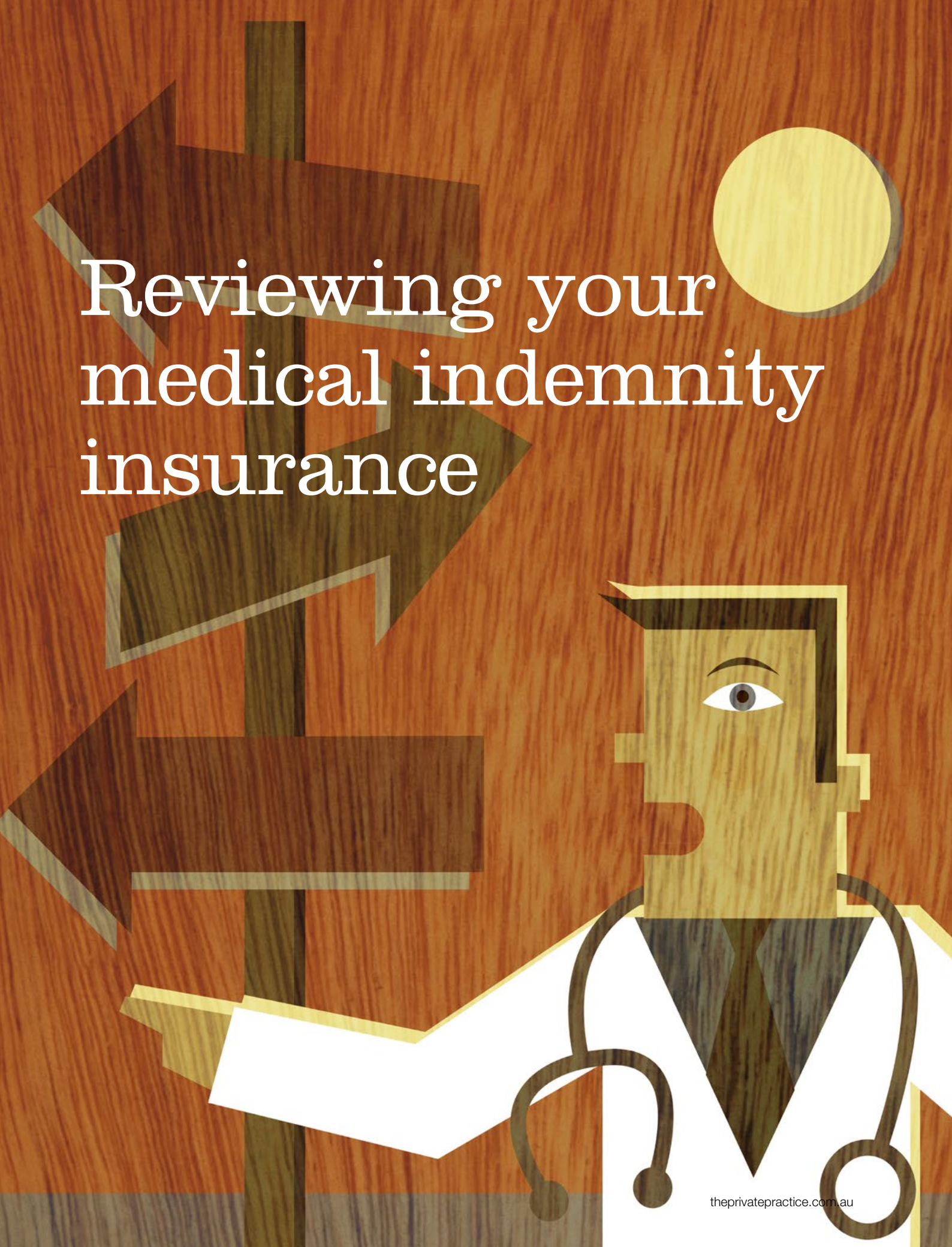
Reviewing your medical indemnity insurance



Chris Mariani explains why the cost of an insurance policy shouldn't be your deciding factor.

