April 2008

Australian Competition & Consumer Commission

Medical indemnity insurance

FIFTH MONITORING REPORT

Australian
Competition &
Consumer
Commission

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Abbreviations

ABS	Australian Bureau of Statistics
ACCC	Australian Competition and Consumer Commission
AIL	Avant Insurance Limited
AMIL	Australasian Medical Insurance Limited
APRA	Australian Prudential Regulation Authority
ASIC	Australian Securities and Investment Commission
Avant	Avant Mutual Group Limited
AWE	average weekly earnings
ECS	exceptional claims scheme
GP	general practitioner
GST	goods and services tax
HCCS	high cost claims scheme
HIC	Health Insurance Commission
IBNR	incurred but not reported
IAAust	Institute of Actuaries Australia
Invivo	Invivo Medical Pty Ltd
MCR	minimum capital requirement
MDAN	MDA National Pty Ltd
MDANI	MDA National Insurance Pty Ltd
MDASA	Medical Defence Association of South Australia Limited
MDAV	Medical Defence Association of Victoria Limited
MDAWA	Medical Defence Association of Western Australia
MDO	medical defence organisation
MIA	Medical Insurance Australia Pty Ltd
MIGA	Medical Insurance Group Australia
MIPS	Medical Indemnity Protection Society Limited
MIPSI	MIPS Insurance Pty Ltd
MPSTas	Medical Protection Society of Tasmania
MISS	medical indemnity subsidy scheme
PIICA	Professional Indemnity Insurance Company Australia Pty Limited
PSS	premium support scheme
QBE	QBE Insurance (Australia) Limited
QDM	Queensland Doctors Mutual Pty Ltd
ROCS	run-off cover scheme
UMP	United Medical Protection Limited (as referred to in legislation)
United	United Medical Protection Limited

Glossary of terms

claims expense	This is all payments made in the year on claims arising from that and previous notification years, as well as any adjustments to outstanding claims provisions across the year.
claims-incurred cover	This occurs when the insurer agrees to indemnify the policy holder for any valid claims arising from incidents that occur during the coverage period, with a claim able to be lodged at any time in the future.
claims-made cover	This occurs when the insurer agrees to indemnify all claims arising from incidents notified during the policy period, so long as the incident occurred during the current period, or any previous periods in which the policyholder has held continuous claims-made cover with the insurer up to and including the current period, or to an earlier retroactive date. Due to the more limited period the insurer is 'on risk', especially in early years, this is typically a cheaper product to underwriting than claims-incurred cover.
claims frequency	This is the ultimate number of claims expected by year of notification expressed as a proportion of the total number of Medicare services provided in the corresponding year.
combined ratio	This is the sum of the loss ratio and the expense ratio showing whether the sum of expenses (claims expenses and other expenses) is lower or higher than premium revenue for the year.
excess of loss reinsurance	This refers to when the direct insurer carries all individual losses incurred in each individual claim up to a certain limit, and the reinsurer pays the loss in excess of this amount (known as the attachment point) for each and every claim. There may also be an aggregate limit for all claims assumed by the reinsurer.
expense ratio	This is the sum of all underwriting and general expenses (excluding reinsurance expenses) as a proportion of premium revenue for the year.
incident	An incident resulting in a personal injury or death which may develop into a claim against the medical practitioner.
incurred but not reported claims (IBNRs)	These are claims arising from incidents or losses that have occurred but are yet to be reported to the insurer.
indemnified members	These are the number of members that are 'at risk', that is, those members for whom the medical indemnity provider may be required to pay a claim (the measure excludes those non-indemnified members such as students and those that are employer indemnified).
long-tail class	This is a class of insurance in which there may be a delay of many years before a claim is reported and/or paid.
loss ratio	This is the total claims expense in a year as a proportion of premium revenue for that year.
minimum capital requirement (MCR)	The MCR is the amount of capital APRA requires insurers to hold as a buffer to absorb unusual or extreme shocks. The minimum capital requirement is commensurate with an insurer's risk profile, but subject to a minimum of $5 million.

medical defence organisation (MDO)	An MDO is a not-for-profit mutual organisation created and owned by medical practitioners to provide various services to members, including indemnity (indemnity was only able to be offered by MDOs before 1 July 2003).
medical indemnity provider	This is an organisation that provides liability insurance, either as an insurer or as an authorised representative of an insurer, that indemnifies medical practitioners for financial loss arising from actions brought against them as a result of the performance of their professional duties.
notification year	This is the year in which the insurer is notified of a claim or an incident that may potentially give rise to a claim.
personal injury or death claim	This is a claim relating to an incident that results in the injury or death of a third party individual.
premium revenue	This is the amount of gross written premium that is 'earned' during the period, earned being the proportion of risk covered.
pure risk premium	This is the amount of premium needed just to meet the cost of expected medical indemnity claims and associated costs.
reinsurance	This is the contract/agreement by which an insurer cedes some of its premium in exchange for the reinsurer accepting some of the risks underwritten by that premium. Simply put, this is insurance for an insurer.
reinsurance ratio	This is the reinsurance expense as a proportion of premium revenue for that year.
retroactive cover	This is cover purchased to extend the period of incidents for which notifications are covered. This type of cover is purchased from the medical indemnity provider to which the medical practitioner is moving, enabling them to notify their new provider of claims which relate to incidents that occurred before joining that provider. Typically, this cover applies to claims-made cover.
return on net assets	This is the emerging surplus net of tax as a percentage of the total net assets held over the period.
run-off cover	This is the cover purchased to extend the period for notifying an insurer of a potential claim. This type of cover is purchased from the medical indemnity provider from which the medical practitioner is leaving. This type of cover typically applies to claims-made cover.
stop loss reinsurance	The reinsurer is obliged to cover any part of the total annual loss burden that exceeds an aggregate retention, where the retention is defined as a percentage of annual premium or a fixed sum.
ultimate claims costs	These are all the claims costs that the insurer expects will eventually be paid for claims arising in a given notification year.
ultimate number of claims	These are the total number of notifications that the insurers expect will eventually become claims and be paid.
underwriting performance	This is a measure of the performance of the underwriting activities of an insurer, comparing the claims expense and operating expenses of running an insurance operation against the premiums charged to support the insurance operation.
underwriting year	This is the year in which an insurance policy was issued.

Summary

Background

Medical indemnity insurance is a form of liability insurance that indemnifies medical practitioners for financial loss arising from actions brought against them as a result of the performance of their professional duties. Claims against medical practitioners relate to personal injury and death, and are lodged against a medical practitioner as a result of a breach, or perceived breach, of a given standard of care in the treatment of a patient.

Before 1 July 2003 medical indemnity protection was typically offered by medical defence organisations (MDOs), which operated on a not-for-profit basis as 'mutuals' that were owned and operated by members. Indemnity was offered on a 'discretionary' basis since the MDO had no contractual obligation to indemnify a medical practitioner.

In May 2002 the largest medical indemnity provider in Australia, United Medical Protection (United), was placed into provisional liquidation resulting in a potential lack of indemnity cover for many doctors. At the same time, medical practitioners were experiencing significant increases in subscriptions charged across all medical indemnity providers.

The Australian Government responded to these concerns by introducing a framework of reforms aimed at ensuring a viable and ongoing medical indemnity insurance market. The reform package included a variety of measures, including premium subsidies, government assistance to medical indemnity providers and medical practitioners for high cost claims and placing the industry within a new regulatory framework. This meant that medical indemnity cover needed to be provided as an insurance contract, which was only able to be provided by a licensed insurer.

ACCC's monitoring role

In October 2002 the Australian Government announced that the Australian Competition and Consumer Commission (ACCC) would monitor medical indemnity premiums on an annual basis to assess whether they are actuarially and commercially justified. On 16 March 2005 the Australian Government asked the ACCC to extend its monitoring to examine, to the extent possible, the actuarial and commercial justification of premiums within each jurisdiction in more detail. On 29 May 2006 the Australian Government asked the ACCC to continue to examine the actuarial and commercial justification of medical indemnity premiums, including within jurisdictions, for a further three years. The ACCC was also requested to extend its monitoring to include the new entrant to medical indemnity insurance, Invivo, which is a corporate authorised representative of QBE Insurance (Australia) Limited (QBE).

The ACCC asked the six authorised medical indemnity insurers to private medical practitioners as at 30 June 2007 to supply a range of quantitative and qualitative information about their premium-setting arrangements, cost structures and the impact of a number of government reforms on their operations for the current underwriting period.

The six medical indemnity insurers as at 30 June 2007 were Australasian Medical Insurance Limited (AMIL), MDA National Insurance (MDANI), Medical Insurance Australia Pty Ltd (MIA), MIPS Insurance Pty Ltd (MIPSI), Professional Indemnity Insurance Company Australia Pty Ltd (PIICA) and QBE.

The ACCC also obtained consolidated information supplied from Avant Insurance Limited (AIL), which commenced operation on 1 July 2007 following the merger of the MDO parent entities of AMIL and PIICA.

Qualifications

The ACCC analysis is based on information supplied by each of the insurers. The ACCC has relied on the information provided by insurers rather than performing an independent verification of their information or actuarial advice. As the MDO parent entities of insurers are no longer able to sell insurance, the ACCC has generally not examined their operations or membership pricing. In preparing this report, it was necessary for the ACCC to maintain the confidentiality of individual insurers' information. Therefore, some quantitative aspects of the ACCC analysis, particularly on its assessment of individual insurers' information, could not be disclosed in this report.

Findings of previous ACCC medical indemnity insurance monitoring reports

The ACCC's first four medical indemnity insurance monitoring reports examined the actuarial and commercial justification of premiums for the 2003–04, 2004–05, 2005–06 and 2006–07 underwriting periods.[1] The ACCC's third and fourth monitoring reports also examined the actuarial and commercial justification of premium relativities between jurisdictions.

All reports found that the premiums charged by medical indemnity insurers were generally actuarially and commercially justified. The third and fourth reports also found that jurisdictional premium relativities were considered actuarially and commercially justified for all insurers.

ACCC assessment methodology

The ACCC's methodology focused on how premiums were derived by insurers from an actuarial and commercial perspective.

The ACCC assessment of the actuarial justification of premiums considers the technical actuarial aspects of pricing. It examines the process adopted by insurers to derive premium rates, the approach taken to construct those premiums, the level of detail used to support pricing assumptions and the breadth of issues taken into consideration (such as medical indemnity and tort law reforms).

1 The ACCC's first monitoring report was released by the Australian Government on 23 February 2004, the second on 16 March 2005, the third on 16 February 2006 and the fourth on 12 April 2007.

The ACCC assessment of the commercial justification of premiums considers the ability of insurers to meet their commercial obligations to key stakeholders. It assesses how premium rates were affected by the Australian Prudential Regulation Authority's minimum capital requirements that insurers must achieve to reach a fully capitalised position by 30 June 2008, as well as broader commercial obligations such as solvency targets and emerging surplus.

This report also provides information on the actuarial and commercial justification of premium relativities between jurisdictions. The ACCC's assessment of these premium relativities examines the extent and the level of detail of the analysis to confirm or modify existing relativities, and the extent to which insurers took into account tort law reform in setting their jurisdictional relativities. The ACCC's assessment of the commercial justification of premium relativities between jurisdictions compares the actuary's recommended relativities against the actual relativities adopted. It also examines the quantification of cross-subsidies (as well as the incorporation of board policy) in the relativities.

