2002

THE PARLIAMENT OF THE COMMONWEALTH OF AUSTRALIA

HOUSE OF REPRESENTATIVES

Medical Indemnity (Prudential Supervision and Product Standards) Bill 2002

EXPLANATORY MEMORANDUM

(Circulated by authority of the Minister for Revenue and Assistant Treasurer,

Senator the Hon Helen Coonan)

Table of Contents

Outline

1. The purpose of the Bill is to ensure that health care professionals have access to medical indemnity cover that is provided by properly regulated insurers, and to specify minimum standards for medical indemnity cover in certain circumstances.

2. On 31 May 2002, the Prime Minister announced key elements of the Governments strategy for ensuring that medical indemnity insurance is made a viable commercial product. One of the elements of that strategy was improving transparency in the financial reporting of medical defence organisations (MDOs) and bringing all of the insurance business of MDOs into the prudential framework for general insurers.

3. On 23 October 2002, the Prime Minister announced further details of the Governments strategy. With respect to prudential supervision, the Prime Minister announced that MDOs would be subject to a range of prudential safeguards to mitigate insolvency risks under a regulatory framework administered by the Australian Prudential Regulation Authority (APRA). The Prime Minister also announced that minimum product standards would be applied to medical indemnity cover.

4. This Bill gives effect to these components of the Prime Ministers announcements.

5. The Bill provides that medical indemnity cover is only to be provided by general insurers and only under contracts of insurance. The intent is to ensure that providers of medical indemnity cover are subject to appropriate prudential supervision by APRA.

6. The Bill provides for transitional arrangements for certain providers of medical indemnity cover to meet minimum capital requirements. The transitional arrangements will be accessible to MDOs currently operating in Australia, and their related bodies corporate, provided an approved funding plan is lodged with APRA. The transitional arrangements will be in force until 30 June 2008.

7. The Bill also provides for minimum product standards for medical indemnity insurance contracts. A minimum cover amount of $5 million (or such other amount as prescribed by regulation) will be required.

8. In order that insureds have continuous cover where claims made cover is offered or provided, then, in general terms, an offer of retroactive cover or run-off cover must also be made if such cover is required to ensure that continuous cover is available to the individual practitioner.

9. The Bill also contains anti-avoidance provisions to ensure that its objectives are not circumvented.

Abbreviations

The following abbreviations are used in this explanatory memorandum.

AMIL	-	Australasian Medical Insurance Limited
APRA	-	Australian Prudential Regulation Authority
ASIC	-	Australian Securities and Investments Commission
DDR cover	-	Death, disablement and retirement cover
ERB cover	-	Extended reporting benefits cover
IBNR	-	Incurred but not reported
Insurance Act	-	Insurance Act 1973
Insurance Contracts Act	-	*Insurance Contracts Act 1984*
MDO	-	Medical Defence Organisation
UMP	-	United Medical Protection Limited

Financial Impact Statement

3.1 The Bill provides for APRA and ASIC to have general administration of the Parts of the Bill related to their responsibilities. The Bill is only expected to have a marginal financial impact on APRA and ASIC. The financial impact of administration will be recouped from industry, in line with the existing arrangements for funding those organisations.

Regulation Impact Statement

Problem identification

Industry Background

3.2 Medical indemnity cover provides pecuniary protection to medical practitioners and other health professionals in relation to claims arising from actual or alleged negligence or misconduct.

3.3 In Australia, medical indemnity cover is provided primarily by MDOs. MDOs are not-for-profit mutual organisations that offer discretionary indemnity cover as a benefit to members in return for an annual subscription. MDOs also provide education, risk management and legal advice services.

3.4 MDOs currently operating in Australia are:

- the Medical Defence Association of South Australia Limited (MDASA);
- the Medical Defence Association of Victoria (MDAV);
- the Medical Defence Association of Western Australia (Incorporated) (MDAWA);
- the Medical Indemnity Protection Society (MIPS);
- the Medical Protection Society of Tasmania (MPST);
- the Queensland Doctors Mutual (QDM); and
- UMP (in provisional liquidation).

3.5 MDOs have traditionally provided protection to medical practitioners in their home state. Over time, MDOs have expanded operations into other States and Territories. The predominant MDO in Australia is UMP, providing protection to over half of all Australian members of MDOs.

3.6 MDOs are generally associated with authorised insurers. All MDOs operating in Australia have established subsidiary or captive insurance companies. These captives have been established primarily for the purpose of providing cover in the nature of reinsurance to the parent MDO. AMIL, the captive insurer of UMP, differs by providing a direct, retail contract of insurance to UMP members with the first layer of reinsurance provided on a discretionary basis through UMP and subsequently reinsured back through AMIL.

3.7 State and Territory Governments indemnify medical practitioners working within the public system and, in specific but limited circumstances, private practitioners.

Discretionary Cover

3.8 MDOs provide protection to their members on a discretionary basis. Discretionary cover entitles a member to seek indemnification from an MDO. However, a member has no legal right to be indemnified, and the MDO can exercise its discretion not to indemnify the member. In practice, MDOs generally exercise this discretion in favour of members.

3.9 The existence of discretionary cover has two important implications for MDO members lack of prudential regulation and certainty of indemnification.

<u>Prudential Regulation</u>

3.10 While medical indemnity cover appears in substance to be an insurance product, MDOs are not authorised insurance companies. The discretionary cover provided by MDOs falls outside of the definition of insurance business for the purposes of the Insurance Act. Consequently, APRA does not regulate MDOs nor are MDOs subject to the prudential standards applicable to general insurers.

3.11 It is recognised internationally that prudential regulation provides a high level of certainty that financial promises made by financial institutions to their customers will be met. The key elements of prudential regulation are minimum benchmarks for capital, corporate governance and risk management that a financial institution must maintain in order to obtain and continue to hold a licence to operate.

3.12 In addition, until mid 2002, considerable debate surrounded the proper accounting treatment of the liabilities arising from MDOs discretionary indemnity products. Some MDOs argued that the ability to exercise a discretion meant that no liability arose until such time as a claim had been reported to the MDO and the MDO had made a decision to exercise its discretion in favour of the member. Other MDOs argued that the liabilities of an MDO should be treated for accounting purposes in the same manner in which insurance companies account for insurance liabilities. Specifically, insurance companies are required by accounting standards to recognise a liability for IBNR claims.