Dr X contacted us last year requesting our advice on their medical indemnity renewal. They were paying ~$90,000 annually (the sort of premium many Obstetricians and Neurosurgeons pay) and had never had a patient claim against them. The doctor was in the position where 80% of their work was low risk surgery, but they were charged based on the highest risk surgery profile of their speciality. We provided an alternative insurer quote at ~$45,000 and also assisted the doctor to write a letter to their current provider who revised their renewal quote to ~$60,000. We then sat with the doctor and talked with them on the pros and cons of staying/switching insurers.

If you were faced with the above scenario (which is a real life case), would you switch insurers? The answer to this question is not straight forward, as price is only one of the factors you need to consider. In this doctor's case, after discussing the pros and cons, the doctor decided to stay with their current insurer – but the work done meant a ~$30,000 saving from the previous year.

Doctors now have five Medical Indemnity Insurers to choose from:

- Avant
- MDA National
- MIGA
- MIPS
- TEGO (backed by Berkshire Hathaway)

Historically doctors tended to join a Medical Defence Organisation (MDO) based on who provided the nicest free pen at a medical student or intern event. For older doctors, the MDOs during their training years were largely state based and choice was therefore limited or non-existent. Joining during student or training years was either free, or a few hundred dollars. Pre ~2000, the MDOs largely provided 'discretionary assistance' meaning it was impossible to compare what one MDO would cover versus another.

Fast forward to 2017 and medical indemnity is provided as a regulated insurance contract – the "small print" matters and there is no one best policy that suits every doctor – as individual circumstances and needs are unique. Doctors tell us the biggest issue is they simply do not have the time (or insurance expertise) to wade through the hundreds of pages of product disclose statements, category guides and other documentation – in order to determine the differences between the insurers.

Having specialised in medical indemnity insurance for over 10 years (I previously wrote the policy for one of the above insurers) – if I was the doctor above, what criteria would I use to make the decision to stay with my current provider, or to switch to the new insurer? The table on the following page provides some points to consider. But before reading the table go to the end of this article and you will see a disclaimer that says:

The information provided in this article is of a general nature and does not take into account your objectives, financial situation or need. Please refer to the relevant Product Disclosure Statement before purchasing any insurance product.

Putting this statement in a doctor/patient scenario – it is akin to saying:

- here's my prescription/referral pad, make your own decisions about the right treatment for you.
- this is the only treatment option we provide and we are not going to advise you on whether there is a better, more appropriate treatment option down the road.

If I was confronted by these statements by my doctor I would seek another doctor who was acting in my best interests and who was providing me a diagnosis and treatment plan. The reality when dealing directly with an insurer is they provide the disclaimers which mean they have no obligation to tell you if there is a better, more suitable product down the road. So if you see the words "general advice", run for the hills!

The easiest way to deal with this 'relationship issue' is to ask a simple question and to have the person provide a written response – "please provide your personal advice recommendation in writing that your product is the best, most suitable product for my circumstances". If they cannot or will not do this, then you are being sold a product, rather than getting advice.