Avant Insurance

On 1 July 2007 AIL commenced operation as a medical indemnity insurer as a result of the merger of the MDO parent entities of AMIL and PIICA. All former AMIL and PIICA insurance policies have now been transferred to AIL.

In this report the ACCC assessed the actuarial and commercial justification of premiums, including within jurisdictions, set by AMIL and PIICA before the merger.[2] In addition the ACCC also considered consolidated information supplied by AIL for PIICA and AMIL as part of its assessment of the commercial justification of premiums.

QBE/Invivo

In the previous report the ACCC, following a request from the Australian Government, commenced monitoring the activities of Invivo, which was a new entrant into the medical indemnity insurance market. Invivo is a corporate authorised representative of QBE, which also owns half of Invivo. Invivo has exclusive arrangements with QBE to distribute and manage professional indemnity insurance covering medical practitioners. QBE as an APRA-regulated insurer is, however, ultimately responsible for providing insurance cover and services to policyholders.

The ACCC's monitoring of the actuarial and commercial justification of premiums is being undertaken by assessing decisions made by medical indemnity insurers (rather than their authorised representatives) on the setting of premiums. The monitoring of Invivo by the ACCC will therefore necessitate consideration of the decisions made by QBE in setting premiums for medical indemnity insurance. In this report 'QBE premiums'[3] refer to premiums paid to Invivo for a QBE professional indemnity policy. Invivo, as the authorised representative of QBE, provided information to the ACCC on QBE premiums.

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2 These premiums relate to the 2007 underwriting year for AMIL and the 2007–08 underwriting year for PIICA.

3 Unlike other medical indemnity insurers QBE does not have a common renewal date and premiums are based on its latest premium review. The premiums in this report are based on premiums set in late 2006 for the 2007 calendar year.

Assessment of the actuarial justification of medical indemnity premiums

The ACCC found that premiums were considered to be actuarially justified for all six insurers that were operating as at 30 June 2007.

The ACCC found that the aggregate premium pool of each insurer was actuarially justified. It was evident that insurers had made extensive use of actuaries in premium liability assessments, in most pricing reports, funding plans and financial forecasts. In each case the ACCC considered that the construction of the recommended premium pool was soundly based and incorporated all major cost implications for the pricing of medical indemnity insurance. Most insurers adopted an aggregate premium pool after considering advice from the actuary. One insurer set the premium pool on commercial grounds that were later supported by actuarial advice.

The ACCC analysis of specialty premium rates found that all insurers conducted detailed analysis on the risk relativities between specialties or relied on recent risk relativity analysis. As in previous monitoring reports, the ACCC found that insurers generally cited the unwinding of existing cross-subsidisation between specialties as an objective. The ACCC noted that this was a long-term process and potentially not all cross-subsidies would be removed for a variety of reasons, including commercial factors as well as data limitations. However, the ACCC still found these rates and the relativities for income bands to be actuarially justified because the extent of cross-subsidisation was understood and, where possible, quantified.

The ACCC analysis of the impact of government reforms on premiums includes an examination of Australian Government medical indemnity reports (including the high cost claims scheme and the run-off cover scheme), and Commonwealth, state and territory tort law reforms. The ACCC found that all insurers factored HCCS and ROCS into their premium determination and most insurers took full account of HCCS in their reinsurance programs. The two insurers that did not reflect HCCS in their reinsurance program did so because of an unwillingness of reinsurers to fully reflect the full benefits of the scheme in their reinsurance pricing and structure. Importantly, both insurers took HCCS recoveries into full account when establishing their pure risk premium. All insurers took tort law reform into account in setting their aggregate premium pools for 2007–08.

QBE/Invivo

The ACCC also conducted separate analysis on QBE's 2007 premiums and found them to be actuarially justified. This analysis recognised that this is only QBE's second year of underwriting medical indemnity insurance, so it had limited claims experience available. The ACCC's assessment included revisiting the original methodology used to set premiums, which compared scheduled premium rates with the actuary's recommended premium rates. It also involved an assessment of the impact of specific government reforms on premiums and changes in rates based on emerging experience and other identified issues.

Assessment of the commercial justification of medical indemnity premiums

The ACCC found that, in the current market environment, the premiums set by medical indemnity insurers (which included consolidated information supplied by AIL for PIICA and AMIL) were commercially justified.

MDO-owned insurers

The net asset position of all insurers as at 30 June 2007 was an improvement on the strong position observed as at 30 June 2006. However, the degree to which the net asset position had improved depended on the circumstances of individual insurers.

The ACCC notes that one insurer continued its practice of not incorporating sufficient capital within its insurance premiums to maintain its target ratio of capital to net assets. To compensate for this, the insurer's parent entity is scheduled to make a capital injection in 2007–08, as well as further injections in future years. The ACCC found that while this may not be a viable long-term strategy, 2007–08 premiums for this insurer were still commercially justified because the injections were appropriately budgeted for and had MDO board approval.

QBE/Invivo

The ACCC examined the commercial justification of QBE's premiums by examining Invivo's financial projections and how these are consolidated within QBE's professional indemnity insurance business.

Based on this analysis, the ACCC found that QBE's premiums for the 2007 underwriting year were commercially justified.

Assessment of the actuarial and commercial justification of medical indemnity premiums within each jurisdiction

The ACCC found that jurisdictional premium relativities were considered to be actuarially and commercially justified for the six insurers that were operating as at 30 June 2007.

For the actuarial justification of premium relativities, the ACCC considered the extent of the analysis used to determine the relativities, as well as the extent to which insurers took into account jurisdictional variations in tort law reform. The ACCC found that insurers' analyses continue to be limited because of a lack of reliable claims experience in some jurisdictions. In the absence of this data the ACCC considered the approach used by insurers to be actuarially justified. The lack of reliable claims experience by jurisdiction also affected the ability of insurers to take into account tort law reform in premium relativities.

For the commercial justification of premium relativities, the ACCC considered the extent to which relativities recommended by actuaries were adopted in final premium rates as well as the level of cross-subsidisation in the premium relativities. The ACCC found that in some instances recommendations were not adopted in final premium rates due to a lack of statistically significant claims experience in some jurisdictions. The ACCC also noted that one insurer made a commercial decision not to change jurisdictional relativities and relied on previously undertaken relativity analysis when setting premiums for the 2007–08 underwriting year. Consistent with previous reports, the ACCC found that, while no insurer explicitly cross-subsidised between jurisdictions, cross-subsidies may exist because of the lack of reliable claims experience data. The relativities adopted were considered commercially justified.

1 Introduction

1.1 Background

In May 2002 the largest medical indemnity provider in Australia, United Medical Protection (United), was placed into provisional liquidation resulting in a potential lack of indemnity cover for many doctors. At the same time, medical practitioners were experiencing significant increases in subscriptions charged across all medical indemnity providers. In extreme cases, medical practitioners were paying over a third of their incomes for indemnity cover, while others left the profession or ceased some high-risk procedures like obstetrics. In response to this crisis, the Australian Government introduced a framework of reforms to ensure a viable and ongoing medical indemnity insurance market.

The reform package included a variety of measures including premium subsidies, government assistance to medical indemnity providers and medical practitioners for high cost claims and placing the industry within a new regulatory framework. The government's reform measures are outlined in more detail in chapter 3.

As part of the reform framework, the Australian Government announced that the Australian Competition and Consumer Commission would monitor medical indemnity premiums to assess whether they are actuarially and commercially justified. This report is the fifth ACCC report to the Australian Government arising from this role.

1.2 Ministerial request

On 19 November 2002 the former Treasurer, the Hon. Peter Costello, wrote to the ACCC about this new role and indicated that the ACCC's monitoring role was to start on 1 January 2003 for three years and was not a direction under the *Prices Surveillance Act 1983*.[4]

On 29 May 2006 the former Minister for Revenue and Assistant Treasurer, the Hon. Peter Dutton, wrote to the ACCC requesting that it continue to examine the actuarial and commercial justification of medical indemnity premiums, including within jurisdictions, for a further three years. The ACCC was also requested to extend its monitoring to include the new entrant to medical indemnity insurance, Invivo, which is a corporate authorised representative of QBE Insurance (Australia) Limited (QBE).

4 The *Prices Surveillance Act 1983* was repealed on 1 March 2004 when its main provisions were incorporated into Part VIIA of the *Trade Practices Act 1974*. Division 5 of Part VIIA provides for the minister to direct the ACCC to monitor prices, costs and profits of a business or industry.

1.3 Scope of report

The ACCC's monitoring role is limited to medical indemnity insurance written in Australia by insurers that indemnify medical practitioners (i.e., doctors) working in the private health sector. As at 30 June 2007 there were six medical indemnity insurers:

- Australasian Medical Insurance Limited (AMIL)
- MDA National Insurance Pty Ltd (MDANI)
- Medical Insurance Australia Pty Ltd (MIA)
- MIPS Insurance Pty Ltd (MIPSI)
- Professional Indemnity Insurance Company Australia Pty Ltd (PIICA)
- QBE Insurance (Australia) Limited (QBE).

Medical indemnity insurance is also offered by some other commercial insurers to medical professionals who practise in the private health sector, such as hospital and ancillary staff (including nurses and other medical staff). Medical practitioners who practise in the Australian public health sector are generally indemnified against medical malpractice by the relevant state-based public sector insurer for the work they perform in the public health system.[5] They do not need to take out their own private medical indemnity insurance to cover this work.

Avant Insurance

On 1 July 2007 Avant Insurance Limited (AIL) commenced operation as a medical indemnity insurer as a result of the merger of the MDO parent entities of AMIL and PIICA. All former AMIL and PIICA insurance policies have now been transferred to AIL.

In this report the ACCC assessed the actuarial and commercial justification of premiums, including within jurisdictions, set by AMIL and PIICA prior to the merger.[6]

In addition the ACCC also considered consolidated information supplied by AIL for PIICA and AMIL as part of its assessment of the commercial justification of premiums.

QBE/Invivo

In the previous report, following a request from the Australian Government, the ACCC commenced monitoring the activities of Invivo, which was a new entrant into the medical indemnity insurance market. Invivo is a corporate authorised representative of QBE, which also owns half of Invivo. Invivo has exclusive arrangements with QBE to distribute and manage professional indemnity insurance covering medical practitioners. QBE as an APRA-regulated insurer is, however, ultimately responsible for providing insurance cover and services to policyholders.

The ACCC's monitoring of the actuarial and commercial justification of premiums is being undertaken by assessing decisions made by medical indemnity insurers (rather than their authorised

5 Revised explanatory memorandum, Medical Indemnity (Prudential Supervision and Product Standards) Bill 2002, p. 6.

6 These premiums relate to the 2007 underwriting year for AMIL and the 2007–08 underwriting year for PIICA.

representatives) on the setting of premiums. The monitoring of Invivo by the ACCC, therefore, necessitates consideration of the decisions made by QBE in setting premiums for medical indemnity insurance. In this report 'QBE premiums'[7] refer to premiums paid to Invivo for a QBE professional indemnity policy. Invivo, as the authorised representative of QBE, provided information to the ACCC on QBE premiums.