3.13 As MDOs rarely exercise a discretion against a claim for indemnification, the lack of prudential regulation and reliable, transparent public reporting of IBNR liabilities leaves medical practitioners under-informed as to the financial viability of their cover provider.

3.14 In June 2002, an Abstract (Number 47) was agreed by the Australian Accounting Standards Board requiring MDOs to account for all IBNR liabilities. However, there remains doubt as to the consistency of liability recognition practices across the industry. Similar concerns with respect to the consistent application of accounting standards to the valuation of the liabilities of general insurers resulted in the introduction of a requirement to comply with a prudential standard providing greater specification on the valuation of insurance liabilities.

3.15 The risks inherent in not appropriately recognising and provisioning for liabilities incurred are magnified by the nature of the business written.

3.16 Medical indemnity cover (as with other forms of professional indemnity insurance) is regarded as long tail business. That is, there is generally a long delay between an incident that may give rise to a claim occurring, a claim being reported and the finalisation of the claim. This places considerable pressure on providers of such cover to be able to identify the likely cost of future claims and build this into their pricing (premium) structures.

Certainty of Indemnification

3.17 The current system of discretionary cover provides considerable uncertainty to doctors as to the extent to which a claim for indemnity will be met. Unlike insurance contracts, discretionary products are not subject to the consumer protection provisions of the Insurance Contracts Act and there is no legal obligation on an MDO to indemnify its members.

3.18 In addition, MDOs generally undertake to provide unlimited cover (although in practice the cover is limited by the capital available to the MDO). Insurance companies are prevented from providing unlimited cover by the Insurance Contracts Act. This is in recognition that no company has access to unlimited capital. Cover is only available where the provider has sufficient resources to meet claims.

3.19 The experience of UMP has shown that doctors are not prepared to provide unlimited capital to MDOs by paying calls to fund unlimited claims.

Access to Appropriate Cover

3.20 Traditionally, MDOs provided cover to members on an incidents-occurring (or claims-incurred) basis. Since 1997, a number of MDOs have offered (in some cases exclusively) claims-made cover. Claims-made cover is standard within the insurance market for professional indemnity insurance contracts, as it reduces the risk to insurers inherent in underwriting long tail classes of insurance.

3.21 Incidents occurring cover provides indemnity for valid claims arising from incidents that occur during the period of cover, with a claim able to be lodged at any time in the future (including when a person is no longer a member of the MDO and subject to the MDO exercising its discretion in favour of the member). Claims-made cover allows a member to notify a claim within the terms of the current cover, in relation to an incident that occurred within a recognised period (usually their claims-made membership period with the MDO).

3.22 While incidents occurring cover provides more generous protection to doctors, it is essential that where this type of cover is offered, medical indemnity providers hold appropriate capital, reserves and reinsurance against the risk of claims. Where medical practitioners take out claims-made cover, they may be exposed to risks arising from uninsured past events if they decide to change MDO providers, or in the event of death, retirement or incapacity, and they have not taken out or do not have access to adequate tail cover.

Objectives

3.23 The proposed regulatory measures are designed to ensure the long-term financial sustainability of the market for medical indemnity cover and to provide greater certainty to medical practitioners as to the adequacy and availability of ongoing cover.

Identification of Options

Option 1 Proceed with regulatory measures

3.24 On 31 May and 23 October 2002, the Prime Minister announced a comprehensive package of measures to address difficulties in the medical indemnity market. These difficulties arise from a number of factors, including the financial position of UMP and its wholly owned subsidiary, AMIL.

3.25 A key part of this package was the announcement that MDOs would be brought into the regulatory framework administered by APRA and be subject to a range of prudential safeguards to mitigate insolvency risks. In addition, it was announced that medical indemnity products would be subject to product safeguards to ensure continuity of cover. Further, any MDO that has liabilities arising from discretionary cover will not be able to become an authorised insurer.

Option 2 No specific action

3.26 Under this option, no measures would be introduced. MDOs would continue to be unregulated entities offering discretionary cover to members and would not be subject to product safeguards.

Impact Analysis

Impact Group Identification

3.27 The main groups likely to be affected by the proposed regulation are:

- the Commonwealth Government and Commonwealth Government agencies;
- MDOs (some of which could be classified as small to medium businesses);
- medical practitioners, including those engaged in high risk specialties;
- patients;
- State and Territory Governments.

Assessment of Costs and Benefits

Option 1 Proceed with legislative amendments

<u>Commonwealth Government and Commonwealth Government Agencies</u>

3.28 The Governments announced response to current difficulties in the medical indemnity market involves considerable cost to taxpayers. The cost of the package is estimated at around $55 million in 2002-03, and around $65 million in following years. This cost excludes the guarantee to UMP/AMIL (which has not been called on to date), and the IBNR scheme (where the liability was recorded in 2001-02, and which is funded from the IBNR levy, which over time, is designed to offset the

unfunded liabilities that the Commonwealth has underwritten). The Government stepped in to ensure that essential medical services would continue to be offered. Ensuring that MDOs are on a sounder financial footing and subject to appropriate regulation will reduce the likelihood that governments will need to act this way again in the future.

3.29 The introduction of prudential and product regulation will impose additional administrative costs on APRA and the ASIC.

3.30 APRA will be required to meet the marginal costs of authorising and supervising additional entities. However, it is anticipated these costs will be recovered through levies imposed on financial institutions to cover the cost of regulation. In addition, as APRA is already responsible for the regulation of MDOs captive insurance companies, the ability to supervise the parent MDO will improve the overall value and ability of APRA to supervise these entities.

3.31 ASIC will be required to monitor compliance by MDOs with new and existing product standard and disclosure requirements. This represents an additional marginal cost to ASIC. ASIC is principally funded through company fees and the APRA industry levies.

MDOs

3.32 The movement to a new regulatory regime will place MDOs on a prudentially sound footing. Hence many of the costs outlined below cannot be considered to be additional to those which MDOs would incur if they voluntarily operated in a prudentially sound manner. MDO groups will incur transitional costs in moving to the new regime.

3.33 MDOs may need to restructure their corporate groups in order to ensure compliance with the requirement that medical indemnity cover must be provided by an authorised insurer. A range of corporate structures will be possible under the new regime and the restructuring costs will vary depending on the existing arrangements of MDOs. In addition, some providers will need to raise additional capital to meet prudential requirements going forward (a transition period of up to five-years will apply). There will be associated capital raising and capital servicing costs.