Topic	Summary
Am I getting "Personal Advice"?	Get in writing from each insurer: 1. "this is the best, most appropriate policy for me". 2. "these are the pros and cons of our product" As noted in the article look for 'personal advice' and avoid the 'general advice' disclaimers.
Does the policy suit my practice structure?	Where applicable ensure the policy extends to cover your practice entity and employed staff. The insurer policies vary widely in this regard and you may require an additional 'practice indemnity'.
What does the policy cover?	All of the insurers provide $20million cover for a patient's civil claim against you. But check the additional covers they provide around employment and hospital disputes, training disputes, medicare audits and other 'non-civil' issues covered. These are where you need your own lawyer to assist you to manage these issues. Again insurer policies vary widely.
Where does the policy stop and can you provide me advice on other insurances I need?	Particularly where you run your own practice, employ staff, lease/own rooms, you will likely require a range of other insurances to protect some. Some policies like workers compensation are required by law and penalties apply if you do not comply.
Is my 'tail covered' if I switch?	Ensure your tail is covered with the new insurer. This means selecting the appropriate 'retroactive date' with the new insurer if you switch. Secondly, ensure you report all claims and circumstances to your current insurer before you switch. If in doubt, report it! (Read the section on the following page 'will my tail be covered if I switch' for more information)
Will I lose the continuous cover benefit?	Some of the policies provide 'continuous cover' which means as long as you stay continuously insured with that insurer, you can 'late notify' a claim, that you should have notified in an earlier policy with that insurer. You lose this benefit when switching insurers, so again it's important – If in doubt, report it!
What "Membership" benefits apply?	What membership benefits will you lose when leaving your current MDO (if any), against those you may gain from the new provider. For example, one MDO provides a loyalty payment which increases based on tenure, therefore reducing premiums over time. We had a doctor with almost $100,000 of 'retirement reward' dividend due to them but this would be lost if they left the MDO before retirement.
What about my future premiums?	Don't just look at the premium quoted. What will the premiums be in future years, especially where you are starting out in private practice, changing specialities or billings – as these can all significantly change future premiums. Ask about the insurers rating model – is it a 'step-up' model whereby premiums increase over the first few years?
What is your financial strength?	Read the annual report of the insurer. What are their net assets (i.e. the money they have aside to pay claims)? What has their financial performance been over the last few years and is there any indications on whether premiums may rise in the future. Have they set 'excess capital' aside which you own a part of as a member (MDO applicable).
What are my future plans and do I need to consider my run-off requirements?	Understand your particular circumstances. For example, a doctor planning to retire from private practice is eligible for free "ROCS" (Run-Off Cover Scheme).

Topic	Summary
What is the experience and quality of their claims and legal team?	Ultimately, this is what you are paying for. You don't want the cheapest (or no) lawyer to represent you when your AHPRA registration is on the line. Read the insurers reports and medico-legal papers. Ask for documents that show how they have assisted doctors and what legal cases they have run and supported. Determine if you value having expert local claims managers and lawyers in your state.
Does my policy comply with my PII Registration Standard?	Download the Professional Indemnity Registration Standard from http://www.medicalboard.gov.au/Registration-Standards.aspx

WILL MY TAIL BE COVERED IF I SWITCH?

Legislation* requires a medical indemnity insurer to provide you an offer to cover your tail (known as retroactive cover). There are however two important items you need to address to ensure your tail is covered when switching insurers:

1. You need to ensure you provide the new insurer with the correct 'retroactive date'. This date should be stated on your current policy schedule (see below for further details).
2. You need to ensure before you cancel (or allow your current policy to lapse), that you report to your existing insurer all claims (and circumstances that a reasonable person would expect may result in a claim being made against you in the future).

The insurer's application form will ask about your 'retroactive cover' requirements. Your retroactive date will depend on your circumstances and may be:

- The date you first commenced practice in Australia (or first registered)
- The date your insurance cover moved from an 'occurrence' policy to a 'claims made' policy (the MDOs moved to 'claims made' policies between 1997 and 2004)
- If you have purchased a run-off policy with a previous insurer and continue that cover, your new policy may provide a retroactive date starting at the end of the run-off policy.

Even if you are not switching insurers, it is wise to check the retroactive date noted on your policy covers you correctly. If you discover the date is not correct, it can be changed by contacting your insurer and providing the correct details. Your insurer will rely on the retroactive date you declare, so if it's wrong, you risk a gap in your cover.

A NOTE ON 'CLAIMS MADE' POLICIES

Medical indemnity insurance in Australia is generally provided under a 'claims made and notified' policy. This means the 'trigger' is the date you first become aware of a claim (or a circumstance that a reasonable person would expect may result in a claim) and first report it to your insurer.

Generally claims made policies require you to report the claim to the insurer during the policy period (however some policies provide 'continuous cover' which we recommend as a key policy feature when advising our clients). Our general rule when advising clients is 'if in doubt – report it!' This is particularly relevant when you are switching insurers. Ⓟ

*_The Medical Indemnity (Prudential Supervision and Product Standards) Act 2003 Cth_ requires an insurer to make a compulsory offer covering all 'otherwise uncovered prior incidents'.

Time to review your medical indemnity and other insurances?

Please contact Chis Mariani on 0419 017 011 or **chris@mgrs.com.au**