1.4 Approach to monitoring

In assessing the actuarial justification of premiums, the ACCC considers the technical actuarial aspects of pricing. It examines the process adopted by insurers to derive premium rates, the approach taken to construct those premiums, the level of detail used to support pricing assumptions and the breadth of issues taken into consideration. The ACCC's assessment framework is discussed further in chapter 5.

In assessing the commercial justification of premiums, the ACCC considers the ability of insurers to meet their commercial obligations to key stakeholders.[8] It assesses how premium rates were affected by the Australian Prudential Regulation Authority's minimum capital regulatory requirements that the MDO-owned insurers must achieve to reach a fully capitalised position by 30 June 2008, as well as broader commercial obligations, such as solvency targets and emerging surplus levels.
The ACCC's assessment framework is discussed further in chapter 6.

This report also provides information on the actuarial and commercial justification of premium relativities between jurisdictions. To assess these premium relativities, the ACCC examines the extent and the level of detail of the analysis to confirm or modify existing relativities. It also looks at the extent to which insurers took into account jurisdictional variations in tort law reform in setting their jurisdictional relativities. In assessing the commercial justification of premium relativities between jurisdictions, the ACCC compares the actuary's recommended relativities against the actual relativities adopted—and examines the quantification of cross-subsidies (as well as the incorporation of board policy) in the relativities.

The ACCC's analysis covered the six insurers in Australia that offered insurance to private medical practitioners as at 30 June 2007 and included information from AIL, which commenced operation on 1 July 2007. In May 2007 the ACCC requested a range of quantitative and qualitative information from the six insurers about their premium-setting arrangements, cost structures and the effect of various government reforms (including tort reforms) on their operations.[9] Details of the ACCC's information request can be found in appendix A.

7 Unlike other medical indemnity insurers QBE does not have a common renewal date, and premiums are based on its latest premium review. The premiums in this report are based on premiums set in late 2006 for the 2007 calendar year.

8 In assessing the commercial justification of medical indemnity premiums for the 2007–08 underwriting year, the ACCC also considered consolidated information supplied by AIL for PIICA and AMIL.

9 Invivo, as the authorised representative of QBE, provided information to the ACCC on QBE premiums.

This report examines premiums set by existing insurers as at 30 June 2007 for the underwriting period of 1 July 2007 to 30 June 2008, except for United/AMIL and QBE, which had an underwriting period of 1 January 2007 to 31 December 2007. The ACCC has specifically not adjusted United/AMIL's calendar year results to the financial year except where otherwise noted. QBE's results, however, where identified in this report are provided on a financial year basis.

The ACCC engaged actuarial consultants *am actuaries* to provide actuarial advice in preparing this report.

1.5 Qualifications

The ACCC analysis is based on information supplied by each of the insurers. The ACCC has relied on the information provided by insurers rather than performing an independent verification of their information or actuarial advice. As the MDO parent entities of medical indemnity insurers are no longer able to sell insurance, the ACCC has generally not examined their operations or membership pricing. In preparing this report, it was necessary for the ACCC to maintain the confidentiality of individual medical indemnity insurers' information. Therefore, some quantitative aspects of the ACCC analysis, particularly its assessment of individual medical indemnity insurers' information, could not be disclosed in this report.

1.6 Previous reports

This is the fifth annual monitoring report produced by the ACCC for the Australian Government.

The four previous reports found that the premiums charged by medical indemnity insurers were generally actuarially and commercially justified.

The third and fourth reports also made assessments regarding the actuarial and commercial justification of premiums within each jurisdiction. Both reports found that jurisdictional premium relativities were actuarially and commercially justified respectively for the 2005–06 and 2006–07 underwriting years.

1.7 Report outline

This report contains seven chapters and two appendixes.

Chapter 2 provides a brief overview of the medical indemnity insurance industry in Australia by examining the main features of medical indemnity insurance as well as the industry structure, concentration and regulatory arrangements.

Chapter 3 examines Australian Government reforms to medical indemnity insurance.

Chapter 4 examines historical trends in costs, premiums and the financial performance of the industry between 1997–98 and 2006–07.

Chapter 5 presents ACCC findings on the actuarial justification of medical indemnity premiums charged for the 2007–08 underwriting period by the six insurers that were operating as at 30 June 2007.

Chapter 6 presents ACCC findings on the commercial justification of medical indemnity premiums charged for the 2007–08 underwriting period by the six insurers that were operating as at 30 June 2007.

Chapter 7 presents ACCC findings on the actuarial and commercial justification of medical indemnity premiums charged in different jurisdictions for the 2007–08 underwriting period by the six insurers that were operating as at 30 June 2007.

Appendix A describes the nature of the reports and other information the ACCC requested from medical indemnity providers.

Appendix B identifies some of the differences in methodology between this report and APRA's National Claims and Policies Database reports.

2 Overview of the medical indemnity industry

On 1 July 2003 Australian Government legislative reforms changed the nature of the medical indemnity insurance product offered to medical practitioners and the environment in which the industry operates in Australia. This chapter briefly examines the nature of the medical indemnity product and the pre-reform and post-reform characteristics of the medical indemnity industry.

Specific information about the medical indemnity legislative reforms implemented by the Australian Government is in chapter 3.

2.1 What is medical indemnity insurance?

Insurance provides protection against the unfortunate consequence of future events by transferring the risk of possible loss from a person or organisation (the insured) to the insurer. To gain this benefit, the insured pays the insurer a sum of money, known as a premium, for the cost of insurance.[10]

2.1.1 Liability insurance

Medical indemnity insurance is a form of liability insurance. Liability insurance is when an insurer undertakes to indemnify the insured for losses incurred as a result of the insured becoming liable for a breach of duty imposed by common law, contract or legislation.

Depending on the type of duty, compensation may be based on the common law principles of tort. A tort is a wrong involving a breach of duty, such as the duty of care under the law of negligence, but does not include a criminal wrong. Tort law aims to restore the person who suffered from the breach of duty to the position they were in before the tort was committed—known as 'restitution'. Therefore, if a tort is found to be committed on one party by another party—referred to as the 'tortfeasor'—the tortfeasor is considered to be liable and is required to make restitution for damage suffered.

A number of different types of liability insurance exist—for example, workers compensation, motor vehicle compulsory third party, public liability and professional indemnity. Liability insurance differs from first party insurance, as the latter covers an insured party's direct risks. Liability insurance covers the risks that third parties are exposed to because of the actions of the insured.

Medical indemnity insurance is a type of professional indemnity insurance. Professional indemnity insurance indemnifies professional people for their legal liability to their clients and others relying on their advice and/or services.[11] With medical indemnity insurance, the professional being insured is the medical practitioner—indemnity coverage reduces their exposure to financial losses arising

10 Insurance Council of Australia, background paper no. 7 to the HIH Royal Commission, 'A profile of the general insurance industry', November 2001, p. 3.

11 ibid., p. 26.

from personal injury actions brought against them as a result of the performance of their professional duties.

2.1.2 Medical malpractice

Malpractice insurance is another name for professional indemnity insurance, but this term has generally been reserved for the medical professions.[12] Although medical indemnity insurance provides protection similar to that for other professionals, the nature of medical malpractice claims against medical practitioners will generally differ from claims against other professionals.

For example, accountants, lawyers, investment advisers and valuers are usually sued for 'economic loss'—that is, loss of past and/or future income resulting from advice provided. Claims against architects and engineers are often for some physical damage leading to economic loss. They may also involve personal injury.

Claims against medical practitioners relate to personal injury or death and are lodged against a medical practitioner for a breach, or perceived breach, of a given standard of care in the treatment of a patient. This may lead to the injured party seeking compensation from the insured for general pain and suffering, past economic loss, future economic loss, medical costs, attendant care costs and legal costs.

These types of compensation are typically referred to as 'heads of damage' and are similar to claims arising in public liability insurance in which personal injury claims represent a major portion of overall claims costs.

2.1.3 Long-tail insurance

As with other types of liability insurance, medical indemnity insurance is often referred to as 'long-tail' insurance. This means that many years may pass between the period for which cover was provided and the date when claims are finally settled. This contrasts with most claims for damage to motor vehicles or homes, which tend to be made in the year in which cover is provided, with final settlement usually occurring soon after the claim is lodged.

Depending on the statute of limitations, which varies between each state and territory, medical indemnity claims can be made years after an incident, even if the medical practitioner is no longer practising medicine. Although tort law reforms have reduced limitation periods, this long-tail characteristic continues to place considerable pressure on providers of such cover to be able to identify the likely cost of future claims and build this into their pricing (premium) structures.[13]

12 Insurance Council of Australia, submission to ministerial forum, *Addressing the issues in professional indemnity insurance*, March 2002, p. 1.

13 Revised explanatory memorandum, Medical Indemnity (Prudential Supervision and Product Standards) Bill 2002, p. 8.

2.1.4 Types of indemnity coverage

Traditionally medical indemnity cover was provided to medical practitioners on a claims-incurred (sometimes referred to as 'incidents-occurring') basis. Claims-incurred cover provides indemnity for valid claims arising from incidents that occur during the period of cover, with a claim able to be lodged at any time in the future.[14] Under this type of protection, the medical practitioner is indemnified for claims arising from incidents that occurred during the period of cover, even if the claim is lodged with the insurer after the practitioner ceases to practise (due to retirement, disablement or death) or has moved to another indemnity provider.

Since 1997 several medical indemnity providers have offered claims-made cover, in some cases exclusively. Claims-made cover allows a medical practitioner to notify the insurer of a claim within the terms of the current cover for an incident that occurred within a recognised period.[15] Claims-made cover is standard within the broader general insurance industry for professional indemnity insurance contracts.

Claims-made cover is different to claims-incurred cover because, for the former, the incident must have occurred and the claim must have been notified to the indemnity provider during the period of coverage. This means that, for claims-made cover, the medical practitioner is not covered for past incidents notified to the indemnity provider after the practitioner ceases practising medicine or moves to another indemnity provider.[16]

2.2 Characteristics of the industry—pre 1 July 2003

Before 1 July 2003 medical indemnity cover was traditionally offered by medical defence organisations, which operated on a not-for-profit basis as 'mutuals' (i.e. owned and operated by its members). MDOs offered indemnity protection to medical practitioners as part of a range of services to their members.[17]

Indemnity cover provided by MDOs was 'discretionary' in that the medical practitioner had no contractual right to be indemnified by the MDO. Rather, the MDO retained the discretion to decide whether to provide indemnity to the medical practitioner. In practice, however, it was rare for an MDO not to provide indemnity, except for cases of fraud, criminal activity, sexual misconduct or drug abuse.

At 30 June 2003 there were seven MDOs that provided indemnity protection in Australia:

- Medical Defence Association of South Australia Limited (MDASA)
- Medical Defence Association of Victoria Limited (MDAV)
- MDA National Pty Ltd (MDAN)[18]
- Medical Indemnity Protection Society Limited (MIPS)

14 ibid., p. 8.

15 Before 1 July 2003 this 'recognised' period related to the medical practitioner's annual membership with the insurer. After 1 July 2003 the recognised period relates to the policy period specified in the insurance contract issued by the medical indemnity insurer to the medical practitioner.