3.34 MDOs will also incur transitional costs in the preparation of contracts and required disclosure documentation for the provision of medical indemnity insurance, and the establishment of internal administrative systems to deliver the product and advise members/policyholders of changes.

3.35 MDOs will be subject to costs associated with prudential and product regulation, including the requirement to pay supervisory levies. The APRA supervisory levy applying to general insurers for 2002-03 is set at 0.030 per cent of assets with a minimum levy amount of $5,000 and a maximum of $330,000. Due to the great difference in the size and assets of the MDOs, it is estimated that the levy on MDOs will range from the minimum amount for the smallest MDOs to the maximum amount for the largest MDO.

3.36 Further, MDOs are taxed on a different basis to insurers. The ongoing net impact of this change on premiums will be specific to the financial position of each MDO group. There will also be roll-over tax effects and other tax impacts such as the requirement to pay stamp duty under State and Territory laws.

3.37 UMP/AMIL has publicly stated that the new requirements will see a 6 per cent increase in their current premiums. However, AMIL is already an authorised insurer providing contracts of insurance. Other MDOs might face higher costs.

Medical Practitioners

3.38 Recent events surrounding the provisional liquidation of UMP/AMIL created considerable uncertainty for medical practitioners. This situation resulted in the possible withdrawal of medical services, particularly in high risk specialties, as practitioners were unprepared to risk incidents

occurring for which they may not have indemnity cover. Bringing MDOs into the prudential supervisory framework will provide doctors with greater certainty as to the financial viability of MDOs and their continuing ability to provide cover. It will also ensure greater transparency, enabling medical practitioners to better assess the risk associated with a particular product provider.

3.39 The product measures will ensure that medical practitioners can obtain an appropriate level of continuous cover with a legally enforceable right to indemnification.

3.40 As identified above, these measures will impose some additional costs on MDOs. These costs may be reflected in insurance premiums (or membership subscriptions). Some MDOs will need to raise additional capital. As mutual organisations, this capital will need to be funded by members (although this additional cost will be spread out over a period of up to five years).

3.41 Offsetting these impacts, the Commonwealth is introducing a range of other measures intended to address premium affordability for medical practitioners. These include direct subsidies to medical practitioners in certain high risk specialties, and a high cost claims scheme, whereby the Commonwealth will meet 50 per cent of the amount by which a claim settlement or award exceeds $2 million.

3.42 To the extent that these measures provide competitive neutrality and promote the entry of new providers into the market, medical practitioners will have access to a greater range of potential product providers.

Patients

3.43 Patients will benefit from a higher level of certainty that claims against a medical practitioner for professional negligence or misconduct will be met. In addition, these measures will reduce the risk of a significant withdrawal of private health services in circumstances where medical practitioners do not have access to adequate and ongoing medical indemnity cover.

3.44 The additional costs that may be incurred by medical practitioners may be passed on to patients. However, a range of other Commonwealth measures designed to address premium affordability for medical practitioners will offset this impact.

State and Territory Governments

3.45 As medical indemnity cover formerly provided under discretionary arrangements will now be provided under contracts of insurance, State and Territory Governments will potentially benefit by the receipt of increased stamp duty receipts for these insurance contracts. However, the Prime Minister has written to his counterparts asking that they consider not applying stamp duty to medical indemnity premiums as medical indemnity providers are brought into the general insurance regulatory arrangements. To the extent that stamp duty is already remitted, the Prime Minister has asked the States and Territories to consider removing it in order to help maximise the positive impact of other Commonwealth and State measures on premium affordability and service provision.

Option 2 No specific action

3.46 Under this option, MDOs would remain outside the prudential requirements applying to general insurers. Medical practitioners, patients and the Government would be exposed to a higher risk of further difficulties in the medical indemnity market. In addition, medical practitioners and patients would continue to be exposed to the uncertainty of discretionary cover. The ability of medical practitioners to change providers of medical indemnity cover would be restricted by their ability to obtain suitable run-off protection.

3.47 MDOs would not be required to meet the additional compliance and capital costs associated with moving to a prudentially regulated regime. As a result these additional costs would not be passed on to medical practitioners and patients. Further, APRA and ASIC would not incur additional costs in

supervising these entities. However, APRA would continue to be required to supervise the captive insurers of MDOs without adequate supervisory powers over the parent MDO.

Consultation

3.48 Following the Prime Ministers announcement of 31 May 2002, extensive consultation was undertaken with MDOs and other stakeholders. These included the MDOs, medical associations and colleges (including the Australian Medical Association), commercial insurers and the Institute of Actuaries of Australia. There was general support for existing MDOs to be subjected to prudential standards currently applying to general insurers.

3.49 The majority of the MDOs accept the general requirement for prudential supervision by APRA, and have been participating in a working group to develop appropriate prudential regulation for MDOs. However, a minority of MDOs, representing less than 15 per cent of the market, remain opposed to the requirement to be subject to the Insurance Act and regulated by APRA. Those MDOs maintain that they are financially viable without the need for prudential regulation, and that the move to a prudentially regulated contractual environment will unnecessarily increase the cost of cover to medical practitioners without delivering significant benefits.

3.50 Further consultations with MDOs, other relevant insurers, APRA and ASIC have been held in relation to the implementation detail of these proposed measures.

Conclusion and recommended option

3.51 Option 1 carries a significant benefit in providing more certain and continuous coverage of medical indemnity cover and will provide competitive neutrality in this market. On balance, it is considered that these benefits outweigh any additional costs to MDOs and medical practitioners that may be incurred in moving to a prudentially regulated environment and subject to product regulation.

3.52 Option 1 is the preferred option.

Implementation and review

3.53 It is proposed that entities will be prohibited from providing medical indemnity cover unless the entity is an authorised insurer under the Insurance Act. APRA will be responsible for the administration of these provisions. Transitional provisions will apply so that entities wishing to provide medical indemnity cover will have up to five years to comply with the capital adequacy requirements of the Insurance Act. Further, under the Bill:

- an MDO that is not carrying any old discretionary liabilities will be able to become authorised and will not be subject to the prudential requirements for the transitional period;
- an MDO that has old discretionary cover will not be able to be authorised under the Insurance Act as an insurer; and
- if an MDO sets up a new vehicle to carry on the going forward business of the group, that new related entity will get the benefit of the transitional relief.

