2019

THE PARLIAMENT OF THE COMMONWEALTH OF AUSTRALIA

HOUSE OF REPRESENTATIVES

MEDICAL AND MIDWIFE INDEMNITY LEGISLATION AMENDMENT BILL 2019

EXPLANATORY MEMORANDUM

(Circulated by authority of the Minister for Health, the Hon Greg Hunt MP)

MEDICAL AND MIDWIFE INDEMNITY LEGISLATION AMENDMENT BILL 2019

OUTLINE

The Australian Government's Medical Indemnity and Midwife framework is designed to promote stability in the medical indemnity insurance industry, keep premiums affordable for privately practising medical practitioners, and ensure availability of affordable professional indemnity insurance for eligible midwives. Collectively, these schemes are known as the Indemnity Insurance Fund (IIF).

The Medical and Midwife Indemnity Legislation Amendment Bill 2019 (the Bill) gives effect to the Government's commitment in the 2018-19 *Mid-Year Economic and Fiscal Outlook* (MYEFO) to maintaining and improving the IIF, supporting the long-term stability and affordability of medical indemnity premiums for medical practitioners, while ensuring health care quality, patient safety and the sustainability of the overall medical system.

As announced in the 2018-19 MYEFO, the Australian Government agreed to work with industry and practitioner groups on implementing the recommendations arising from the 2018 Australian Government First Principles Review[1] (FPR) of the IIF to improve the Government's support for medical and health care professional indemnity arrangements. This includes improved administration, simplifying eligibility and claim requirements for the Midwife Professional Indemnity Scheme (MPIS) and for eligible practising health practitioners.

The Bill amends the *Medical Indemnity Act 2002*, the *Medical Indemnity (Prudential Supervision and Product Standards) Act 2003* and the *Midwife Professional Indemnity (Commonwealth Contribution) Scheme Act 2010* to:

- simplify the current legislative structure underpinning the Government's support for medical indemnity insurance;
- repeal redundant legislation;
- remove the existing contract requirements for the Premium Support Scheme (PSS) and incorporate the necessary requirements in legislation;
- require all medical indemnity insurers to provide universal cover to medical practitioners;
- maintain support for high cost claims and exceptional claims made against allied health professionals and enable exceptional cost claims to be made, which is provided for in a separate scheme to medical practitioners;
- support high cost claims and exceptional cost claims made against private sector employee midwives not covered under the MPIS;

[1]Department of Health, *First Principles Review of the Medical Indemnity Insurance Fund*, April 2018 https://www1.health.gov.au/internet/main/publishing.nsf/Content/F923F31B70D61C37CA25815C00142243/$File/First%20Principles%20Review%20of%20the%20Medical%20Indemnity%20Insurance%20Fund%20-%202.pdf

- clarify eligibility for the Run-off Cover Schemes (ROCS) and permit access for medical practitioners and eligible midwives retiring before the age of 65;
- cause an actuarial assessment to report on the stability and affordability of Australia's medical indemnity market, with the report to be laid before each House of Parliament; and
- streamline reporting obligations and improve the capacity for monitoring and information sharing.

The amendments reflect the Australian Government's commitment to contribute towards the availability of medical services in Australia by providing Commonwealth financial assistance to support affordable access by medical practitioners and allied health professionals (including eligible midwives) to arrangements that indemnify them for claims arising in relation to their practice of their medical and allied health professions.

The Bill contains important measures that will deliver a level playing field, by ensuring that all insurers accessing the medical indemnity schemes are subject to the same requirements including the obligation to provide indemnity cover to any medical practitioner who requires insurance in line with universal cover provisions.

The PSS is currently administered under contractual arrangements between the Commonwealth and four medical indemnity insurers. Universal cover arrangements enabling all eligible medical practitioners to access indemnity insurance are currently encompassed under the PSS. The Bill provides for PSS and universal cover obligations to be embedded in legislation. In this way, universal cover obligations will apply to all medical indemnity insurers, providing additional security to medical practitioners.

FINANCIAL IMPACT

The legislative changes have nil financial impact.

Statement of Compatibility with Human Rights

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

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The Bill 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 Bill

The purpose of the Bill is to amend the *Medical Indemnity Act 2002*, the *Medical Indemnity (Prudential Supervision and Product Standards) Act 2003* and the *Midwife Professional Indemnity (Commonwealth Contribution) Scheme Act 2010* to:

- simplify the current legislative structure underpinning the Government's support for medical indemnity insurance;
- repeal redundant legislation;
- remove the existing contract requirements for the Premium Support Scheme (PSS) and incorporate the necessary requirements in legislation;
- require all medical indemnity insurers to provide universal cover to medical practitioners;
- maintain support for high cost claims and exceptional claims made against allied health professionals and enable exceptional cost claims to be made, which is provided for in a separate scheme to medical practitioners;
- support high cost claims and exceptional cost claims made against private sector employee midwives not covered under the MPIS;
- clarify eligibility for the Run-off Cover Schemes (ROCS) and permit access for medical practitioners and eligible midwives retiring before the age of 65;
- cause an actuarial assessment to report on the stability and affordability of Australia's medical indemnity market, with the report to be laid before each House of Parliament; and
- streamline reporting obligations and improve the capacity for monitoring and information sharing.

Human rights implications

The Bill engages the following human rights:

- the right to be presumed innocent until proven guilty in Article 14(2) of the *International Covenant on Civil and Political Rights* (ICCPR);
- the rights against arbitrary or unlawful interference with an individual's privacy, family, home or correspondence in Article 17(1) of the ICCPR; and

- the right to health in Article 12(1) of the *International Covenant on Economic, Social and Cultural Rights* (ICESCR).

Right to be presumed innocent until proven guilty
Schedule 5 to the Bill engages with the right to be presumed innocent until proven guilty in Article 14(2) of the ICCPR.

Article 14(2) of the ICCPR provides that everyone charged with a criminal offence shall have the right to be presumed innocent until proven guilty according to law. The protections in Article 14(2) of the ICCPR only apply in criminal proceedings. Generally, consistency with the presumption of innocence requires the prosecution to prove each element of a criminal offence beyond reasonable doubt. Offence provisions that place an evidential or legal burden on the defendant and no-fault offences, such as strict and absolute liability offences, which allow for the imposition of criminal liability without the need to prove fault, will engage the presumption of innocence. This is because a defendant's failure to discharge the burden or the lack of a burden altogether may permit their conviction despite reasonable doubt as to their guilt.

A failure to comply with new sections 53A, 53C and 53E, which are inserted by Schedule 5 to the Bill, will be offences of strict liability. The amendments in Schedule 5 will ensure that the new strict liability offences will apply with respect to a failure to keep and retain records, failing to report and failing to give information.

The provisions contained in that Schedule are compatible with human rights, as they do not limit human rights or freedoms of individuals. The provisions regulate insurance companies (medical indemnity insurers) to ensure they are providing adequate professional indemnity cover to practitioners and to monitor these activities in the interest of practitioners and patients.

The offence provisions in sections 53A, 53C and 53E deal with circumstances where fault may be difficult to prove due to the complex nature of medical indemnity operations and the prevalence of multiple insurance arrangements. The requirement to keep records, report and provide information are designed to keep records of whether insurance companies are maintaining their requirements to provide universal cover to medical practitioners.

A penalty of 30 penalty units is considered appropriate for a failure to comply with a direction (general or remedial) given to a Medical Defence Organisations or medical indemnity insurer by the Secretary of the Department of Health (new sections 53A, 53C and 53E). This is lower than, and consistent with, the preference stated in *A Guide To Framing Commonwealth Offences, Infringement Notices and Enforcement Powers, September 2011* for a maximum 60 penalty units for offences of strict liability.

Rights against arbitrary or unlawful interference with an individual's privacy, family, home or correspondence

Items 17 and 28 of Schedule 3 to the Bill, which is near identical, amend sections 77 and 88 of the *Medical Indemnity Act 2002* and the *Midwife Professional Indemnity Act (Commonwealth Contribution) Scheme Act 2010*, respectively. Sections 77 and 88 of the relevant Acts prohibit the disclosure of protected information and documents (protected material) which gives rise to a criminal offence, except in limited circumstances. The effect of items 17 and 28 create further circumstances in which protected material may be disclosed. These circumstances include:

- monitoring, assessing or reviewing the operation of the medical indemnity legislation (legislation operation), and
- conducting, or assisting a person to conduct, the evaluation mentioned in section 78A (section 78A evaluation).

These measures engage the right to privacy under Article 17 of the ICCPR, which prohibits arbitrary or unlawful inference with an individual's privacy, family, home or correspondence. The right to privacy includes respect for informational privacy, including in respect of storing, using and sharing private information and the right to control the dissemination of personal and private information.

The purpose of the provisions is to assist with the monitoring and assessing of medical indemnity legislation and for the conduct of a section 78A evaluation. This is a reasonable, legitimate and necessary objective, as well as proportionate to the objectives it seeks to achieve, as this goes to the functioning of the relevant legislative schemes.

Items 17 and 28 provide a prescribed list of persons who may disclose protected information in the circumstances specified above and limits the persons to whom that information may be divulged. Having a prescribed lists of specified persons who may disclose and receive the protected information for a specified certain purpose is reasonable and proportionate.

The section 78A evaluation would require the Minister to table a report in each House of the Parliament (item 19 of the Bill), consideration has been given to how item 19 would operate with regard to protected information. Protected information would not be included in a report unless such information is appropriately de-identified.

Right to health

Article 12(1) of the ICESCR promotes the right of all individuals to enjoy the highest attainable standard of physical and mental health. This includes the creation of conditions which would assure to all service and medical attention in the event of sickness (Article 12(2)(d)). While the ICESCR contains no definition of health, the UN Committee on Economic Social and Cultural Rights ('the Committee') provides further guidance, stating that the right to health is not to be understood as a right to be healthy.

Accordingly, the right also contains entitlements, which include the right to a system of health protection, which provides equality of opportunity for people to enjoy the highest attainable level of health.

The amendments in the Bill, and its primary focus, is to further strengthen a system of protection and access to services for Australians by ensuring that medical and allied health practitioners, including midwives, have access to affordable medical indemnity insurance and that medical indemnity market remains stable. These practitioners are required to maintain professional indemnity insurance in order to practice in Australia. Affordable and stable medical indemnity insurance enhances patient access to health care services.

The remainder of the amendments made by the Bill are mechanical or technical in nature and do not abridge or otherwise engage with applicable human rights or freedoms.

Conclusion

The Bill is compatible with human rights, and in particular, supports the right to health.

The Hon Greg Hunt MP, Minister for Health

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NOTES ON CLAUSES

Clause 1 – Short title
This is a formal provision specifying the short title of the Act.

Clause 2 – Commencement
The table in this clause sets out the commencement dates for when the provisions of the Act will commence.

Sections 1 to 3 of the Act will commence the day the Act receives Royal Assent.
Schedules 1 to 5 of the Act will commence on 1 July 2020.
Schedule 6 of the Act will commence on 1 July 2020 immediately after the commencement of Schedules 1 to 5.

Clause 3 - Schedules
This clause provides that any Act that is specified in a Schedule to the Bill is amended or repealed as set out in the applicable items in the Schedule concerned, and any other item has effect according to its terms. This is a technical provision that gives operational effect to the amendments contained in the Schedule.

Schedule 1 — Competitive advantage payment and UMP support payment
The amendments in this Schedule remove redundant legislation by repealing two pieces of legislation: the *Medical Indemnity (Competitive Advantage Payment) Act 2005* and the *Medical Indemnity (UMP Support Payment) Act 2002* (items 1 and 2 in Part 1 of Schedule 1 to the Bill).

The last United Medical Protection Limited (UMP) support payment occurred in 2007. In April 2006, United Medical Protection (UMP) (Now Avant Mutual Group Limited (Avant)) as the only Medical Defence Organisation subject to the competitive advantage payment, entered into a Deed of Agreement with the Commonwealth, which led to UMP no longer being required to pay this payment.

Items 3 to 53 in Part 2 of Schedule 1 to the Bill make consequential amendments to other legislation (listed below) that currently refers to the *Medical Indemnity (Competitive Advantage Payment) Act 2005* and the *Medical Indemnity (UMP Support Payment) Act 2002*, or to concepts related to those Acts, such as definitions of ***imposition day*** or ***net IBNR exposure***.

Changes are made to the following Acts in accordance with the amendments described above:

- *Health Insurance Act 1973*
- *Human Services (Medicare) Act 1973*

- *Income Tax Assessment Act 1997*
- *Medical Indemnity Act 2002*
- *National Health Act 1953*

Consequential changes to the *Medical Indemnity Act 2002* repeal the definition of, and references to, ***medical indemnity payment***. The existing definition of ***medical indemnity payment*** collectively refers to three types of payments payable under the *Medical Indemnity Act 2002*: UMP support payment, run-off cover support payment, and competitive advantage payment. Removing this term simplifies the Act by referring to the one remaining medical indemnity payment by name, the ***run-off cover support payment***.

Part 1 – Repeals

Medical Indemnity (Competitive Advantage Payment) Act 2005
Item 1: The whole of the Act
This item repeals the *Medical Indemnity (competitive Advantage Payment) Act 2005*.

The *Medical Indemnity (Competitive Advantage Payment) Act 2005* imposed an annual tax on Medical Defence Organisations (MDO) participating in the IBNR (incurred but not reported) Indemnity Scheme and as there is only one participating Medical Defence Organisation (MDO) in this scheme, this legislation imposes a tax on that MDO to neutralise any competitive advantage they have as a result in participating in the IBNR Indemnity Scheme.

Section 59B of the *Medical Indemnity Act 2002* provides that a medical indemnity insurer is liable to pay a competitive advantage payment amount for a financial year if the financial year is a contribution year and the insurer is not exempted from the payment by regulations made under section 59C. Section 25A of the *Medical Indemnity Regulations 2003* provides that an insurer is exempt from the competitive advantage payment if the insurer pays a lump sum (pursuant to a deed of agreement with the Commonwealth) to redress the competitive advantage received by the insurer through participation in the IBNR Indemnity Scheme.

In April 2006, the only MDO subject to the competitive advantage payment (UMP, now Avant) entered into such a Deed with the Commonwealth. Consequently, the MDO is no longer liable to pay the competitive advantage payment, resulting in the *Medical Indemnity (Competitive Advantage Payment) Act 2005* being redundant.

Medical Indemnity (UMP Support Payment) Act 2002
Item 2: The whole of the Act
This item repeals the *Medical Indemnity (UMP Support Payment) Act 2002*.

A UMP payment is a payment made by an MDO to the Commonwealth to recoup some of the associated costs of the IBNR Indemnity Scheme.
As UMP (now Avant) is the only MDO participating in the IBNR Indemnity Scheme, the UMP support payment was only payable by that MDO.

The *Medical Indemnity (UMP Support Payment) Regulations 2002* (established under the *Medical Indemnity (UMP Support Payment) Act 2002*) declare that the financial year starting on 1 July 2006 is the last contribution year for UMP (now Avant). As UMP support payment is no longer payable, the legislation and regulations are redundant.

Part 2 – Amendments

Health Insurance Act 1973
Item 3: Subsection 130(25) (paragraphs (b) and (d) of the definition of ***indemnity legislation***)
This item repeals paragraphs (b) and (d) of the definition of ***indemnity legislation*** in subsection 130(25) of the *Health Insurance Act 1973.* Items 1 and 2 repeal the Acts referred to in these provisions.

Human Services (Medicare) Act 1973
Item 4: Paragraphs 42(2)(aa) and (c)
This item repeals paragraphs (aa) and (c) within subsection 42(2) of the *Human Services (Medicare) Act 1973*. Items 1 and 2 repeal the Acts referred to in these provisions.

Income Tax Assessment Act 1997
Item 5: Section 12-5 (table item headed "United Medical Protection Limited support payments")
This item repeals table item headed "United Medical Protection Limited support payments" under section 12-5 of the *Income Tax Assessment Act 1997*.

Item 6: Section 25-105
This item repeals section 25-105 of the *Income Tax Assessment Act 1997.* Section 25-105 allows for the deduction of the amount consisting of a United Medical Protection Limited support payment that is paid for a particular income year. This support payment is payable under Division 1 of Part 3 of the *Medical Indemnity Act 2002*, which is being repealed (Item 28 refers).

Item 7: Subsection 995-1(1) (definition of the ***United Medical Protection Limited support payment***)
This item repeals the definition of ***United Medical Protection Limited support payment*** in subsection 995-1(1) of the *Income Tax Assessment Act 1997*. This is consequential on the repeal of Division 1 of Part 3 of the *Medical Indemnity Act 2002* (Item 28 refers).

Medical Indemnity Act 2002
Item 8: Before subsection 3(1)
This item inserts the subheading "*Availability of medical services*" in the object provisions of the *Medical Indemnity Act 2002*.
Item 9: Subsection 3(4)
This item repeals the current subsection 3(4) of the *Medical Indemnity Act 2002*, and substitutes with another objective of the *Medical Indemnity Act 2002.* New subsection

3(4) provides that an objective of the *Medical Indemnity Act 2002* “is to allow the Commonwealth to recover costs of providing the assistance referred to in paragraph (2)(ab) by requiring payments from medical indemnity insurers”.

Item 10: Subsection 4(1) (definition of ***contribution year***)
This item repeals the definition of ***contribution year*** in subsection 4(1) of the *Medical Indemnity Act 2002*, and substitutes it with new definition “***contribution year*** has the same meaning as in the *Medical Indemnity (Run-off Cover Support Payment) Act 2004*”.

Item 11: Subsection 4(1) (definition of ***imposition day***)
This item repeals the definition of ***imposition day*** in subsection 4(1) of the *Medical Indemnity Act 2002.* This definition is redundant because item 28 of Schedule 1 to the Bill repeals Division 1 of Part 3 of the *Medical Indemnity Act 2002.*

Item 12: Subsection 4(1) (paragraphs (b) and (c) of the definition of ***late payment penalty***)
This item repeals paragraphs (b) and (c) of the definition of ***late payment penalty*** in subsection 4(1) of the *Medical Indemnity Act 2002*, and substitutes with a new paragraph (b) “in relation to a run-off cover support payment – means a penalty payable under section 65”.

Item 13: Subsection 4(1) (note 1 to the definition of ***medical indemnity cover***)
This item replaces “Note 1” with “Note” to the definition of ***medical indemnity cover*** in subsection 4(1) of the *Medical Indemnity Act 2002.* This is a minor amendment consequential to item 14.

Item 14: Subsection 4(1) (note 2 to the definition of ***medical indemnity cover***)
This item repeals note 2 to the definition of ***medical indemnity cover*** in subsection 4(1) of the *Medical Indemnity Act 2002*.

Item 15: Subsection 4(1) (definition of ***medical indemnity payment***)
This item repeals the definition of ***medical indemnity payment*** in subsection 4(1) of the *Medical Indemnity Act 2002*.

Item 16: Subsection 4(1) (definition of ***medical indemnity payment legislation***)
This item substitutes the definition of ***medical indemnity payment legislation*** with a new definition that provides that the definition has the same meaning as in the *Medical Indemnity (Run-off Cover Support Payment) Act 2004*.

Item 17: Subsection 4(1)
This item repeals the following definitions: ***medicare benefit*** and ***net IBNR exposure*** in subsection 4(1) of the *Medical Indemnity Act 2002.*
Item 18: Subsection 4(1)
This item inserts the new definition for ***run-off cover support payment*** in subsection 4(1) of the *Medical Indemnity Act 2002* as meaning a payment payable under Division 2 of Part 3 of the *Medical Indemnity Act 2002.*

The term is currently defined in subsection 34ZT(2) of the *Medical Indemnity Act 2002* by reference to the definition in the *Medical Indemnity (Run-off Cover Support Payment) Act 2004*. The definition of a run-off cover support payment to be included in subsection 4(1) is consistent with the current definition in the *Medical Indemnity (Run-off Cover Support Payment) Act 2004*.

Item 19: Subsection 10(2) (table item 9, column headed "Provisions")
This item removes reference to "section 38" in subsection 10(2) (table item 9, column headed "Provisions") of the *Medical Indemnity Act* 2002, and substitutes with a reference to "sections 27C and 38". This amendment inserts reference to new section 27C (Item 21 refers). Subsection 27C(4) describes some of the information that the Chief Executive Medicare may request and to be provided by a participating MDO.

Item 20: Paragraph 19(b)
This item repeals paragraph 19(b) of the *Medical Indemnity Act 2002*. This paragraph refers to a determination by the Chief Executive Medicare under section 53. Section 53 is one of the provisions repealed by item 28.

Item 21: At the end of Division 1 of Part 2
This item inserts new section 27C in Division 1 of Part 2 of the *Medical Indemnity Act 2002*. Item 21 moves the existing Incurred-But-Not-Report (IBNR) exposure annual assessment and reporting process under current section 56 of the *Medical Indemnity Act 2002* into the relevant Part of that Act, that is, new section 27C. The IBNR exposure annual assessment and reporting requirements has been amended from a contribution year to a financial year as there is no concept of a contribution year for the purpose of the IBNR scheme. The Commonwealth originally introduced these reporting requirements to ensure the Minister for Health was provided with a report that included the Actuary's assessment of the IBNR exposure.

Report by the Actuary
New subsection 27C(1) provides that for each financial year, the Actuary must give the Minister for Health a written report that:

- states the Actuary's assessment of the participating MDO's IBNR exposure as at the end of the financial year; and
- sets out the reasons for the assessment.

New subsection 27C(2) provides that in preparing the report, the Actuary must take into account any information that the Chief Executive Medicare gives the Actuary in relation to the participating MDO under subsection (6).
Chief Executive Medicare's information gathering powers
New subsection 27C(3) allows the Chief Executive Medicare to request that the participating MDO give the Chief Executive Medicare information relevant to assessing the participating MDO's IBNR exposure as at the end of a financial year, if the Chief Executive Medicare believes on reasonable grounds that the participating MDO is

capable of giving that information. Failure to comply with the request is an offence (see section 45 of the *Medical Indemnity Act 2002*).

New subsection 27C(4) provides that, without limiting subsection 27C(3), the kind of information that may be requested includes information in the form of:

- financial statements; and
- a report prepared by a suitably qualified actuary assessing the participating MDO's IBNR exposure as at the end of a financial year.

New subsection 27C(5) sets out that the request:

- must be made in writing; and
- must state what information the participating MDO is to give to the Chief Executive Medicare; and
- may require the information to be verified by statutory declaration; and
- must specify the day on or before which the information must be given; and
- must contain a statement to the effect that a failure to comply with the request is an offence.

The day specified under paragraph 27C(5)(d) must be at least 28 days after the day on which the request is made.

New subsection 27C(6) requires the Chief Executive Medicare to give any information that the participating MDO gives the Chief Executive Medicare to the Actuary for the purposes of preparing the report for the Minister for Health under subsection (1).

<u>Item 22: Section 34ZT (heading)</u>
This item inserts the word "support" after reference to "run-off cover" in the heading of section 34ZT of the *Medical Indemnity Act 2002*. This addition clarifies that the section relates to information about the run-off cover support payment.

<u>Item 23: Subsection 34ZT(1)</u>
This item inserts the word "support" after reference to "run-off cover" in subsection 34ZT(1) of the *Medical Indemnity Act 2002*. This addition clarifies that the requirement to provide information in accordance with subsection 34ZT(1) is a requirement in relation to information about a run-off cover support payment.

<u>Item 24: Paragraph 34ZT(2)(b)</u>
This item repeals paragraph 34ZT(2)(b) of the *Medical Indemnity Act 2002*, and substitutes it with a new section 34ZT(2)(b), which aligns the period in which a medical indemnity insurer must notify the Chief Executive Medicare of information regarding run-off cover support payments with the amendments made to section 61 of the *Medical Indemnity Act 2002*.

<u>Item 25: Subsection 34ZV(2) (definition of ***run-off cover support payment***)</u>

This item repeals the local definition of ***run-off cover support payment*** in subsection 34ZV(2) of the *Medical Indemnity Act 2002*. As this term is used in other provisions in the *Medical Indemnity Act 2002*, item 18 inserts the definition of ***run-off cover support payment*** in section 4 of the *Medical Indemnity Act 2002,* along with other defined terms.

Item 26: Section 44A

This item repeals section 44A of the *Medical Indemnity Act 2002*. This is a consequential amendment of repealing the Division 1 of Part 3 of the *Medical Indemnity Act 2002,* specifically in relation to repealing the UMP support payments from the medical indemnity legislation.