16 Where a medical practitioner is indemnified on a 'claims-made' basis, this may necessitate the purchase of what is known as 'run-off' or 'retroactive' cover. Run-off cover provides the medical practitioner with indemnity coverage for claims notified to the insurer after the end of the recognised period for incidents occurring during that period. Retroactive cover allows the insured to notify the insurer of an incident that occurred before the current period of cover.

17 These services included legal advice for non-indemnity related situations, medical practise advice and representations at medical board matters, disciplinary proceedings and coronial inquests.

18 MDAN was previously known as the Medical Defence Association of Western Australia (MDAWA).

- Medical Protection Society of Tasmania (MPSTas)
- Queensland Doctors Mutual Pty Ltd (QDM)[19]
- United Medical Protection Limited (United).

The above MDOs operated mainly along state lines[20] and were outside the prudential framework regulated by the Australian Prudential Regulation Authority. Although MDOs were not insurance companies authorised by APRA to conduct insurance business, they did have some associations with authorised insurers. Before 1 July 2003 all MDOs operating in Australia had access to subsidiary or 'captive' insurance companies, which were established primarily to provide reinsurance cover to the parent MDO.

2.3 Characteristics of the industry—post 1 July 2003

These arrangements changed on 1 July 2003 when the government implemented a legislative requirement that medical indemnity cover be provided as an insurance contract between the medical practitioner and an insurer authorised by APRA to conduct insurance business. This meant that MDOs were no longer able to provide indemnity protection and coverage could no longer be discretionary. Therefore, the MDOs applied to APRA to make their captive insurers fully authorised to conduct insurance business.

As at 30 June 2007, the six authorised providers of medical indemnity insurance in Australia were:

- Australasian Medical Insurance Limited (AMIL)—writing insurance for members of United
- MIPS Insurance Limited (MIPSI)—writing insurance for members of MIPS and MPSTas (and previously to QDM before it merged with MIPS)
- MDANI—writing insurance for members of MDAN
- Medical Insurance Australia Pty Ltd (MIA)—writing insurance for members of MDASA
- Professional Indemnity Insurance Company Australia Pty Limited (PIICA)—writing insurance for members of MDAV
- QBE Insurance (Australia) Limited (QBE).

Avant Mutual Group Limited (Avant) commenced operation on 1 July 2007 following the merger of United and MDAV, the parent MDOs of AMIL and PIICA.

From 1 July 2007 Avant became the holding company of United, MDAV, Avant Insurance Limited (AIL, formerly named AMIL) and PIICA. From 1 October 2007 PIICA ceased to offer insurance policies and PIICA's insurance portfolio (i.e., its assets and liabilities relating to insurance) was transferred to AIL. All former AMIL and PIICA insurance policies have now been transferred to AIL.

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19 QDM subsequently merged with MIPS on 22 July 2004.

20 The first monitoring report found the following MDOs had the largest market shares in each state and territory:
- New South Wales/Australian Capital Territory—United
- Victoria—MDAV
- Queensland—United
- South Australia—MDASA
- Western Australia—MDAN
- Tasmania—MPSTas
- Northern Territory—United

However, MDOs generally had a presence in jurisdictions outside their home states.

2.3.1 Market shares

The number of indemnified members that belong to each medical indemnity provider is one measure that can be used to determine the distribution of market shares within the industry. Only indemnified Australian medical practitioners are included in the analysis. Total membership of medical indemnity providers will typically be higher due to the inclusion of members who are not medical practitioners, but are health professionals (such as optometrists and dentists) or for whom medical indemnity providers are not required to meet claims—that is, students and those indemnified by employers.

In preparing this analysis the ACCC relied on information provided by each medical indemnity provider. Although data on membership numbers provided by different medical indemnity providers may not be comparable in some instances due to underlying data collection methodologies, it nevertheless provides an indication of the general market shares of all industry participants.

Chart 2.1 shows the percentage of the total number of indemnified[21] members in Australia with each medical indemnity provider based on the most recently available data provided for the five financial years from 2002–03[22] to 2006–07.[23, 24]

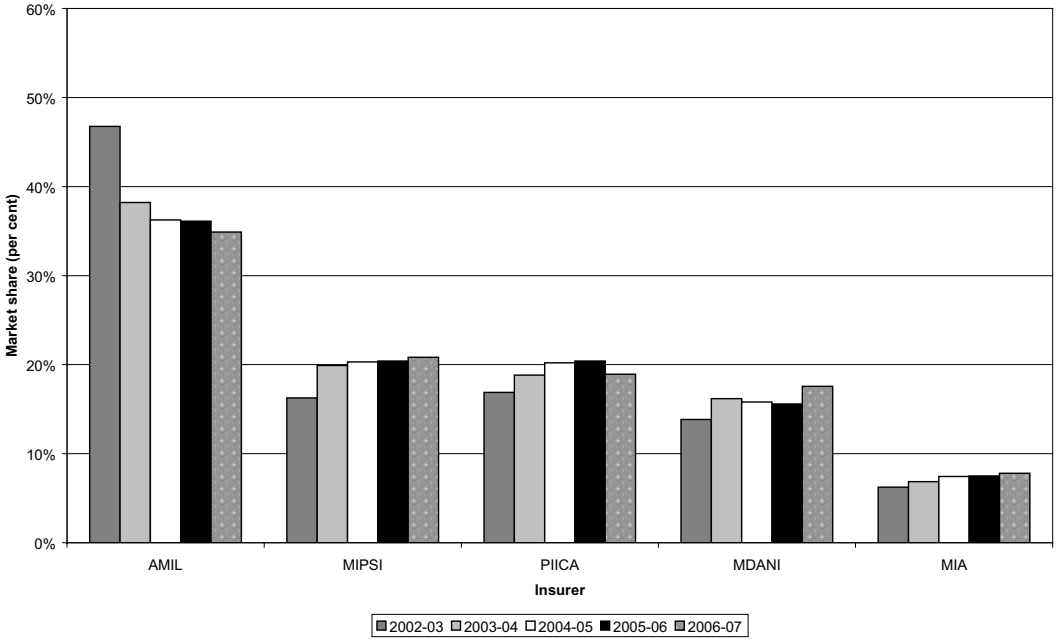
21 Where possible, the ACCC has excluded membership numbers that relate to non-indemnified members such as students or practitioners who are employer-indemnified.

22 Market shares for 2002–03 are based on indemnity membership of the relevant MDO. In the case of MIPSI, this incorporates the membership of MIPS, MPSTas and QDM.

23 AMIL membership numbers relate to the previous calendar year—that is, membership for the 2006 calendar year has been recorded against the financial year ending 30 June 2007. The ACCC understands that AMIL membership levels are assessed in August each calendar year and therefore this allocation is expected to have no material effect on market shares.

24 As Avant Insurance Limited did not become operational until 1 July 2007, for the purpose of this report, market share information is only available for AMIL and PIICA. The ACCC has specifically excluded QBE from its analysis of market share because its policyholder numbers were provided on the condition of confidentiality.

Chart 2.1 Medical indemnity provider indemnity members, 2002–03 to 2006–07[25]



Source: derived by ACCC from membership data for five MDO-owned insurers.

The largest medical indemnity provider is AMIL, which had approximately 35 per cent of all indemnified members in Australia in 2006–07. AMIL's market share has been reducing since 2002–03; however, the rate of decline has slowed in recent years. MIPSI, PIICA and MIA's market share remained relatively stable in 2006–07, while MDANI gained some market share. Based on these figures, the new merged entity AIL is likely to have a market share in excess of 50 per cent.

2.3.2 Regulatory arrangements

Since 1 July 2003 it has been a legislative requirement that medical indemnity insurance be provided in the form of an insurance contract between an authorised insurer and the medical practitioner.[26] This means that authorised insurers are unable to offer discretionary unlimited indemnity protection. This change extended APRA's prudential supervision to encompass medical indemnity insurance because it required all medical indemnity insurers to comply with APRA's prudential standards that apply to general insurance.

25 Results may not be directly comparable to those shown in previous reports due to revised data and the exclusion of some non-medical practitioners and non-indemnified members from historical market share data.

26 An insurance contract forms a legally binding arrangement between the policyholder and the insurer, setting out the terms and conditions under which indemnity is to be provided.

These requirements include:

- compliance with APRA's liability valuation standards, which mandates the appointment of an actuary who estimates the liabilities and risk margin
- having risk management systems, including pricing and underwriting control mechanisms
- holding a minimum level of capital based on an assessment of identified risks (but subject to a minimum of $5 million)[27]
- regular provision of data and reports.

APRA established a scheme for transitional arrangements for the five MDO-owned insurers whereby providers have up to five years from 1 July 2003 to 30 June 2008 to comply with these minimum capital requirements.[28] From 1 July 2008 these insurers must be fully capitalised.

To participate in these transitional arrangements, the five insurers were required to submit a funding plan to APRA for approval. APRA released a series of guidelines early in 2003 specifying the content of the funding plan and the role of actuaries and auditors in constructing these plans.

As an existing general insurer QBE does not have access to transitional arrangements because it is already expected to comply with APRA's capital requirements.

The *Insurance Act 1973* also sets out requirements for firms seeking to exit the industry, with guidelines for assigning liabilities, transfers and amalgamations, and winding up.

The Australian Securities and Investment Commission (ASIC) has a regulatory role in respect of medical indemnity insurance. It is responsible for the general administration of product standards and disclosure requirements that apply to medical indemnity insurance policies. These include:

- the minimum cover limit that an insurer may offer or provide to a medical practitioner is $5 million
- the contract must provide an offer for retroactive and run-off cover for otherwise uncovered prior incidents.[29]

ASIC also has an enforcement role in medical indemnity insurance and is responsible for ensuring that premiums for cover contained within the terms of compulsory offers are reasonable.

27 An insurer's minimum capital requirement is determined by considering a range of risk factors that may threaten the ability of the insurer to meet policyholder obligations. These risks fall into three broad types: insurance risk (the risk that the true value of net insurance liabilities could be greater than the value determined under the liability valuation); investment risk (the risk of an adverse movement in the value of an insurer's assets and/or off-balance sheet exposures); and concentration risk (the risk associated with an accumulation of exposures to a single catastrophic event). Sourced from APRA Prudential Standard GPS 110, available from the APRA website (www.apra.gov.au).

28 Existing general insurers seeking to enter the medical indemnity industry are unable to participate in these arrangements because they should already be capitalised.

29 Retroactive cover provides medical practitioners joining a new medical indemnity provider with protection against incidents incurred before joining the provider but notified after. Run-off cover provides medical practitioners leaving practise with protection against claims arising from previous incidents.

3 Government reforms of medical indemnity insurance

In 2002 rising medical indemnity insurance premiums and the provisional liquidation of the largest provider, United Medical Protection Limited (United), led to significant problems of affordability and availability of medical indemnity insurance for private medical practitioners. In response to these problems the Australian Government introduced a series of reforms aimed at ensuring a viable and ongoing medical indemnity insurance market. This chapter examines those medical indemnity reforms.

3.1 Medical indemnity reform by the Australian Government

This chapter briefly examines the reforms programs which were operational as at 1 July 2007 and which insurers need to take into account when considering their price-setting arrangements for the 2007–08 underwriting year (this is discussed in more detail in chapter 5).