In summary, under these arrangements, no entities will have split old and new business for prudential purposes going forward.

3.54 Amendments to the prudential framework for general insurers would be examined in the context of any insurance industry wide review of the efficacy of this legislation.

3.55 It is also proposed that product standards be applied to medical indemnity cover. These standards will require that medical indemnity cover be offered and provided by means of a contract of insurance and that minimum product standards relating to cover limits, retroactive and run-off cover will be introduced.

3.56 Regulations under the Corporations Act will be prepared to apply the retail client product disclosure requirements to medical indemnity insurance contracts. A transitional period to March 2004 already exists in relation to compliance with these obligations.

3.57 ASIC will have responsibility for the administration of provisions in the Bill relating to product standards.

Proposed Legislation

Part 1 Introductory

Division 1 Preliminary

Clause 1 Short title

4.1 This clause provides the title by which the Act may be cited, that is the *Medical Indemnity (Prudential Supervision and Product Standards) Act 2002*.

Clause 2 Commencement

4.2 This clause provides that the Act will commence or will be taken to have commenced on 1 July 2003. The provisions of the Act will generally apply to all arrangements entered into that come into effect or are renewed, on or after 1 July 2003.

Clause 3 Objects

4.3 This clause describes the objectives of the Act. These objectives are two fold. First, to ensure that medical practitioners and other health care professionals have access to medical indemnity cover that is provided only by properly regulated insurers (and only by way of contracts of insurance). The provision of medical indemnity cover by regulated insurers will mitigate against insolvency risks and encourage continued availability of cover. Second, to provide for certain minimum standards to apply to medical indemnity cover offered to medical practitioners or other prescribed health care professionals, to ensure they can obtain adequate and continuous cover.

Division 2 - Interpretation

Clause 4 Definitions

4.4 This clause defines key terms and concepts used in the Act. In particular:

Claim is defined broadly and includes claims against a health care professional as well as claims by a health care professional under an arrangement for medical indemnity cover. It also includes administrative and disciplinary proceedings. A claim against a health care professional for compensation or damages is further defined as a ***compensation claim***. (Contracts of insurance can define the term claim, in the context of a claim against the insured, in a number of different ways. The Bill is intended to include all such possible definitions.)

General insurer is an insurer authorised under the *Insurance Act 1973* (Insurance Act).

Health care professional is defined as an individual providing health care, and includes medical practitioners and registered health professionals. This definition is expressed to cover circumstances in which the individual provides such health care whether for reward or not, as an employee, as part of a business or on some other basis.

Medical practitioner is defined as an individual licensed or registered (as the case may be) as a medical practitioner under a law of a State or Territory.

Provide a financial service takes its meaning from that term as it is used in Chapter 7 of the *Corporations Act 2001* (Corporations Act).

Registered health professional is defined as an individual who practises a health care related vocation who must also be registered under a State or Territory law to practise that vocation.

4.5 Sub-clause (2) clarifies that if a person either makes a payment or agrees to make a payment for someone else, then the latter person is being indemnified for the purposes of this Act. The purpose of this sub-clause is to address the situation whereby a person may exercise a discretion to make a payment for someone else. This sub-clause is not intended to exclude the ordinary meaning of the term indemnify.

4.6 Sub-clause (3) clarifies the circumstances in which a health care professional does not have medical indemnity cover for a health care incident. This sub-clause also establishes when a health care professional does not have medical indemnity cover for past health care incidents, such as where:

- a health care professional held claims-made based cover with a previous insurer, and does not have a run-off product from that insurer to cover their exposure to incidents that occurred during the period of the previous cover;
- the health care professional has never had cover in relation to certain incidents; or
- the person has cleanskin claims-made based cover (ie only covering claims for incidents that occurred since the person first took out that cover) whereby the incident would need to have occurred and the claim made within the cover period.

4.7 Under sub-clause (3), if a person has an arrangement under which there are exclusions or deductibles, this does not mean the person is without medical indemnity cover.

4.8 Sub-clause (4) defines the time from which a medical indemnity contract of insurance or other arrangement for medical indemnity cover can be taken to have come into effect. This sub-clause recognises that a contract can be formally entered into in advance of the commencement of the contract period. The effect of this definition is that, if a contract is entered into before 1 July 2003 with a contract period commencing or coming into effect from 1 July 2003, that contract would be need to comply with the requirements of the Act. See also the anti-avoidance provisions in clause 31.

4.9 Sub-clause (5) assists in defining when a contract of insurance or other medical indemnity arrangement is renewed, and includes when a contract is deemed to come into force by virtue of subsection 58(3) of the *Insurance Contracts Act 1984* (Insurance Contracts Act).

4.10 Sub-clause (6) identifies the constitutional bases for the Act, in addition to the Commonwealths power over constitutional corporations, which is specifically referred to in relevant clauses throughout the Act.

4.11 Sub-clause (7) establishes that amounts payable in relation to a compensation claim include those costs (including legal and other costs) directly attributable to actions relating to a demand for compensation.

4.12 Sub-clause (8) specifies when a regulated contract (see sub-clause 21(1)) does not comply with the minimum cover requirements under Part 3 of the Act.

4.13 Sub-clause (9) is included to capture the different ways that cover under a claims-made arrangement is triggered. These include where:

- the claim is made and/or notified to the insurer during the period of cover; or

- the incident that gives rise to the claim is notified to the insurer during the period of cover (in this regard see also subsection 40(3) of the Insurance Contracts Act).

Sub-paragraph (g) is included so that, if the cover provided by the contract is expressed in a particular way to take it outside the definition of claims-made based cover, regulations can be made to capture that contract.

Clause 5 Providing medical indemnity cover

4.14 This clause defines what is meant by providing medical indemnity cover for a health care professional. This definition is critical to determining the scope of the Act. The clause is drafted broadly and captures both cover provided by means of a contract of insurance, and the discretionary cover traditionally provided by Medical Defence Organisations (MDOs). Under the latter, the health care professional has no legal right to indemnity. This clause also establishes that the medical indemnity cover does not need to be an arrangement directly between the cover provider and a medical practitioner, but could involve an interposed entity, such as a body corporate employer, a medical practice, a medical association or a trust. The essential feature of the definition is that the individual health care professional is or may be indemnified for claims in relation to health care incidents. The definition is not intended to capture arrangements in the nature of reinsurance. Some arrangements are also expressly excluded by clause 8. The emphasis is on the cover provided to health care professionals as consumers of medical indemnity cover.