Item 27: Paragraphs 45(1)(a) to (baa)

This item repeals paragraphs 45(1)(a) to (baa) of the *Medical Indemnity Act 2002*, and substitutes it with new paragraphs 45(1)(a) and (b), which reference "subsection 27B(1)" and "subsection 27C(3)" (respectively).

This amendment removes references to subsections 13(3) and 23(3) of the *Medical Indemnity Act 2002*, which are being repealed as part of the simplification of the legislative structure and the consolidation of instruments made under the *Medical Indemnity Act 2002*.

It inserts a new reference to subsection 27C(3). This means, consistent with other provisions in the *Medical Indemnity Act 2002*, failure to comply with a request for information made under this provision is an offence. Information may be requested under new subsection 27C(3) if the Chief Executive Medicare believes on reasonable grounds that the participating MDO is capable of giving information that is relevant to assessing the participating MDO's IBNR exposure as at the end of a financial year. This information enables the Actuary to reassess the Commonwealth's IBNR exposure annually, for advice to the Minister.

The existing penalty of 30 penalty units is considered appropriate for a failure to comply with a direction (general or remedial) given to a medical indemnity insurer. This is lower than, and consistent with, the preference stated in *A Guide To Framing Commonwealth Offences, Infringement Notices and Enforcement Powers*, September 2011, for a maximum 60 penalty units for offences of strict liability.

Item 28: Division 1 of Part 3

This item repeals Division 1 of Part 3 of the *Medical Indemnity Act 2002.* This Division of the *Medical Indemnity Act 2002* is being repealed as it establishes matters relating to the UMP support payment, which no longer exist.

Item 29: Subsection 57(3) (table item 5, column headed "Provisions")

This item removes references to "sections 61 and 62" within table item 5, column titled "Provisions" in subsection 57(3) of the *Medical Indemnity Act 2002*, and substitutes it with a new reference to "section 61" (refer to item 35).

This amendment supports the repeal of existing sections 61 and 62, which will be replaced with a simplified provision that describes when run-off cover support payments must be paid and removes redundant references to the UMP support payment and the competitive advantage payment (refer to item 35 which inserts a new section 61).

Item 30: Division 2A of Part 3
This item repeals Division 2A of Part 3 of the *Medical Indemnity Act 2002*. Division 2A of Part 3 contains provisions pertaining to the competitive advantage payment; therefore, it is necessary to repeal this division in accordance with the repeal of the *Medical Indemnity (Competitive Advantage Payment) Act 2005*.
Item 31: Division 3 of Part 3 (heading)
This item removes the reference to "medical indemnity payments" in Division 3 of Part 3 of the *Medical Indemnity Act 2002*, and substitutes it with reference to "run-off cover support payments".

Item 32: Subsection 60(1)
This item removes reference to "UMP support payments, run-off cover support payments and competitive advantage payments" in subsection 60(1) of the *Medical Indemnity Act 2002*, and substitutes with reference to "run-off cover support payments". This is a consequential amendment in repealing the UMP support and competitive advantage payments legislation.

Item 33: Subsection 60(2) (table)
This item repeals the table in subsection 60(2) of the *Medical Indemnity Act 2002*, and substitutes it with a new table. This amendment is consequential to omitting the UMP support payments from the medical indemnity legislation in Division 1 of Part 3 of the *Medical Indemnity Act 2002*.

Item 34: Subdivision B of Division 3 of Part 3 (heading)
This item removes reference to "medical indemnity payments" in the heading of Subdivision B of Division 3 of Part 3 of the *Medical Indemnity Act 2002*, and substitutes it with a reference to "run-off cover support payments".

Item 35: Sections 61 and 62
This item repeals sections 61 and 62 of the *Medical Indemnity Act 2002*, and substitutes it with new section 61. New section 61 provides that a run-off cover support payment that a person is liable to pay for a contribution year becomes due and payable on:

- 30 June in the contribution year; or
- such other day as is specified in the rules as the payment day for the contribution year either generally for all people, for the class of people that includes the person or for the person, as the case may be.

The repeal of these sections is a consequential amendment to repealing Division 1 of Part 3 of the *Medical Indemnity Act 2002* in particular due to the removal of UMP support

payment and the competitive advantage payment from the medical indemnity legislation, that are referred to in these provisions.

Item 36: Paragraph 65(1)(a)
This item removes reference to "medical indemnity payment" within paragraph 65(1)(a) of the *Medical Indemnity Act 2002*, and substitutes it with reference to "run-off cover support payment".

Item 37: Subsection 66(1)
This item repeals subsection 66(1) of the *Medical Indemnity Act 2002*, which refers to medical indemnity payment, and substitutes with a new subsection 66(1). The repeal of subsection 66(1) is consequential to the repeal of Divisions 1 and 2A of Part 3 of the *Medical Indemnity Act 2002*, such that late payment penalties, to be paid to the Chief Executive Medicare, only relate to a run-off cover support payment.

Item 38: Subsection 66(3)
This item removes reference to "or 66B" in subsection 66(3) of the *Medical Indemnity Act 2002.* This is a consequential amendment resulting from the repeal of Division 1 of Part 3 of the *Medical Indemnity Act 2002* and removes the cross-reference to section 66B.

Item 39: Subsection 66(5)
This item repeals subsection 66(5) of the *Medical Indemnity Act 2002*. This is a consequential amendment from repealing the definition of, and references to, medical indemnity payment. The existing definition of medical indemnity payment collectively refers to three types of payments payable under the *Medical Indemnity Act 2002*: UMP support payment, run-off cover support payment, and competitive advantage payment. Removing this term simplifies that Act by referring to the one remaining medical indemnity payment by name, the run-off cover support payment.

Item 40: Sections 66A and 66B
This item repeals sections 66A and 66B within the *Medical Indemnity Act 2002*. This is a consequential amendment resulting from the repeal of Division 1 of Part 3 of the *Medical Indemnity Act 2002* and the repeal of UMP support payments. Both provisions refer to UMP support payment.

Item 41: Subsection 67(1) (heading)
This item removes reference to "medical indemnity payment" within the heading in subsection 67(1) within the *Medical Indemnity Act 2002*, and substitutes it with a reference to "run-off cover support payment".

Item 42: Paragraph 67(1)(a)
This item removes references to "medical indemnity payment" within paragraph 67(1)(a) of the *Medical Indemnity Act 2002*, and substitutes it with a reference to "run-off cover support payment".

Item 43: Paragraphs 67(1)(b) and (c)
This item repeals paragraphs 1(b) and (c) in section 67 of the *Medical Indemnity Act 2002*, and substitutes it with a new paragraph (b): "a late payment penalty in relation to a run-off cover support payment for a contribution year". Paragraph 67(1)(b) refers to medical indemnity payment, and paragraph 67(1)(c) refers to paragraph 66A(4)(b) (refer to item 40) that are being repealed.

Item 44: Subsection 68(1)
This item removes reference to "medical indemnity payment" within subsection 68(1) of the *Medical Indemnity Act 2002*, and substitutes with a reference to "run-off cover support payment".

Item 45: Subsection 68(2)
This item repeals subsection 68(2) within the *Medical Indemnity Act 2002.* This is a consequential amendment from the repeal of Division 1 of Part 3 of the *Medical Indemnity Act 2002*, in particular the reference to UMP support payments, which this Bill removes.

Item 46: Subsection 68(3)
This item removes reference to "or 66B" in subsection 68(3) within the *Medical Indemnity Act 2002*. This is a consequential amendment with the repeal of Division 1 of Part 3 of the *Medical Indemnity Act 2002* and removes the cross-reference to section 66B (refer to item 41).

Item 47: Subsection 68(4)
This item removes reference to "(1), (2) or (3)" and substitutes "(1) or (3)" in subsection 68(4) of the *Medical Indemnity Act 2002* because of the repeal of subsection 68(2) (refer to item 46).

Item 48: Paragraph 70(1)(a)
This item repeals paragraph 70(1)(a) of the *Medical Indemnity Act 2002*, and substitutes it with a new paragraph 70(1)(a) that now relates to run-off cover support payment. This is a consequential amendment resulting from the repeal of Division 1 of Part 3 of the *Medical Indemnity Act 2002* as it imposes a liability to pay a late payment regarding a UMP support payments, payments that this Bill removes.

Item 49: Paragraphs 71(1)(a) and (b) and 72(1)(a)
This item removes reference to "medical indemnity payment" within paragraphs 71(1)(a) and (b) and 72(1)(a) of the *Medical Indemnity Act 2002*, and substitutes it with a reference to "run-off cover support payment".

Item 50: Subsection 73(1)
This item removes subsection 73(1) of the *Medical Indemnity Act 2002*, and substitutes it with a new subsection 73(1): "this section applies if a person is given a request for information under section 71(1)." This is a consequential change as both sections 56 and 59E of the *Medical Indemnity Act 2002*, which are currently referred to in subsection 73(1) are being repealed (refer to items 29 and 31).

Item 51: Section 74A
This item repeals section 74A within the *Medical Indemnity Act 2002*. This is a consequential amendment resulting from the repeal of Division 1 of Part 3 of the *Medical Indemnity Act 2002.* The amendment removes references to the UMP support payments, which are redundant payments under the *Medical Indemnity Act 2002* that this Bill removes.

Item 52: Subsection 77(1) (at the end of the definition of ***medical indemnity legislation***)
This item adds two paragraphs in subsection 77(1) within the *Medical Indemnity Act 2002*. These additions include "the repealed *Medical Indemnity (Competitive Advantage Payment) Act 2005"* and "the repealed *Medical Indemnity (UMP Support Payment) Act 2002* within the meaning of ***medical indemnity legislation***. This ensures that even though these Acts will be repealed by this Bill, the requirements in section 77 to observe secrecy and to handle information obtained under medical indemnity legislation in the specified way continues to extend to these Acts.

National Health Act 1953
Item 53: Subsection 135A(24) (paragraphs (b) and (d) of the definition of ***indemnity legislation***)
This item repeals paragraphs (b) and (d) in subsection 134A(24) within the *National Health Act 1953*, which currently include the *Medical Indemnity (Competitive Advantage Payment) Act 2005* and the *Medical Indemnity (UMP Support Payment) Act 2002* within the definition of indemnity legislation for the purposes of the secrecy provision in that Act.

Item 54: Application
Subitems 53(1) and (5) provide that the amendments to the *Health Insurance Act 1973* and the *National Health Act 1953* made by Part 2 of Schedule 1 to the Bill apply in relation to any recording, disclosure (divulging or communicating) of information after the commencement of item 54, which is 1 July 2020.

Subitem 53(2) makes it clear that the amendments to the *Income Tax Assessment Act 1997* made by Part 2 apply only in relation to income years starting on or after 1 July 2020.

Subitem 53(3) provides that section 27C of the *Medical Indemnity Act 2002* and the repeal of section 56 of that Act, apply in respect of financial years starting on or after 1 July 2019. This means information relating to the IBNR exposure for the 2019-2020 financial year will be sought under new section 27C.

Subitem 53(4) provides that despite the amendments of section 45 and 73 of the *Medical Indemnity Act 2002*, those sections will continue to operate in relation to any request for information given before the commencement of this item, as if the amendments to those provisions have not been made. This means that if a request was made under subsections 13(3) or 23(3) prior to the commencement of the amendments,

then the request continues to operate and the person commits an offence under section 45 if the person fails to comply with the request.

Schedule 2 — Indemnity scheme payments

The amendments in Part 1 of Schedule 2 to the Bill address the lack of clarity around the claiming criteria under the High Cost Claim Scheme (HCCS) when claims have more than one defendant.

Changes in Part 1 of Schedule 2 to the Bill clarify that a claim or claims are eligible related claims (for the purposes of aggregation) where the claim is against the same medical practitioner, in relation to the same incident, or series of incidents, and:

- the claims are part of the same class action or representative proceeding (i.e. they have been joined before a court), or
- the incident, or series of incidents, are in connection with a pregnancy or birth of a child or children (i.e. in respect of a single birth event).

Amendments made by Part 2 relate to the separation of the eligibility of medical practitioners and allied health providers to the HCCS and the Exceptional Claims Scheme (ECS).

Changes made by Part 2 to Schedule 2 of the Bill clarify that the HCCS and the ECS are only intended to apply in respect of medical practitioners (Schedule 6 of the Bill creates a high cost claim and exceptional claims scheme for people who practise allied health professions). This is achieved through changes regarding eligibility to access the schemes, which make it clear that eligibility is related to a "person's practice as a medical practitioner".

Changes made by Part 3 of Schedule 2 to the Bill enable medical practitioners and midwives who permanently retire from practice before the age of 65 to access the ROCS without waiting three years. This follows a recommendation of the FPR Report (page 42) to move away from "differential treatment of practitioners based on the age at which they permanently retired and their period of continuous cover" and ensuring that patients continue to be protected despite a related practitioner retiring. The FPR Report (pages 46-48) also recommended eligible midwives who permanently retire from practice before the age of 65 to access the midwives ROCS without waiting three years.

Upon leaving the workforce, the ROCS will cover the types of claims that a medical practitioner's last medical indemnity insurance contract covered. In other words, if a medical practitioner's last medical indemnity insurance contract includes additional coverages clauses such as civil liability investigation costs; the ROCS will cover these types of claims.

Part 1 – Aggregation of claims for high cost claim indemnity schemes

Medical Indemnity Act 2002
Item 1: Subsection 4(1)
This item inserts a definition of ***eligible related claims*** in subsection 4(1) of the *Medical Indemnity Act 2002* by reference to meaning given by new section 8A.

Item 2: Section 8A
This item replaces section 8A of the *Medical Indemnity Act 2002* with a new section 8A. This provision provides that a claim or claims are eligible related claims (for the purposes of aggregation of the claims) where the claim/s is/are against the same medical practitioner, in relation to the same incident or series of incidents, and:

- all the claims are part of the same class action or representative proceeding (i.e. they have been joined before a court); or
- the incident, or series of incidents, occurred in connection with a pregnancy or birth of a child or children (i.e. in respect of a single birth event).

New section 8A applies to the HCCS and the new Allied Health High Costs Claim Scheme (AHHCCS) (refer to Schedule 6) and is relevant to the aggregation of claims for the purposes of eligibility for the HCCS and the high cost claim threshold (see items 3 to 9 below).

The relevant high cost claim threshold (in respect of an aggregated claim) is the applicable threshold at the time the insurer was first notified of the first claim or incident. For example, if there are a group of eligible related claims being aggregated, it is the time that the insurer was first notified of a claim or incident in that group that will determine the applicable high cost claim threshold.

The policy intent is that the aggregation of claims can only apply in respect of the same individual practitioner. A single high cost claim threshold cannot be applied across multiple practitioners in relation to the same event.
Further, in relation to aggregating qualifying payments, the intent is that an event that impacts a woman and her unborn 'children' of that same pregnancy or claims regarding one or more child of a single birth event (e.g. twins) can be aggregated.

Item 3: Paragraph 30(1)(d) to (f)
This item removes paragraphs 30(1)(d) to (f) of the *Medical Indemnity Act 2002*, and substitutes with new paragraphs 30(1)(d) to (f) to make clear the rules regarding aggregation of eligible related claims for the purposes of the HCCS.

New paragraph 30(1)(d) provides that a high cost claim indemnity is payable to an MDO or insurer under section 30 of the *Medical Indemnity Act 2002* if the MDO or insurer is first notified of:

- the incident; or
- the claim; or
- an eligible related claim;

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

The basic payability rule with respect to the time for first notification of the claim or the incident has not changed. New paragraph 30(1)(d) has been reframed to include eligible related claims (i.e. for the purposes of aggregation of eligible related claims).

New paragraph 30(1)(e) provides that a high cost claim indemnity is payable to an MDO or insurer if the MDO or insurer has a qualifying payment in relation to the claim, or the claim and one or more eligible related claims.

New paragraph 30(1)(f) provides that a high cost claim indemnity is payable to an MDO or insurer if the amount of the qualifying payment, or the sum of the amounts of the qualifying payments, exceeds what was the high cost claim threshold at the earliest of the following times:

- when the MDO or insurer was first notified of the incident;
- when the MDO or insurer was first notified of the claim; or
- when the MDO or insurer was first notified of an eligible related claim.

The relevant high cost claim threshold in respect of an eligible related claim will be the applicable threshold at the time the insurer was first notified of the first claim or incident. For example, if there are a group of eligible related claims being aggregated, it is the time that the insurer was first notified of a claim or incident in that group that will determine the applicable high cost claim threshold.

New paragraph 30(1)(f) applies to applications for HCCS payments made on or after commencement of that paragraph (see item 10). The high cost claim threshold at the earliest of the first incident notification, claim notification or eligible related claim notification will apply, even if that notification occurred before new paragraph 30(1)(f) commenced.

Item 4: Subsection 30(2)
This item removes reference to "in relation to the claim if" in subsection 30(2) of the *Medical Indemnity Act 2002*, and substitutes it with a reference to "in relation to a claim if". This supports new provisions clarifying the intent regarding the aggregation of eligible related claims.

Item 5: Paragraph 31(1)(a)
This item inserts "that relates to an incident or a series of incidents" after "a claim" in paragraph 31(1)(a) of the *Medical Indemnity Act 2002.*

Item 6: Paragraph 31(1)(b)
This item removes reference to "an amount in relation to the same claim (the ***insurer amount***)" and substitutes with "an amount (the ***insurer amount***) in relation to the same

claim or an eligible related claim" in paragraph 31(1)(b) of the *Medical Indemnity Act 2002*.

Item 7: Subparagraph 30(2)(a)(i)
This item inserts reference to "or an eligible related claim" after "claim" in subparagraph 31(2)(a)(i) of the *Medical Indemnity Act 2002.*
Item 8: Subparagraph 31(2)(a)(ii)
This item removes reference to "30(1)(a) to (e)" in subparagraphs 31(2)(a)(ii) of the *Medical Indemnity Act 2002*, and substitutes it with reference to "30(1)(e)".

Item 9: At the end of paragraph 31(2)(a)
This item inserts a new subparagraph 31(2)(a)(iii) in the *Medical Indemnity Act 2002.* New subparagraph 31(2)(a)(iii) deems the MDO to have been notified of the claim when the insurer was first notified. That is:

- if the insurer was notified before the MDO, the time the insurer was notified will be the time that applies for paragraphs 30(1)(d) and (f); and
- if the MDO was notified first, that will be the time that applies for those paragraphs.

Item 10: Application
This item provides for amendments made by Part 1 of Schedule 2 to the Bill to apply in respect of any application for a HCCS payment made on or after commencement of this item, irrespective of whether the claim was made before or after the commencement of the amendments.

Part 2 – Medical professions

Part 2 clarifies the eligibility of medical practitioners (distinct from allied health professionals) in respect of the HCCS and the Exceptional Claims Scheme (ECS). Items 12 to 15 amend the relevant provisions to make it clear that the HCCS and ECS are only intended to apply to medical practitioners. From 1 July 2020, allied health professionals will have access to the AHHCCS and the allied health exceptional claims scheme (AHECS) in respect of incidents that occurred on or after 1 July 2020. Pre-1 July 2020 incidents will continue to be covered under the existing HCCS (noting that allied health professionals do not currently have access to the ECS).

Medical Indemnity Act 2002
Item 11: Paragraph 4(1A)(a)
This item removes reference to "or other health professional" in paragraph 4(1A)(a) of the *Medical Indemnity Act 2002*.

The currently defined term ***health professional*** will be removed from section 4 of the *Medical Indemnity Act 2002* to provide greater clarity as to the intended scope of each of

the schemes. The schemes will apply in respect of a medical practitioner or an allied health professional (which may include certain classes of midwives – refer to Schedule 6).

Removing the reference to "or other health professional" makes it clear that the scope of the ROCS, as set out in Division 2B of Part 2 of the *Medical Indemnity Act 2002*, relates only to medical practitioners.

<u>Item 12: Subsection 28(1)</u>
This item substitutes reference to "practice by the person of a medical profession, other than practice as an eligible midwife" in subsection 28(1) of the *Medical Indemnity Act 2002* with "person's practice as a medical practitioner".

<u>Item 13: Paragraph 30(1)(b)</u>
This item substitutes reference to "practice by the practitioner of a medical profession, other than practice as an eligible midwife" in paragraph 30(1)(b) of the *Medical Indemnity Act 2002* with "practitioner's practice as a medical practitioner".

<u>Item 14: Paragraph 34A(1)(a)</u>
This item substitutes reference to "practice by the person of a medical profession (other than practice as an eligible midwife)" in paragraph 34A(1)(a) of the *Medical Indemnity Act 2002* with "person's practice as a medical practitioner".

<u>Item 15: Paragraph 34E(1)(b)</u>
This item substitutes reference to "practice by the practitioner of a medical profession, other than practice as an eligible midwife" in paragraph 34E(1)(b) of the *Medical Indemnity Act 2002* with "practitioner's practice as a medical practitioner".
<u>Item 16: Application</u>
This item provides that amendments in Part 2 of Schedule 2 to the Bill do not affect a claim if the claim relates to an incident that occurred prior to 1 July 2020, or a series of related incidents at least one of which occurred before 1 July 2020. Practitioners who have claims in respect of pre-1 July 2020 incidents and who were eligible for the HCCS and ECS prior to 1 July 2020 will continue to have their claims covered under the HCCS or the ECS on and after 1 July 2020.

Part 3 – Run-off cover on retirement

Changes made by Part 3 of Schedule 2 to the Bill implement the Government's policy decision to enable medical practitioners who permanently retire from private medical practice before the age of 65 to access the ROCS without waiting three years. This follows a recommendation of the FPR Report (page 42) to move away from "differential treatment of practitioners based on the age at which they permanently retired and their period of continuous cover" and ensuring protections for patients making claims against medical practitioners after they permanently retire (in relation to events that occurred while they were practising).

As part of the FPR Report (pages 46-48), it was recommended that amendments also be made to the Midwife Professional Indemnity Run-Off Cover Claim Scheme within the *Midwife Professional Indemnity (Commonwealth Contribution) Scheme Act 2010* to enable eligible midwives who permanently retire from private practice before the age of 65 to access the midwives ROCS without waiting three years. This aligns with Government's policy intent to enable an eligible midwife to have immediate access to ROCS when they permanently retire from private practice, regardless of the age at which they retire.

Age Discrimination Act 2004
Item 16: Schedule 2 (table items 6 and 7)
This item removes the age discrimination exemptions for Part 3 of the *Medical Indemnity (Prudential Supervision and Product Standards) Act 2003* and *Medical Indemnity (Prudential Supervision and Product Standards) Regulations 2003* from Schedule 2 of the *Age Discrimination Act 2004.*

Medical Indemnity Act 2002
Item 18: Subparagraph 34ZB(1)(d)(i)
Consistent with contemporary drafting practices, this item removes reference to "subsection 34ZB(2)" in subparagraph 34ZB(1)(d)(i) of the *Medical Indemnity Act 2002*, and substitutes it with "subsection (2)".

Item 19: Paragraph 34ZB(2)(a)
This item removes reference to "aged 65 years or over" in paragraph 34ZB(2)(a) of the *Medical Indemnity Act 2002*. This achieves the policy intent of enabling medical practitioners who retire permanently from private medical practice to access the ROCS.
Item 20: Application and transitional
The item provides for application and transitional arrangements. Subitem 20(1) enables medical practitioners who have retired permanently from private practice before the age of 65, before or after the amendment to paragraph 34ZB(2)(a) commences, to access the scheme immediately in relation to claims made after the amendment commences.

This provision ensures that where, on commencement of the amendment, a medical practitioner immediately becomes eligible for the ROCS, any contracts of insurance for run-off cover that are valid at the time of the changes and were entered in accordance with section 23 of the *Medical Indemnity (Prudential Supervision and Product Standards) Act 2003* (which requires an insurer to make a compulsory offer of run-off cover) are not automatically in breach of paragraph 26A(4)(f) of the *Medical Indemnity (Prudential Supervision and Product Standards) Act 2003.*

Paragraph 26A(4)(f) requires that no premium or other consideration is payable for the medical indemnity cover. However, consistent with the law prior to the amendment described in item 19, insurers could charge a nominal amount for run-off cover offered to medical practitioners who permanently retired from private medical practice under the age of 65 (but who had not been retired for three years, such that their eligibility to access the ROCS had not yet been enlivened). To avoid this issue, item 20 of the Bill 'switches

off' the requirement in paragraph 26A(4)(f) of the *Medical Indemnity (Prudential Supervision and Product Standards) Act 2003* for the remaining period of the cover (i.e. until that contract expires). On expiry of that medical practitioner's cover, the requirement in paragraph 26A(4)(f) will enliven again and insurers will not be able to charge a premium for the run-off cover.