These reforms include the:

- exceptional claims scheme (ECS)
- run-off cover scheme (ROCS)
- UMP support payment (UMP SP)
- high cost claims scheme (HCCS)
- premium support scheme (PSS).

More detailed information on the development of the medical indemnity reform package from its inception to its current form is contained in previous ACCC monitoring reports.

3.1.1 Exceptional claims scheme

ECS was developed to provide protection for medical practitioners against personal liability for private practice claims that exceed their maximum level of insurance cover.

Under ECS, the government assumes liability for 100 per cent of damages payable against a practitioner above the individual's insurance contract limit for claims notified after 1 January 2003, as long as the practitioner has cover equal to or over a threshold amount. The threshold is currently set at $20 million and is subject to review. The scheme can be activated by either a single very large claim or an aggregate of claims that together exceed the threshold.

There is no sunset clause for ECS, although it can be ended by regulation. It is anticipated that the scheme will be reviewed from time to time in close consultation with the medical profession and insurers to determine if it remains necessary in light of state and/or territory tort law reform and claims trends.[30]

30 Medical Indemnity Policy Review Panel, *Achieving stability and premium affordability in the Australian medical indemnity marketplace,* February 2007.

3.1.2 Run-off cover scheme

ROCS came into effect on 1 July 2004 and was developed in response to concerns within the medical profession about the capacity of doctors to pay for run-off cover when they no longer earn an income.

Under ROCS, medical indemnity insurers are required to provide run-off cover for eligible doctors (generally retired doctors over 65 years and those who are no longer earning income from private medical practice). On becoming eligible, ROCS will cover the types of claims that were covered by a medical practitioner's last insurance contract. The government guarantees to pay the cost of claims under this cover.

The scheme is funded on an ongoing basis through a charge on insurers called the run-off cover scheme support payment, which is levied as a percentage of insurers' medical indemnity insurance income and is shown on doctors' premium notices. ROCS therefore ensures that eligible doctors receive medical indemnity cover that is secure, does not require further payment and is based on the cover they had while they were working.[31]

3.1.3 High cost claims scheme

The HCCS was established to address upward pressure on medical indemnity premiums by reducing the cost of these large claims to insurers. It does so by reimbursing insurers 50 per cent of the cost of medical indemnity claims above a threshold amount up to the limit of the practitioner's cover for claims notified on or after 1 January 2003.[32]

3.1.4 Premium support scheme

The PSS was introduced to replace the medical indemnity subsidy scheme (MISS), which provided premium subsidies specifically to neurosurgeons, obstetricians, procedural general practitioners and GP registrars undertaking procedural training.[33]

Under the PSS, medical practitioners do not have to make a separate application to receive a subsidy because the PSS is provided directly to insurers and then offset against the medical practitioner's total premium.

The PSS applies to the following:

- medical practitioners whose gross indemnity costs exceed 7.5 per cent of estimated income from private billings—the subsidy is 80 per cent of the amount by which the member's gross indemnity cost exceeds the base amount

31 ibid.

32 ibid.

33 The PSS was enacted under s. 43(1) of the *Medical Indemnity Act 2002*, which came into operation on 17 June 2004. MISS was contained in the medical indemnity subsidy scheme that commenced on 20 June 2003 and applied to indemnity payments made on or after 1 January 2003 until 30 June 2004. The PSS replaced MISS from 1 January 2004.

- medical practitioners who have applied for and been deemed eligible for MISS—the subsidy is calculated as the greater of that under MISS or the PSS
- special category members—the subsidy is 80 per cent of the total cost to the member for the premium period of the member's gross indemnity costs.[34]

3.1.5 UMP support payment

The UMP SP was introduced by the Australian Government in 2002, when United entered provisional financial liquidation. The UMP SP provides ongoing assurance for medical professionals who were members of UMP on 30 June 2000, in the form of indemnity for past incidents.

To provide this assurance, the government agreed to fund most of these claims with members of UMP funding around one third of the arrangement over a period of six years through the UMP SP (formerly IBNR levy).

The final year of the UMP SP program is 2007–08.[35]

3.2 Tort law reforms

Since early 2001 tort law reforms have been introduced progressively by Commonwealth, state and territory governments in response to concerns about the availability and affordability of public liability and professional indemnity insurance. Many of the reforms deal directly with constraining the number and size of personal injury payouts. As most medical indemnity claims are related to personal injury cases, some of these reforms are expected to have an impact on the cost of providing medical indemnity insurance.

The major reforms to tort law include the introduction of:

- caps on damages for economic loss (i.e., loss of past and/or future income) and non-economic loss (i.e., compensation for pain and suffering)
- minimum thresholds of impairment to access damages for non-economic loss settlement awards
- changes in the limitation periods for personal injury cases
- increases in discount rates that apply to claims payouts.

For more information on tort law reforms introduced by Commonwealth, state and territory governments, see the Australian Government publication, *Available and affordable—improvements in liability insurance following tort law reform in Australia*, available free online at www.treasury.gov.au.

34 A special category member is a member who:

- no longer practises as a doctor, or
- no longer derives a private medical income from practising as a doctor, or
- practises as a doctor only in the public sector and has a contract of insurance providing indemnity cover that does not offer indemnity for damages awarded against a doctor (except arising from good Samaritan acts or gratuitous advice for which no income is received), or
- has a liability in a premium period for run-off cover or retroactive cover and does not at any time have a contract of insurance providing medical indemnity cover with any other medical indemnity provider.

35 Sourced from the Medicare Australia website (www.medicareaustralia.gov.au).

4 Trends in costs and premiums in medical indemnity insurance

The Australian Government asked the Australian Competition and Consumer Commission to monitor medical indemnity premiums to assess whether they are actuarially and commercially justified. To do this, the ACCC requested a range of information about costs and pricing from the six authorised providers of medical indemnity insurance operating as at 30 June 2007.

The ACCC used this information to determine trends in the costs associated with providing medical indemnity insurance to 30 June 2007 and trends in premiums charged for indemnity protection.[36, 37]

The ACCC has not included data from QBE Insurance (Australia) Limited within the historical trend analysis of medical indemnity insurance in this chapter. This is because QBE is a large insurer that underwrites significant volumes of professional indemnity insurance business other than medical indemnity and it is difficult to disaggregate QBE's medical indemnity insurance results from its other professional indemnity business. In addition QBE is in its second year of underwriting medical indemnity insurance and has relatively limited claims experience in medical indemnity insurance. Information on QBE's costs and premiums are, however, analysed in chapters 5, 6 and 7.

4.1 Cost components of medical indemnity insurance

The ACCC examined the cost components of the five medical defence organisation (MDO)-owned insurers' total premium pools for the five underwriting years between 2003–04 and 2007–08. Table 4.1 shows the percentage of the actuarially recommended aggregate premium pool for each cost category, which is presented as an average estimate based on the responses across insurers.

36 With the exception of section 4.1 and chart 4.7, all analysis contained in this chapter includes United/Australasian Medical Insurance Limited results on a financial year basis.

37 In some instances the results for this report for historical years may differ from those in previous reports due to revised data being provided by insurers

Table 4.1 Components of actuarially recommended aggregate premium pool: 2003–04 to 2007–08

	2003–04 %	2004–05 %	2005–06 %	2006–07 %	2007–08 %
Expected surplus[a]	35	26	21	19	16
Net claims costs[b]	33	36	40	45	44
Reinsurance expenses	17	16	14	13	14
Underwriting and general expenses	15	22	25	23	26
Total premium pool[c]	100	100	100	100	100

Source: derived by ACCC from data from MDO-owned insurers.

(a The expected surplus was typically raised for the purpose of capital accumulation or maintenance. This is discussed in more detail in section 5.3.5.

(b) The net cost of claims is the expected ultimate claims cost net of recoveries received or expected to be received, including those from the Australian Government under the high cost claims scheme (HCCS), the run-off cover scheme (ROCS) or the UMP support scheme.

(c) The components of the premium pool in table 4.1 may not add to 100 in some years due to rounding.

Note: the table represents the actuarially determined premium pool and does not include statutory third party collections such as stamp duty, the goods and services tax (GST) or the ROCS levy.

The table shows that for the 2007–08 underwriting year the net cost of claims was the largest component of the premium pool at 44 per cent. Expected surplus represented 16 per cent; underwriting and general expenses, 26 per cent; and reinsurance expenses, 14 per cent.

The proportion of premium pool represented by the expected surplus has fallen significantly over the period, while the proportion represented by the net claims costs has risen due to a decrease in the actual amount of surplus raised (as insurers approach their capital targets) and an increase in the actual amount expected for net claims costs. Reinsurance expenses have fallen marginally while underwriting and general expenses rose significantly in 2004–05, but remained relatively constant thereafter.

4.2 Trends in medical indemnity claims

The cost of claims is the most significant driver of premiums in medical indemnity insurance. This section examines the major cost component of medical indemnity insurance by examining trends in the following indicators[38]:

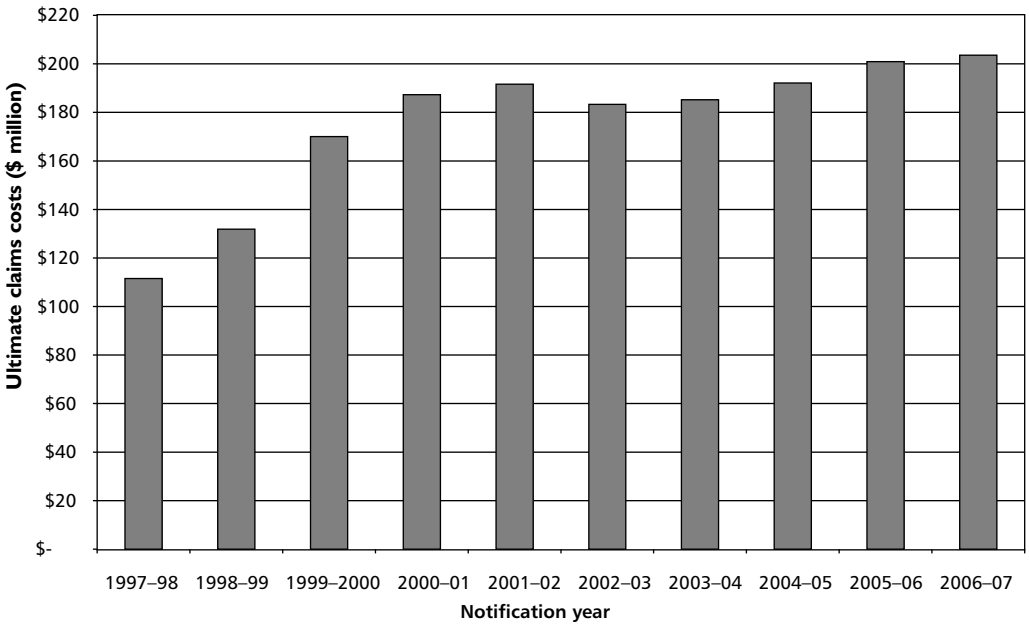
38 For the fifth monitoring report the ACCC specifically requested that insurers provide the total number of claims (including likely incidents as well as open and closed claims), the total amount of claims paid to date and the actuarial outstanding claims liability (inflated but undiscounted) as at 30 June 2007. This ensured that insurers provided information to the ACCC on a consistent basis. Due to differing data sources, the results shown in section 4.2 may not be directly comparable with those shown in previous monitoring reports.