Clause 6 Claims-made based cover and incident-occurring based cover

4.15 This clause establishes a definition for claims-made-based cover and incident-occurring based cover. The definition of claims-made based cover importantly provides that the contract period (during which claims must be made to be covered by the arrangement) is fixed.

4.16 The clause also clarifies that claims made and notified cover is claims-made cover. (The application of section 54 of the Insurance Contracts Act to claims made and notified policies has been the subject of several court cases.)

4.17 The definition of incident-occurring based cover contrasts with that of claims-made based cover. Under incident-occurring based cover (sometimes also known as claims-incurred cover), a claim may be made to the insurer at any time, even after the contract period has expired, provided the incident covered under the contract occurred during the period specified in the contract. The Notes clarify that Extended Reporting Benefits (ERB) and Death, Disablement and Retirement (DDR) cover are not incident-occurring based cover.

Clause 7 When certain DDR arrangements are taken to be entered into

4.18 The intention behind clause 7 is that if an arrangement for DDR cover has not commenced before 1 July 2003, then the arrangement to provide DDR cover will be subject to the requirements of the Act. To meet this intention, this clause identifies whether certain arrangements, typically called DDR, were entered into before or after 1 July 2003.

4.19 DDR arrangements sometimes provide that cover will or may be provided automatically once a health care professional has been a member of the entity providing the cover for a certain period.

4.20 If there is some qualifying period of membership before DDR cover is available, then, for the purposes of this Act, such an arrangement to provide DDR is only to be regarded as having been entered into when that qualifying period has expired.

Division 3 Application of Act

Clause 8 Application of Act

4.21 This clause specifies that the Act does not apply to:

- medical indemnity cover that is State insurance or that is provided by a State or Territory or their authorities or agencies;
- insurance that is provided by the Commonwealth;
- bodies corporate that are prescribed by the regulations as exempt from the application of the Act;
- medical indemnity cover provided by a person to a health care professional who is an employee of that person; and
- medical indemnity cover provided by employers in relation to claims against health care professionals engaged by them to provide health care to the employers employees, in relation to health care incidents arising from that activity.

4.22 It is not expected that the regulations would prescribe a body corporate under this clause except in exceptional circumstances (such as to avoid any unintended consequences of the application of the Act).

Clause 9 Act extends to external Territories

4.23 This clause ensures that health care professionals in the external territories are also protected under the Act.

Part 2 Prudential requirements for provision of medical indemnity cover

Division 1 Provision of medical indemnity cover

Clause 10 Medical Indemnity Cover to be provided only by authorised insurers and only under contracts of insurance

4.24 This clause establishes that it is an offence for a cover provider to:

- offer to enter into;
- invite an offer to enter into;
- or enter into;

an arrangement providing medical indemnity cover for a health care professional where the cover provider is not a general insurer or where the medical indemnity cover is not, or would not, be a contract of insurance.

4.25 The clause also extends the offence to those circumstances in which a cover provider offers to renew or does renew, such an arrangement. Sub-clause (3) makes it clear that the prohibitions apply to offers or invitations received in Australia and the external territories, irrespective of where any subsequent arrangement is entered into or is renewed. Sub-clause (3) is intended to ensure that the Act extends offences to unregulated foreign providers, and/or their agents.

4.26 Underlying clause 10 is the concept that, by requiring a cover provider to only make medical indemnity arrangements by offer of a contract of insurance, medical indemnity arrangements will constitute insurance business in Australia, so requiring the cover provider to be authorised under the Insurance Act.

4.27 The offence created in clause 10 applies to constitutional corporations and to other persons where the arrangement(s) is held to have a relevant constitutional connection.

4.28 The clause does not apply to arrangements already in effect before 1 July 2003. For example, where a person had incidents-occurring membership with an MDO in 1999, the arrangement for the

provision of medical indemnity cover resulting from that membership will not be subject to Part 2 of the Act.

4.29 The penalty is 12 months imprisonment.

Clause 11 Intermediaries

4.30 This clause establishes that it is an offence for an intermediary (such as an agent or broker or other representative) that provides a financial service (whether or not as an authorised representative of an Australian Financial Services licensee) in the course of providing the financial service, to arrange or offer to arrange for someone to enter or renew medical indemnity cover, or recommend that someone enter into or renew medical indemnity cover, where that cover is either not provided by a general insurer or is not a contract of insurance.

4.31 It is not intended that clause 11 or clause 27 in any way limit the operation of any of the provisions of Chapter 7 of the Corporations Act.

4.32 Sub-clause (3) stipulates that the ability to impose a penalty on the intermediary is not limited by whether or not the cover provider has committed an offence under clause 10.

4.33 The penalty is 12 months imprisonment.

Division 2 Transitional Arrangements

4.34 This Division provides a scheme for transitional arrangements for certain bodies corporate (specifically described in sub-clause 13(1)) from compliance with any minimum capital requirements imposed by a prudential standard (or standards) made under the Insurance Act.

4.35 In the absence of such transitional arrangements, an applicant for authorisation as a general insurer under the Insurance Act must satisfy all prudential standards made pursuant to section 32 of that Act, including those dealing with capital requirements. The prudential standard currently in force dealing with capital requirements specifies the methods by which a general insurers minimum capital requirement should be determined, and requires that no insurer can hold less than $5 million capital.

Clause 12 Effect of determination under subsection 13(3)

4.36 This clause provides that the Australian Prudential Regulation Authority (APRA) must not refuse to authorise a body corporate described at sub-clause 13(1) as a general insurer, or revoke an authorisation of such body corporate, only on the grounds that the body corporate cannot satisfy the minimum capital requirements imposed by a prudential standard, where a determination under clause 13 remains in force at that time.

4.37 Sub-clause (4) provides that, to the extent that any prudential standard imposes a minimum capital requirement, it does not apply to a body corporate that is granted a declaration for the transition period.

4.38 This clause does not prevent APRA from refusing to authorise, or from revoking an authorisation of a body corporate, in circumstances where the body corporate has not complied with other prudential standards or requirements under the Insurance Act.

