services (now Services Australia) and a review of submissions made by stakeholders over the past three years.<sup>2</sup>

The Thematic Review found that the three instruments were, for the most part, still required in order to describe the conditions medical indemnity providers must meet in order to receive Commonwealth support relating to the Incurred But Not Reported (IBNR) indemnity scheme, run-off cover indemnity scheme and Premium Support Scheme. The Thematic Review also suggested that the three instruments should be remade as part of a consolidated instrument under the Act.

### IBNR indemnity scheme

The IBNR indemnity scheme provisions are set out in Part 2 of these Regulations and are substantially drawn from the IBNR Protocol. The IBNR indemnity scheme provisions allow the Chief Executive Medicare to make payments of claim handling fees to medical defence organisations (MDOs). They would include provisions relating to:

- when a claims handling fee is payable to an MDO in respect of an IBNR claim, and
- the amount of claim handling fee that is payable in different circumstances.

The provisions would also establish eligibility criteria for the payments and set out the process and timing of payments, including a provision to address the recovery of overpayments.

As for all application provisions in the Regulations, the MDO will be required to make a complying application for payment of the fee and to provide any additional information relating to the fee that the Chief Executive Medicare requests.

The term ‘complying application’ has been defined as an application to the Chief Executive Medicare that:

- is made in a form approved by the Chief Executive Medicare, and
- is accompanied by the documents and information (if any) required by the form.

This approach reflects the previous application process (provided for under section 7 of the IBNR Protocol) but draws on the term ‘complying application’, which has been defined to enable the term to be used wherever an application is required under these Regulations.

### Run-off cover indemnity scheme

The purpose of the run-off cover indemnity scheme provisions in the Regulations is to allow the Chief Executive Medicare to make payments:

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<sup>2</sup> Department of Health, *Thematic Review of Commonwealth Medical and Midwife Indemnity Legislation*, February 2018  
[https://www1.health.gov.au/internet/main/publishing.nsf/Content/F923F31B70D61C37CA25815C00142243/\\$File/Thematic%20Review%20of%20Commonwealth%20Medical%20and%20Midwife%20Indemnity%20Legislation.pdf](https://www1.health.gov.au/internet/main/publishing.nsf/Content/F923F31B70D61C37CA25815C00142243/$File/Thematic%20Review%20of%20Commonwealth%20Medical%20and%20Midwife%20Indemnity%20Legislation.pdf) See pages 15-16 of the Thematic Review.

- of claim handling fees to MDOs and medical indemnity insurers, and
- for certain costs incurred by medical indemnity insurers in respect of complying with their obligations under Division 2A, Part 3 of the *Medical Indemnity (Prudential Supervision and Product Standards) Act 2003* (the PPS Act).

The substance of Parts 1 to 4 of the ROCS Protocol is included in the Regulations. The ROCS Protocol enabled the payment of certain costs to medical indemnity insurers, including:

- when a claims handling fee is payable and the amount of claims handling fee that is payable (Part 2)
- when a payment in respect of ongoing administration is payable and the method for calculating the amount of such costs (Part 3)
- applications for payment under the Protocol, payment dates and recovery of overpayments (Part 4).

The redrafting of Part 3 of the repealed ROCS Protocol as it now appears in Part 4 of the Regulations, provides for:

- the payment of ongoing administration costs (including to any new insurers entering the medical indemnity insurance market on or after 1 July 2007), and
- a one-off payment to Guild Insurance Limited and Berkshire Hathaway Specialty Insurance Company in respect of past run-off cover administration costs incurred in previous contribution years (where to date there has been no legal mechanism to make the relevant payments).

As identified in the Thematic Review, in remaking the provisions of the ROCS Protocol in the Regulations, a change was required to section 7 of the ROCS Protocol regarding the payment of ongoing administration costs. This change enables the payment of ROCS administration costs to insurers that have entered the medical indemnity insurance market since the instrument was made in 2006.

### Premium Support Scheme

The 2004 PSS established the Premium Support Scheme (PSS) on 1 July 2004. The objective of the PSS is to help ensure the continued availability of medical services in Australia by providing assistance to eligible medical practitioners, via their medical indemnity insurers, with the cost of obtaining appropriate medical indemnity cover.

Prior to 1 July 2020, the ‘rules’ relating to the PSS were spread across both legislation and contracts between medical indemnity insurers and the Commonwealth. The Commonwealth made subsidy payments to contracted medical indemnity providers on behalf of medical practitioners, where those providers had agreed to administer the PSS on behalf of the Commonwealth. The Commonwealth also made payment of an administration fee, now referred to as an administration payment, to contracted medical indemnity providers to help meet the cost of administering the PSS on behalf of the Commonwealth.

On 30 June 2020, the PSS contracts will expire and all matters relating to the PSS will be set out in the Regulations. The PSS provisions in the Regulations have been drawn

from the 2004 PSS and the PSS contracts between the Commonwealth and providers. However, a number of changes have been made to:

- simplify provisions wherever possible;
- remove overly detailed or prescriptive provisions;
- remove definitions that are used broadly in Acts and delegated legislation; and
- make changes consistent with recommendations of the [First Principles Review](#) and [Thematic Review](#) including in relation to the definition of rural and remote practitioners, as well as changes to risk surcharge.

The term *professional indemnity cover*, used in relation to the universal cover provisions in the *Medical Indemnity Rules 2020*, has also been used for the purposes of this Part to simplify the drafting of the PSS provisions.

The inclusion of some of the provisions in these Regulations rely on authority set out in the *Medical and Midwife Indemnity Legislation Amendment Act 2019*, which commences on 1 July 2020, and provides for matters previously set out in individual Protocols to instead be consolidated in these Regulations. These Regulations are being made in advance of this commencement date. This is possible in accordance with section 4 of the *Acts Interpretation Act 1901*, which allows for the exercise of powers between enactment and commencement of an Act including, for example, the power to make Regulations.

### **Human rights implications**

The instrument does not engage any of the human rights and freedoms recognised in the seven core international human rights treaties which Australia has ratified. However, the overarching purpose of the medical indemnity legislation is to enable payments to be made to insurers to subsidise the cost of medical indemnity insurance for medical practitioners and allied health professionals such that persons who make legitimate claims against medical practitioners or allied health professionals are able to be compensated for any loss they have suffered. This supports Article 12(2)(d) of the International Covenant on Economic, Social and Cultural Rights such that it creates “conditions which would assure to all medical service and medical attention in the event of sickness”.

### **Conclusion**

This Legislative Instrument is compatible with human rights, and in particular, supports the right to health.

**The Hon Greg Hunt MP, Minister for Health**