- ultimate claims costs by notification year—the ultimate costs of claims[39] expected to be met by insurers by year of notification[40]
- claim frequency—the ultimate number of claims expected by year of notification expressed as a proportion of the total number of Medicare services provided in the corresponding year
- average size of claims—the ultimate expected[41] average size of claims arising from a given notification year that will eventually be settled.

4.2.1 Ultimate claims costs

Chart 4.1 shows the trend in ultimate claims costs[42] for claims notified between 1997–98 and 2006–07.

Chart 4.1 Ultimate claims costs by year of notification: 1997–98 to 2006–07



Source: derived by ACCC from data from MDO-owned insurers.

39 'Ultimate cost of claims' refers to all claim costs an insurer reasonably expects will eventually be paid for claims arising in that notification year. For example, an insurer may not finish paying out on claims arising in a notification year for several years, so until all notifications for that year have been finalised, the ultimate cost includes all payments made for claims to date as well as all those expected payments. Both past payments and expected payments are in nominal dollars for the years in which they were/are expected to be made. Due to ultimate claims costs and numbers being largely based on expectations, which can change from year to year, data contained within this section may not be directly comparable with that shown in earlier reports.

40 The notification year is the year in which an insurer is either notified of an incident occurring or, where no prior notification has been made, when a claim is lodged with an insurer.

41 The ultimate cost of claims is based on an insurer's past payments as well as a reasonable estimate of future expected payments on unfinalised claims. As this estimate of future expected payments is uncertain, the average claim size for any given year will be an **expected** average size, until all claims have been settled for that notification year.

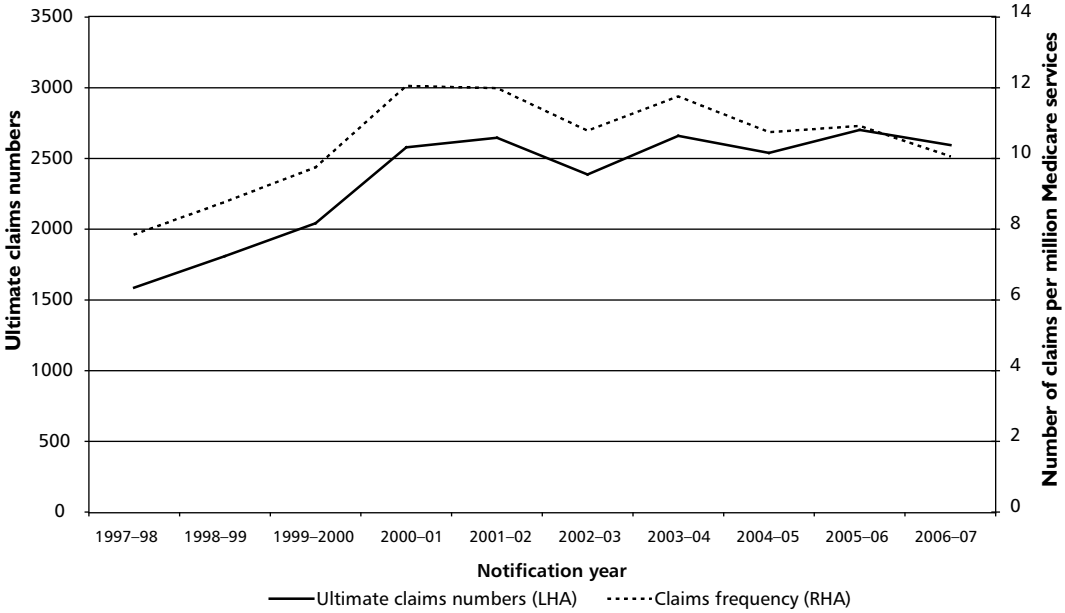
42 Calculated as total past payments and gross inflated and undiscounted outstanding claims liabilities. As a result, the ultimate cost includes all payments in the nominal dollar values in which the insurer expects the payment to be made.

The ultimate cost of claims expected by year of notification increased between 1997–98 and 2000–01 from $112 million to $187 million. The ultimate size of claims then fluctuated around this level over the next four years before increasing in 2005–06 to $201 million. In 2006–07 the ultimate cost of claims increased marginally to $204 million. It should be noted that the recent notification years largely reflect actuarial estimates. The ultimate claims cost is likely to change over time as these estimates are replaced by actual experience.

4.2.2 Claims frequency

Chart 4.2 shows the ultimate number of claims expected to be met by insurers for each notification year between 1997–98 and 2006–07, and the corresponding claims frequency for the number of claims per million Medicare services provided.

Chart 4.2 Ultimate claim numbers and claims frequency by year of notification: 1997–98 to 2006–07



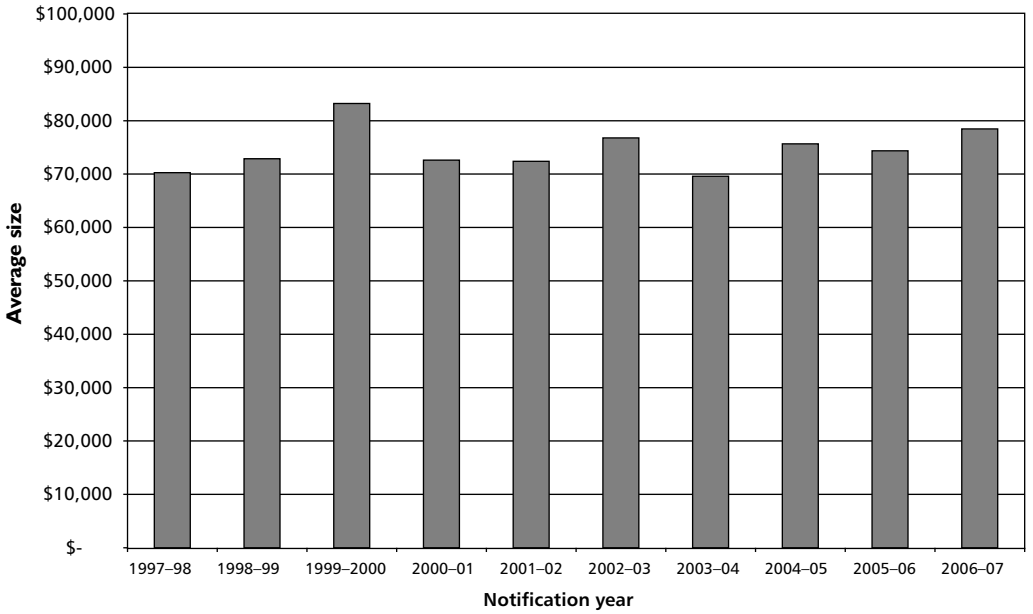
Source: derived by ACCC from MDO-owned insurers.

The ultimate number of claims increased by 67 per cent between 1997–98 and 2001–02 (from 1587 to 2646). The ultimate number of claims fell in 2002–03 but generally remained around the level experienced in 2001–02 over the next four years. The most recent actuarial estimate of the ultimate number of claims expected for the 2006–07 notification year is 2595.

Claims frequency has followed a largely similar trend to the ultimate number of claims. The ultimate number of claims per million Medicare services increased from eight to 12 between 1997–98 and 2001–02. The claims frequency fell to 11 per million Medicare services in 2002–03 and then fluctuated around this level for the next three years before falling again in 2006–07 to 10 claims per million Medicare services.

Chart 4.3 shows the trend in the ultimate average size of claims expected by notification year between 1997–98 and 2006–07.

Chart 4.3 Ultimate average sizes of claims by year of notification: 1997–98 to 2006–07



Source: derived by ACCC from MDO-owned insurers.

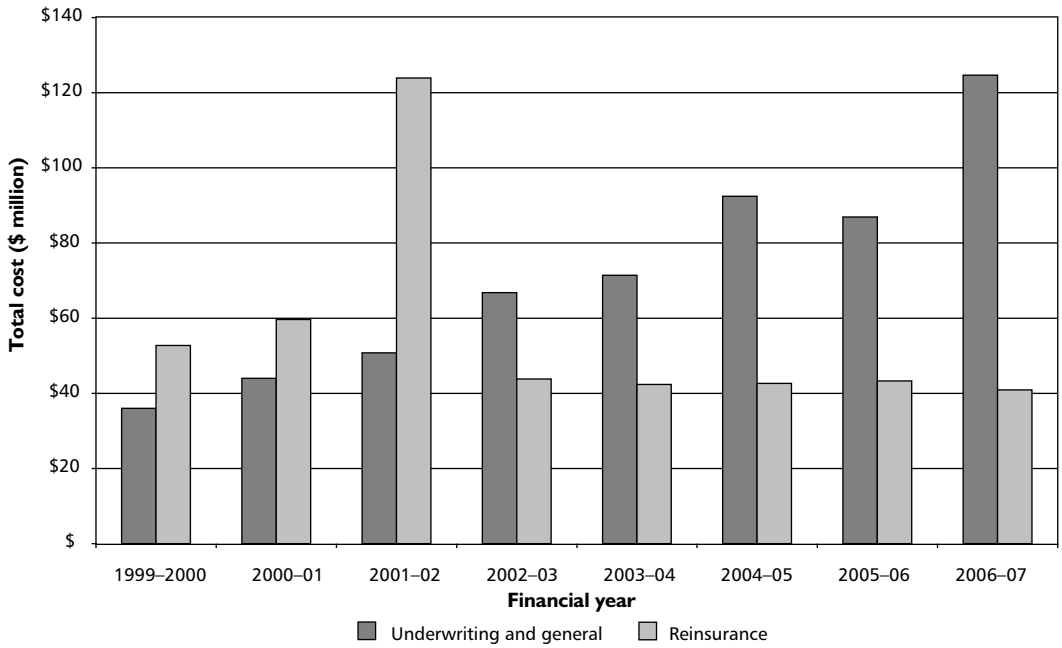
The ultimate average size of claims increased by 18 per cent from $70 272 to $83 220 between 1997–98 and 1999–00. The ultimate average cost of claims decreased to $72 627 in 2000–01 and has remained around this level in subsequent years. The most recent actuarial estimate of the ultimate average size of claims for the 2006–07 notification year is $78 458.

4.3 Trends in other expenses

The ACCC examined trends in two other major categories of expenses—underwriting and general expenses, and reinsurance expenses. Underwriting and general expenses relate to all expenses incurred by insurers, other than reinsurance expenses and claims costs and related expenses. Reinsurance expenses refer to the amount of premium ceded to reinsurers for reinsurance during the period. As with other costs, the ACCC has not assessed whether the level of these costs is appropriate.

Chart 4.4 shows reinsurance expenses and underwriting and general expenses for the years 1999–2000 to 2006–07.

Chart 4.4 Reinsurance expenses and underwriting and general expenses: 1999–2000 to 2006–07



Source: derived by ACCC from MDO-owned insurers.

Notes: one insurer's reinsurance cost as sourced from its annual report has been adjusted based on information provided directly by that insurer.[43]

One insurer's underwriting and general expenses have been adjusted to remove some APRA-approved transfers.