Clause 13 APRA determination that minimum capital requirements do not apply

4.39 This clause is intended to allow certain medical indemnity providers to reach appropriate levels of prudential capital over time, given the industry has generally not been subject to prudential supervision. It should be noted that the transitional arrangements apply only in respect of prudential standards that impose capital requirements. Compliance with other prudential standards are not within the scope of the transitional relief available by this clause.

4.40 Clause 13 provides that certain bodies corporate may apply to APRA for a determination that the minimum capital requirements do not apply to them during the period 1 July 2003 to 1 June 2008 (the transition period).

4.41 Under sub-clause (2), an application must be in the form prescribed by the regulations under the Act, and be accompanied by a funding plan in the form prescribed in the regulations under the Act. The funding plan must satisfy the criteria set out in sub-paragraph (3)(d), which also specifies that the funding plan must be certified by an independent actuary and by an independent auditor. Sub-clauses (3), (9) and (10) provide APRA with the power to issue guidelines that identify those matters that must be addressed by applicants in their funding plan. Sub-clause (10) provides APRA with the flexibility to specify such matters as periodic reporting requirements and the specific matters that must be reported. The guidelines are disallowable instruments under sub-clause (11).

4.42 Where a funding plan is submitted in accordance with the specified criteria set down in clause 13, APRA must determine that the body corporate be granted transitional relief from the capital requirements for the transition period to 30 June 2008.

4.43 Importantly, the funding plan requirements set out in sub-clause (3) do not apply if a body corporate defined at sub-clause (1) does not wish to seek the transitional relief. In addition, where the body corporate would be able to satisfy the minimum capital requirements at the time they seek authorisation under the Insurance Act, they should not be considered for transitional relief.

4.44 Sub-clause (3) provides that a determination by APRA must be in writing and be provided to the body corporate within 7 days. Sub-clause (4) provides that a determination remains in force until the earlier of 30 June 2008 or, if APRA revokes the determination, the date on which APRA specifies as the revocation date. Under sub-paragraph 6(b), at least 28 days must expire between a revocation and it taking effect. Under subparagraph(7) APRA must provide a copy of the revocation with 7 days to the body corporate.

4.45 Sub-clause (5) provides that APRA can revoke a determination in certain circumstances, including where the body corporate fails to achieve substantial compliance with the funding plan. A body corporate that has been granted a determination may also seek to have the determination revoked.

4.46 Sub-clause (8) provides that a new determination that the transitional period applies to the body corporate under this clause cannot be made by APRA after 1 July 2005. After this period, a body corporate seeking to offer medical indemnity cover which has not previously obtained a determination from APRA under this clause that remains in force, will need to comply with the minimum capital requirements imposed by any prudential standard under the Insurance Act.

Clause 14 Administrative Review

4.47 This clause provides that a decision by APRA not to make a determination that the transitional period applies to a body corporate, or to revoke a determination, is a reviewable decision to the Administrative Appeals Tribunal.

Clause 15 Application of section 115A of the Insurance Act 1973

4.48 Section 115A of the Insurance Act provides for an authorised person to access the premises of an insurer or certain related entities to ascertain whether there has been a breach of an Act specified in the section. The *Medical Indemnity (Prudential Supervision and Product Standards) (Consequential Amendments) Bill 2002* amends section 115A to include this Bill as one of the Acts specified in the section. Clause 15 makes it clear that section 115A will also apply to funding plans lodged under clause 13.

Part 3 Product standards for medical indemnity insurance contracts

4.49 This Part provides for minimum product standards that must be complied with by insurers when they offer or provide contracts of medical indemnity insurance to medical practitioners or prescribed registered health professionals.

Division 1 Minimum cover

4.50 It is not intended that the minimum cover limit requirements be taken to have the effect of limiting the amount of cover that an insurer may offer or provide a medical practitioner to $5 million only (or the amount prescribed in the regulations).

Clause 16 Minimum cover amount

4.51 This clause specifies that for the purpose of Division 1, the minimum cover amount is $5 million or such other amount (which may be more or less than $5 million) that is prescribed by the regulations.

4.52 The clauses of Part 3 make clear that the minimum cover amount does not apply to provisions of medical indemnity contracts that do not provide cover for a compensation claim. This has the effect of excluding general legal expenses policies from the minimum cover requirements. That is, an insurer will be able to offer and provide a medical practitioner with a higher (but not lower) contract cover limit.

Clause 17 Minimum cover for single claim

4.53 This clause makes it an offence at sub-clause (2) for an insurer to provide medical indemnity cover to a medical practitioner or to a prescribed registered health professional if the insurance contract under which that cover is provided does not include a minimum cover amount of $5 million (or such other amount prescribed by the regulations) in relation to a single compensation claim against the health care professional within the contract period.

4.54 The requirement to provide in the contract of insurance for the minimum cover amount applies to both claims-made based cover and incidents-occurring based cover. The minimum cover limit is applicable to costs arising in relation to a demand for compensation, including legal defence costs, and any subsequent settlement or damages awards resulting from that demand. However, sub-clause (4) provides that the requirement to offer the minimum cover amount does not apply where every health care incident to which the compensation claim would relate would occur, or would have occurred, outside Australia and its external territories.

4.55 The penalty is imprisonment for 12 months.

4.56 Sub-clause (4) works as a type of deeming provision. It provides that in circumstances where the cover amount provided for in a medical indemnity contract of insurance is expressed as an amount that is less than the minimum cover limit applicable at the time the contract was entered into, came into effect or renewed, the maximum cover limit will be taken to be the statutory minimum cover amount of $5 million (or the amount that is prescribed in the regulations). For example, if at the time the contract is entered into, the minimum cover limit is $5 million, but (for whatever reason) the contract that is executed by the parties provides for a cover limit of $2 million, the contract will be treated as though it provides for $5 million cover. In this way, the sub-clause will operate to ensure that a medical practitioner who has been provided with a contract that does not comply with the minimum cover amount is protected for a payment of up to the minimum cover amount.

4.57 Sub-clause (6) provides that this deeming outcome applies whether or not the insurer is actually convicted of the offence at sub-clause (2).

Clause 18 Minimum annual cover incident-occurring based cover

4.58 Sub-clause (3) establishes that it is an offence for an insurer to provide an incident-occurring based medical indemnity contract of insurance to a medical practitioner or a prescribed registered health professional if the insurance contract does not provide at least the minimum cover amount applicable at the time the contract was entered into, came into effect or was renewed, in relation to all compensation claims in relation to health care incidents that occur during the incident period specified in the contract. (Sub-clause 6(5) defines incident-occurring based cover).