Midwife Professional Indemnity (Commonwealth Contribution) Scheme Act 2010
Item 21: Paragraph 31(2)(a)
This item removes reference to "aged 65 years or over" within subsection 31(2)(a) within the *Medical Indemnity Act 2002*. This achieves the policy intent of enabling eligible midwives who retire permanently from private practice to access the ROCS.

Item 22: Application
This item allows for midwives who have retired permanently from private practice under the age of 65, before or after the commencement of the amendment made by Item 21, to access the scheme immediately in relation to claims made after the amendment commences.

Part 4 – Health service incidents

The objective of Part 4 of Schedule 2 to the Bill is to clarify the intent of the medical indemnity law that payments will only be made if the claim relates to the provision of a health service (for example rather than a workplace or occupier's liability issue). The intention is to clarify that the limit of the IIF is for matters that arise from the provision of health services.
Medical Indemnity Act 2002
Item 23: Subsection 4(1)
This item inserts a definition of "***health service*** as meaning any service, care, treatment, advice or goods provided in respect of the physical or mental health of a person" in subsection 4(1) of the *Medical Indemnity Act 2002*.

Item 24: Subsection 4(1) (definition of ***incident***)
This item repeals the definition of ***incident*** in subsection 4(1) of the *Medical Indemnity Act* 2002, and substitutes it with a new definition, which provides that "***incident*** means any incident (including any act, omission or circumstance) that occurs, or that is claimed to have occurred, in the course of, or in connection with, the provision of a health service".

Midwife Professional Indemnity (Commonwealth Contribution) Scheme Act 2010
Item 25: Subsection 5(1)
This item inserts a definition of "***health service*** as meaning any service, care, treatment, advice or goods provided in respect of the physical or mental health of a person" in subsection 5(1) of the *Midwife Professional Indemnity (Commonwealth Contribution) Scheme Act 2010*. This covers birthing, midwifery and related services.

Item 26: Subsection 5(1) (definition of ***incident***)

This item substitutes the definition of ***incident*** in subsection 5(1) of the *Midwife Professional Indemnity (Commonwealth Contribution) Scheme Act* 2010, with a new definition. The new definition provides that "***incident*** means any incident (including any act, omission or circumstance) that occurs, or that is claimed to have occurred, in the course of, or in connection with, the provision of a health service".

Item 27: Application
The amendments of the *Medical Indemnity Act 2002* and the *Midwife Professional Indemnity (Commonwealth Contribution) Scheme Act 2010* made by this Part apply in relation to any incident that occurs, or is claimed to have occurred, after the commencement of this item.

Schedule 3 – Administration

Schedule 3 to the Bill deals with administrative changes that streamline and/or clarify the operation of the legislation. These changes:

- insert subsection headings to improve readability;
- enable the Chief Executive Medicare to treat an application as having been withdrawn if further information requested is not provided by the date specified (items 4 and 11);
- streamline the process for annual reporting on the ROCS to enable the Secretary to publish the Actuary's report on the Department of Health's website (items 5-7 and 22-24);
- enable more efficient information sharing between relevant agencies by specifying the circumstances in which it will not be an offence to share protected information and documents where it is for the purposes of monitoring, assessing or reviewing operation of the medical indemnity legislation (items 18 and 29). Specifically, it will not be an offence for the Secretary of the Department, the Chief Executive Medicare, the Actuary, Australian Prudential Regulation Authority or Australian Securities and Investments Commission to share information where it is for the purposes of the medical indemnity legislation or the midwife professional indemnity legislation, in particular to monitor and report to Parliament on the effectiveness of Government financial support for the medical indemnity sector;
- confirm that the Chief Executive Medicare may use a computer program to make decisions etc. under the *Medical Indemnity Act 2002* and the *Midwife Professional Indemnity (Commonwealth Contribution) Scheme Act 2010* (items 15 and 26); and
- confirm the Secretary's ability to delegate powers and functions under the *Medical Indemnity Act 2002* and the *Midwife Professional Indemnity (Commonwealth Contribution) Scheme Act 2010* to persons prescribed in those Acts (items 15 and 26).

In the 2016 Australian National Audit Office (ANAO) report,[2] it was noted that there are no arrangements in place to assess the impact of the Government's support for medical indemnity insurance including the impact of the Government's measures on the stability of the indemnity insurance market, the affordability of premiums and the Government's exposure to risk.

To address this and ensure that the Government can draw from current information sources from within different areas of Government in a coordinated fashion and report publicly, the Government is introducing these legislative provisions in Schedule 3. Schedule 3 provides for an evaluation of the affordability and stability of the medical indemnity market. The relevant amendments for this include new powers for the Secretary to seek information that will enable an evaluation of the medical indemnity market (items 14 and 25 give the power to request information and item 20 provides for the Minister for Health to commission an actuarial evaluation in the medical indemnity market). The intent of these provisions is to evaluate and report to Parliament on the effectiveness of the Government's support for medical indemnity insurance and whether objectives are being achieved.

Medical Indemnity Act 2002
Item 1: Subsection 4(1)
This item inserts a new definition: "***administrative action*** has the meaning given by subsection 76A(4)" in subsection 4(1) of the *Medical Indemnity Act 2002.*

Item 2: Subsection 4(1) (definition of ***Human Services Minister***)
This item repeals the definition of ***Human Services Minister***, as there is no Human Services Minister in office and the term in now redundant.

Item 3: Subsection 34I(1)
This item substitutes reference to "subsection (2)" in subsection 34I(1) of the *Medical Indemnity Act 2002* with "subsections (2) and (3)". This is consequential on the amendment made by item 4.

Item 4: At the end of section 34I
This item adds subsections 34I (3) and(4) at the end of section 34I of the *Medical Indemnity Act 2002*. New subsections (3) and (4) enables the Chief Executive Medicare to treat an application as having been withdrawn where information requested by the Chief Executive Medicare under section 38 in relation to the application is not given by the applicant by the end of the day specified in the request.
The power to request information ensures that the Chief Executive Medicare has the information needed in relation to applications, claims payable or payments to be made under each of the indemnity schemes. While section 45 of the *Medical Indemnity Act 2002* establish offences in respect of the failure to comply with a request for information,

[2] Australian National Audit Office, *The Management, Administration and Monitoring of the Indemnity Insurance Fund* (ANAO Report No.20 2016-17) page 8
https://www.anao.gov.au/sites/default/files/ANAO_Report_2016-17_20.pdf

there is no clear (or proportionate) way in which the Chief Executive Medicare can deal with the application that is on foot.

Amending section 34I provides administrative clarity and finalises the Chief Executive Medicare's consideration of an application for a qualifying claim certificate by enabling the Chief Executive Medicare to treat the application as withdrawn where further information requested is not given to the Chief Executive Medicare in the specified period. In this scenario, the application has not been refused and the applicant may re-apply with the necessary information. For this reason, it is appropriate that a decision to treat the application as withdrawn in the circumstances described is not a reviewable decision.

The Chief Executive Medicare must notify the MDO or insurer if an application is treated as having been withdrawn.

<u>Item 5: Subsection 34ZW(1)</u>
This item repeals subsection 34ZW(1) of the *Medical Indemnity Act 2002*, and substitutes it with a new subsection 34ZW(1) that provides that after the end of each financial year, the Actuary must give the Secretary a report on the operation of this Division. This amendment will streamline the ROCS reporting requirements by enabling information that is currently included in reports from the Minister to Parliament to instead be published as part of the Department of Health's annual report.

<u>Item 6: Subsection 34ZW(2)</u>
This item removes reference to "in relation to a financial year" in subsection 34ZW(2) of the *Medical Indemnity Act 2002*.

<u>Item 7: After subsection 34ZW(2)</u>
This item inserts new subsection 34ZW(2A) in the *Medical Indemnity Act 2002*, which requires the Secretary to publish Actuary's report on the run-off cover scheme report for medical indemnity on the Department's website within 30 days after receiving the report.

<u>Item 8: Subsection 37(1)</u>
This item removes reference to "subsection (2)" in subsection 37(1) of the *Medical Indemnity Act 2002,* and substitutes it with a reference to "subsections (2) and (2A)".
<u>Item 9: Before subsection 37(2)</u>
This item inserts a heading "Payment will not be made until requested information is given" before subsection 37(2) of the *Medical Indemnity Act 2002*.

<u>Item 10: Subsection 37(2)</u>
This item removes "If" in subsection 37(2) of the *Medical Indemnity Act 2002*, and substitutes it with "subject to subsection (2A), if".

<u>Item 11: After subsection 37(2)</u>
This item inserts new subsections 37(2A) and (2B) after subsection 37(2) of the *Medical Indemnity Act 2002*.

Section 37 establishes the payment date for IBNR indemnities, high cost claim indemnities and run-off cover indemnities. The relevant payment date will depend on whether the Chief Executive Medicare has made a request for further information under section 38 of the *Medical Indemnity Act 2002* in relation to the application for indemnity.

New subsection 37(2A) enables the Chief Executive Medicare to deal with circumstances in which the MDO or insurer who made the application does not provide the further information sought under section 38. It does this by enabling the Chief Executive Medicare to treat an application as having been withdrawn if the applicant does not give information that is requested by the Chief Executive Medicare under section 38 in relation to the application.

In this scenario, the application for an indemnity has not been refused and the applicant may re-apply with the information necessary for the application to be determined. For this reason, it is appropriate that a decision to treat the application as withdrawn in the circumstances described is not a reviewable decision.

New subsection 37(2B) provides that the Chief Executive Medicare must notify the MDO or insurer if an application is treated as having been withdrawn.

Item 12: Subsection 38(1) (note)
This item removes reference to "Note" within subsection 38(1) (note) of the *Medical Indemnity Act 2002*, and substitutes it with a reference to "Note 1".

Item 13: At the end of subsection 38(1)
This item adds "Note 2: Failure to comply may affect certain indemnity scheme payments: see sections 34I, 34ZZN and 37" at the end of subsection 38(1) of the *Medical Indemnity Act 2002*.

Item 14: At the end of Part 2
This item inserts new Division 8 at the end of Part 2 of the *Medical Indemnity Act 2002* titled "monitoring", and new section 50.

This provision allows for the making of rules setting out the kinds of information that a medical indemnity insurer is required to provide to the Secretary. New section 50 provides that the rules may require a medical indemnity insurer to provide to the Secretary information about any of the following:

- premium costs of medical indemnity cover provided by contracts of insurance with the insurer;
- the income of medical practitioners, or persons who practise an allied health profession, for whom contracts of insurance with the insurer provide medical indemnity cover;
- the profitability of the insurer;
- the insurer's reinsurance arrangements and costs.

The intention of this provision is to distinguish the information that can be requested by the Chief Executive Medicare for the purposes of processing a claim or imposing a levy, from information requested by the Secretary for the purposes of monitoring the impact of the indemnity schemes over time. This will assist in reporting on the stability of the medical indemnity insurance market and the availability of affordable medical indemnity cover, ensuring that objectives of the Government's support for medical indemnity are being met.

Item 15: After section 76

This item inserts new section 76A in the *Medical Indemnity Act 2002*, allowing the Chief Executive Medicare to arrange for the use of computer programs for any purposes for which the Chief Executive Medicare may or must take administrative action under that Act or a legislative instrument made under that Act. This will enable the processing of medical indemnity claims and payments to be streamlined.

New subsection 76A(2) provides that the computer decision is taken to be a decision of the Chief Executive Medicare. This will ensure the Chief Executive Medicare is accountable for any administrative action taken by the operation of a computer program.

New subsection 76A(3) allows the Chief Executive Medicare to substitute a decision made by the operation of a computer program if the Chief Executive Medicare is satisfied that the initial decision was incorrect. There will be quality assurance processes to ensure that systems are operating correctly. If any decisions are made in error, they will be identified and substituted quickly.

This item inserts a definition of ***administrative action***, as meaning any of the following:

- making a decision;
- exercising any power or complying with any obligation;
- doing anything else that relates to making a decision or exercising a power or complying with an obligation.

This item also inserts new subsection 76B(1) in the *Medical Indemnity Act 2002*, which expressly confirms that the Secretary is able to delegate, in writing, all or any of their functions or powers under *Medical Indemnity Act 2002* or a legislative instrument made under that Act to any of the following persons:

- the Chief Executive Medicare; or
- an SES employee, or an acting SES employee, in the Department or the Department administered by the Minister administering the *Human Services (Medicare) Act 1973*.

This item also inserts new subsection 76B(2), which provides that in exercising a delegated function or power, the delegate must comply with written directions of the Secretary.

Item 16: Before subsection 77(1)
To guide the reader, this item inserts a heading “Definitions” before subsection 77(1) of the *Medical Indemnity Act 2002*.

Item 17: Before subsection 77(2)
To guide the reader, this item inserts a heading “Offence” before subsection 77(2) of the *Medical Indemnity Act 2002*.

Item 18: After subsection 77(2)
This item inserts a new subsection 77(2A) in the *Medical Indemnity Act 2002.* This provision prescribes persons that may make a copy or record of, or divulge to any other prescribed person in that subsection, protected information or a protected document so long as it is “for the purposes of monitoring, assessing or reviewing the operation medical indemnity legislation”.
This provision ensures that information obtained under or in relation to medical indemnity legislation can be shared between the Secretary, the Chief Executive Medicare, the Australian Government Actuary, the Australian Prudential Authority, the Australian Securities and Investments Commission. Under new subsection 77(2B), a person conducting, or assisting a person to conduct, the evaluation mentioned in new section 78A of the *Medical Indemnity Act 2002* (see item 20 of Schedule 3 to the Bill) is also a prescribed person for the purposes of the evaluation mentioned in section 78A.

The purpose of the provisions is to assist with the monitoring and assessing of medical indemnity legislation and for the conduct of a section 78A evaluation. This is a reasonable, legitimate and necessary objective, as well as proportionate to the objectives it seeks to achieve, as this goes to the effective operation of the relevant legislative schemes.

Items 18 and 29 provide a prescribed list of persons who may disclose protected information in the circumstances specified above and limits the persons to whom that information may be divulged. Prescribing persons who may disclose and receive the protected information for a specified certain purpose goes to the reasonableness and proportionality of the measures.

Additionally, in view of the fact that in accordance with new section 78A (refer to item 20 of Schedule 3 to the Bill) the Minister must table a report of an actuarial evaluation in each House of the Parliament, consideration has been given to how a report of an actuarial evaluation would deal with protected information. Consistent with current public reporting, protected information would not be included in a report unless such information is appropriately de-identified.

Item 19: Subsection 77(5)
This item removes reference to “subsection (3)” in subsection 77(5) within the *Medical Indemnity Act 2002*, and substitutes it with a reference to “subsection (2A), (2B), (3)”.

Item 20: After section 78

This item inserts new section 78A into the *Medical Indemnity Act 2002*, which provides for an actuarial evaluation of the medical indemnity market.

New subsection 78A(1) provides that the Minister for Health must cause to be conducted an actuarial evaluation of the stability of the medical indemnity insurance industry and the affordability of medical indemnity insurance.

New subsection 78A(2) provides that the Minister for Health must cause to be prepared a report of an evaluation under subsection 78A(1).

New subsection 78A(3) provides that the Minister for Health must cause to be tabled the actuarial evaluation report in each House of the Parliament by 28 February 2021.

The intent of these provisions is for an actuarial evaluation on the stability and affordability of Australia's medical indemnity market to be conducted, with the report being tabled before each House of Parliament by 28 February 2021. The evaluation will provide insight as to whether the objectives of the schemes are being achieved, including to better inform the impact of any future changes to the schemes.

Midwife Professional Indemnity (Commonwealth Contribution) Scheme Act 2010

Item 21: Subsection 5(1)

This item inserts new definitions: "***administrative action*** has the meaning given by subsection 76A(4)" and "***Secretary*** means the Secretary of the Department" in subsection 5(1) of the *Midwife Professional Indemnity (Commonwealth Contribution) Scheme Act 2010*.

Item 22: Subsection 48(1)

This item repeals subsection 48(1) of the *Midwife Professional Indemnity (Commonwealth Contribution) Scheme Act 2010*, and substitutes it with a new subsection 48(1). This amendment will streamline the ROCS reporting requirements by enabling information that is currently included in reports from the Minister to Parliament to instead be published as part of the Department of Health's annual report.

Item 23: Subsection 48(2)

This item removes reference to "in relation to a financial year" in subsection 48(2) within the *Midwife Professional Indemnity (Commonwealth Contribution) Scheme Act 2010*.

Item 24: After subsection 48(2)

This item inserts subsection 48(2A) within the *Midwife Professional Indemnity (Commonwealth Contribution) Scheme Act 2010*, to include a requirement that the Secretary must publish the Actuary's report on the run-off cover scheme for midwife professional indemnity on the Department of Health's website within 30 days after receiving the report.

Item 25: At the end of Part 4 of Chapter 2

This item inserts new Division 8 at the end of Part 4 of Chapter 2 of the *Midwife Professional Indemnity (Commonwealth Contribution) Scheme Act 2010,* titled "monitoring", and a new section 71A.

New section 71A allows for rules to be made in relation to the kinds of information that are insurers may be required to provide to the Secretary. New section 71A provides that the rules may require an eligible insurer to provide to the Secretary information about any of the following:

- premium costs for midwife professional indemnity cover provided by contracts of insurance with the insurer;
- the income of eligible midwives for whom contracts of insurance with the insurer provide midwife professional indemnity cover;
- the profitability of the insurer;
- the insurer's reinsurance arrangements and costs.

Item 26: After section 87

This item inserts new section 87A in the *Midwife Professional Indemnity (Commonwealth Contribution) Scheme Act 2010*, allowing the Chief Executive Medicare to arrange for the use of computer programs for any purposes for which the Chief Executive Medicare may or must take administrative action under that Act or a legislative instrument made under that Act. This will enable the processing of midwife professional indemnity claims and payments to be streamlined.

New subsection 87A(2) provides that the computer decision is taken to be a decision of the Chief Executive Medicare. This will ensure the Chief Executive Medicare is accountable for any administrative action taken by the operation of a computer program.

New subsection 87A(3) allows the Chief Executive Medicare to substitute a decision made by the operation of a computer program if the Chief Executive Medicare is satisfied that the initial decision was incorrect. There will be quality assurance processes to ensure that systems are operating correctly. If any decisions are made in error, they will be identified and substituted quickly.

This item also inserts a new definition for "***administrative action***" as meaning any of the following:

- making a decision;
- exercising any power or complying with any obligation;
- doing anything else that relates to making a decision or exercising a power or complying with an obligation.

This item also inserts new section 87B, allowing the Secretary to delegate, in writing, all or any of the functions or powers of the Secretary under the *Midwife Professional*

Indemnity (Commonwealth Contribution) Scheme Act 2010 or a legislative instrument made under that Act to any of the following persons:

- the Chief Executive Medicare; or
- an SES employee, or an acting SES employee, in the Department or the Department administered by the Minister administering the *Human Services (Medicare) Act 1973*.

This provision provides that in performing a delegated function or exercising a delegated power, the delegate must comply with any written directions of the Secretary.

Item 27: Before subsection 88(1)
This item inserts a heading "Definitions" before subsection 88(1) of the *Midwife* Professional *Indemnity (Commonwealth Contribution) Scheme Act 2010*.
Item 28: Before subsection 88(2
This item inserts a heading "Offence" before subsection 88(2) of the *Midwife Professional Indemnity (Commonwealth Contribution) Scheme Act 2010.*

Item 29: After subsection 88(2)
This item inserts a heading and new subsection 88(2A) in the *Midwife Professional Indemnity (Commonwealth Contribution) Scheme Act 2010.* New subsection 88(2A) prescribes persons that may make a copy or record of, or divulge to, any other prescribed person, protected information or a protected document so along as it is "for the purposes of monitoring, assessing or reviewing the operation of the midwife professional indemnity legislation".

This provision ensures that information obtained under or in relation to midwife professional indemnity legislation can be shared between the Secretary, the Chief Executive Medicare, the Australian Government Actuary, the Australian Prudential Authority, the Australian Securities and Investments Commission. Under new subsection 88(2B) a person conducting, or assisting a person to conduct, the evaluation mentioned in new section 78A of the *Medical Indemnity Act 2002* (see item 20 of Schedule 3 to the Bill) is also a prescribed person for the purposes of the evaluation mentioned in section 78A of the *Medical Indemnity Act 2002*.

This provision also notes that a defendant bears an evidential burden in relation to the matters in new subsection 88(2A) and (2B) of the *Midwife Professional Indemnity (Commonwealth Contribution) Scheme Act 2010*, and refers the reader to subsection 13.3(3) of the *Criminal Code.*

Item 30: Subsection 88(4)
This item removes reference to "subsection (3)" in subsection 88(4) of the *Midwife Professional Indemnity (Commonwealth Contribution) Scheme Act 2010*, and substitutes it with a reference to "subsection (2A), (2B) or (3)".

Item 31: Application

This item sets out when the application of the amendments in Schedule 3 commence.

Subitem 31(1) provides that amendments to enable the Chief Executive Medicare to treat an application as having been withdrawn only apply in relation to requests for further information that are made after the commencement of the amendments, irrespective when the relevant applications are made.

Subitem 31(2) provides that amendments to the process for annual reporting on the ROCS will apply in relation to financial years on or after 1 July 2019 (that is, future reporting will be in accordance with the new provisions outlined in the Bill).

Subitem 31(3) provides that amendments to the disclosure of protected information or a protected document will commence at the same time as the amendments to enable sharing take effect (and will relate to information or documents obtained before or after the changes commence).

Schedule 4 – Instruments

Amendments set out in Part 1 of Schedule 4 to the Bill enable the restructure and consolidation of delegated legislation (as identified through the Thematic Review). This reduces the number of separate legislative instruments used for the purpose of regulating the Government's support for medical indemnity.

The items in Part 1 are minor and machinery in nature to enable all matters to be prescribed under the powers in the *Medical Indemnity Act 2002* to be consolidated in new Medical Indemnity Rules or Medical Indemnity Regulations. This will reduce the nine instruments currently made under the *Medical Indemnity Act 2002* to two instruments, ensuring that some matters are appropriately included in regulations (such as, details regarding requests for information by the Chief Executive Medicare, where failure to comply with the request is an offence) and others are set out in Rules.

In addition to amendments to support the restructure and consolidation of legislative instruments, this Part sets out the following changes:

- inserts references to regulations made for the purposes of the new allied health schemes as required;
- removes redundant references (specifically, the references to "short-term bond rate" in section 34ZS of the *Medical Indemnity Act 2002* and section 44 of the *Midwife Professional Indemnity (Commonwealth Contribution) Scheme Act 2010*); and
- creates the power of the Minister to make rules required or permitted by the *Medical Indemnity Act 2002*, or necessary or convenient for carrying out or giving effect to the *Medical Indemnity Act 2002* (noting that item 138 places limits on what the rules can do (for example, the rules cannot create offences or civil penalties, impose taxes or amend the text of the *Medical Indemnity Act 2002*)).

Part 2 of Schedule 4 specifies when the various changes made by Part 1 of Schedule 4 to the Bill will take effect.

Medical Indemnity Act 2002

Item 1: Subsection 4(1) (note to the definition of ***exceptional claims indemnity***)
This item removes reference to "the Exceptional Claims Protocol" in subsection 4(1) of the *Medical Indemnity Act 2002,* and substitutes it with a reference to "regulations made for the purposes of section 34X (exceptional claims payments)". This amendment is consequential to the amendment made by item 81, which replaces the existing power of the Minister to determine an Exceptional Claims Protocol with the power to make regulations relating to matters currently contained in the Exceptional Claims Protocol.

Restructuring the provision in this way will enable all delegated matters made under the *Medical Indemnity Act 2002* to be set out either in new Medical Indemnity Rules or in new Medical Indemnity Regulations.

Item 2: Subsection 4(1) (definition of ***Exceptional Claims Protocol***)
This item repeals the definition of ***Exceptional Claims Protocol*** in subsection 4(1) of the *Medical Indemnity Act 2002.* This amendment is consequential to the amendment made by item 81.

Item 3: Subsection 4(1) (note to the definition of ***high cost claim indemnity***)
This item removes the reference to "High Cost Claims Protocol" within the note to the definition of ***high cost claim indemnity*** in subsection 4(1) within the *Medical Indemnity Act 2002*, and substitutes it with a reference to "regulations made for the purposes of section 34AA (high cost claims payments)". This amendment is consequential to the amendment made by item 62, which replaces the existing power of the Minister to determine a High Cost Claims Protocol with the power to make regulations relating to matters currently contained in the High Cost Claim Protocol.

