Level 24, 91 King William Street
Adelaide SA 5000
T 08 8113 5312

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Mr Michael Wellham
Department of Treasury
Langton Crescent
CANBERRA ACT 2600

Dear Michael

MIIAA response on Treasury discussion paper: Employer Insurance Arrangements and the Medical Indemnity (Prudential Supervision and Product Standards) Act 2003

In 2002-2003 the Australian Government introduced reforms to ensure a viable and ongoing medical indemnity industry. The reforms included providing premium subsidies to doctors in high risk speciality categories, financial assistance to medical indemnity providers in relation to high cost claims, and the provision of a new regulatory framework for medical indemnity insurance.

In 2003 the Medical Indemnity Panel reviewed medical indemnity insurance for private medical practice and made recommendations to secure an affordable and sustainable system of medical indemnity insurance fair to patients, taxpayers and doctors. A report was delivered in December 2003 to the Prime Minister and further initiatives were introduced.

MIIAA considers that this package of measures has been critically important to the viability of the medical indemnity industry and has provided improved affordability of medical indemnity premiums. It considers that it is critical that the package of measures continues and that any changes introduced should ensure the ongoing viability of the medical indemnity industry. The medical indemnity industry is relatively small. Prudential regulation imposes obligations on Medical Indemnity Insurers which would make them unable to compete in an insurance market where other insurers are able to avoid those obligations.

The Medical Indemnity (Prudential Supervision and Product Standards) Act 2003 (the Act) imposes product standards for medical indemnity insurance. Public healthcare provider employers and others are exempted under Section 8 of the Act but the requirements of the Act apply when Medical Indemnity insurance is obtained (Section 5). Arrangements are exempted through the Regulations promulgated under the Act (Regulation 4).

The Treasury options paper raises the following issues:

1. Without the present temporary regulations the product standards for insurance arrangements of employers requires employers of medical practitioners to provide retroactive cover for the prior employment of their employee doctors and $5 million cover for each doctor.

2. A $5 million cover amount for each doctor in an employer/employee arrangement is unaffordable or unobtainable for organisations that employ a large number of doctors and may far exceed the risk profile of the organisation.

3. The paper comments that the two main stakeholder concerns with the existing exemptions are:
   a. Doctors who do not buy their own insurance do not have the benefit of product standards which may result in an employee doctor being exposed to a claim where the employer is uninsured and insolvent;
   b. Doctors may use an exception for employers to buy cheaper cover.

The paper notes:

1. Currently, individual employee doctors can purchase the level of cover required for registration, or required by their employer or as they deem appropriate to their circumstances. If they do, insurers are required to offer them retroactive and run-off cover and a minimum level of cover.

2. “Any doctor who bought limited cover from an insurer (because their employer is indemnifying them) who finds that the employer is insolvent after notification of a claim can seek a complying offer of cover with an appropriate retroactive date.” **This is incorrect** as any such cover would not include cover for any claim (or circumstance) already notified. Notified claims are excluded from any offer of cover therefore the claim already notified cannot be subsequently insured.

THE OPTIONS RAISED

The paper discusses the following options:

Option 1 – Formalise current exemption

Option 2 – Exempt individual insurance arrangements

Option 3 – Actuarially-certified minimum cover

Option 4 – Formula-derived minimum cover

Option 5 – List of exemptions

Option 6 – Offer of run-off cover to employee doctors

DISCUSSION

In considering the options the overall objectives of the Medical indemnity package must be paramount. Any change exempting medical practitioners from the product standards for insurance arrangements has the potential to destabilise the medical indemnity industry. Medical indemnity insurers operate with relatively small numbers of insureds in single line businesses. The loss of significant numbers of insureds could impact dramatically on the stability of the industry. **Any removal of product standards for a significant group of medical practitioners has the potential to severely damage the objectives of the medical indemnity reforms.**

MIIAA believes that the issue presently impacts on a small number of doctors, as most doctors prefer to maintain private medical indemnity cover within the individual product standards, which may be subsidized or paid for by a corporate employer.

Any solution, other than requiring that all doctors practising in Australia have their own individual policy, with the exception of Government employed / contracted doctors, has the potential to destabilize the industry and expose patients to inadequate protection.

In considering appropriate product standards for insurers of employers of medical practitioners it is critical that there be a clear definition of "employer". Where the employer is a doctor-controlled entity employing doctors, or a doctor or doctors who control that entity, it is critical that the product standards for individual medical practitioners apply to those employed practitioners.

The corporatisation of private medical practice has increased significantly, with private hospitals providing emergency clinics and career medical officer roles, and corporate medicine playing a significant role in general practice and dominating Pathology and Radiology. Other areas of medical practice will follow.