Underwriting and general expenses increased in almost all years, from $36 million in 1999–2000 to $87 million in 2005–06, before increasing significantly to $125 million in 2006–07. However, the industry results observed in 2006–07 do not reflect the individual experience of all insurers and mainly reflect abnormal increases in expenses by some insurers.

43 This insurer had previously held a reinsurance contract that included ongoing adjustment premiums for which the insurer held reserves. As experience developed, the insurer was able to release these reinsurance premium reserves and these releases were allocated to the reinsurance expense on the profit and loss statement. The effect of these reserve releases was that this insurer experienced a positive reinsurance expense in the three years to 2005–06, which distorted the actual reinsurance costs experienced by the industry. The ACCC sought information on the actual reinsurance cost for each year between 2003–04 and 2005–06, excluding the impact of any release of reserves.

Reinsurance expenses increased from $53 million in 1999–2000 to $60 million in 2000–01, before increasing markedly to $124 million in 2001–02.[44] Reinsurance expenses then fell significantly to $44 million in 2002–03 and remained constant at this level over the following four years, with reinsurance expenses in 2006–07 at $41 million.

4.4 Trends in premiums

The ACCC examined medical indemnity premiums by examining trends in total premium revenue[45] and the average premium. The average premium is the total premium revenue earned per financial year divided by the total number of indemnified policyholders for that year in real terms.[46]

4.4.1 Total premium revenue

Chart 4.5 shows the trend in the total gross premium revenue[47] by underwriting year for the period 1999–2000 to 2006–07.

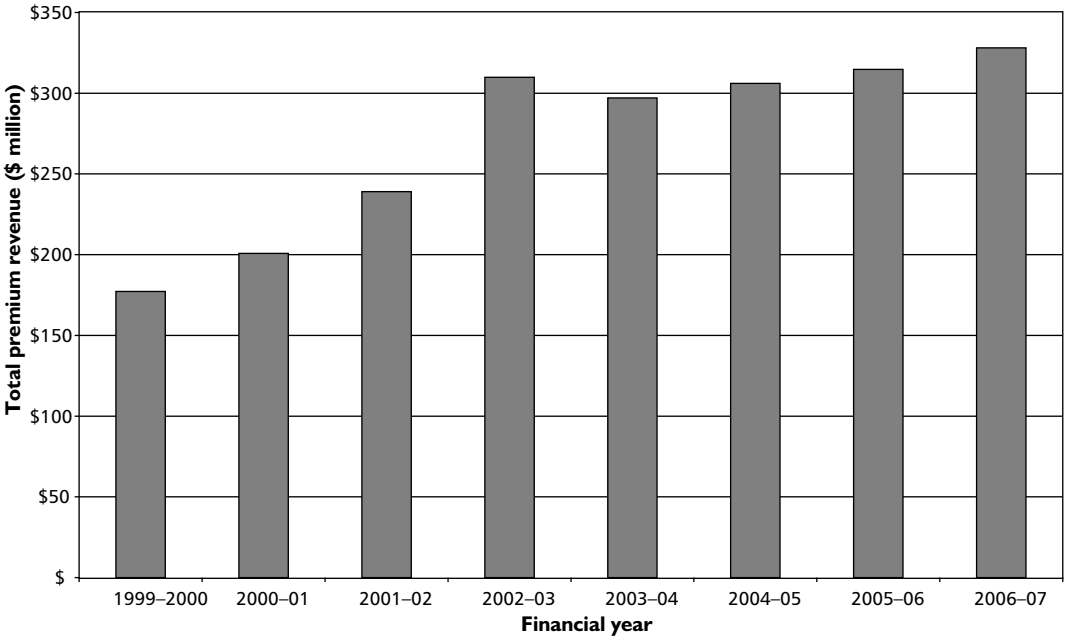
44 The spike in reinsurance expenses in 2001–02 was largely driven by the reinsurance arrangements of one insurer.

45 Total premium revenue as sourced from insurer's annual reports includes revenue earned from medical indemnity insurance policies provided to medical practitioners and, for some insurers, premium revenue from medical indemnity insurance policies provided to other health professionals (such as optometrists and dentists).

46 Adjusted to 30 June 2007 values using the average weekly earnings index published by the Australian Bureau of Statistics (catalogue number 6302.0).

47 Premium revenue is earned premium—that is, the total amount of gross written premium earned during the period ('earned' being that proportion of risk covered by the policy that expired at the end of the reporting period).

Chart 4.5 Total gross premium revenue by underwriting year: 1999–2000 to 2006–07



Source: derived by ACCC from MDO-owned insurers.

Note: excludes call revenue.[48]

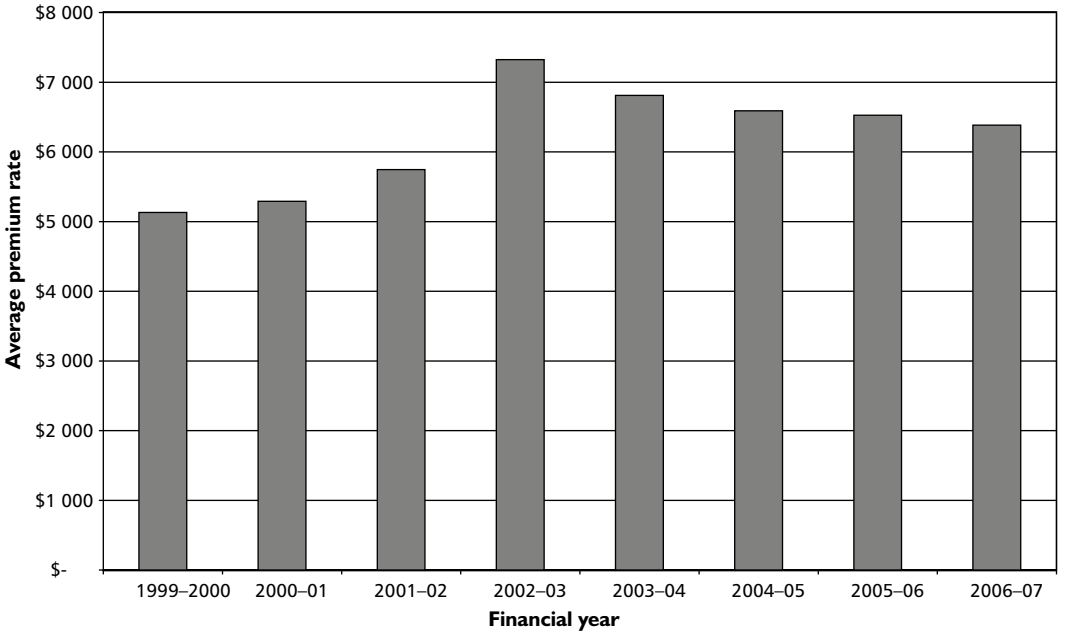
The total gross premium revenue rose significantly, from $177 million in 1999–2000 to $310 million in 2002–03. The total gross premium revenue fell marginally in 2003–04 to $297 million before rising gradually over the next three years. In 2006–07 total gross premium revenue increased to $328 million.

4.4.2 Average premium

Chart 4.6 shows the trend in real average premium revenue (noting that it excludes stamp duty, GST and ROCS) generated by medical indemnity providers from indemnified members. This average gives an indication of the trend in real average premiums paid by medical indemnity policyholders between 1999–2000 and 2006–07.

48 Before MDOs were regulated from 1 July 2003, a 'call' was a request by MDOs for additional funding from members to cover current or anticipated future shortfalls. To ease the burden on members, MDOs generally gave members the option of taking several years to pay the amount of the call.

Chart 4.6 Average premium—real terms: 1999–2000 to 2006–07



Source: derived by ACCC from MDO-owned insurers.

Notes: data is shown in real terms adjusted to 30 June 2007 values using the average weekly earnings (AWE) index published by the Australian Bureau of Statistics (ABS).

Rates exclude third party statutory collections such as stamp duty, GST and ROCS.

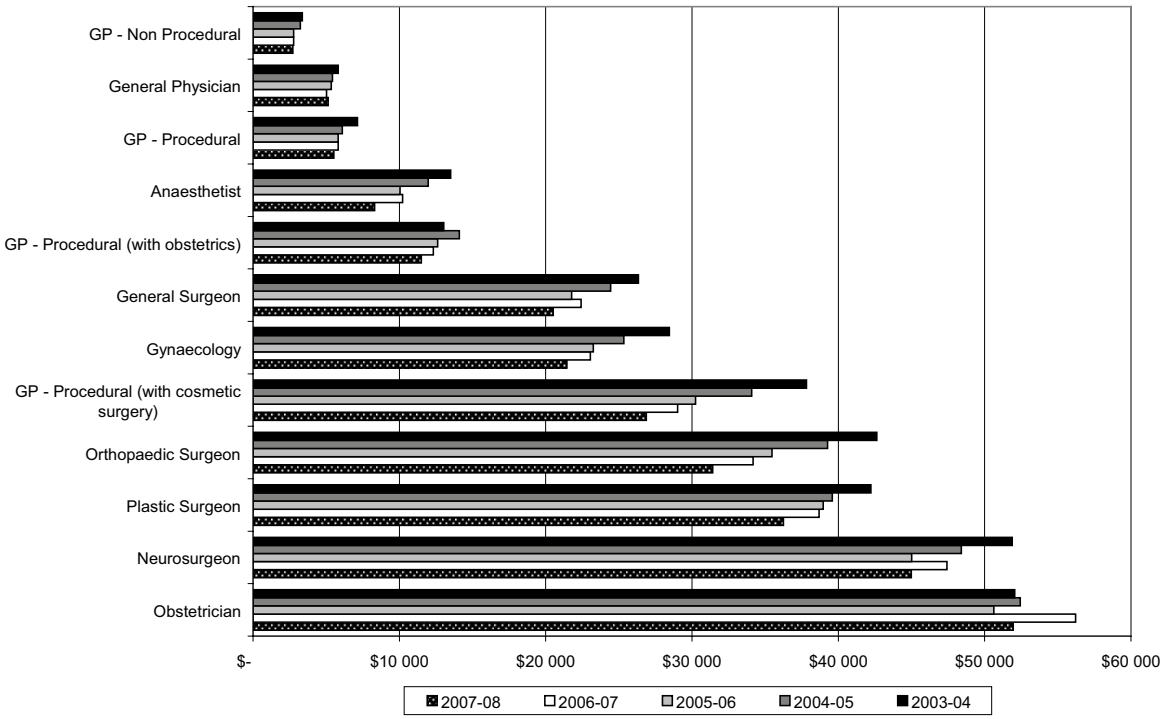
The average premium increased steadily between 1999–2000 and 2001–02, from $5130 to $5746 (representing an increase of 12 per cent), before increasing sharply in 2002–03 to $7325 (representing an increase of 27 per cent). The average premium then fell gradually in the next four years to 2006–07. In 2006–07, the average premium fell by 2 per cent to $6383.

Medical practitioners who practise relatively more complex medical procedures are likely to face a higher risk of medical negligence claims against them than ones who perform less complex procedures. The complexity of medical procedures is also a key determinant of the size of medical negligence claims. Because levels of risk vary with specialties so do the premiums charged by all medical indemnity insurers for different types of specialties.