Restructuring the provision in this way will enable all delegated matters made under the *Medical Indemnity Act 2002* to be set out either in new Medical Indemnity Rules or in new Medical Indemnity Regulations.

Item 4: Subsection 4(1)
This item repeals the definition of ***High Cost Claims Protocol*** and ***IBNR Claims Protocol*** in subsection 4(1) of the *Medical Indemnity Act 2002*. The repeal of the definition of ***High Cost Claims Protocol*** is consequential to the amendment made by item 62. The repeal of the definition of ***IBNR Claims Protocol*** is consequential to the amendment made by item 42, which replaces the existing power of the Minister to determine a High Cost Claims Protocol with the power to make regulations relating to matters currently contained in the High Cost Claim Protocol.

Restructuring the provision in this way will enable all delegated matters made under the *Medical Indemnity Act 2002* to be set out either in new Medical Indemnity Rules or in new Medical Indemnity Regulations.

Item 5: Subsection 4(1) (note to the definition of ***IBNR indemnity***)
This item removes reference to "the IBNR Claims Protocol" in the note to the definition of ***IBNR indemnity*** in subsection 4(1) of the *Medical Indemnity Act 2002,* and substitutes it with a reference to "regulations made for the purposes of section 27A (IBNR claims payments)". This amendment is consequential to the amendment made by item 42.

Item 6: Subsection 4(1) (definition of ***participating MDO***)
This item repeals the definition of ***participating MDO*** within subsection 4(1) in the *Medical Indemnity Act 2002,* and substitutes it with a revised definition of ***participating MDO*** to mean UMP. This amendment makes it clear that there is only one participating MDO, and that references through the legislation to the 'participating MDO' are references to UMP.

Item 7: Subsection 4(1) (definition of ***participating member***)
This item repeals the definition of ***participating member*** in subsection 4(1) of the *Medical Indemnity Act 2002*.

Item 8: Subsection 4(1)
This item inserts a new definition within subsection 4(1) of the *Medical Indemnity Act 2002* for the term ***rules***, which "means the rules made under section 80". This amendment is consequential to the amendment made by item 138.

Item 9: Subsection 4(1) (definition of ***Run-off Cover Claims and Administration Protocol***)
This item repeals the definition of ***Run-off Cover Claims and Administration Protocol*** within subsection 4(1) of the *Medical Indemnity Act 2002*. This amendment is consequential to the amendment made by item 99, which provides for matters relating to run-off claims to be prescribed in the regulations, rather than the former Run-off Cover Claims and Administration Protocol, which replaces the existing power of the Minister to determine a Run-off Cover Claims and Administration Protocol with the power to make regulations relating to matters currently contained in the Run-off Cover Claims and Administration Protocol.

Restructuring the provision in this way will enable all delegated matters made under the *Medical Indemnity Act 2002* to be set out either in new Medical Indemnity Rules or in new Medical Indemnity Regulations.

Item 10: Subsection 4(1) (note to the definition of ***run-off cover indemnity***)
This item removes reference to "the Run off Cover Claims and Administration Protocol" in subsection 4(1) of the *Medical Indemnity Act 2002*, and substitutes it with "regulations made for the purposes of section 34ZN (run-off claim payments)". This amendment is

consequential to the amendment made by item 99, which provides for matters relating to run-off claims to be consolidated in the regulations, rather than specified in a separate Run-off Cover Claims and Administration Protocol.

Item 11: Subsection 4(1)
This item repeals the definition of ***unfunded IBNR exposure*** and ***unfunded IBNR factor*** in subsection 4(1) of the *Medical Indemnity Act 2002*. The repeal of the definition of ***unfunded IBNR exposure*** is consequential to the amendment made by item 18, which repeals the provisions that refer to this term. Regarding the repeal of the definition of ***unfunded IBNR factor***, the term is currently defined by reference to the factor worked out under section 22 of the *Medical Indemnity Act 2002*, which is repealed by item 36 of the Bill.

Item 12: Section 5
This item removes reference to "regulations" in section 5 of the *Medical Indemnity Act 2002* (wherever occurring), and substitutes it with "rules". This amendment allows matters determining whether a body corporate is an ***MDO*** to be specified in rules (see item 138), rather than regulations.

Item 13: Subsection 10(1)
This item removes reference to "an MDO for the incident on 30 June 2002 and the MDO is a participating MDO", and substitutes with "the participating MDO for the incident on 30 June 2002". This amendment is consequential to the amendments made by items 6 and 18.

Item 14: Subsection 10(1A)
This item removes reference to "determination of an IBNR Claims Protocol that can" in subsection 10(1A) of the *Medical Indemnity Act 2002,* and substitutes with a reference to "regulations and rules to". This amendment is consequential to the amendments to Division 1 of Part 2 of the *Medical Indemnity Act 2002*, which enable matters relating to IBNR claims to be consolidated in the new rules and regulations, rather than specified in a separate IBNR Claims Protocol.

Item 15: Subsection 10(2) (table item 1)
This item repeals the item and substitutes new table item 1, which, in relation to the question, "which MDO is the participating MDO?", refers readers of the guide to the IBNR indemnity provisions to the definition of ***participating MDO*** in subsection 4(1).

Item 16: Subsection 10(2) (table item 5, column headed "Provisions")
This item removes reference to "sections 21 to 23" in subsection 10(2) of the *Medical Indemnity Act 2002*, and substitutes it with a reference to "section 21". This amendment is consequential to the amendment made by item 36, which repeals sections 22 and 23 of the *Medical Indemnity Act 2002*.

Item 17: Subsection 10(2) (table item 6A)

This item repeals table item 6A in subsection 10(2) of the *Medical Indemnity Act*, and substitutes it with “6A” (in column headed “Item”), “what regulations can deal with section” (in column headed “Issue”), and “section 27A” (in column headed “Provisions”). This amendment is consequential to the amendment made by item 42.

Item 18: Subdivision B of Division 1 of Part 2

This item repeals Subdivision B of Division 1 of Part 2 of the *Medical Indemnity Act 2002*. The subdivision is being repealed because there is only one participating MDO and changes to the definition of ***participating MDO*** will reflect that the one participating MDO means UMP (see also item 6).

This amendment will enable the repeal of the *Medical Indemnity (Non-participating MDOs) Determination 2003*, which is currently made under section 12 of the *Medical Indemnity Act 2002* for the purposes of determining MDOs that are not participating MDOs. Repealing Subdivision B of Division 1 of Part 2 of the *Medical Indemnity Act 2002* and defining ***participating MDO*** to specify that UMP is the participating MDO makes the law clearer.

Items 19; 20; 21; 22; 23; 24; 25; 26; 27; 28; 29; 30; 31:

These items make various amendments to Paragraph 14(e); Paragraph 16(1)(c); Subsection 16(1) Subsection 16(4) (heading); Subsection 16(4); Subsection 16(5) (heading); Paragraph 17(1)(c); Subsection 17(1); Subsection 17(4) (heading); Subsection 17(4); Subsection 17(5) (heading); and Subsections 17(5) and (6) to reflect that there is only one participating MDO. The amendments are consequential to the amendments made by items 6 and 18.

Item 32: Paragraph 19(d)

This item removes reference to “prescribed by the regulations” in paragraph 19(d) of the *Medical Indemnity Act*, and substitutes it with a reference to “specified in the rules”. This provision allows for IBNR indemnity payment exceptions to be included in rules, rather than regulations.

Item 33: Subsection 21(1)

This item repeals subsection 21(1) of the *Medical Indemnity Act 2002*, and substitutes it with a new subsection 21(1). This provision sets out that the amount of the IBNR indemnity is the adjusted amount of the payment determined in accordance with subsection 21(2) of the *Medical Indemnity Act 2002.* This provision also provides a note that in certain circumstances, an amount may be repayable under section 24 of the *Medical Indemnity Act 2002.*

The formula previously applied by subsection 21(1) is no longer required because there is only one participating MDO (see items 6 and 18). The provision has been simplified to describe the way the adjusted amount of the payment is determined, which in turn informs the amount of the IBNR indemnity.

Item 34: Subsection 21(2)

This item removes reference to “***adjusted amount of the payment***” in subsection 21(2) of the *Medical Indemnity Act 2002*, and substitutes it with “adjusted amount of the

payment”. This amendment is consequential to the amendment made by item 33 - adjustment amount of the payment is no longer a defined term.

Item 35: Paragraphs 21(3)(c) and 4(d)
This item removes reference to “prescribed by the regulations” in paragraphs 21(3)(c) and 4(d) of the *Medical Indemnity Act 2002*, and substitutes it with a reference to “specified in the rules”. This provision allows for the specified matters relating to the amount of the IBNR indemnity to be included in rules, rather than regulations.

Item 36: Sections 22 and 23
This item repeals sections 22 and 23 of the *Medical Indemnity Act 2002*, which enabled the Minister to determine the unfunded IBNR factor for a participating MDO. As there is only one participating MDO and section 21 has been amended to define the amount of the IBNR indemnity, there is no longer any need for sections 22 and 23. These changes do not impact the current IBNR factors or indemnity amounts.

Item 37: Subsection 24(2)
This item removes reference to “the amount obtained by applying the relevant participating MDO’s unfunded IBNR factor to” in subsection 24(2) of the *Medical Indemnity Act 2002*. This amendment is consequential to the amendment made by item 36.

Item 38: Subsection 24(3)
This item repeals subsection 24(3) of the *Medical Indemnity Act 2002*. This amendment is consequential to the amendments made by items 6 and 18.

Item 39: Paragraph 27(2)(a)
This item removes reference to “prescribed rate” in subsection 27(2)(a) of the *Medical Indemnity Act 2002*, and substitutes it with a reference to “rate specified in the rules”. This provision allows the rate to be included in rules, rather than regulations.

Item 42: Subsection 27A(1)
This item repeals subsection 27A(1) of the *Medical Indemnity Act 2002*, and substitutes it with a new subsection 27A(1). This provision sets out that regulations may provide in relation to:

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

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

This provides for matters relating to IBNR claims to be consolidated in the regulations, rather than specified in a separate IBNR Claims Protocol determined by the Minister for Health in the form of a legislative instrument.

Items 40; 41; 43; 44; 45; 46; 47
These items make various amendments to Subdivision F of Division 1 of Part 2 (heading); section 27A (heading); subsection 27A(2); subsection 27A(2)(b); subsection 27A(3); subsection 27A(4) and paragraphs 27B(1)(a) and (b). The amendments are consequential to the amendment made by item 42.

Item 50: Subsection 28(2) (table item 8, column headed "Provisions")
This item removes reference to "sections 39 and 40" in subsection 28(2) (table item 8, column headed "Provisions") of the *Medical Indemnity Act 2002*, and substitutes it with a reference to "section 39". This amendment is consequential to the amendments made by item 116.

Item 62: Subsection 34AA(1)
This item repeals subsection 34AA(1) of the *Medical Indemnity Act 2002*, and substitutes it with a new subsection 34AA(1). This provision sets out that regulations may provide in relation to:

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

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

This amendment provides for matters relating to the High Cost Claims to be consolidated in the regulations, rather than specified in a separate High Cost Claims Protocol.

Items 48; 49; 51; 52; 53; 54; 55; 56; 57; 58; 59; 60; 61; 63; 64; 65; 66; 67
These items make various amendments to subsection 28(1A); subsection 28(2) (table item 4A); paragraph 29(1)(b); subsection 29(2); subparagraph 30(1)(d)(ii); paragraph 30(1)(g); subsection 30(1A); subsection 30(3); paragraph 32(b); paragraph 32(c); paragraph 34 (1)(b); subsection 34(2); subdivision C of Division 2 of Part2 (heading); section 34AA (heading); subsection 34AA(2); paragraph 34AA(2)(b); subsection 34AA(5); paragraphs 34AB(1)(a) and (b). The amendments are consequential to the amendment made by item 62.

Item 68: Subsection 34A(2)
This item removes a reference to "determination of an Exceptional Claims Protocol that can" in subsection 34A(2) of the *Medical Indemnity Act 2002* and inserts a reference to "regulations and rules to". This amendment is consequential to the amendment made by item 81 and other amendments made by this Schedule that allow certain matters relating

to the Exception Claims scheme to be specified in the rules (see for example items 70; 71 and 72).

Item 70: Paragraphs 34E(1)(c)
This item removes reference to "regulations" in paragraph 34E(1)(c) of the *Medical Indemnity Act 2002*, and substitutes it with a reference to "rules". This amendment allows circumstances in which an incident occurring outside of Australia and an external Territory may be certified as part of a qualifying claim to be specified in the rules, rather than regulations.
Item 71: Paragraphs 34E(1)(h) and (i)
This item removes reference to "of a class specified in regulations", and substitutes with "specified in rules". This amendment allows claims that cannot be certified as a part of a qualifying claim to be specified in the rules, rather than the regulations. The claims that may be specified in the rules include individual claims and classes of claims (see subsection 13(3) of the *Legislation Act 2003*).

Item 72: Paragraph 34F(1)(b)
This item removes reference to "regulations" in paragraph 34F(1)(b) of the *Medical Indemnity Act 2002*, and substitutes it with a reference to "rules". This is a consequential amendment. This amendment allows the relevant threshold to be specified in the rules, rather than regulations.

Item 73: Paragraph 34F(2) to (4)
This item repeals subsections 34F(2) to (4) of the *Medical Indemnity Act 2002*, and substitutes it with new subsections 34F(2) to (4). This amendment is consequential to the amendments made by item 72.

Item 74: Subsection 34G(1)
This item removes reference to "regulations" in subsection 34G(1) of the *Medical Indemnity Act 2002*, and substitutes it with a reference to "rules". This amendment allows the termination date for the exceptional claims indemnity scheme to be specified in the rules, rather than the regulations.

Item 75: Subsection 34G(2)
This item removes reference to "earlier than 1 January 2006, and cannot be before the date on which the regulations are entered" in subsection 34G(2) of the *Medical Indemnity Act 2002*, and substitutes it with a reference to "before the date on which the rules are registered". This amendment is consequential to the amendment made by item 74.

Item 76: Subparagraph 34J(1)(c)(ii)
This item removes reference to "the Exceptional Claims Protocol" in subsection 34J(1)(c)(ii) of the *Medical Indemnity Act 2002* and replaces it with a reference to "regulations made for the purposes of section 34X (exceptional claims payments)". This amendment is consequential to the amendment made by items 79 to 81.

Item 77: Paragraph 34K(2)(a)

This item substitutes the reference to "regulations" in subsection 34K(2)(a) of the *Medical Indemnity Act 2002*, with "rules". This amendment is consequential to the amendments made by item 71.

Item 78: Paragraphs 34S(2)(c), 34T(5)(c) and 34W(2)(a)
This item removes reference to "regulations", and substitutes with "rules". This amendment allows exceptions to section 34S(1) and amounts paid exempted from the operation of section 34T to be specified in the rules, rather than the regulations.
Item 81: Subsection 34X(1)
This item repeals subsection 34X(1) of the *Medical Indemnity Act* 2002, and substitutes it with a new subsection 34X(1). This provision provides that the regulations may provide in relation to making payments to insurers of claim handling fees, and payments on account of legal, administrative or other costs incurred by insurers (whether on their own behalf or otherwise), in respect of claims in relation to which qualifying claim certificates have been issued.

This amendment provides for matters relating to the Exceptional Claims to be consolidated in the regulations, rather than specified in a separate Exceptional Claims Protocol.

Items 69; 72; 76; 79; 80; 82; 83; 84; 85; and 86
These items make various amendments to subsection 34A(3) (table item 8); subsection 34G(1); subparagraph 34J(1)(c)(ii); subdivision E of Division 2A of Part (heading); section 34X (heading); subsection 34X(2); subsection 34X(2)(b); subsection 34X(3); subsection 34X(4); and paragraphs 34Y(1)(a) and (b). These amendments are consequential to the amendment made by item 81.

Item 87: Subsection 34Z(1) (note)
This item removes reference to "regulations to exclude classes of claims and classes of" in subsection 34Z(1)(note) of the *Medical Indemnity Act 2002*, and substitutes with "rules to exclude claims and". This amendment is consequential to the amendment made by item 71.

Item 90: Paragraph 34ZB(2)(f)
This provision removes reference to "regulations" in subsection 34ZB(2)(f) of the *Medical Indemnity Act 2002*, and substitutes it with a reference to "rules". This amendment allows persons against whom a claim can be an *eligible run-off claim* to be specified in the rules, rather than regulations.

Item 91: Subsection 34ZB(2)
This provision removes reference to "if the person is included in a class of persons that the regulations" in subsection 34ZB(2) of the *Medical Indemnity Act 2002*, and substitutes it with a reference to "if the person is included in a class of persons that the rules". This amendment allows persons against whom a claim cannot be an *eligible run-off claim* to be specified in the rules, rather than regulations.

Item 92: Subsection 34ZB(3)
This item removes reference to "regulations" in subsection 34ZB(3) of the *Medical Indemnity Act 2002*, and substitutes it with a reference to "rules". This amendment allows the termination date for the run-off cover indemnity scheme to be specified in the rules, rather than regulations.

Item 93: Subsection 34ZB(4)
This item removes reference to "regulations in question are entered" in subsection 34ZB(4) of the *Medical Indemnity Act 2002*, and substitutes it with a reference to "rules in question are registered". This amendment is consequential to the amendment made by item 92.

Item 94: Paragraph 34ZB(4A)(d)
This item removes references to "regulations" in subsection 34ZB(4A)(d) of the *Medical Indemnity Act 2002*, and substitutes it with a reference to rules. This is a consequential amendment. Consistent with items 90-92 details that were used to be specified in the regulations, are now to be specified in the rules.

Item 95: Paragraph 34ZG(b)
This item removes reference to "prescribed by the regulations" in subsection 34ZG(b) of the *Medical Indemnity Act 2002*, and substitutes it with a reference to "specified in the rules". This amendment allows exceptions to payments that can be covered by a run-off cover indemnity to be specified in the rules, rather than regulations.

Item 96: Paragraphs 34ZI(2)(d), 34ZJ(5)(d) and 34ZM(2)(a)
This item removes reference to "regulations", and substitutes with "rules". This amendment allows certain amounts that can be excluded from the calculation of the amount of a run-off cover indemnity to be specified in the rules, rather than regulations. The amounts that may be specified in the rules include individual amounts and classes of amounts (see subsection 13(3) of the *Legislation Act 2003*).

Item 99: Subsection 34ZN(1)
This item repeals subsection 34ZN(1) of the *Medical Indemnity Act* 2002, and substitutes it with a new subsection 34ZN(1). This provision provides regulations may provide in relation to:

- making payments to MDOs and medical indemnity insurers of claim handling fees in respect of eligible run-off claims; and
- making payments on account of legal, administrative or other costs incurred by MDOs and medical indemnity insurers (whether on their own behalf or otherwise) in respect of eligible run-off claims; and
- making payments on account of legal, administrative or other costs incurred by medical indemnity insurers (whether on their own behalf or otherwise) in respect of complying with Division 2A of Part 3 of the *Medical Indemnity (Prudential Supervision and Product Standards) Act 2003*.

This amendment provides for matters relating to the Run-off Cover Claims and Administration to be consolidated in the regulations, rather than specified in a separate Run-off Cover Claims and Administration.

Items 88; 89; 97; 98; 100; 101; 102; 103; 104; 111
These items amend subsection 34ZA(2); subsection 34ZA(3) (table item 5); subdivision D of Division 2B of Part 2 (heading); section 34ZN (heading); subsection 34ZN(2); paragraph 34ZN(2)(b); subsection 34ZN(3); subsection 34ZN(4); paragraphs 34ZO(1)(a) and (b); and paragraph 34ZW(2)(b). These amendments are consequential to the amendment made by item 99.

Item 105: Paragraph 34ZP(2)(a)
This item removes reference to "the Minister, by legislative instrument, determines" in subsection 34ZP(2)(a) of the *Medical Indemnity Act 2002*, and substitutes it with a reference to "the rules provide". This amendment provides for alternative arrangements after termination of the run-off cover indemnity scheme to be specified in the rules, rather than in a separate determination.

Item 106: Paragraph 34ZP(2)(b)
This item removes reference to "determination is made" in subsection 34ZP(2)(b) of the *Medical Indemnity Act 2002*, and substitutes it with a reference "rules made for the purposes of paragraph (a) commence". This amendment is consequential to the amendment made by item 105.

Item 107: Subsection 34ZS(4) (definition of ***applicable interest rate***)
This item repeals the definition of ***applicable interest rate*** in subsection 34ZS(4) of the *Medical Indemnity Act 2002*, and substitutes it with a new definition. This amendment allows the ***applicable interest rate*** to be specified in the rules, rather than regulations. The new definition no longer provides for the ***short-term bond rate*** to apply if no rate is specified.

Items 108 and 109
These items amend subsection 34ZS(4) (definition of ***June quarter***) and subsection 34ZS(4) (definition of ***short-term bond rate***) to repeal these definitions. The amendments are consequential to the amendment made by item 107.

Item 110: Subparagraph 34ZU(2)(c)(ii)
This item removes reference to "as the Minister determines by legislative instrument" in subsection 34ZU(2)(c)(ii) of the *Medical Indemnity Act 2002*, and substitutes it with a reference to "specified in the rules". This amendment allows the notification period for cessation of run-off cover for a person to be extended if specified in the rules, rather than a separate determination.

Item 112: Subsection 36(1)
This item removes reference to "(1)" in subsection 36(1) of the *Medical Indemnity Act 2002*. This amendment is consequential to the amendment made by item 113.

Item 113: Subsections 36(2) and (3)
This item repeals subsections 36(2) and (3) within the *Medical Indemnity Act 2002.* These amendments are consequential to the amendments made by Item 36, and items 6, 18, 20 and 26.

Item 114: Subsection 39(1)
This item removes reference to "the IBNR Claims Protocol, the High Cost Claims Protocol, the Exceptional Claims Protocol or the Run off Cover Claims and Administration Protocol" in subsection 39(1) of the *Medical Indemnity Act 2002*, and substitutes it with a reference to "regulations made for the purposes of section 27A (IBNR claims payments), 34AA (high cost claims payments), 34X (exceptional claims payments), 34ZN (run off claims payments), 34ZZF (allied health high cost claims payments) or 34ZZZC (allied health exceptional claims payments)". These amendments are consequential to the amendments made by items 42, 62, 81 and 99 of this Schedule, and item 26 of Schedule 6.

Item 115: Paragraphs 39(1)(d) and (1A)(b)
This item removes reference to "determined by the Chief Executive Medicare" in paragraphs 39(1)(d) and (1A)(b) of the *Medical Indemnity Act 2002*, and substitutes it with a reference to "specified in the rules". This amendment allows other records that must be kept by applicants for indemnity scheme payments to be specified in the rules, rather than a determination by the Chief Executive Medicare.

Item 116: Subsections 39(2) to (4)
This item repeals subsections 39(2) to (4) of the *Medical Indemnity Act 2002*, and substitutes with new subsections 39(2) and (3).

New subsection 39(2) provides that records must be retained by a person who applies for payment for a period of 5 years (or any other period specified in the rules) starting on the day on which the records were created. A failure to retain the records is an offence (see section 47 of the *Medical Indemnity ACT 2002*). This amendment does not change the former record retention period of 5 years from creation, however a different period may now be specified in the rules, rather than regulations. Old paragraph 39(2)(b) is no longer required because more than 5 years has passed since the days specified at subparagraphs 39(2)(b)(i)-(v) occurred.

New subsection 39(3) provides that Rules made for the purposes of paragraph 39(1)(d) or 39(1A)(b) must not commence earlier than 14 days after the day on which the rules are registered on the Federal Register of Legislation. This amendment is consequential to the amendments made by item 115.

Items 119; 120; and 121
These items make various amendments to subsection 40(1); Paragraphs 40(1)(a) to (d); and Paragraph 40(1)(e).

The amendments retain the existing obligation for the participating MDO to keep the additional records relevant to determining its IBNR exposure, and now also places the same obligation on insurers that apply for an IBNR indemnity. The requirements for the participating MDO to keep records relevant to determining its participating members, its IBNR exposure as at 30 June 2002 and its unfunded IBNR factor are no longer required and have been removed.

The amendments also require an insurer or MDO that applies for an IBNR indemnity to keep any additional records that are specified in the rules.

Items 117; 118
These items make various amendments to Section 40 (heading) and Subsection 40(1) (heading). The amendments are consequential to the amendment made by items 119, 120, and 121.