Some employers arrange their own insurance for all medical indemnity cover, including the actions of doctors and other health care providers. Cover is extended to the doctors who work for the employer (typically payroll employees) and may extend to 'contractors' in some cases.

We believe that presently, more often, employers require doctors to obtain their own insurance and arrange cover for the business on the basis that the doctor contractually indemnifies the employer for claims arising from his/her acts and omissions. Doctors who obtain their own insurance have insurance complying with the individual product standards.

Some employers would have insurance arrangements which combine both scenarios above. For example, certain employees might have the benefit of employer indemnity while others (maybe contractors) won't. Part time medical staff, working in private practice elsewhere, will have medical indemnity cover for their private medical practice, which is easily extended to the "employer" environment.

There are two distinct different types of employers of doctors:

1. Independent/corporate entities – private hospitals and commercial entities operating medical practices employ medical practitioners to deliver medical services.

2. Doctor-controlled entities – entities owned by a doctor or doctors and/or their families where any profit will be for the benefit of the family or a family related entity. In many cases this involves a single doctor being employed by a corporate entity for the purpose of delivering a medical service. These doctors will maintain their own personal indemnity cover.

In approaching the question of employer insurance arrangements a distinction should be drawn between the independent entity and the doctor-controlled entity.

A doctor-controlled entity effectively involves medical practitioners providing direct medical services to the patients. Doctors practising within those entities should be required to obtain individual cover that meets products standards.

Independent entities can be distinguished from doctor-controlled entities as they are either operated on a not for profit basis or on a commercial basis, and are controlled by boards of directors acting in the overall interest of the entity. Independent entities should not be required to meet product standards existing for individual medical practitioners.

Individual standards are not appropriate for an independent entity.

However, an independent entity employer should be required to obtain indemnity insurance from a regulated insurer, with different product standards applying to that entity, including:

1. Insurance cover for all employees

2. Run-off and retroactive cover

   A successor business should be responsible for arranging (retro) cover for assumed businesses. This can be contentious if for instance the purchaser of a business wants to negotiate that the seller must obtain run-off cover for prior risks. However as unlimited run-off cover is not available, it would seem necessary for the purchaser to provide cover on an ongoing basis. This could be folded up into their other insurance arrangements.

   If there is no successor business and the entity is winding up, the entity could be required to purchase run-off cover for a period of time. The best the market (and the wound up entity) could bear is likely to be 3 years.

   However once the run-off cover period is completed, or no run-off cover can be purchased, what options are available?

   1. No standard is specified which may result in unfunded claims.

   2. *Impose* an obligation on the last insurer to provide insurance. However this could be difficult to achieve!

3. Medical indemnity insurers (MII's) provide to doctors' retrocover, at a realistically costed premium, if the doctor is continuing to practise, or run-off cover if retired. Presumably, claims would eventually fall into ROCS. If so, do the regular ROCS rules apply? For example, if the doctor is over 65 and retired, then would they go straight into ROCS? This approach ignores the insurance needs of other healthcare professionals previously employed by the corporate which may impact the quantum of compensation payouts.

4. Claims fall into ROCS or a similar scheme. Claims handling and premium collection would need to be extended to overseas insurers, which would be difficult.

5. The independent entity could be required in the event that it ceases to carry on business as an employer of medical practitioners and ceases to take out insurance, to advise all employed and previously employed medical practitioners that it has ceased business.

3. A minimum level of cover

A minimum level of cover should be expressed in terms of an any one claim limit. The standard might specify a minimum of $20 million in any one claim.

There is much debate concerning the appropriateness of any level of the sum insured (too much or too little) but, as $20m is a de-facto benchmark for individual doctors, it is suggested that it should apply to all corporates, to avoid the possibility of 2 different compensation outcomes (i.e. a two tier indemnity system). $20m represents 4 times the minimum individual product standard. A minimum limit, what ever it is, would need to be reviewed periodically to allow for developments in claims costs.

There should be no limit to the retention a corporate may take under insurance.

TREASURY OPTIONS

Option 1 – Formalise current exemption

We do not believe that the current exemptions meet the Government policy intention of securing access for patients to rights of compensation from insurers or other entities with the financial capability to deliver on those obligations. We believe the current exemptions:

1. Impose no minimum policy coverage.
2. Do not impose retrospective or run-off cover obligations on employers of medical practitioners or their insurers.
3. Do not adequately define an employer and thereby create a potential for medical practitioners intended to be covered under the medical indemnity arrangements to acquire a lesser product in coverage and possibly security.