4.59 Sub-clause (2) establishes that the applicable minimum cover amount is to be provided on a per annum (or part thereof) basis. Sub-clause (4) makes clear that the obligation to comply with the applicable minimum cover amount does not apply where all the incidents expected to be covered by the contract would occur, or would have occurred, outside Australia and its external territories.

4.60 The penalty is imprisonment for 12 months.

4.61 Sub-clause (5) operates in a similar manner as sub-clause 17(4) described above, with the distinction that sub-clause (5) applies in circumstances where the cover limit provided under the contract of insurance for multiple compensation claims (rather than a single claim) is less than the applicable minimum cover limit.

4.62 Sub-clause (7) is intended to operate in the same manner as sub-clause 17(6) described above.

Clause 19 Minimum annual cover other cover

4.63 Clause 19 is intended to operate in much the same manner as clause 18 described above, although it applies only to medical indemnity cover that is not incidents-occurring based cover (including, for example, claims made cover, ERB and DDR). That is, it is an offence for an insurer to provide non incidents-occurring based medical indemnity cover under a contract of insurance if that contract of insurance provides for a maximum cover amount for aggregate claims that is less than the applicable minimum cover amount.

4.64 The penalty is imprisonment for 12 months.

4.65 As in clause 18, clause 19 contains a deeming provision such that the maximum amount payable in aggregate by the insurer under the contract in relation to all the multiple claims will be taken to be the applicable minimum cover limit, if the contract of insurance provides for less than that amount.

Clause 20 Amount payable by insurer

4.66 This clause makes clear that in determining the amount payable by the insurer in respect of any claim under a contract of insurance, the maximum amount is not to be calculated by reference to the rights that the insurer may have under the *Medical Indemnity Act 2002* in respect of high cost claims, or pursuant to any right of contribution from another insurer or to any right of subrogation the insurer may have under the contract of insurance. It is intended that the clause control the minimum cover amount, rather than an insurers net liability.

Division 2 Offers to provide retroactive and run-off cover for otherwise uncovered prior incidents

Subdivision A Regulated insurance contracts

Clause 21 Regulated insurance contracts

4.67 This clause is central to the operation of Part 3, Division 2, which sets out the minimum offer obligations that must be complied with by insurers in circumstances where claims-made cover is or is to be provided to medical practitioners (or to any other prescribed registered health professional) in relation to compensation claims. This clause also defines client in sub-clause (2) and claims period in sub-clause (3) in relation to the regulated contract of insurance.

Subdivision B Insurers responsibilities

4.68 This Division is binding in relation to regulated insurance contracts, which are defined at clause 21 as claims-made based medical indemnity contracts provided to medical practitioners or prescribed registered health professionals.

Clause 22 Additional offer of retroactive cover when regulated insurance contract is entered into, comes into effect or is renewed.

4.69 This clause provides that it is an offence for an insurer to enter into or renew a regulated insurance contract, or for such a contract to comes into effect in circumstances where the insurer does not make a complying offer (defined at clause 24) to provide cover for all past health care incidents for which the health care professional does not presently have medical indemnity cover. Sub-clause 21(4) sets out when a health care professional does not have cover for health care incidents. This type of cover is commonly termed retroactive or tail cover, and the offer the insurer is required to make is referred to in this clause as a compulsory offer. Note that the other party to the regulated insurance contract (the client) to whom the compulsory offer must be made, need not be the health care professional, but may be an entity interposed between the insurer and the health care professional (see clause 5).

4.70 It is also an offence if the regulated insurance contract is entered into, renewed or comes into effect before a response is received. This effectively requires the insurer to ensure that the client responds in writing to the offer before entering into a regulated insurance contract.

4.71 The penalty is imprisonment for 12 months.

4.72 Sub-clause (3) stipulates that the insurer must retain written copies of the compulsory offer and the health care professionals written response to the compulsory offer, as well as copies of any other offers made to the health care professional whilst the compulsory offer remained open for acceptance by the health care professional.

4.73 It is an offence for the insurer not to keep these records for a period of five years from the day on which the compulsory offer is made. The penalty is imprisonment 6 months.

4.74 The burden of proof in relation to whether an offer needs to be made resides with the general insurer.

4.75 It should be noted that sub-clause (4) provides that it is not an offence not to make a compulsory offer in certain defined circumstances. These include the circumstance in which the regulated insurance contract currently provides cover for the health care professional for past health care incidents (for example, if the contract has a retroactive date that covers the whole period the health professional has had claims made cover), or where there are no past health care incidents to be covered (for example, if the professional has only just commenced practice).

4.76 Importantly, this clause is intended to ensure that clients who are offered claims-based cover for medical practitioners or other prescribed registered health professionals are also offered the opportunity to purchase cover for any claims that arise in the new contract period for past health care incidents. However, a client may choose not to purchase this cover. Under the Act, where a compulsory offer is made under this clause, and the client offered the product provides a written response to the insurer declining the offer, then the parties would be free to negotiate other forms of retroactive cover, if desired.

4.77 Sub-clause (5) provides that it is not an offence under sub-clause (1) where the only reason for the offer not satisfying the compulsory offer requirement in respect of the health care professionals otherwise uncovered prior incidents is that the insurer has reasonable grounds for believing that the offer does extend to those incidents.

Clause 23 Additional offer of run-off cover when particular events happen during claims period for regulated insurance contract

4.78 Clause 23 provides that it is an offence for an insurer not to make a complying offer (as defined at clause 24) of ERB cover) also known as run-off cover) for a period of 5 years (or such longer period as prescribed in the regulations) to that person. The offer of the ERB cover must be made within 28 days of the insurer becoming aware that a triggering event (as set out in paragraph (1)(b) has occurred. Such events include the death or retirement of the health care professional covered by the contract. This offer is referred to as a compulsory offer. (Note that the other party to the regulated insurance contract (the client) to whom the compulsory offer must be made need not be the medical practitioner or prescribed registered health professional but may be an entity interposed between the insurer and the health care professional (see clause 5).

4.79 The penalty is imprisonment for 12 months.

4.80 ERB cover is intended to provide cover to a person in relation to claims made against the person in relation to health care incidents that occurred before the commencement of the ERB cover, and for which the person would otherwise not have medical indemnity cover.