Item 122: Subsections 40(2) to (4)
This item repeals subsections 40(2) to (4) of the *Medical Indemnity Act 2002*, and substitutes with new subsections 40(2) and (3).

Records to be retained for certain period
New subsection 40(2) provides that the records must be retained for a period of 5 years (or any other period specified in the rules) starting on the day on which the records were created. A failure to retain the records is an offence (see section 47 of the *Medical Indemnity Act 2002*). This amendment does not change the former record retention period of 5 years from creation, however a different period may now be specified in the rules, rather than regulations. Old paragraph 40(2)(b) is no longer required because more than 5 years has passed since the Act commenced.

Rules regarding additional matters
New subsection 40(3) provides that rules made for the purposes of paragraph 40(1)(e) must not commence earlier than 14 days after the day on which the rules are registered on the Federal Register of Legislation. This amendment is consequential to the amendment made by item 121.

Item 124: Subsection 43(1)
This item repeals subsection 43(1) of the *Medical Indemnity Act 2002*, and substitutes it with a new subsection 43(1). This amendment allows for the PSS arrangements to be consolidated in the regulations, rather than being provided for under a separate legislative instrument made by the Minister and related contractual arrangements, as is currently in place.

Item 123; 128; 131
These items make various amendments to Section 43 (heading); Paragraphs 44(1)(a) and (b); Paragraph 48(c). The amendments made by these items are consequential to the amendment made by item 124.
Items 125 and 127

These items amend various references to “medical indemnity providers” in subparagraphs 43(1)(a)(ii) and (aa)(ii); subsection 43(5) and, where relevant, substitute those references with “medical indemnity insurers”.

The term “medical indemnity provider” is no longer relevant because only medical indemnity insurers can provide medical indemnity cover (see section 10 of the *Medical Indemnity (Prudential Supervision and Product Standards) Act 2003*).

<u>Item 115: Paragraph 43(1)(aa)</u>
This item removes reference to “medical indemnity payments” in paragraph 43(1)(aa) of the *Medical Indemnity Act 2002*, and substitutes it with a reference to “run-off cover support payments”. This amendment is consequential to items 1 and 2 of Part 1 of Schedule 1 to this Bill, which repeal the *Medical Indemnity (Competitive Advantage Payment) Act 2005* and the *Medical Indemnity (UMP Support Payment) Act 2002*. The term "medical indemnity payment" is no longer required because only run-off cover support payment remains payable.

<u>Item 125; 126: Paragraphs 43(2)(d) and (e)</u>
This item repeals paragraphs 43(2)(d) and (e) of the *Medical Indemnity Act 2002*, and substitutes it with new paragraphs 43(2)(d) and (e).

The purpose of this amendment is to incorporate Premium Support Scheme arrangements into the primary and delegated legislation.
New paragraph 43(2)(e) removes reference to the contracts within the *Medical Indemnity Act 2002.*

New paragraph 43(2)(d) ensures that consistent reference to “medical indemnity insurers” is used throughout the legislation and removes redundant references to “medical indemnity providers” (see items 125 and 127).

<u>Item 129: Paragraphs 48(aa), (baa) and (bb)</u>
This item repeals paragraphs 48(aa), (baa) and (bb) of the *Medical Indemnity Act 2002*. These provisions provide that the Consolidated Revenue Fund is appropriated for the purposes of amounts payable under the IBNR Claims Protocol, amounts payable under the High Cost Claims Protocol, and amounts payable under the Exceptional Claims Protocol (respectively). This amendment is consequential to items 42, 62 and 81, which provide for the IBNR Claims, High Cost Claims and Exceptional Claims schemes to be specified under the regulations, rather than individual protocols.

<u>Item 130: Paragraph 48(bd)</u>
This item repeals paragraph 48(bd) of the *Medical Indemnity Act 2002*, and substitutes it with new paragraphs 48(bd), (be) and (bf).

The purpose of this amendment is to expand the scope for which the Consolidated Revenue Fund is appropriated for to include allied health related claims (see Schedule 6), and as a consequential amendment to items 42, 62 and 81, which provide for the IBNR

Claims, High Cost Claims and Exceptional Claims schemes to be specified under the regulations, rather than individual protocols.

Item 132: Subsection 59(1)
This item removes a reference to “regulations” (wherever occurring) in subsection 59(1) of the *Medical Indemnity Act 2002*, and substitutes it with a reference to “rules”. This amendment allows exemptions from run-over cover support payment to be specified in the rules, rather than regulations.

Item 133: Subsection 59(2)
This item removes reference to “Regulations” in subsection 59(2) of the *Medical Indemnity Act 2002*, and substitutes it with a reference to “Rules”. This amendment is consequential to the amendment made by item 132.

Item 134: Paragraph 65(2)(a)
This item removes reference to “prescribed rate” in paragraph 65(2)(a) of the *Medical Indemnity Act 2002*, and substitutes it with a reference to “rate specified in the rules”. This amendment allows matters relating to late payment penalties to be set out in the rules, rather than regulations.

Item 135: Subsection 66(4)
This item removes reference to “regulations” in subsection 66(4) within the *Medical Indemnity Act 2002*, and substitutes it with a reference to “rate specified in the rules”. This amendment allows methods for paying run-off cover support payments to be specified in the rules, rather than regulations (see also item 37 of Part 2 of Schedule 1).
Items 136 and 137: Paragraph 77(4)(a) and (b)
Item 136 removes reference to “a prescribed authority or person” in paragraph 77(4)(a) of the *Medical Indemnity Act 2002*, and substitutes it with a reference to “specified in rules made”.

Item 137 removes a reference to “regulations” in paragraph 77(4)(b) of the *Medical Indemnity Act 2002*, and substitutes it with a reference to “rules”.

These amendments allow the persons to whom, the Secretary or Chief Executive of Medicare may divulge protected information, and the kinds of protected information that may be divulged, to be set out in the rules, rather than regulations.

Item 138: At the end of Part 4
This item inserts a new section 80 at the end of the *Medical Indemnity Act 2002* providing the Minister power to make rules prescribing matters under the Act.

This section provides that the rules may not create an offence or civil penalty; provide powers of arrest or detention or entry, search or seizure; impose a tax; set an amount to be appropriated from the Consolidated Revenue Fund; or directly amend the text of the *Medical Indemnity Act 2002.* This section also provides that, if the rules are inconsistent with the regulations, the rules will have no effect to the extent of that inconsistency.

Medical Indemnity (Prudential Supervision and Product Standards) Act 2003
Item 139: Division 1 of Part 2 (heading)
This item repeals the heading of Division 1 of Part 2 of the *Medical Indemnity (Prudential Supervision and Product Standards) Act 2003*. This amendment is consequential to the amendment made by item 140.

Item 140: Division 2 of Part 2
This item repeals Division 2 of Part 2 of the *Medical Indemnity (Prudential Supervision and Product Standards) Act 2003*. This Division provides transitional arrangements that allowed MDOs to be exempt from minimum capital requirements between 1 July 2003 and 30 June 2008. This Division is no longer required because the transition period has passed.

Item 141: Paragraph 26A(4)(d)
This item repeals paragraph 26A(4)(d) of the *Medical Indemnity (Prudential Supervision and Product Standards) Act 2003*, and substitutes it with a new paragraph 26A(4)(d).

Subsection 26A(4) sets out the requirements for medical indemnity cover in relation to the provision of run-off cover to certain medical practitioners.

New paragraph 26A(4)(d) provides that medical indemnity cover meets the requirements of this subsection if it is provided on the terms and conditions on which the last medical indemnity cover provided for the practitioner was provided, to the extent they are relevant to the provision of medical indemnity cover.

Item 142: Subsection 26D(4) (note)
This item corrects the reference to "26A(d)" in subsection 26D(4)(note) of the *Medical Indemnity (Prudential Supervision and Product Standards) Act 2003*, by removing and substituting it with a reference to "26A(4)(e)".

Medical Indemnity (Run off Cover Support Payment) Act 2004
Item 143: Subparagraph 7(1)(a)(i)
This item removes reference to "formulated" in subparagraph 7(1)(a)(i) of the Medical *Indemnity (Run off Cover Support Payment) Act 2004.* This amendment is for consistency with amendments to the *Medical Indemnity Act 2002* made by this schedule to remove other uses of "formulated" within the medical indemnity legislation (see for example items 128 and 131).

Midwife Professional Indemnity (Commonwealth Contribution) Scheme Act 2010
Item 144: Subsection 5(1)
This item inserts the definition of ***Rules*** as meaning the rules made under section 90 of the *Midwife Professional Indemnity (Commonwealth Contribution) Scheme Act 2010* in subsection 5(1).

Item 145: Subsection 44(4) (definition of ***applicable interest rate***)
This item repeals the definition of ***applicable interest rate*** in subsection 44(4) of the *Midwife Professional Indemnity (Commonwealth Contribution) Scheme Act 2010*, and substitutes it with a new definition. The new definition provides that an a*pplicable interest rate* is the rate of interest, for the financial year, specified in the rules for the purposes of this subsection. The new definition no longer provides for the ***short-term bond rate*** to apply if no rate is specified.

Item 136 and 147
These items amend Subsection 44(4) (definition of ***June quarter***) and Subsection 44(4) (definition of ***short-term bond rate***) to repeal the definitions. These amendments are consequential to the amendment made by item 145.

Part 2 – Application and transitional

Items 148: IBNR indemnity scheme
This item specifies how changes to the IBNR indemnity scheme apply.

Subitem 148(1) provides that changes to the definition of "participating MDO" and most other changes to the IBNR indemnity scheme (see exceptions below) apply in relation to any applications made after the commencement.

Subitem 148(2) provides that changes to section 24 of the *Medical Indemnity Act 2002* apply in relation to any amount to be repaid after the commencement (regardless of when the amount to be repaid was paid to the insurer).
Subitem 148(3) provides that if an amount due to be repaid under section 24 before commencement is repaid late (that is, on or after the commencement of this item), the late payment penalty imposed under the unamended section 27 and the regulation in force prior to the commencement of the amendments apply.

Subitem 148(4) provides that section 27B continues to apply as it was in force immediately prior to commencement, in respect of requests for information made by the Chief Executive Medicare under that section (regarding payments made or payable under the IBNR Protocol).

Item 149: Exceptional claims indemnity scheme
This item specifies how changes to the exceptional claims scheme apply.

Subitem 149(1) provides that amendments to sections 34E (certification of qualifying claims) and 34F (the relevant threshold) of the *Medical Indemnity Act 2002* apply to a qualifying claims certificate where the application for that certificate is made after commencement. This means that any rules made for the purposes of sections 34E or 34F will only apply to applications for certificates made after commencement.

Subitem 149(2) provides that amendments to sections 34J (obligation to notify the Chief Executive Medicare if information provided in connection with an application for a

certificate is incorrect or incomplete) and 34K (revocation or variation of qualifying claim certificates) apply in relation to any qualifying claim certificate regardless of when the certificate was issued.

Item 150: Run-off cover indemnity scheme

This item specifies how changes to the run-off cover scheme provisions for the purposes of consolidating instruments apply.

Subitem 150(1) provides that changes to subsection 34ZB(2) (to specify certain matters relating to the run-off cover indemnity scheme in the rules, rather than regulations) apply only to claims madeafter commencement of this item. Any existing regulations made for the purposes of subsection 34ZB(2) will continue to apply to claims made before commencement. The changes to subsection 34ZB(2) will also only apply to any requirement to provide medical indemnity cover under Division 2A of Part 3 of the *Medical Indemnity (Prudential Supervision and Product Standards) Act 2003* after commencement of this item.

Subitem 150(2) provides that any penalty imposed, where an amount that was due to be repaid under subsection 43ZJ(3) before commencement is repaid late, will continue to apply as if changes to section 34ZM of the *Medical Indemnity Act 2002* had not been made (that is, the late penalty amount will be in accordance with the rate specified in the existing regulations).

Subitem 150(3) provides that section 34ZO as it was in force immediately prior to commencement continues to apply to requests for information made by the Chief Executive Medicare under section 34ZO (regarding payments made or payable under the Run-off Cover Claims and Administration Protocol) made before commencement.
Subitem 150(4) provides that changes to section 34ZS (the calculation of total run-off cover credits in the instance the run-off cover scheme is terminated) apply in relation to any financial year (that is, financial years before and after the change to section 34ZS).

Subitem 140(5) provides that changes to section 34ZW (to specify matters relating to what must be contained in the annual run-off cover scheme report in the rules, rather than regulations) apply to financial years commencing on or after 1 July 2020.

Item 151: Administration of the indemnity schemes

This item sets out how the application of changes relating to the administration of the indemnity scheme will work.

Subitem 151(1) provides that records required to be retained by sections 39 and 40 of the *Medical Indemnity Act 2002* prior to the commencement of amendments to those sections, continue to be subject to the requirements of those sections as in force immediately before commencement.
Subitem 151(2) provides section 48 of the *Medical Indemnity Act 2002* (appropriation) continues to apply in relation to any amount payable (before or after commencement)

under the IBNR Claims Protocol, the ROC Claims and Administration Protocol and the Premium Support Scheme.

Subitems 151(3) and (4) provide that the late payment penalty provisions under section 65 of the *Medical Indemnity Act 2002* and the method for making repayments provisions under section 66 will continue to apply in respect of any medical indemnity payment or late payment penalty due and payable before the commencement of the amendments to sections 65 and 66.

Item 152: Midwife professional indemnity
This item provides for the changes to section 44 of the *Midwife Professional Indemnity (Commonwealth Contribution) Scheme Act 2010* (the calculation of total run-off cover credits in the instance the run-off cover scheme is terminated) apply to any financial year (that is, financial years before and after the change to section 44 commence).

Item 153: Rules
This item enables the Minister to make rules in relation to matters of a transitional nature that relate to the amendments or repeals to be made by this Bill, or the repeal any instruments made under the *Medical Indemnity Act 2002* on commencement.

The rules may modify the medical indemnity legislation for the first 12 months after commencement, for transitioning between the existing law and the law following the commencement of the amendments. However, the rules may not do the things described in subitem 153(2) (for example, create offences or impose taxes). Subitem 153(4) authorises the making of rules that have retrospective applications.

Rules made under this provision legislative instruments, are required to be tabled in the Parliament and are subject to disallowance.

Schedule 5 – Universal cover

Schedule 5 to the Bill inserts a new Part 2A in the *Medical Indemnity Act 2002*. Part 2A sets out the universal cover obligation and the risk surcharge requirements. Schedule 5 implements changes announced in 2018-19 MYEFO by providing for universal cover in the *Medical Indemnity Act 2002* as a result of discontinuing the current approach to Premium Support Scheme (PSS) contracts (which currently provide for universal cover in respect of the four medical indemnity insurers with whom the Commonwealth contracts for the purposes of the PSS).

These amendments address the four main issues with universal cover identified through the First Principles Review of the Indemnity Insurance Fund, including that: currently only medical indemnity insurers that have entered into a PSS contract are bound by universal cover requirements; that the universal cover obligations are currently not evenly distributed between the contracted insurers; there are currently limited market-based mechanisms to constrain the practice of medical practitioners with a high claims history based on inappropriate practice; and that the real cost of insurance is not fully borne by

the person generating the risk (as would be the case under normal market conditions), the cost is instead spread across all medical practitioners through cross subsidisation.

The universal cover obligation requires that all medical indemnity insurers must offer professional indemnity cover to any medical practitioner who seeks it. It will also provide that medical indemnity insurers must not refuse a medical practitioner professional indemnity cover except in circumstances prescribed by law.

If a medical indemnity insurer refuses to offer or renew professional indemnity cover, or makes an offer that includes a risk surcharge, the medical indemnity insurer must, at the time of notifying the medical practitioner of the refusal or the application of a risk surcharge, also inform the medical practitioner of his or her right to refer the dispute to the Australian Financial Complaints Authority (AFCA).

AFCA's jurisdiction to consider a complaint about matters covered by this Part is set out in the AFCA Complaint Resolution Scheme Rules. This Part also deals with the provision of interim medical indemnity cover while AFCA is dealing with a complaint.

The underlying policy premise of universal cover is:

- adverse events occur in medical practice (regardless of the competency of the practitioner);
- not only do medical practitioners rely on professional indemnity insurance to meet the costs of adverse events, it is also a mandatory requirement under the *Health Practitioner Regulation National Law Act 2009* (National Law) for registered medical practitioners to have professional indemnity cover; and
- if a medical practitioner were to be denied cover (on the basis of their claims history/performance/adverse events) this would prevent them from privately practicing.

Requirements relating to universal cover and the risk surcharge have been included in the *Medical Indemnity Act 2002*. Additional requirements can be prescribed in the rules and will be subject to Parliamentary scrutiny.

Medical Indemnity Act 2002
Item 1: After subsection 3(3)
This item inserts a new object of the *Medical Indemnity Act 2002* and the medical indemnity payment legislation, relating to the universal cover obligations, in new subsection 3(3A).

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

Item 2: Subsection 4(1)

This item inserts the following definitions in subsection 4(1) of the *Medical Indemnity Act 2002*: ***AFCA***, ***Health Practitioner Regulation National Law***, ***private medical practice***, ***Professional indemnity cover***, and ***risk surcharge***.

These definitions are included for the purposes of integrating universal cover into the *Medical Indemnity Act 2002*. Where possible, definitions to be inserted are consistent with terms used in other Commonwealth legislation (for example, the *Corporations Act 2001*).

The definition of ***professional indemnity cover*** is used only for the purpose of simplifying the phrase "a contract of insurance with a medical practitioner to provide medical indemnity cover for the practitioner in relation to the practitioner's private medical practice" in Schedule 5.

Item 3: Subsection 34ZB(5)
This item repeals subsection 34ZB(5) of the *Medical Indemnity Act 2002*. This subsection currently defines the term ***private medical practice*** for the purposes of section 34ZB. Item 1 moves the definition to subsection 4(1) of the *Medical Indemnity Act 2002* so that the definition has broader application across the Act.

Item 4: After Part 2
This item inserts new Part 2A in the *Medical Indemnity Act 2002* for the purposes of introducing the universal cover obligation and the risk surcharge requirements into legislation. Part 2A inserts Division 1 (sections 51 and 51A), Division 2 (sections 52, 52A, 52B, 52C and 52D), and Division 3 (53, 53A, 53B and 53C, 53D and 53E). New Part 2A sets out the universal cover obligation, exceptions to universal cover, circumstances in which risk surcharge can be applied, the maximum value of the risk surcharge, interim cover requirements, notification and reporting requirements, and access to dispute resolution.

Under the previous arrangements, matters regarding universal cover were set out in Part 6 of the PSS contract between the Commonwealth and each of the medical indemnity insurers that participated in the PSS. These amendments establish what was previously in those contracts in legislation. Ceasing PSS contracts streamlines the operation of the PSS and removes unnecessary burden and duplication, as recommended by the FPR. This will allow for matters relating to the PSS to be consolidated in the *Medical Indemnity Act 2002* and delegated legislation, rather than being spread across contracts and legislation as per the current arrangements.

The current Australian Financial Complaints Authority (AFCA) complaints process, provided for under the PSS contracts and AFCA Rules to resolve disputes on the universal cover obligations and application of risk surcharge, will be maintained when this obligation is brought into the legislation.

To support the implementation of the measures in this Bill, AFCA, in consultation with the Australian Medical Association (AMA), will ensure that in hearing medical

indemnity disputes, AFCA panels will have appropriately qualified medical practitioners as panel members to hear a complaint. Formal panel arrangements will be set as part of AFCA's administrative process in consultation with the AMA.

Division 1—Introduction
Section 51 Guide to the universal cover obligation provisions
New section 51 of the *Medical Indemnity Act 2002* provides a guide to the universal cover obligation provisions. This section assists readers of the Act to identify the purpose and structure of Part 2A:

New subsection 51(1) states that Part 2A prevents medical indemnity insurers from refusing to provide medical indemnity cover for medical practitioners in relation to private medical practice, except in certain circumstances.

New subsection 51(2) states that Part 2A specifies when a medical indemnity insurer may require a medical practitioner to pay a risk surcharge.

New subsection 51(3) states that medical indemnity insurers must keep records and provide information in relation to the requirements set out in Part 2A.

Section 51A Winding up of medical indemnity insurer
New section 51A of the *Medical Indemnity Act 2002* provides that Part 2A has effect subject to section 116 of the *Insurance Act 1973*. A note to section 51A explains that, under that section, a general insurer must not carry on insurance business after it starts to be wound up. A general insurer will not contravene Part 2A by refusing to enter into an insurance contract if the winding up of the insurer has started.

Division 2—Requirements in relation to providing professional indemnity cover
Section 52 Division applies for the purposes of the AFCA scheme
New section 52 provides that a medical indemnity insurer is not required to comply with Division 2 other than for the purposes of the AFCA scheme (within the meaning of the *Corporations Act 2001*). This Division has no effect for any other purpose other than the AFCA scheme.

The intention of this provision is that, in accordance with the previous contractual universal cover arrangements between the Commonwealth and medical indemnity insurers made in accordance with Part 2 of the *Premium Support Scheme 2004*, a contravention of this Division is not, in itself, a contravention of the provisions of the *Corporations Act 2001*.

A note to section 52 explains that a practitioner can complain to AFCA about a breach of Division. It is intended that the AFCA rules will be changed so that AFCA will apply this Division when resolving disputes about universal cover, risk surcharges and interim cover.

Universal cover obligations will be managed under existing AFCA arrangements whereby a practitioner can make a complaint to AFCA about a potential breach of this Division. AFCA will be empowered to deal with the complaint under existing AFCA rules. Medical indemnity insurers must comply with an AFCA decision or assessment.

The AFCA Rules set out how a complaint may be submitted to AFCA and can be found on the AFCA website - https://www.afca.org.au/about-afca/rules-and-guidelines/

Section 52A Universal cover obligation
New section 52A of the *Medical Indemnity Act 2002* describes the universal cover obligation and the circumstances in which a medical indemnity insurer is able to refuse to enter into a contract of insurance with a medical practitioner to provide professional indemnity cover.

The circumstances in which a medical indemnity insurer can refuse to provide medical professional indemnity cover are where:

- In relation to a medical professional indemnity insurance contract between the practitioner and the insurer:
  - the practitioner failed to comply with the duty of the utmost good faith or the duty of disclosure (within the meaning of the *Insurance Contracts Act 1984*); or
  - the practitioner made a misrepresentation to the insurer during the negotiations for the contract but before it was entered into; or
  - the practitioner failed to comply with a provision of the contract, including a provision with respect to payment of the premium; or
  - the practitioner made a fraudulent claim under the contract; or
- the practitioner places the public at risk of substantial harm in the practitioner's private medical practice because the practitioner has an impairment (within the meaning of the Health Practitioner Regulation National Law);
- the practitioner poses an unreasonable risk of harm to members of the insurer's staff because of persistent threatening or abusive behaviour towards members of the insurer's staff; or
- the practitioner has persistently failed to comply with reasonable risk management requirements of the insurer; or
- additional circumstances in which cover may be refused may also be specified in the rules (new subsection 52A(f)). Any rules made will be a legislative instrument, and subject to Parliamentary scrutiny.

Where relevant, the basis of a refusal to provide medical indemnity cover is aligned to legislation regulating health practitioners on what constitutes "fit-for-practice" under the Australian Health Practitioner Regulation Agency "impairment" requirements. AHPRA provides guidance on interpretation of the meaning of impairment under the Health Practitioner National Law, and insurers and AFCA when applying the provision should follow that guidance.

New paragraph 52A(b) closely aligns notifiable conduct for a medical practitioner under the *Health Practitioner Regulation National Law Act 2009* (Qld) (National Law)and the requirement to provide universal cover. If a doctor's impairment is severe enough to warrant notifiable conduct under the Health Practitioner National Law then they should not have access to universal cover.

The threshold for refusing indemnity cover (and therefore stopping someone from practising medicine), on the basis of an impairment, is the same threshold as in section 140(1)(c) of the National Law Act for a mandatory notification. the practitioner places the public at risk of substantial harm in the practitioner's private medical practice because the practitioner has an impairment.

Grounds for refusal regarding the duty of utmost good faith and the duty of disclosure have been aligned with the *Insurance Contracts Act 1984*.

It is intended that AFCA will determine whether a practice poses "an unreasonable risk" and whether a "risk management requirement" is reasonable, as part of their dispute resolution process, subject to a complaint being made.