Option 2 – Exempt individual insurance arrangements

Under this arrangement if employees are required to purchase individual cover the insurance arrangements of the employer would be exempt from the product standards. It appears, practically speaking, that in most cases medical practitioners already purchase individual cover, making this an appropriate option. All doctors have the benefit of the product standards. The options paper suggests that there would be significant administration and enforcement costs. However, whilst there would be some additional costs, it is submitted that most costs are not as significant as suggested. Where an employee doctor is insured, in most states the employer is entitled to seek indemnity from the doctor's insurer, under the doctor's policy. Funding of the individual premium can be at the cost of the doctor, the employer or shared, and is a matter between employer and the doctor.

Option 3 – Actuarially-certified minimum cover

The discussion paper notes this option is complex. It does not protect the insured employees where the hospital no longer takes the necessary insurance, that is, run-off cover protection.

Option 4 – Formula-derived minimum cover

Like option 3 this could be administratively complex and does not address the issue of run-off cover protection.

Option 5 – List of exemptions

Under this proposal insurance arrangements of specified employers would be exempt from the standards based on an estimate of the financial stability. This option seems to be overly complex.

Option 6 – Offer of run-off cover to employee doctors

The proposal would require medical indemnity insurers to offer run-off cover to a doctor who is no longer covered/ insured under an employer's insurance policy. In the discussion paper it is suggested the option would pose a moral hazard by discouraging doctors from paying for run-off cover while practising and that those doctors buying insurance would incur the cost of run-off cover of those employee doctors. As against this there are only a small number of doctors presently not separately insured.

This is a viable option if the requirement for an insurer to provide the cover at no or nominal cost is removed. The cost should be borne by those receiving the benefit under the cover. This means that such a doctor will need to meet the cost themselves and/or have their employer agree to meet the cost as part of severance arrangement and/or for the Government agree that the premium be recoverable all or in part by the PSS.

The impact of ROCS needs to be considered. Would this indemnity fall straight into ROCS or be met by the MII for the first 3 years and then fall into ROCS? If it falls immediately into ROCS, there are equity issues. If it falls to MII's they must be able to charge a realistic premium. Would it matter that the doctor is retired and over 65? Would this doctor be immediately eligible for ROCS?

MIIAA POSITION

The MIIAA considers that the package of measures provided to support the medical indemnity industry continue to be critical to the ongoing viability of the industry and that any proposed changes must be compatible with that package.

The medical indemnity industry is relatively small. Prudential regulation imposes obligations on Medical Indemnity Insurers which would make them unable to compete if other insurers are able to avoid those obligations.

In considering appropriate product standards for insurers of employers of medical practitioners it is critical that there be a clear definition of "employer". Where the employer is a doctor-controlled entity employing doctors or a doctor or doctors who control that entity it is critical that the product standards for individual medical practitioners apply to those employed practitioners. A significant proportion of private medical practitioners practice in doctor controlled corporate entities.

Product standards for employers of medical practitioners must relate to independent corporate entities and not doctor-controlled entities.

None of the proposed options provides a complete solution. Any solution is complex, and needs to ensure that individual cover and corporate cover can operate, seamlessly, side by side.

- Option 2 is viable provided the definition of employer is dealt with as recommended above.

- Option 6 is viable provided the requirement for insurers to provide cover at no or minimal cost is removed.

- A combination of option 2 and 6 may provide a workable solution to the problems.

- In both option 2 or 6 or any other proposed solution at the employer level it is necessary to impose standards that require:

    - Insurance cover for all employees, and past employees;
    - Retroactive cover to the date of commencement of business by the entity including all predecessors in business;
    - Run-off cover;
    - A minimum level of cover.

- In addition, the independent entity could be required in the event that it ceases to carry on business as an employer of medical practitioners and ceases to take out insurance, to advise all employed and previously employed medical practitioners that it has ceased business and of the potential exposure to its past and present employees.

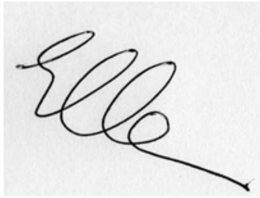
- A different set of product standards should apply to employing entities and their insurers. Employees of those complying entities should then be exempt from the individual product standards.

- Public institutions should have permanent exemptions.

- The benefits of the Medical indemnity package should be limited to those insured under the product standards for individual insured doctors.

We look forward to further discussions with Treasury following consideration of the input from the participants in the round table. If you have any questions regarding the content of this submission, please contact me.

Yours sincerely



Ellen Edmonds-Wilson
Chief Executive Officer