4.81 Sub-clause (2) provides an option for the insurer in relation to the offer of ERB cover to offer that cover either for a single period that includes the whole of the extended cover period (being 5 years or such longer period prescribed in the regulations), or for a period of one year provided the offer contains an option for the insured to renew the cover annually to at least the end of the extended cover period.

4.82 The minimum cover limit that must be offered to the medical practitioner or prescribed registered health professional (or their representative as applicable) for the ERB cover is the maximum cover limit under the current contract (see sub-clause 24(4)).

4.83 Sub-clause (3) establishes that it is also an offence where the insurer makes a compulsory offer to provide ERB cover, and then enters into a contract that provides ERB cover before receiving a written response to the compulsory offer.

4.84 Sub-clause (4) provides that the insurer commits an offence where it does not retain a copy of the compulsory offer, and either the persons written response to the compulsory offer or a written record that that person has failed to respond within 14 days of the expiry of the compulsory offer period, and copies of any other offers made to the person whilst the compulsory offer remained open for acceptance.

4.85 The penalty for the offence at sub-clause (4) is imprisonment for 6 months.

4.86 Sub-clause (5) provides that the obligation to offer the extended cover period does not apply where all the incidents expected to be covered by the contract would occur, or would have occurred, outside Australia and its external territories.

4.87 Sub-clause (6) provides that it is not an offence under sub-clause (1) where the only reason for the offer not satisfying the compulsory offer requirement in respect of the health care professionals otherwise uncovered prior incidents is that the insurer has reasonable grounds for believing that the offer does extend to those incidents.

Clause 24 Complying offer

4.88 Sub-clause 24(1) sets out the general test for a complying offer for the purposes of a compulsory offer under clause 22 dealing with retroactive cover and clause 23 dealing with extended reporting benefits cover.

4.89 Sub-clause (2) sets down the criteria that must be satisfied for a compulsory offer to be a complying offer. The criteria include: that the offer be in writing; that the premium is reasonable having regard to the factors outlined at sub-clause (3), including any guidelines that APRA may issue in this context; that the offer is clear and precise in explaining the nature of the medical indemnity

cover being offered, the risks involved in the health care professional not accepting the offer, and other options that may be available to the health care professional in obtaining cover; and that the terms of the cover offered are reasonable and appropriate having regard to the nature of the risk being insured.

4.90 References to writing in this clause are to be interpreted in accordance with the *Acts Interpretation Act 1901* (the Acts Interpretation Act) and the *Electronic Transactions Act 1999*.

4.91 Importantly, the offer must remain open for acceptance by the health care professional for a period of 28 days after the day on which the compulsory offer under clause 22 or clause 23 is made, and must be made to the health care professionals legal personal representative if the health care professional is deceased or (in certain circumstances) becomes disabled.

Clause 25 APRA Guidelines

4.92 This clause allows APRA to issue guidelines for the purposes of this Part, to assist in determining whether a premium payable by a health care professional in respect of cover that is offered under clause 22 or clause 23 is reasonable.

4.93 The guidelines are a disallowable instrument under the Acts Interpretation Act.

4.94 It should be noted that under clause 30, the Australian Securities and Investments Commission (ASIC) and not APRA, has the role of enforcing the provisions of Part 3. In enforcing the requirement that premiums in relation to cover that is contained within the terms of compulsory offers is reasonable, ASIC may have regard to those guidelines.

Clause 26 Federal Court may order insurer to make an offer

4.95 Clause 26 provides that the Federal Court of Australia may, on application by a health care professional or by ASIC, order the insurer to make a complying offer under clauses 22, 23 and 24 (as applicable) and may specify the terms on which such an offer is to be made, the time by which such an offer is to be made and the period during which the health care professional may accept the offer.

Division 3 Intermediarys responsibilities

Clause 27 Intermediarys responsibilities

4.96 Clause 27 establishes an offence where intermediaries that provide a financial service (as defined in the Corporations Act) arrange, offer to arrange, or recommend that a medical practitioner enter into a regulated insurance contract defined at clause 21 that is not offered or provided in a manner consistent with the requirements specified in this Bill.

4.97 This obligation will apply irrespective of whether the intermediary currently holds or would hold an Australian Financial Services Licence (AFSL) under the Corporations Act, is an authorised representative of an AFSL holder, or is currently subject to the requirements of the *Insurance (Agents and Brokers) Act 1984*.

4.98 Sub-clause (1) provides that an intermediary commits an offence under the Bill where the intermediary arranges, offers to arrange, or recommends that a medical practitioner enter into a regulated insurance contract that is not offered or provided in a manner consistent with the requirements specified in this Bill, whether or not the insurer commits an offence against the compulsory offer and minimum cover amount requirements at clauses 17, 18, 19 and 22.

4.99 The penalty is imprisonment for 12 months.

4.100 Sub-clause (3) establishes a defence where the intermediary, in making a recommendation, has reasonable grounds to believe that the offer the requirements specified in this Bill will be complied with before the contract is entered into.

Part 4 Administration

Clause 28 APRA to have general administration of this Part

4.101 This clause provides that APRA is responsible for the administration of Part 2.

4.102 However, the relevant Minister may give APRA directions in relation to the performance or exercise of its powers or functions.

Clause 29 APRA Act secrecy provisions apply

4.103 This clause confirms that the secrecy provisions of the APRA Act apply to information received under this Act.

Clause 30 ASIC to have general administration of Part 3

4.104 ASIC will be the agency responsible for the enforcement of Part 3.

4.105 However, the relevant Minister may give ASIC directions in relation to the performance or exercise of its powers or functions.

Part 5 Miscellaneous

Clause 31 Anti-avoidance measures

4.106 This clause deems certain arrangements entered into, renewed or that come into effect before 1 July 2003 to be entered into etc on or after 1 July 2003 for the purposes of the Bill. This deeming applies if the sole, dominant or substantial purpose of the timing of the arrangement being entered into before 1 July 2003 was to avoid the application of the Bill. The effect of this clause is that such arrangements will be subject to the provisions of the Bill (including the offence provisions).

Clause 32 Act not to affect State and Territory laws

4.107 This section notes that the Act is not intended to exclude or limit the concurrent operation of any law of a State or Territory.

Clause 33 Regulations

4.108 This section confers a general regulation making power regarding the Act on the Governor-General. Matters that may be prescribed include the registered health professionals in relation to whom various provisions of the Bill will operate.