Section 52B Medical indemnity insurer to notify of refusal
New section 52B of the *Medical Indemnity Act 20002* provides that if a medical indemnity insurer refuses to enter into a contract of insurance with a medical practitioner to provide professional indemnity cover, the insurer must notify the practitioner in writing in accordance with any requirements specified in the rules. Notification will allow the practitioner to understand the reason for the refusal so that the practitioner can decide how to respond to the refusal. For example, the practitioner might disagree with the refusal and decide to make a complaint to AFCA, or the practitioner might decide to remedy behaviour or other circumstances within their control and seek medical professional indemnity cover from another insurer.
It is intended that the rules will specify the information to be included in the notification (for example, reasons for the refusal) and the timeframe within which the MDO or insurer must notify. For instance, at least 60 days prior to the expiration of the existing contract of insurance, unless, in the reasonable opinion of the insurer, urgent action is necessary, in which case the insurer must give written notice of the refusal and reasons for the refusal to the insured medical practitioner as soon as reasonably practicable.

Section 52C Risk surcharge requirements
New section 52C sets out the circumstances in which a medical indemnity insurer may apply a ***risk surcharge***.

A medical indemnity insurer may require a medical practitioner to pay, as part of the amount payable for medical indemnity cover provided for the practitioner in relation to the practitioner's private medical practice, an amount (the risk surcharge):

- to reflect that, because the practitioner engages, or has engaged, in conduct that deviates from good medical practice, the practitioner's private medical practice is likely to pose a higher risk to patients than the private medical practice of a comparable medical practitioner; or
- in circumstances specified in the rules.

New subsection 52C(2) provides that the private medical practice of another medical practitioner (the ***comparison practitioner***) is a similar practice if the insurer reasonably considers that the practitioner and the comparison practitioner have similar practice profiles for the purposes of calculating premiums for professional indemnity cover, except that the comparison practitioner does not engage, and had not engaged, in conduct that deviates from good medical practice.

Deviating from good medical practice is part of a medical practitioner's practice profile. If a medical practitioner, for example, is found to have deviated from what the Australian Medical Board considers "good medical practice", this will affect the medical practitioner's risk profile.

New subsection 52C(3) provides that the risk surcharge must not exceed the amount specified, or worked out in accordance with a method specified, in the rules.

New subsection 52C(4) provides that the offer to enter into the contract of insurance to provide the professional indemnity cover must:

- identify the amount of the risk surcharge; and
- state the reason for requiring payment of the risk surcharge.

AFCA will manage complaints in relation to the application of risk surcharge by medical indemnity insurers.

Notification by insurers will allow the practitioner to understand the reason for a risk surcharge being applied so that the practitioner can decide how to respond to the refusal. For example, the practitioner might disagree with the reasons for applying a risk surcharge and make a complaint to AFCA about the risk surcharge, or the practitioner might decide to remedy behaviour or other circumstances within their control to reduce the likelihood that a risk surcharge will be applied to future insurance premiums.

Section 52D Medical indemnity insurer may be required to offer interim cover until complaint is finalised

New section 52D provides that a medical indemnity insurer may be required to offer interim cover while AFCA is determining a complaint. The intent of proposed new section 52D is to ensure that a medical practitioner continues to receive appropriate professional indemnity cover while AFCA is dealing with a complaint, and up until the complaint is finalised.

New subsection 52D(1) provides that a medical indemnity insurers must offer to enter into a contract of insurance with a medical practitioner to provide professional indemnity cover if:

- a contract of insurance between the insurer and the practitioner provides professional indemnity cover (the ***initial cover***); and
- the insurer refuses to enter into a contract of insurance with the practitioner to provide professional indemnity cover (the ***subsequent cover***) starting after the initial cover ceases; and
- the practitioner makes a complaint to AFCA in relation to the refusal; and
- the initial cover, or professional indemnity cover provided as a result of an offer made for the purposes of this section, ceases before the complaint finalisation date.

This ensures that both initial cover and interim cover offered in accordance with this provision must continue to be renewed consistent with the complaint finalisation date requirement.

New subsection 52D(2) provides that the offer must comply with any requirements specified in the rules.

New subsection 52D(3) provides that the medical indemnity insurer is not required to offer to enter into a contract of insurance that provides professional indemnity cover after the complaint finalisation date. For example, where the complaint is determined in favour of the insurer's refusal to provide cover, the insurer is not required to continue to offer interim insurance any longer than 60 days after AFCA makes its determination.

New subsection 52D(4) provides that ***complaint finalisation date*** means the earlier of:

- the day the subsequent cover stats; and
- the day 60 days after the complaint is finalised.

New subsection 52D(4) also provides that, consistent with the scope of AFCA's powers as set out in the ACFA Rules, a complaint is ***finalised*** when:

- the complaint is resolved by agreement between the insurer and the practitioner; or
- the complaint is withdrawn; or
- AFCA closes the complaint because:
    - it has excluded the complaint, or decided not to continue to consider the complaint, and the timeframe in which the practitioner may object to the decision has expired; or
    - it has made a preliminary assessment in relation to the complaint and the timeframe for requesting a determination of the complaint has expired; or
    - it has determined the complaint; or
- the complaint otherwise ceases to be dealt with by AFCA.

Division 3—Records, reporting and information
Section 53 Records
New section 53 enables the rules to require medical indemnity insurers to keep records relating to:

- a refusal by the insurer to enter into a contract of insurance with a medical practitioner to provide professional indemnity cover;
- a requirement by the insurer that a medical practitioner pay a risk surcharge.

New section 53 also provides that these records required to be kept by the rules must be retained for a period of 5 years (or any other period specified in the rules) starting on the day on which the records were created. This is consistent with other provisions requiring medical indemnity insurers to keep records in the *Medical Indemnity Act 2002.*

Failure to keep the records is an offence (see new section 53A).

Section 53A Failing to keep and retain records
New subsection 53A(1) applies if section 52D or rules made for the purposes of that section require a person to keep records or to retain records for a particular period.

New subsection 53A(2) provides that a person commits an offence if the person fails to keep record or fails to retain the records for the particular period. The maximum penalty for the offence if a person is convicted of an offence is 30 penalty units.

New subsection 53A(3) provides that the offence is an offence of strict liability.

Compliance with the record keeping requirements in particular in relation to information regarding reasons and decisions for refusal by the insurer to enter into contract of insurance with a medical practitioner to provide the professional indemnity cover and requirement relating to the payment of a risk surcharge would enable the effective supervision and implementation of the universal cover obligation and risk surcharge requirements.

In order to enforce these requirements for the integrity of these schemes, non-compliance with these requirements is a strict liability offence. The strict liability offence provision in new section 53A deals with circumstances where fault may be difficult to prove due to the complex nature of medical indemnity operations and regime, and the prevalence of multiple insurance arrangements. The requirement to keep records is imposed on medical indemnity insurers and accordingly can only apply to a body corporate and not an individual. It is not anticipated that this regulatory approach would change in the future given the nature of the industry and the requirements imposed.

The requirement to keep records is also designed to ensure the integrity of the regulatory regime by enabling the Commonwealth to determine whether insurance companies are meeting the requirements to provide universal cover to medical practitioners.

In addition, a penalty of 30 penalty units is considered appropriate for a failure to comply with a direction (general or remedial) given to a medical indemnity insurer. This is lower than the benchmark for offences of strict liability stated in *A Guide To Framing Commonwealth Offences, Infringement Notices and Enforcement Powers*, September 2011, and consistent with existing like offences in the *Medical Indemnity Act 2002*. Strict liability offences will generally only be pursued where the Chief Executive Medicare can confidently determine that conduct is non-compliant with regulatory obligations and that such action reduces the risk of ongoing non-compliance.

Section 53B Medical indemnity insurer must report annually
New subsection 53B(1) provides that if, in a financial year, a medical indemnity insurer refuses to enter into a contract of insurance with a medical practitioner to provide professional indemnity cover, the insurer must notify the Secretary within 2 months after the end of the financial year of:

- the number of times in the financial year the insurer refused to enter into a contract of insurance with a medical practitioner to provide professional indemnity cover; and
- any other matter that relates to the insurer's obligations under Division 2 and that is specified in the rules

New subsection 53B(2) provides that, if in a financial year, a medical indemnity insurer requires a medical practitioner to pay a risk surcharge, the insurer must notify the Secretary within 2 months after the end of the financial year, of:

- the number of times in the financial year the insurer required a medical practitioner to pay a risk surcharge; and
- any other matter that relates to the insurer's obligations under Division 2 and that is specified in the rules.

Failure to notify is an offence (see section 52G).

New subsection 53B(3) provides that the Secretary may, by notifiable instrument, approve a form for the purposes of notification under subsection 52F(1) or (2).

New subsection 53B(4) provides that if the Secretary does so, the notification must be in the approved form.

New subsection 53B(5) provides that within 3 months after the end of the financial year, the Secretary must publish on the Department's website any information notified under paragraph (1)(a) or (2)(a) in relation to the financial year.

This provision facilitates the monitoring by the Secretary of refusals to provide cover and the application of risk surcharges, to ensure that the Universal Cover Obligation does not result in any increased pricing, or in an expanded class of practitioners that are subject to higher premiums.

Section 53C Failing to report
New subsection 53C(1) provides that new section 53C applies if a person is required to notify the Secretary of a matter within a particular period under new section 53B.

New subsection 53C(2) provides that a person is liable to a maximum penalty of 30 penalty units if:

- if the Secretary has approved a form for the purposes of the notification—the person fails to notify the Secretary of the matter in the approved form within that period; or
- otherwise—the person fails to notify the Secretary of the matter within that period.

New subsection 53C(3) provides an offence against new subsection 52G(2) is an offence of strict liability.

Compliance with the reporting requirements, in particular, for information regarding reasons and decisions for refusal by the insurer to enter into contract of insurance with a medical practitioner to provide the professional indemnity cover and requirement relating to the payment of a risk surcharge would enable the effective supervision and implementation of the universal cover obligation and risk surcharge requirements. In order to enforce these requirements for the integrity of these schemes, non-compliance with these requirements is a strict liability offence. The strict liability offence provision in new section 53C deals with circumstances where fault may be difficult to prove due to the complex nature of medical indemnity operations and regime, and the prevalence of multiple insurance arrangements. The requirement to report is imposed on medical indemnity insurers and accordingly can only apply to a body corporate and not an individual. It is not anticipated that this regulatory approach would change in the future given the nature of the industry and the requirements imposed.
The requirement to report is also designed to ensure the integrity of the regulatory regime by enabling the Commonwealth to determine whether insurance companies are meeting the requirements to provide universal cover to medical practitioners.

In addition, a penalty of 30 penalty units is considered appropriate for a failure to comply with a direction (general or remedial) given to a medical indemnity insurer. This is lower than the benchmark for offences of strict liability stated in *A Guide To Framing Commonwealth Offences, Infringement Notices and Enforcement Powers*, September 2011, and consistent with existing like offences in the *Medical Indemnity Act 2002*. Strict liability offences will generally only be pursued where the Chief Executive Medicare can confidently determine that conduct is non-compliant with regulatory obligations and that such action reduces the risk of ongoing non-compliance.

Section 53D Secretary may request information
New subsection 53D provides that the Secretary may request a medical indemnity insurer to give the Secretary the following information, in the form requested by the Secretary:

- the number of times in a period the insurer refused to enter into a contract of insurance with a medical practitioner to provide professional indemnity cover;
- the number of times in a period the insurer required a medical practitioner to pay a risk surcharge;
- other information that relates to the insurer's obligations under Division 2 and that is specified in the rules.

Section 53D(2) requires the Secretary's request for information under this section to be in writing, to specify the day on or before which the information must be given (at least 28 days after the request is made) and to contain a statement to the effect that a failure to comply with the request is an offence. The Secretary's request may require the information to be verified by a statutory declaration.

This is an additional reporting requirement to section 53D, which may be used if more regular reporting is required than annually. Failure to comply with the request is an offence (see new section 53E).

Section 53E Failing to give information
New subsection 53E(1) provides that new section 53E applies if a person is given a request for information under new section 53D; new subsection 53E(2) provides that a person is liable to a penalty of 30 penalty units if the person fails to comply with the request; and new subsection 53E(3) provides an offence against new subsection 53E(2) is an offence of strict liability.

Compliance with the requirement to give information, in particular, in relation to information regarding reasons and decisions for refusal by the insurer to enter into contract of insurance with a medical practitioner to provide the professional indemnity cover and requirement relating to the payment of a risk surcharge would enable the effective supervision and implementation of the universal cover obligation and risk surcharge requirements. In order to enforce these requirements for the integrity of these schemes, non-compliance with these requirements is a strict liability offence. The strict liability offence provision in new section 53E deals with circumstances where fault may be difficult to prove due to the complex nature of medical indemnity operations and regime, and the prevalence of multiple insurance arrangements. The requirement to provide information is imposed on medical indemnity insurers and accordingly can only apply to a body corporate and not an individual. It is not anticipated that this regulatory approach would change in the future given the nature of the industry and the requirements imposed.

The requirement to give information is also designed to ensure the integrity of the regulatory regime by enabling the Commonwealth to determine whether insurance companies are meeting the requirements to provide universal cover to medical practitioners.

In addition, a penalty of 30 penalty units is considered appropriate for a failure to comply with a direction (general or remedial) given to a medical indemnity insurer. This is lower than the benchmark for offences of strict liability stated in *A Guide To Framing Commonwealth Offences, Infringement Notices and Enforcement Powers*, September 2011, and consistent with existing like offences in the *Medical Indemnity Act 2002*. Strict liability offences will generally only be pursued where the Chief Executive Medicare can confidently determine that conduct is non-compliant with regulatory obligations and that such action reduces the risk of ongoing non-compliance.
Medical Indemnity (Prudential Supervision and Product Standards) Act 2003

Item 5: Subsection 26A(9) (definition of ***private medical practice***)
This item removes reference to "section 34ZB of" in the definition of "private medical practice" in subsection 26A(9) of the *Medical Indemnity (Prudential Supervision and Product Standards) Act 2003*. This is because ***private medical practice*** is now defined under subsection 4(1) (rather than section 34ZB) of the *Medical Indemnity Act 2002* (see items 1 and 2).

Item 6: Application
This item clarifies the application of sections 52A, 52B and 52D of the *Medical Indemnity Act 2002,* the universal cover provisions (including the circumstances in which an insurer can refuse to enter into a contract of insurance, and the requirements for notification and interim cover) apply to any refusal of cover that occurs after the commencement of this item (regardless of if and when a request to enter a contract is made).

Similarly, the requirements for a risk surcharge (new section 52C) apply in relation to professional indemnity cover provided or to be provided by a contract of insurance entered into after the commencement of the Bill.

The annual reporting requirement under section 53B, applies in relation to financial years starting on or after 1 July 2020. Similarly, the Secretary's power to request information under section 53D applies to any period starting on or after 1 July 2020.

Schedule 6 – Allied health professionals

In the 2018-19 MYEFO, the Government decided to continue to provide support for insurers currently providing professional indemnity insurance to registered privately practising allied health professionals, and that these schemes would be independent to schemes available to medical practitioners.

Schedule 6 creates high cost claim and exceptional claims schemes in new Divisions of Part 2 of the *Medical Indemnity Act 2002* specifically designed for access by allied health professionals. The allied health high cost claim scheme (AHHCCS) is set out in Division 2C and the AHECS is in new Division 2D. This approach ensures that the new schemes are included with other Commonwealth indemnity schemes set out in Part 2 (Commonwealth payments), while providing clarity as to access and operation of the

schemes by separately identifying the Commonwealth indemnity schemes based on their application to a medical practitioner or to an allied health professional.

The provisions in these schemes are modelled on (and significantly mirror) the provisions in the existing HCCS and ECS as they apply to medical practitioners.

New definitions relevant to the new schemes are included in section 4 of the *Medical Indemnity Act 2002* (for example, definitions of ***allied health high cost claim threshold*** and ***allied health profession*** are inserted by item 2 of Schedule 6 to the Bill).

In addition, definitions and concepts that are common to both the medical practitioner and allied health high cost claim and exceptional claim schemes are moved from Division 2 and Division 2A in Part 2 of the Act, to Part 1 of the *Medical Indemnity Act 2002*. For example, item 9 of Schedule 6 moves existing section 34C to a new section 8B, and the definition of ***practitioner's contract limit*** in section 34B to section 4, so that the treatment of deductibles as described in that section apply to both the ECS and the AHECS.

A number of technical changes are also made to clearly distinguish the schemes (for example, changes in Division 2A to clearly identify that the provisions in that Division refer to the exceptional claims scheme for medical practitioners.
The allied health schemes will only be available to an eligible MDO or an eligible insurer. To be an ***eligible MDO*** or ***eligible insurer***, the insurer must provide, as part of their insurance business, medical indemnity cover for medical practitioners and for persons who practise an allied health profession. They must also be specified in the rules.

It is Government's intent that the new allied health schemes will initially only be accessed by those medical indemnity insurers that are currently providing medical indemnity cover for both medical practitioners and for persons who practise an allied health profession. The rules are therefore intended to prescribe those medical indemnity insurers that currently access the HCCS.

For the AHHCCS to apply, claims must meet the basic payability rule that the claim relates to incidents that occur or occurred in the course of, or in connection with, the provision of a health care related service. The HCCS and AHHCCS do not cover claims that are not directly related to the provision of a health care related services such as claims relating to workplace harassment, breaches of workplace health and safety or occupier's liability (for example, a slip and fall).

Amendments are also made by Schedule 6 to the Bill that change the current exclusion of all eligible midwives and expand coverage to claims against employee midwives not covered under the MPIS back under the cover of the AHHCCS and the AHECS.

Employee midwives are currently excluded from the MIPS established under the *Medical Professional Indemnity (Commonwealth Contribution) Scheme Act 2010*. Through

amendments in Schedule 6 to the Bill, the Government is addressing this gap by enabling private sector employee midwives to access the AHHCCS and AHECS.

In 2010, when the MPIS commenced, midwives covered under the MPIS were excluded from coverage under the HCCS and ECS. The Government is closing this gap in the HCCS and ECS by including private sector employee midwives in the AHHCCS and AHECS.

Medical Indemnity Act 2002
Item 1: At the end of section 3
This item inserts new subsections (5) and (6) at the end of section 3 of the *Medical Indemnity Act 2002*, inserting a new object of the Act for the AHHCCS and AHECS. The object of the AHHCCS and AHECS is to contribute towards the availability of certain health services in Australia by supporting allied health practitioners to access certain indemnity arrangements.

Item 2 and item 7: Subsection 4(1)
These items insert definitions in subsection 4(1) of the *Medical Indemnity Act 2002* to provide a specific meaning to certain words and phrases when used in the Act, including in relation to the AHHCCS and AHECS, and the ECS. The words and phrases defined are *allied health exceptional claims indemnity; allied health high cost claim indemnity; allied health high cost claim threshold*; *allied health termination date*; *conducted appropriately* (for a defence of a claim against a person); *defence*; *eligible insurer*; *eligible MDO*; and *exceptional claims termination date; practitioner's contract limit; qualifying allied health claim certificate; qualifying allied health liability; qualifying allied health payment; qualifying liability; qualifying payment: see subsection 30(2); relevant allied health threshold;* and *relevant threshold)***.**

These definitions are included for the purposes of incorporating the AHHCCS and the AHECS into the medical indemnity legislation, including where new defined terms are required and where existing definitions can be drawn from terms used in other schemes in the *Medical Indemnity Act 2002*.

Item 3: Subsection 4(1) (definition of ***health professional***)
This item repeals the definition of ***health professional*** in section 4(1) of the *Medical Indemnity Act 2002*, which is no longer used across any of the indemnity schemes. For clarity, eligibility under each of the indemnity schemes is identified either by reference to a person's practice as a medical practitioner or by the practice of a practitioner of an allied health profession (i.e. an allied health professional).

Item 4: Subsection 4(1) (at the end of the definition of ***indemnity scheme payment***)
This item inserts at the end of the definition for ***indemnity scheme payment*** in subsection 4(1) two additional paragraphs 4(1)(e) to (f) in the *Medical Indemnity Act 2002* to expand the references to "indemnity scheme payment" to include the new allied health high cost claim indemnity and exceptional claims indemnity schemes.

Item 5: Subsection 4(1) (after paragraph (ab) of the definition of ***late payment penalty***)
This item inserts new paragraph 4(1)(ac) in the *Medical Indemnity Act 2002*, “(ac) in relation to a debt owed under section 34ZZY—means a penalty payable under section 34ZZZB” to expand the references to “late payment penalty” to include late payment penalties in relation to amounts overpaid under the AHECS.

Item 6 and Item 8: Subsection 4(1) (definition of ***payment***); Subsections 4(3) and (4)
These items amend the meaning of payments in relation to claims to replace the reference to “Division 2A” in subsections 4(1), 4(3) and 4(4) of the *Medical Indemnity Act 2002*, with a reference to “Division 2A and 2D”. This amendment provides that, for the purpose of the Act, the definition of ***payment*** does not apply in relation to the ECS (Division 2A) or the AHECS (Division 2D).

Item 9: Before section 9
This item inserts new section 8B before section 9 of the *Medical Indemnity Act 2002.* This provision provides for the treatment of deductibles for the ECS and the AHECS, on substantially the same terms that previously applied to the ECS under former section 34C. The provision has been moved in order to have application across both schemes.

New subsection 8B(1) provides that if, under a contract of insurance that provides medical indemnity cover for a person (the ***practitioner***), the insurer is entitled to count an amount (the ***deductible amount***):

- incurred by the insurer in relation to a claim against the practitioner; or
- paid or payable by the practitioner or another person in relation to a claim against the practitioner;

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

New subsection 8B(2) provides that for the purpose of the definition of ***practitioner’s contract limit*** in subsection 4(1), the maximum amount payable, in aggregate, under the contract in relation to claims against the practitioner is as stated in the contract, even though the insurer (because of the deductible amount) may not actually be liable to pay the whole of that maximum amount.

New subsection 8B(3) provides that for the purpose of the references in paragraphs 34L(1)(e) and (f), and 34ZZQ(1)(e) and (f) to an amount that an insurer has paid or is liable to pay under a contract of insurance, the deductible amount is to be counted as if it were an amount that the insurer has paid or is liable to pay under the contract.
New subsection 8B(4) provides that for the purpose of the references in paragraphs 34L(1)(e) and 34ZZQ(1)(e) to an amount that an insurer would have been liable to pay under a contract of insurance, the deductible amount is not to be counted as if it were an amount that the insurer would have been liable to pay under the contract.

Item 10: Sections 34B and 34C
This item repeals sections 34B and 34C in the *Medical Indemnity Act 2002*.

The repeal of section 34B, together with amendments made by items 2 and 7, in effect move the definitions of *practitioner's contract limit*; *qualifying liability* and *termination date* (now renamed the *exceptional claims termination date*) to subsection 4(1) such that these definitions have application across both the ECS and the AHECS.

The repeal of section 34C is consequential to the amendment made by item 9.

Item 11: Section 34D
This item removes reference to "section 34B" in section 34D of the *Medical Indemnity Act 2002*, and substitutes it with a reference to "subsection 4(1)". This amendment is consequential to the amendments made by items 2, 7 and 10.

Items 12; 13; 15; 16; 22; 23 and 24
These items amend paragraph 34E(1)(g); subsection 34E(1) (note 2); section 34G (heading); subsection 34G(1) (note); section 34O (heading); paragraph 34O(b) and section 34O to reflect the renaming of "termination date" to "exceptional claims termination date". These amendments are consequential to the amendments made by items 2, 7 and 10.

Renaming this term distinguishes it from the new term to be included in the AHECS relating to the termination date for that scheme, which is the ***allied health exceptional claims termination date*.**

Item 14: Subsection 34F(1)
This item removes reference to "For the purposes of subparagraph 34E(1)(e)(ii), the" in subsection 34F(1) of the *Medical Indemnity Act 2002*, and substitutes it with a reference to "The". This is a minor change to clarify that "relevant threshold" is not only referred to in subparagraph 34E(1)(e)(ii).

Item 17: Subsection 34L(1) (notes 1 to 6)
This item repeals notes 1 to 6 in subsection 34L of the *Medical Indemnity Act 2002*, and substitutes it with new notes 1 and 2. This amendment makes the notes easier to read, without changing their meaning. This amendment also reflects the definition of deductibles being moved to new section 8B (see items 9 and 10).

Items 18; 19; 20; 21 and 25
Item 21 repeals subsections 34M(2) and (3) of the *Medical Indemnity Act 2002*. In combination with item 2, this has the effect of moving the definitions of ***defence*** and ***conducted appropriately*** to subsection 4(1) to provide specific meaning to those words where used in the Act, including in relation to both the ECS and the AHECS.
Items 18; 19; 20 and 25 amend subsection 34M(1); paragraph 34M(1)(b);and paragraph 34Z(3)(a). The amendments made by these items are consequential to the amendments made by Items 2 and 21.

Item 26: After Division 2B of Part 2

This item inserts "Division 2C – Allied health high cost claim indemnity scheme" and "Division 2D—Allied health exceptional claims indemnity scheme" into the *Medical Indemnity Act 2002*. The purpose of inserting these amendments into the medical indemnity legislation is to clarify the application of the high cost claim indemnity scheme in relation to allied health professionals and to largely replicate the exceptional claims indemnity scheme so that it can apply to allied health professionals.

The AHHCCS applies in respect of claims against a practitioner, in relation to an incident which occurs in the course of, or in connection with, the practice by the practitioner of an allied health profession (new subsection 34ZY(1) of the *Medical Indemnity Act 2002*).

Allied health profession is defined in section 4 of the *Medical Indemnity Act 2002* to mean a health profession within the meaning of the Health Practitioner Regulation National Law, other than the medical practitioners (see item 2).

Claims in respect of a person's practice as a medical practitioner continue to be covered by the existing HCCS.

Indemnities under the scheme may be paid to an eligible MDO or eligible insurer (subsection 34ZY(1)). ***Eligible MDO or eligible insurer*** is defined in new section 34ZZ.

In addition to being specified in the rules, to be an ***eligible MDO or eligible insurer***, the insurer must provide, as part of their insurance business, medical indemnity cover for medical practitioners and for persons who practise an allied health profession.

The allied health high cost claim threshold in new section 34ZZA(1) aligns with current high cost claim threshold for the HCCS. Section 29 of the *Medical Indemnity Act 2002* provides that the high cost claim threshold is $2 million, or such other amount as is prescribed by the regulations. For paragraph 29(1)(b) of the Act, the *Medical Indemnity Regulations 2003* currently prescribe the amount of $500,000. This amount is intended to also be prescribed for the purposes of the AHHCCS.

The circumstances in which an AHHCC and AHECS indemnity is payable are described in sections 34ZZB and 34ZZQ (respectively). These provisions are largely consistent with the circumstances described in the HCCS and ECS. Differences include that the incident, or series of incidents, must have occurred on or after 1 July 2020. However, if the incident occurred before 1 July 2020, allied health practitioners will continue be eligible under the HCCS and ECS.

Given the nature of the insurance industry in relation to allied health professionals, the eligibility provisions do not preclude claims relating to contracts of insurance between an employer intermediary and a medical indemnity insurer (that is, corporate policies). However, the liability must relate to claim(s) against the individual and not the corporation or practice.

The AHECS applies in respect of claims against a person (an individual), in relation to an incident which occurs in the course of, or in connection with, the practice by a person of an allied health profession, where the claim has been certified as a qualifying allied health claim (subsection 34ZZH(1) of the *Medical Indemnity Act 2002*).

Division 2C—Allied health high cost claim indemnity scheme
Subdivision A—Introduction
Section 34ZY Guide to the allied health high cost claim indemnity provisions
New subsection 34ZY(1) sets out that Division 2C provides that an allied health high cost claim indemnity may be paid to an eligible MDO or eligible insurer that pays, or is liable to pay, more than a particular amount (referred to as the ***allied health high cost claim threshold***) in relation to a claim against a person in relation to an incident that occurs in the course of, or in connection with, the practice by the person of an allied health profession.

New subsection 34ZY(2) sets out that Division 2C also provides for the regulations and rules to deal with other matters relating to incidents covered by the allied health high cost claim indemnity scheme.
New subsection 34ZY(3) provides a table to tell the reader where to find the provisions dealing with various issues.
Section 34ZZ Eligible MDOs and eligible insurers
New section 34ZZ provides that an MDO is an ***eligible MDO***, or a medical indemnity insurer is an ***eligible insurer***, if:

- it is specified in the rules; and
- it is party to contracts of insurance that provide medical indemnity cover for medical practitioners; and
- it is party to contracts of insurance that provide medical indemnity cover for persons who practise an allied health profession.

It is intended that the rules will initially specify the medical indemnity insurers that currently access the existing HCCS.

The six medical indemnity insurers that currently access the schemes under the *Medical Indemnity Act 2002* are authorised under section 12 of the *Insurance Act 1973* and listed on the Australian Prudential Regulation Authority register of general insurers. The inclusion of *eligible MDOs* in the scheme allows an MDO related to a medical indemnity insurer to make claims and receive payments under the scheme.

Section 34ZZA Allied health high cost claim threshold
New subsection 34ZZA(1) sets out that the allied health high cost claim threshold is:

- $2 million; or
- such other amount as is specified in the rules.

New subsection 34ZZA(2) provides that the rules that specify an amount for the purposes of new paragraph 34ZZA(1)(b) that increases the allied health high cost claim threshold at the time the rules are registered on the Federal Register of Legislation must not commence earlier than 12 months after the day on which the rules are so registered.

It is intended that the rules will specify that the threshold for the AHHCCS is $500,000, consistent with the threshold for the HCCS currently specified under section 29 of the *Medical Indemnity Act 2002*.

Subdivision B—Allied health high cost claim indemnity
Section 34ZZB Circumstances in which allied health high cost claim indemnity payable
Basic payability rule
New subsection 34ZZB(1) sets out the basic payability rule, that is, the criteria that must be met for an allied health high cost claim indemnity to be paid by the Commonwealth to an eligible MDO or eligible insurer. The criteria include:

- The claim must be made against the practitioner for an incident (or incidents) occurring in their practice of an allied health profession (paragraph 34ZZB(1)(a) & (b)), for which a high cost claim indemnity is not payable (paragraph 34ZZB(1)(i)).
- The incident (or incidents) must occur in Australia or an external Territory (paragraph 34ZZB(1)(d)) and after the commencement of the AHHCCS on 1 July 2020 (paragraph 34ZZB(1)(e)). If the AHHCCS is terminated (by rules made under section 34ZZL), the MDO or insurer must also first be notified of the claim or incident before the termination date (paragraph 34ZZB(1)(f)). At least 12 months' notice will be given of the termination date (subsection 34ZZB(5)).
- If the allied health profession is midwifery, the incident (or incidents) must also occur in practice of a kind in relation to which eligible midwives are ordinarily (or expected to ordinarily be) engaged as employees (paragraph 34ZZB(1)(c)). This is because incidents occurring in the practice of midwifery by self-employed eligible midwives are intended to be covered by schemes under the *Midwife Professional Indemnity (Commonwealth Contribution) Scheme Act 2010*. New subsection 34ZZB(2) provides that rules under subsection 11(3A) of the *Midwife Professional Indemnity (Commonwealth Contribution) Scheme Act 2010* are to be applied for this purpose – those rules may specify practices of a kind in relation to which midwives are not ordinarily engaged as employees.
- The MDO or insurer must have a qualifying allied health payment (or payments) in relation to the claim (paragraph 34ZZB(1)(g)) that exceeds the relevant allied health high cost claim threshold (paragraph 34ZZB(1)(h)). A payment is a qualifying allied health payment if it meets the requirements of subsection 34ZZB(4).

Additional payability requirements may also be specified in the rules (paragraph 34ZZB(1)(j)). Any rules made for the purposes of subsection 11(3A) of the *Midwife*

Professional Indemnity (Commonwealth Contribution) Scheme Act 2010 apply for the purposes of determining whether practice is of a kind mentioned in paragraph (1)(c) (subsection 34ZZB(2)). Any additional requirements will only apply to claims made after the rule in question commences (subsection 34ZZB(3)).

Qualifying allied health payments
New subsection 34ZZB(4) provides that the MDO or insurer has a ***qualifying allied health payment*** in relation to a claim if:

- the MDO or insurer:
  - pays an amount in relation to the claim; or
  - is liable to pay an amount in relation to a payment or payments that someone makes, or is liable to make, in relation to the claim under a written agreement between the parties to the claim; or
  - is liable to pay an amount in relation to a payment or payments that someone makes, or is liable to make, in relation to the claim under a judgment or order of a court that is not stayed and is not subject to appeal; or
  - is a Chapter 5 body corporate and is liable to pay a provable amount in relation to the claim; and

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

- the MDO or insurer:
  - pays, or becomes liable to pay, the amount in the ordinary course of the insurer's business; or
  - is a Chapter 5 body corporate and would be able to pay the amount in the ordinary course of the MDO or the insurer's business if it were not a Chapter 5 body corporate.

New subsection 34ZZB(5) provides that the date specified in the rules for the purposes of paragraph 34ZZB(1)(f) must be at least 12 months after the day on which the rules in question are registered on the Federal Register of Legislation.

Indemnity to be paid on trust if MDO or insurer under external administration
New subsection 34ZZB(6) provides that if an allied health high cost claim indemnity is paid to an MDO or insurer that is a Chapter 5 body corporate, the indemnity is, to the extent to which it is attributable to an amount that the MDO or insurer is liable to pay to a person, paid on trust for the benefit of that person.

A Chapter 5 body corporate is defined in subsection 4(1) of the *Medical Indemnity Act 2002* to mean a Chapter 5 body corporate within the meaning of the *Corporations Act 2001* (for example, a body corporate that is being wound up or is in liquidation) or a body corporate to which a provisional liquidator has been appointed.

Section 34ZZC Aggregating amounts paid or payable by an MDO and insurer
New subsection 34ZZC(1) provides that new section 34ZZC (regarding the aggregation of amounts paid or payable by an MDO and insurer) applies if:

- an eligible MDO pays, or is liable to pay, an amount in relation to a claim that relates to an incident or a series of incidents; and
- an eligible insurer also pays, or is also liable to pay, an amount (the ***insurer amount***) in relation to the same claim or an eligible related claim; and
- but for this section, an allied health high cost claim indemnity in respect of the insurer amount:
  - would be payable to the insurer under subsection 34ZZB(1); or
  - would be payable to the insurer under that subsection if paragraph 34ZZB(1)(h) were omitted; and
- the insurer elects in writing to have this section apply to the insurer amount.

New subsection 34ZZC(2) provides that for the purposes of this Division (other than new section 34ZZC):

- the MDO is taken:
  - to have paid, or to be liable to pay, the insurer amount in relation to the claim or eligible related claim; and
  - to satisfy paragraphs 34ZZB(1)(f) and (g) in relation to the insurer amount; and
- an allied health high cost claim indemnity is not payable to the insurer in respect of the insurer amount.

These provisions have the effect that, where an MDO and an insurer both pay (or are liable to pay) an amount in relation to the same claim or an eligible related claim, the insurer may elect in writing to aggregate the two amounts to allow the MDO to be paid any allied health high cost claim indemnity in relation to the claim.

If the insurer elects to apply this provision, no allied health high cost claim indemnity is payable to the insurer. Instead, the MDO is taken to have made a qualifying payment in relation to the insurer amount (for the basic payability rule in paragraph 34ZZB(1)(g)) and may be paid an AHHCCS indemnity if all other requirements are satisfied in respect of the claim. If a termination date has been set for the allied health high cost claim indemnity scheme, the MDO is also taken to have satisfied the basic payability rule under paragraph 34ZZB(1)(f) (first notification prior to termination date) for the insurer amount.

Section 34ZZD Exceptions
New section 34ZZD provides that an allied health high cost claim indemnity is not payable to an MDO or insurer under section 34ZZB in relation to a payment the MDO or insurer makes, or is liable to make, in relation to a claim against a person if:

- the incident, or all the incidents, to which the claim relates occurred in the course of the provision of treatment to a public patient in a public hospital; or
- the claim is specified in the rules; or
- the claim relates to an incident specified in the rules.

Under national registration arrangements, all registered health professionals must be covered by indemnity insurance. Privately practising health practitioners must purchase their own indemnity insurance (but may be covered by an employers' insurance policy). Medical services provided under the public health system are covered by State and Territory professional indemnity arrangements as part of their employment arrangements.

Section 34ZZE Payment partly related to treatment of public patient in public hospital
New subsection 34ZZE(1) provides that new section 34ZZE applies if:

- an MDO or insurer makes, or is liable to make, a payment in relation to a claim against a person in relation to a series of related incidents; and
- some, but not all, of the incidents occurred in the course of the provision of treatment to a public patient in a public hospital.

New subsection 34ZZE(2) provides that for the purposes of Subdivision B, the payment is to be disregarded to the extent to which it relates to, or is reasonably attributable to, the incident or incidents that occurred in the course of the provision of treatment to a public patient in a public hospital.

34ZZF Amount of allied health high cost claim indemnity
New subsection 34ZZF(1) provides that the amount of an allied health high cost claim indemnity is:

- 50%; or
- such other percentage as is specified in the rules;

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

New subsection 34ZZF(2) provides that rules that specify for the purposes of paragraph 34ZZF(1)(b) a percentage that is less than the percentage in force at the time the rules are registered on the Federal Register of Legislation must not commence earlier than 12 months after the day on which the rules are so registered.

Subdivision C—Regulations may provide for payments
Section 34ZZG Regulations may provide for payments in relation to allied health high cost claims
New subsection 34ZZG(1) sets out that the regulations may provide in relation to:

- making payments to eligible MDOs and eligible insurers of claim handling fees; and
- making payments on account of legal, administrative or other costs incurred by eligible MDOs and eligible insurers (whether on their own behalf or otherwise);

in respect of claims relating to incidents in relation to which an allied health high cost claim indemnity is payable (see new section 34ZZB).

New subsection 34ZZG(2) provides that without limiting subsection 34ZZG(1), the regulations may:

- make provision for:
  - the conditions that must be satisfied for an amount to be payable to an MDO or insurer; and
  - the amount that is payable; and
  - the conditions that must be complied with by an MDO or insurer to which an amount is paid; and
  - other matters related to the making of payments, and the recovery of overpayments; and

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

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

New subsection 34ZZG(3) provides that paragraph 34ZZG(2)(b) does not allow the regulations to modify a provision that creates an offence, or that imposes an obligation which, if contravened, constitutes an offence.

New subsection 34ZZG(4) provides that it does not matter for the purposes of paragraph 34ZZG(2)(c) whether claims are subsequently made in relation to the incidents referred to in that paragraph.

Section 34ZZH The Chief Executive Medicare may request information
New subsection 34ZZH(1) provides that if the Chief Executive Medicare believes that a person is capable of giving information that is relevant to determining:

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

- the amount that is payable to an MDO or insurer under regulations made for the purposes of section 34ZZG;

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

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

The power to request information is necessary to ensure effective administration of payments provided for under Regulations made under section 34ZZF. This is equivalent to the Chief Executive Medicare's power to request information in relation to other indemnity scheme payments under section 38 of the *Medical Indemnity Act 2002*. Information and records obtained because of the exercise of this power is protected information or a protected document under section 77 of the *Medical Indemnity Act 2002*.

New subsection 34ZZH(2) provides that without limiting subsection 34ZZG(1), any of the following persons may be requested to give information under that subsection:

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

New subsection 34ZZH(3) provides that without limiting subsection 34ZZG(1), if the information sought by the Chief Executive Medicare is information relating to a matter in relation to which a person is required by section 39 to keep a record, the Chief Executive Medicare may request the person to give the information by giving the Chief Executive Medicare the record, or a copy of the record.

New subsection 34ZZH(4) provides that the request:

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

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

Division 2D—Allied health exceptional claims indemnity scheme
Subdivision A—Introduction
Section 34ZZI Guide to the allied health exceptional claims indemnity provisions
New subsection 34ZZI(1) sets out that Division 2D provides that an AHECS may be paid in relation to a liability of a person if:

- the liability relates to a claim against the person in relation to an incident that occurs in the course of, or in connection with, the practice by the person of an allied health profession, being a claim that has been certified as a qualifying allied health claim; and
- the liability exceeds the amount payable under an insurance contract with an eligible insurer that has a contract limit satisfying the relevant allied health threshold.

New subsection 34ZZI(2) sets out that Division 2D also provides for the regulations and rules to deal with other matters relating to claims that have been certified as qualifying allied health claims.

New subsection 34ZZI(3) provides a table to tell the reader where to find the provisions dealing with various issues.

Section 34ZZJ Interaction with allied health high cost claim indemnity scheme
For the purposes of the definition of ***practitioner's contract limit*** in subsection 4(1), and of new paragraphs 34ZZR(1)(e) and (f), an amount that an insurer has paid or is liable to pay, or would have been liable to pay, under a contract of insurance is not to be reduced on account of an allied health high cost claim indemnity paid or payable, or that would have been payable, to the insurer.

Subdivision B—Certification of qualifying allied health claims
Section 34ZZK When may the Chief Executive Medicare certify a claim as a qualifying allied health claim?
Criteria for certification
New subsection 34ZZK(1) provides that the Chief Executive Medicare may issue a certificate stating that a claim is a qualifying allied health claim if the Chief Executive Medicare is satisfied that:

- the claim is a claim that is or was made against a person (the practitioner); and
- the claim relates to:
  - an incident that occurs or occurred; or
  - a series of related incidents that occur or occurred;

  in the course of, or in connection with, the practice by the practitioner of an allied health profession; and
- if the allied health profession is midwifery:
  - the incident occurs or occurred; or
  - all of the incidents in the series occur or occurred;

in the course of, or in connection with, practice of a kind in relation to which eligible midwives are ordinarily, or could reasonably be expected in the ordinary course of business to be, engaged as employees (and therefore indemnified from liability by their employer); and

- except in the circumstances specified in rules made for the purposes of this paragraph, either:
  - the incident occurs or occurred; or
  - one or more of the incidents in the series occurs or occurred;

  in Australia or an external Territory; and
- either:
  - the incident occurs or occurred; or
  - all of the incidents in the series occur or occurred;

  on or after 1 July 2020; and
- the incident did not occur, or the incidents did not all occur, in the course of the provision of treatment to a public patient in a public hospital; and
- there is a contract of insurance in relation to which the following requirements are satisfied:
  - the contract provides medical indemnity cover for the practitioner in relation to the claim, or would, but for the practitioner's contract limit, provide such cover for the practitioner in relation to the claim;
  - the practitioner's contract limit equals or exceeds the relevant allied health threshold (see new section 34ZZL);
  - the insurer is an eligible insurer;
  - the insurer entered into the contract in the ordinary course of the insurer's business; and
- if a termination date for the allied health exceptional claims indemnity scheme is set (see new section 34ZZM), the incident, or one or more of the incidents, to which the claim relates occurred before the allied health termination date; and
- the claim is not a claim specified in rules made for the purposes of this paragraph; and
- the contract of insurance is not a contract specified in rules made for the purposes of this paragraph; and
- a person has applied for the certificate in accordance with new section 34ZZN; and
- the Chief Executive Medicare could not issue a qualifying claim certificate in relation to the claim if an application for the certificate were made in accordance with section 34H.

Additionally, any rules made for the purposes of subsection 11(3A) of the *Midwife Professional Indemnity (Commonwealth Contribution) Scheme Act 2010* apply for the purposes of determining whether practice is of a kind mentioned in paragraph (1)(c) (subsection 34ZZK(2)).

When a certificate is in force

New subsection 34ZZK(3) provides that the certificate comes into force when it is issued and remains in force until it is revoked.

Matters to be identified or specified in certificate
New subsection 34ZZK(4) provides that the certificate must:

- identify:
    - the practitioner; and
    - the claim; and
    - the contract of insurance in relation to which paragraph (1)(g) is satisfied; and
- specify the relevant allied health threshold.

The certificate may also contain other material.

AAT review of decision to refuse
New subsection 34ZZK(5) provides that applications may be made to the Administrative Appeals Tribunal (AAT) for review of decisions of the Chief Executive Medicare to refuse to issue a qualifying allied health claim certificate. Thus, a person who has been refused the issue of a qualifying allied health claim certificate has standing to request a review of that decision by the AAT.

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

The intent is to maintain the status quo regarding the AAT's jurisdiction. The allied health schemes will cover allied health professionals that are already contemplated as 'medical professions' under the *Medical Indemnity Act 2002*, with the addition of employed midwives. It is expected that the number of employed midwives to whom the scheme will apply will be minimal, and it is therefore not anticipated that there will be any impact to the resourcing of the AAT.

Chief Executive Medicare to give applicant copy of certificate
New subsection 34ZZK(6) provides that if the Chief Executive Medicare decides to issue a qualifying allied health claim certificate, the Chief Executive Medicare must, within 28 days of making the decision, give the applicant a copy of the certificate. However, a failure to issue within that period does not affect the validity of the decision.

Section 34ZZL What is the relevant allied health threshold?
New subsection 34ZZL(1) sets out that the ***relevant allied health threshold*** is $20 million, or such other amount as is specified in the rules as the threshold.

New subsections 34ZZL(2); 34ZZL(3) and 34ZZL(4) provide for the application and commencement of rules that change the threshold. Rule specifying an amount as the threshold (or changing the amount previously so specified) only apply in relation to contracts of insurance entered into after the rule commences. Rules reducing the

threshold may commence on the day the rules are registered on the Federal Register of Legislation, however rules increasing the threshold must not commence for at least 3 months after registration.

Section 34ZZM Setting the allied health termination date
New subsection 34ZZM(1) provides that the rules may set a termination date for the allied health exceptional claims indemnity scheme.

The scheme does not cover incidents that occur after the allied health termination date (see new paragraph 34ZZK(1)(h) and new section 34ZZU).

New subsection 34ZZM(2) provides that the termination date cannot be before the date on which the rules are registered on the Federal Register of Legislation.

Section 34ZZN Application for a qualifying allied health claim certificate
New subsection 34ZZN(1) provides that an application for the issue of a qualifying allied health claim certificate in relation to a claim may be made by the person against whom the claim is or was made, or by a person acting on that person's behalf.

New subsection 34ZZN(2) provides that the application must:

- be made in writing using a form approved by the Chief Executive Medicare; and
- be accompanied by the documents and other information required by the form approved by the Chief Executive Medicare. Thus, the approved form can specify the documents and other information required to be provided by the applicant.

Section 34ZZO Time by which an application must be decided
New subsection 34ZZO(1) provides that subject to subsections (2) and (3), the Chief Executive Medicare is to decide an application for the issue of a qualifying allied health claim certificate on or before the 21st day after the day on which the application is received by the Chief Executive Medicare.
New subsection 34ZZO(2) provides that if the Chief Executive Medicare requests a person to give information under section 38 in relation to the application, the Chief Executive Medicare does not have to decide the application until the 21st day after the day on which the person gives the information to the Chief Executive Medicare. Subsection 34ZZO(2) provides for stop the clock mechanism, such that the 21 days becomes counted after the day the information requested by the Chief Executive Medicare is provided by the applicant.

New subsection 34ZZO(3) provides that the Chief Executive Medicare may treat an application as having been withdrawn if both of the following circumstances occur, although noting that the decision is discretionary:

- the Chief Executive Medicare requests the person who applied for the certificate to give information under section 38 in relation to the application; and
- the person does not give the information to the Chief Executive Medicare by the end of the day specified in the request.

Consistent with the scheme for medical practitioners, new subsection 34ZZO(3) enables the Chief Executive Medicare to deal with circumstances in which the applicant for the certificate does not provide the further information sought under section 38. It does this by enabling the Chief Executive Medicare to treat an application as having been withdrawn if the applicant does not give information that is requested by the Chief Executive Medicare under section 38 in relation to the application.

In this scenario, the application for a certificate has not been refused and the applicant may re-apply with the information necessary for the application to be determined. For this reason, it is appropriate that a decision to treat the application as withdrawn in the circumstances described is not a reviewable decision.

New subsection 34ZZO(4) provides that the Chief Executive Medicare must notify the person who applied for the certificate if the Chief Executive Medicare treats the application as having been withdrawn.

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

New subsection 34ZZP(1) provides that if:

- a qualifying allied health claim certificate is in force in relation to a claim; and
- a person becomes aware that the information provided to the Chief Executive Medicare in connection with the application for the certificate was incorrect or incomplete, or is no longer correct or complete; and
- the person is:
  - the person who applied for the certificate; or
  - another person who has applied for a payment of allied health exceptional claims indemnity, or for a payment under regulations made for the purposes of section 34ZZZD (allied health exceptional claims payments), in relation to the claim;

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

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

New subsection 34ZZP(2) provides that the notification must:

- be made in writing; and

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

Section 34ZZQ Revocation and variation of qualifying allied health claim certificates
Revocation
New subsection 34ZZQ(1) provides that the Chief Executive Medicare may revoke a qualifying allied health claim certificate if the Chief Executive Medicare is no longer satisfied as mentioned in subsection 34ZZK(1) in relation to the claim. Note that subsection 34ZZK(1) lists the matters on which the Chief Executive Medicare must be satisfied as being met before issuing a certificate.

New subsection 34ZZQ(2) provides that to avoid doubt, in considering whether the Chief Executive Medicare is still satisfied as mentioned in subsection 34ZZK(1) in relation to the claim, the Chief Executive Medicare may have regard to matters that have occurred since the decision to issue the qualifying allied health claim certificate was made, including for example:

- the making of rules for the purpose of paragraph 34ZZK(1)(i) or (j); or
- changes to the terms and conditions of the contract of insurance identified in the certificate.

Variation
New subsection 34ZZQ(3) provides that if the Chief Executive Medicare is satisfied that a matter is not correctly identified or specified in a qualifying allied health claim certificate, the Chief Executive Medicare may vary the certificate so that it correctly identifies or specifies the matter.

Effect of revocation
New subsection 34ZZQ(4) provides that if:

- the Chief Executive Medicare revokes a qualifying allied health claim certificate; and
- an amount of allied health exceptional claims indemnity has already been paid in relation to the claim;
  the amount is an amount overpaid which is recoverable as a debt due to the Commonwealth under section 41.

Effect of variation
New subsection 34ZZQ(5) provides that if:

- the Chief Executive Medicare varies a qualifying allied health claim certificate; and
- an amount of allied health exceptional claims indemnity has already been paid in relation to the claim, and that amount exceeds the amount that would have been paid if the amount of indemnity had been determined having regard to the certificate as varied;

the amount of the excess is an amount overpaid to which is recoverable as a debt due to the Commonwealth under section 41 applies.

AAT review of decision to revoke or vary
New subsection 34ZZQ(6) provides that applications may be made to the Administrative Appeals Tribunal for review of decisions of the Chief Executive Medicare to revoke or vary a qualifying allied health claim certificate.

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

Chief Executive Medicare to give applicant copy of varied certificate
New subsection 34ZZQ(7) provides that if the Chief Executive Medicare decides to vary a qualifying allied health claim certificate, the Chief Executive Medicare must, within 28 days of making the decision, give the applicant a copy of the varied certificate. However, a failure to comply does not affect the validity of the decision.
Subdivision C—Allied health exceptional claims indemnity
Section 34ZZQ When is an allied health exceptional claims indemnity payable?
Criteria for payment of indemnity
New subsection 34ZZR(1) provides that the Chief Executive Medicare may decide that an allied health exceptional claims indemnity is payable in relation to a liability of a person (the ***practitioner***) if all of the following are met:

- a claim for compensation or damages (the current claim) is, or was, made against the practitioner by another person; and
- a qualifying allied health claim certificate is in force in relation to the current claim; and
- the liability is a qualifying allied health liability of the practitioner in relation to the current claim (see new section 34ZZS); and
- because of the practitioner’s contract limit in relation to the contract of insurance identified in the qualifying allied health claim certificate, the contract does not cover, or does not fully cover, the liability; and
- the amount that, if the practitioner’s contract limit had been high enough to cover the whole of the liability, the insurer would (subject to the other terms and conditions of the contract) have been liable to pay under the contract of insurance in relation to the liability exceeds the actual amount (if any) that the insurer has paid or is liable to pay under the contract in relation to the liability; and
- the aggregate of:
  - the amount (if any) the insurer has paid, or is liable to pay, in relation to the liability under the contract of insurance; and

  - the other amounts (if any) that the insurer has already paid, or has already become liable to pay, under the contract in relation to the current claim; and
  - the amounts (if any) that the insurer has already paid, or has already become liable to pay, under the contract in relation to any other claim against the practitioner that relates to an incident, or series of related incidents, covered by subsection (2) (being other claims that were first notified to the insurer no later than the time the current claim was notified to the insurer);

  equals or exceeds the relevant allied health threshold identified in the qualifying allied health claim certificate; and
- a person has applied for the indemnity in accordance with section 37A.

New subsection 34ZZR(2) provides that for the purposes of new subparagraph 34ZZR(1)(f)(iii), an incident or series of related incidents is covered by this subsection if the incident occurs or occurred, or the series of related incidents all occur or occur:

- on or after 1 July 2020; and
- in the course of, or in connection with:
  - practice by the practitioner of an allied health profession other than midwifery; or
  - practice of a kind in relation to which eligible midwives are ordinarily, or could reasonably be expected in the ordinary course of business to be, engaged as employees (and therefore indemnified from liability by their employer).

Additionally, any rules made for the purposes of subsection 11(3A) of the *Midwife Professional Indemnity (Commonwealth Contribution) Scheme Act 2010* apply for the purposes of determining whether practice is of a kind mentioned in subparagraph (2)(b)(ii) (subsection 34ZZR(3)).

Who the indemnity is payable to
New subsection 34ZZR(4) provides that the indemnity is to be paid to the person who applies for it. The person who applies for the indemnity could be the person against whom the claim was made or another person acting on their behalf (see section 37A).

Ordinary course of business test for insurance payments
New subsection 34ZZR(5) provides that an amount that an insurer has paid, or is liable to pay, under a contract of insurance does not count for the purpose of new subparagraph 34ZZR(1)(f)(i) or (ii) unless it is an amount that the insurer paid, or is liable to pay, in the ordinary course of the insurer's business.

What if the insurer is a Chapter 5 body corporate?
New subsection 34ZZR(6) provides that if an insurer is a Chapter 5 body corporate (for example, because the insurer is being wound up or is under administration):

- a reference in new paragraphs 34ZZR(1)(e) and (f) to an amount that the insurer is liable to pay under a contract of insurance is a reference to an amount that the insurer is liable to pay under the contract and that is a provable amount; and
- a reference in subsection 34ZZR(5) to an amount that an insurer is liable to pay in the ordinary course of the insurer's business is a reference to an amount that the insurer is liable to pay, and would be able to pay in the ordinary course of the insurer's business if it were not a Chapter 5 body corporate.

AAT review of decision to refuse, or to pay a particular amount of indemnity
New subsection 34ZZR(7) provides that an applications may be made to the Administrative Appeals Tribunal for review of the following decisions of the Chief Executive Medicare:

- a decision to refuse an application for allied health exceptional claims indemnity;
- a decision to pay a particular amount of allied health exceptional claims indemnity.

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

Section 34ZZS Qualifying allied health liabilities
New section 34ZZS provides that a person (the ***practitioner***) has a ***qualifying allied health liability*** in relation to a claim made against the person if:

- one of the following applies:
  - the liability is under a judgment or order of a court in relation to the claim, being a judgment or order that is not stayed and is not subject to appeal;
  - the liability is under a settlement of the claim that takes the form of a written agreement between the parties to the claim;
  - the liability is some other kind of liability of the practitioner (for example, a liability to legal costs) that relates to the claim; and
- the defence of the claim against the practitioner was conducted appropriately up to the time when:
  - if the liability is under a judgment or order of a court—the date on which the judgment or order became a judgment or order that is not stayed and is not subject to appeal; or
  - if the liability is under a settlement of the claim—the date on which the settlement agreement was entered into; or
  - if the liability is some other kind of liability—the date on which the liability was incurred; and

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

For paragraph 34ZZS(b), see the definitions of ***defence*** and ***conducted appropriately*** in subsection 4(1).

Section 34ZZT Treatment of a claim that partly relates to a public patient in a public hospital
New subsection 34ZZT allows for the reduction of amount that an insurer is liable to pay if claim against a person relates to a series of incidents and some of the incidents occurred during the provision of a treatment of a public patient in a public hospital. New section 34ZZT provides that if:

- a claim against a person relates to a series of incidents; and
- some, but not all, of the incidents occurred in the course of the provision of treatment to a public patient in a public hospital;

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

Section 34ZZU Treatment of a claim that relates to a series of incidents some of which occurred after the allied health termination date
Similar to section 34ZZT, new section 34ZZU allows for the reduction in the amount that an insurer is liable to pay to the extent that the amount to be reduced relates to incidents or incidents that occurred after the allied health termination date. New section 34ZZU provides that if:

- a claim against a person relates to a series of incidents; and
- some, but not all, of the incidents occurred after the allied health termination date;

then, for the purposes of applying paragraph 34ZZR(1)(e) and subparagraphs 34ZZR(1)(f)(i) and (ii) in relation to the claim, an amount that an insurer has paid or is liable to pay, or would have been liable to pay, in relation to the claim, is to be reduced by the extent (if any) to which the amount relates or would relate to, or is or would be reasonably attributable to, the incident or incidents that occurred after the allied health termination date.

Section 34ZZV The amount of allied health exceptional claims indemnity that is payable

New section 34ZZV provides that the amount of allied health exceptional claims indemnity that is payable in relation to a particular qualifying allied health liability is the amount of the excess referred to in new paragraph 34ZZR(1)(e).

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

Section 34ZZW How allied health exceptional claims indemnity is to be applied
New subsection 34ZZW(1) provides that this section applies if an allied health exceptional claims indemnity is paid to a person (the ***recipient***) in relation to a liability of a person (the ***practitioner***).

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

Chief Executive Medicare to give recipient of payment a notice identifying the liability to be discharged
New subsection 34ZZW(2) provides that the Chief Executive Medicare must give the recipient a written notice (the ***payment notice***) identifying the liability in relation to which the indemnity is paid, and advising the recipient how this section requires the indemnity to be dealt with.

Recipient's obligation if the amount of the indemnity equals or is less than the liability
New subsection 34ZZW(3) provides that if the amount of the indemnity equals or is less than the undischarged amount of the liability identified in the payment notice, the recipient must apply the whole of the indemnity towards the discharge of the liability.

Recipient's obligation if the amount of the indemnity exceeds the liability
New subsection 34ZZW(4) provides that if the amount of the indemnity is greater than the undischarged amount of the liability identified in the payment notice, the recipient must:

- apply so much of the indemnity as equals the undischarged amount of the liability towards the discharge of the liability; and
- if the recipient is not the practitioner—deal with the balance of the indemnity in accordance with the directions of the practitioner.

Time by which recipient must comply with obligation
New subsection 34ZZW(5) provides that the recipient must comply with whichever of subsections 34ZZW(3) and (4) applies:

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

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

To avoid doubt, the Chief Executive Medicare may vary a direction under new paragraph 34ZZW(5)(a) to specify a different time.

Debt to Commonwealth if recipient does not comply with obligation on time
New subsection 34ZZW(6) provides that if the recipient does not comply with whichever of new subsections 34ZZW(3) and (4) applies by the time required by new subsection 34ZZW(5), the amount of the indemnity is a debt due to the Commonwealth.

New subsection 34ZZW(7) provides that the debt may be recovered:

- by action by the Chief Executive Medicare against the recipient in a court of competent jurisdiction; or
- under section 42.

New subsection 34ZZW(8) provides that if the amount of the indemnity is recoverable, or has been recovered, as mentioned in new subsection 34ZZW(7), no amount is recoverable under section 34ZZZ or section 41 in relation to the same payment of allied health exceptional claims indemnity.

Section 34ZZX Who is liable to repay an overpayment of allied health exceptional claims indemnity?
New subsection 34ZZX(1) sets out that this section applies if, in relation to an allied health exceptional claims indemnity that has been paid, there is an amount overpaid as described in subsection 34ZZZ(2) or 41(2).

New subsection 34ZZX(2) provides that the ***liable person***, in relation to the amount overpaid, is:

- if the indemnity has not yet been dealt with in accordance with whichever of new subsections 34ZZW(3) and (4) applies—the recipient referred to in new subsection 34ZZW(1); or
- if the indemnity has been dealt with in accordance with whichever of those subsections applies—the practitioner referred to in new subsection 34ZZW(1).

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

New subsection 34ZZX(3) provides that if:

- the recipient and the practitioner referred to in subsection 34ZZW(1) are not the same person; and
- when the overpayment is recovered as a debt, the liable person is the recipient;

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

Subdivision D—Payments that would have reduced the amount paid out under the contract of insurance
Section 34ZZY Amounts paid before payment of allied health exceptional claims indemnity
New subsection 34ZZY(1) provides that if:

- an amount (the insurance payment) has been paid under a contract of insurance that provides medical indemnity cover for a person (the practitioner) in relation to a liability of the practitioner; and
- another amount (not being an amount referred to in subsection (2)) has been paid to the practitioner, the insurer or another person in relation to the incident or incidents to which the liability relates; and
- the other amount was not taken into account in working out the amount of the insurance payment; and
- if the other amount had been taken into account in working out the amount of the insurance payment, a lesser amount would have been paid under the contract of insurance in relation to the liability;

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

New subsection 34ZZY(2) provides that new section 34ZZY does not apply to any of the following amounts or payment:

- an amount paid to an insurer by another insurer under a right of contribution;
- a payment of allied health high cost claim indemnity;
- an amount of a kind specified in the rules for the purposes of this paragraph.

Section 34ZZZ Amounts paid after payment of allied health exceptional claims indemnity
New subsection 34ZZZ(1) provides that new section 34ZZZ applies if:

- an amount (the actual indemnity amount) of allied health exceptional claims indemnity has been paid in relation to a qualifying allied health liability that relates to a claim made against a person (the practitioner); and
- another amount (not being an amount referred to in subsection (5)) is paid to the practitioner, an insurer or another person in relation to the incident or incidents to which the claim relates, or in relation to one or more other incidents; and
- the other amount was not taken into account in calculating the actual indemnity amount; and

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

New section 34ZZZ(2) provides that the ***amount overpaid*** is the amount by which the actual indemnity amount exceeds the reduced indemnity amount.

New section 34ZZZ(3) provides that if the Chief Executive Medicare has given the liable person (see new subsection 34ZZX(2)) a notice under new subsection 34ZZZB(1) in relation to the amount overpaid, the amount is a debt owed to the Commonwealth by the liable person.

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

If:

- the recipient and the practitioner referred to in new subsection 34ZZW(1) are not the same person; and
- the practitioner becomes the liable person;

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

New subsection 34ZZZ(4) provides that the amount overpaid may be recovered:

- by action by the Chief Executive Medicare against the liable person in a court of competent jurisdiction; or
- under section 42.

New subsection 34ZZZ(4) provides that new section 34ZZZ does not apply to any of the following:

- an amount paid to an insurer by another insurer under a right of contribution;
- a payment of allied health high cost claim indemnity;
- an amount specified in the rules for the purposes of this paragraph.

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

New subsection 34ZZZA(1) provides that if:

- an amount of allied health exceptional claims indemnity has been paid in relation to a qualifying allied health liability that relates to a claim made against a person (the practitioner); and
- the person (the applicant) who applied for the allied health exceptional claims indemnity becomes aware that another amount has been paid to the

practitioner, an insurer or another person in relation to the incident or incidents to which the claim relates, or in relation to one or more other incidents; and

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

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

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

New subsection 34ZZZA(2) provides that the notification must:

- be in writing; and
- be given to the Chief Executive Medicare within 28 days after the applicant becomes aware that the other amount has been paid.

Section 34ZZZB The Chief Executive Medicare to notify of amount of debt due
New subsection 34ZZZB(1) provides that if:

- an amount of allied health exceptional claims indemnity has been paid in relation to a qualifying allied health liability that relates to a claim made against a person (the practitioner); and
- another amount is paid to the practitioner, an insurer or another person in relation to the incident or incidents to which the claim relates, or in relation to one or more other incidents; and
- because of the payment of the other amount, there is an amount overpaid as described in subsection 34ZZZ(2);

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

- the amount overpaid, and that it is a debt owed to the Commonwealth under subsection 34ZZZ(3); and
- the day before which the amount must be paid to the Commonwealth; and
- the effect of section 34ZZZC.

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

New subsection 34ZZZB(2) provides that the debt becomes due and payable on the day specified under new paragraph 34ZZZB(1)(e).

Section 34ZZZC Penalty imposed if an amount is repaid late
New subsection 34ZZZC(1) provides that if:

- a person owes a debt to the Commonwealth under subsection 34ZZZ(3); and
- the debt remains wholly or partly unpaid after it becomes due and payable;

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

New subsection 34ZZZC(2) specifies how late penalty payment is calculated. New subsection 34ZZZC(2) provides that the late payment penalty is calculated:

- at the rate specified in the rules for the purposes of this paragraph; and
- on the unpaid amount; and
- for the period:
  - starting when the amount becomes due and payable; and
  - ending when the amount, and the penalty payable under this section in relation to the amount, have been paid in full.

New subsection 34ZZZC(3) allows the Chief Executive Medicare to remit some or the whole of the amount of late penalty payment. New subsection 34ZZZC(3) provides that the Chief Executive Medicare may remit the whole or a part of an amount of late payment penalty if the Chief Executive Medicare considers that there are good reasons for doing so.

New subsection 34ZZZC(4) provides that applications may be made to the Administrative Appeals Tribunal for review of decisions of the Chief Executive Medicare not to remit, or to remit only part of, an amount of late payment penalty.

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

New subsection 34ZZZC(5) provides that if:

- the recipient and the practitioner referred to in new subsection 34ZZW(1) are not the same person; and
- the practitioner becomes the liable person; and
- the recipient has or had a liability under this section to pay late payment penalty;

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

Subdivision E—Regulations may provide for payments
Section 34ZZZD Regulations may provide for payments in relation to allied health exceptional claims

New subsection 34ZZZD(1) provides that the regulations may provide in relation to making payments to eligible insurers of claim handling fees, and payments on account of legal, administrative or other costs incurred by eligible insurers (whether on their own behalf or otherwise), in respect of claims in relation to which qualifying allied health claim certificates have been issued.

New subsection 34ZZZD(2) provides that without limiting new subsection 34ZZZD(1), the regulations may:

- make provision for:
  - the conditions that must be satisfied for an amount to be payable to an insurer; and
  - the amount that is payable; and
  - the conditions that must be complied with by an insurer to which an amount is paid; and
  - other matters related to the making of payments, and the recovery of overpayments; and
- provide that this Division applies with specified modifications in relation to a liability that relates to costs in relation to which an amount has been paid under regulations made for the purposes of this section; and
- make provision for making payments on account of legal, administrative or other costs incurred by insurers (whether on their own behalf or otherwise), in respect of incidents notified to insurers that could give rise to claims in relation to which an allied health exceptional claims indemnity could be payable.

New subsection 34ZZZD(3) provides that new paragraph 34ZZZD(2)(b) does not allow the regulations to modify a provision that creates an offence, or that imposes an obligation which, if contravened, constitutes an offence.

New subsection 34ZZZD(4) provides that it does not matter for the purposes of new paragraph 34ZZZD(2)(c) whether claims are subsequently made in relation to the incidents referred to in that paragraph.

Section 34ZZZE The Chief Executive Medicare may request information
New subsection 34ZZZE(1) provides that if the Chief Executive Medicare believes that a person is capable of giving information that is relevant to determining:

- whether an insurer is entitled to a payment under regulations made for the purposes of new section 34ZZZD; or
- the amount that is payable to an insurer under regulations made for the purposes of new section 34ZZZD;

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

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

New subsection 34ZZZE(2) provides that without limiting new subsection 34ZZZE(1), any of the following persons may be requested to give information under that subsection:

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

New subsection 34ZZZE(3) provides that without limiting new subsection 34ZZZE(1), if the information sought by the Chief Executive Medicare is information relating to a matter in relation to which a person is required by section 39 to keep a record, the Chief Executive Medicare may request the person to give the information by giving the Chief Executive Medicare the record, or a copy of the record.

New subsection 34ZZZE(4) provides that the request:

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

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

Subdivision F—Miscellaneous
Section 34ZZZF Modifications and exclusions
New subsection 34ZZZF(1) provides that the regulations may provide that this Division applies with specified modifications in relation to:

- a specified class of claims; or
- a specified class of contracts of insurance; or
- a specified class of situations in which a liability is, whether wholly or partly, covered by more than one contract of insurance.

For the capacity for rules to exclude claims and contracts of insurance, see new paragraphs 34ZZK(1)(i) and (j).

New subsection 34ZZZF(2) provides that the regulations may provide that this Division does not apply, or applies with specified modifications, in relation to a specified class of liabilities or payments.

New subsection 34ZZZF(3) provides that without limiting new subsection 34ZZZF(2), the regulations may specify modifications regarding how this Division applies in relation to a liability under an order of a court requiring an amount to be paid pending the outcome of an appeal, including modifications:

- to count the liability as a qualifying allied health liability (even though new subparagraph 34ZZS(a)(i) may not be satisfied in relation to the order); and
- to deal with what happens if, as a result of the appeal or another appeal, the amount paid later becomes wholly or partly repayable; and
- to deal with what happens if the amount paid is later applied towards a liability that is confirmed as a result of the appeal or another appeal.

New subsection 34ZZZF(4) provides that new section 34ZZZF does not allow the regulations to modify a provision that creates an offence, or that imposes an obligation which, if contravened, constitutes an offence.

<u>Items 27; 28; 29; 30; 31; 32; 33; 34; 39; 40; 41; 42; 43; 44; 45; 46; 47; 48; 49; 50; 51; 52; 53; 54; 55; 56 and 57</u>
These items make various amendments to subsection 35(1); section 36 (heading); subsection 36; Section 37 (heading); subsection 37(1); subparagraphs 37(2)(a) and (d); subsection 37(2); section 37A (at the end of the heading); section 37B (at the end of the heading); subsections 37B(1) and (2); subsection 37B(3); subsection 37B(4); paragraph 38(1)(c); paragraph 39(1)(c); subsection 39(1A) (at the end of the heading); subsection 39(1A); paragraph 39(1A)(a); paragraph 41(3)(a); after paragraph 41(3)(b); subsection 41(3) (notes 1 and 2); paragraph 41(4)(b); subsection 42(1); paragraph 42(3A)(a); paragraph 42(3A)(b); after paragraph 45(1)(bb); subsection 46(1); and subsection 46(3).

These minor and consequential amendments ensure provisions in the *Medical Indemnity Act 2002* that are intended to have equal application across the HCCS and the AHHCCS, or the ECS and the AHECS, reference all relevant schemes (by incorporating references to the new allied health profession schemes). For example, the payment date for a high cost claim indemnity as set out in section 37 should also have application in respect of an allied health high cost claim indemnity. Amendments in items 30 to 33 achieve this intent.

<u>Item 35; 36</u>
Item 35 inserts a new subsection 37A(1A) in the *Medical Indemnity Act 2002.* This provision provides that either the person against whom the claim is made, or someone on his or her behalf, may make an application for an allied health exceptional claims indemnity in relation to a qualifying allied health liability. The amendment made by item 36 is consequential to the amendment made by item 35.

Item 37; 38

Item 38 repeals subsection 37A(4) of the *Medical Indemnity Act 2002*. Subsection 37A(4) is no longer required because more than 28 days has passed since the commencement of Division 2A (which sets out the ECS), making the subsection redundant. The amendment made by item 37, to remove cross-references to subsection 37A(4), is consequential to the amendment made by item 38.

Medical Indemnity (Prudential Supervision and Product Standards) Act 2003

Item 58: After paragraph 20(aa)

This item inserts a new subsection 20(ab) into the *Medical Indemnity (Prudential Supervision and Product Standards) Act 2003*, to exclude any right the insurer may have to an allied health high cost claim indemnity from the calculation of the maximum amount payable by an insurer under a contract of insurance. The maximum amount payable by an insurer under a contract of insurance is used to determine if the insurer is compliant with its obligation under Division 1 of Part 3 of the *Medical Indemnity (Prudential Supervision and Product Standards) Act 2003* to provide a minimum amount of medical indemnity cover in its contracts of insurance.

Item 59: Application and transitional

This item clarifies the intended application of various amendments made by this Schedule to the *Medical Indemnity Act 2002* and the *Medical Indemnity (Prudential Supervision and Product Standards) Act 2003*.

Subitem 59(1) provides that the amendments of Part 1 and Division 2A of Part 2 of the *Medical Indemnity Act 2002* relating to the exceptional claims indemnity scheme made by Schedule 6 to the Bill apply to any claim made after the commencement of this item.

Subitem 59(2) provides that the amendments of section 41 of the *Medical Indemnity Act 2002* made by this Schedule apply in relation to any amount paid by way of an indemnity scheme payment, whether paid before or after the commencement of this item.

Subitem (3) provides that the amendments of section 42 of the *Medical Indemnity Act 2002* made by this Schedule do not affect a direction by the Chief Executive Medicare under that section before the commencement of this item.

Subitem 59(4) provides that the amendments made to section 20 of the *Medical Indemnity (Prudential Supervision and Product Standards) Act 2003* apply to any contract of insurance when finalised or renewed before, on or after the commencement of this item.