To understand the relativities that apply between certain specialties, the ACCC obtained information from insurers on the gross written premiums and membership for individual specialties for the underwriting years between 2003–04 and 2007–08.[49] This information allowed the ACCC to examine the average written premium for selected specialties across the five underwriting years to determine the relativities between specialties as well as any changes in those relativities.

49 The ACCC asked insurers to provide gross written premium and membership numbers as at a specific date in the 2007–08 underwriting year to allow insurers to provide the data before the end of the underwriting year. However, because the majority of insurance is underwritten at the beginning of the underwriting year, the data should provide a reasonable estimate of the full year's results.

Chart 4.7 Average premium by specialty—real terms: 2003–04 to 2007–08



Source: derived by ACCC from MDO-owned insurers.

Notes: data is shown in real terms adjusted to 30 June 2007 values using the AWE index published by the ABS. Rates exclude third party statutory collections such as stamp duty, GST and ROCS.

Chart 4.7 shows that average premiums in real terms for the selected specialties varied between $2714 for a non-procedural general practitioner (GP) to $51 954 for an obstetrician in 2007–08.[50, 51, 52]

The annual change in average written premiums in 2007–08 compared to 2006–07 was generally a decrease across the specialties. In real terms the average written premium decreased ranging from 2 per cent for a non-procedural GP to 19 per cent for anaesthetists. General physicians were the only speciality to experience an increase in average premiums in real terms, with an increase of 2 per cent.

Chart 4.7 also shows the change in the average written premium for the selected specialties between 2003–04 and 2007–08. In real terms the average written premium of all the selected specialties decreased over the period; over the five years these decreases ranged from 0.2 per cent for obstetricians to 38 per cent for anaesthetists.

50 The analysis in chart 4.7 is not directly comparable with that shown in table 4.2 of the ACCC's first monitoring report due to differing methodologies. The ACCC's first monitoring report examined the average of all mature claims-made rates across all income bands, medical indemnity providers and jurisdictions. This analysis examines the total gross written premium for all insurers for selected specialties divided by the total membership for all insurers for those specialties.

51 Due to differing data sources, the results in chart 4.7 may not be directly comparable with those in chart 4.6.

52 The results in this chart reflect changes by two insurers in their basis of pricing of medical indemnity premiums in the 2007–08 underwriting year. To ensure a comparable time series, these two insurers also provided the ACCC with revised historical data.

This analysis may be influenced by differing characteristics of the membership for each specialty. Some specialties may include differing mixes of non-mature claims-made membership[53], different income levels and different jurisdictions.[54] All these factors may influence the average written premium for reasons other than specialty relativities.

53 Under a claims-made policy the insurer agrees to indemnify all claims arising from incidents notified during the policy period, as long as the incident occurred during the current period or any prior periods in which the policyholder has held continuous claims-made cover with the insurer up to, and including, the current period. Due to the more limited period the insurer is 'on risk', this product is discounted during the earlier years, until the policy becomes 'mature', which is typically four to five years.

54 For example, some high-risk categories are more prevalent in jurisdictions where different legislative requirements and historical claims experience results in a higher premium.

5 Actuarial justification of medical indemnity premiums

This chapter presents the findings of the Australian Competition and Consumer Commission (ACCC) on the actuarial justification of medical indemnity premiums charged for the 2007–08 underwriting period[55] by the six authorised providers of medical indemnity insurance to private medical practitioners as at 30 June 2007. This analysis examines the actuarial justification of premiums at an industry level by identifying a number of issues common to medical indemnity pricing across the industry.

The ACCC's findings regarding the actuarial justification of medical indemnity premiums charged within each jurisdiction for 2007–08 are discussed in chapter 7.

5.1 Qualifications

The ACCC's analysis is based on information supplied by each of the six insurers.[56] The ACCC relied on the information provided by insurers rather than performing an independent verification. As the parent entities of the five medical defence organisation owned insurers are no longer able to underwrite risks, the ACCC has generally not examined their operations or membership pricing. ACCC analysis only examined the premiums charged by each insurer for primary medical indemnity insurance and specifically excluded any examination of ancillary policies, allied health care professionals or the subscription charged by the MDO.

In preparing this report it was necessary for the ACCC to maintain the confidentiality of information provided by individual insurers. Accordingly some quantitative aspects of the ACCC's analysis, particularly of its assessment of information provided by individual insurers, could not be disclosed in this report.

5.2 Assessment methodology

5.2.1 Five MDO-owned insurers

For the five MDO-owned insurers the ACCC's review of the actuarial justification of premiums considers the process adopted by insurers in the derivation of premium rates, the approach for constructing those premiums, the level of detail used to support pricing assumptions, the rigour of the analysis and the extent to which other relevant issues (such as medical indemnity and tort reforms) have been considered in setting prices.

55 The 2007 calendar year in the case of AMIL and QBE.

56 Invivo, as the authorised representative of QBE, provided information to the ACCC on the actuarial justification of QBE's premiums.

Specifically, the ACCC examined the following:

- Ratings process—the method used by the medical indemnity insurer's actuary to determine premium rates. The factors considered by the ACCC include:
  - the extent to which premium rates are based on sound actuarial principles and professional standards
  - the method employed by the actuary to construct the aggregate premium pool, associated premium relativities, the assumptions adopted and the rigour associated with setting those assumptions
  - the extent to which the insurer's board adopted the actuary's recommended premium rates
  - the degree to which the recommended actuarial premium pool details in the pricing report are consistent with, and supported by, other reports, such as the financial condition report and the outstanding liability assessment.
- Pure risk premium—the level of premium needed just to meet the cost of expected medical indemnity claims and associated costs. This can be difficult to determine accurately because the ultimate costs associated with these claims are unlikely to be known for some years after the premium has been set (see section 2.1.3). The estimate of pure risk premium excludes the premium amount necessary to cover the insurer's expenses, reinsurance expenses and any surplus required. Factors considered include issues related to the cost structure of claims, such as the:
  - adopted claims frequency assumption
  - allowances for large claims
  - projected rate of claims cost increases
  - legal costs
  - discount rate
  - projected growth rate of membership numbers
  - specialty mix and claims-made profile
  - jurisdiction of claims.
- Expenses—the expense incurred by the insurer as a result of acquiring, writing and servicing the insurance business. Factors considered include assessing the appropriateness of the expected level of costs.
- Reinsurance expenses—the amount of premium ceded to reinsurers for reinsurance. Factors considered include:
  - whether the reinsurance premium is used effectively to minimise the risk exposure of the portfolio
  - the extent to which the cost of reinsurance is included in premium rates recommended by the actuary.
- Surplus—the surplus of funds expected to emerge after the cost of claims, expenses and reinsurance costs are deducted from premium revenue. For insurers, these funds are typically used to meet and maintain target capital levels and provide a contingency margin on expected claims costs. Factors considered by the ACCC include:

  - assessing the capital structure of the insurer and the cost effectiveness of how the capital is raised
  - examining the purpose for building a surplus into premiums and the appropriateness of the amount needed for each purpose
  - quantifying the effect on premiums of any allowance for the surplus.
- Recommended rates/relativities—the premium rate and/or price relativities for each classification used, including specialty and income band relativities. Factors considered include:
  - the method of derivation of relativities across classifications, including the extent of the analysis to confirm or modify risk classifications
  - quantifying cross-subsidies and incorporation of board policy in the recommended rates
  - comparing the actuary's recommended premium relativities against the actual premium rates charged by the insurer, with insurers being asked to explain material differences.

The analyses of jurisdictional relativities have been considered separately in chapter 7.

- Government reforms—the impact of measures arising from the Australian Government's medical indemnity package and relevant tort law reforms introduced by Commonwealth, state and territory governments on costs and premiums. The ACCC requested specific commentary on the following government initiatives:
  - HCCS—insurers were asked to detail the degree of influence this scheme has had on the calculation of the required premium pool and/or recommended premium rates, estimated claims cost reductions, as well as any allowances made for changes in the level and cost of reinsurance and the insurer's capital requirements.
  - ROCS—insurers were asked to detail the degree of influence this scheme has had on the calculation of the required premium pool and/or recommended premium rates, estimated claims cost reductions, as well as any allowances made for changes in the level and cost of reinsurance and the insurer's capital requirements.
  - Tort law reform—insurers were asked to detail the effect of tort reforms on the premium-setting arrangements. This included specific commentary by jurisdiction of the effect on costs, premiums, assumptions and the methodology employed. When no consideration of the effect of tort law reforms on costs and premiums was given, this was to be noted.

5.2.2 QBE

QBE's pricing methodology differs from the MDO-owned insurers which price top-down using an aggregate premium pool combined with risk relativities based on an insured profile to determine individual premium. QBE determines individual premiums for each specialty and jurisdiction on a bottom-up basis. QBE's pricing methodology is described in further detail in section 5.4.1.

Because of this, the ACCC's assessment methodology for QBE differed from that outlined above for the five MDO-owned insurers. The ACCC's assessment of the actuarial justification of QBE's premiums examined the following:

- Ratings process—the method used by QBE's actuary to determine premium rates. The factors considered by the ACCC include the:
  - extent to which premium rates are based on sound actuarial principles and professional standards
  - method employed by the actuary to construct the individual premiums for each specialty, the assumptions adopted and the rigour associated with those assumptions
  - actuary's inclusion of reasonable allowance for expense, reinsurance and surplus loadings in individual premiums
  - extent to which the insurer adopted the actuary's recommended premium rates.
- Government reforms—the impact of measures arising from the Australian Government's medical indemnity package and relevant tort law reforms introduced by Commonwealth, state and territory governments on costs and premiums. The ACCC requested specific commentary on the following government initiatives:
  - HCCS—the ACCC's analysis examined the degree of influence this scheme has had on the calculation of recommended premium rates, estimated claims cost reductions, as well as any allowances made for changes in the level and cost of reinsurance and QBE's capital requirements.
  - ROCS—the ACCC's analysis examined the degree of influence this scheme has had on the calculation of recommended premium rates, estimated claims cost reductions, as well as any allowances made for changes in the level and cost of reinsurance and QBE's capital requirements.
  - Tort law reform—the ACCC's analysis examined the effect of tort reforms on the premium-setting arrangements. This included specific commentary of the effect on costs, premiums, assumptions and the methodology employed.

Due to differences in QBE's pricing methodology, the actuarial justification of QBE's premiums is discussed separately in section 5.4.

5.3 Analysis—MDO-owned insurers

5.3.1 Ratings process

Based on the information provided by insurers, the ACCC found that the method employed in constructing the aggregate premium pool was generally consistent across the MDO-owned insurers. Insurers estimated the aggregate premium pool required by establishing the estimated cost of claims, reinsurance costs and administration expenses, plus an additional margin for capital growth or maintenance.

The methodology adopted by all insurers to establish their actual premium pools were supported by actuarial advice.

In general the insurer determined the actual premium pool after considering advice from the actuary. One insurer set the premium pool based on commercial considerations. Subsequent supporting actuarial analysis was supplied to the ACCC.

On this basis the ACCC found that the ratings processes used and the aggregate premium pool adopted by all five MDO-owned insurers were considered to be actuarially sound.

The ACCC, however, encourages the involvement of actuaries in each stage of the rating process.

5.3.2 Pure risk premium

The ACCC considered the pure risk premium component of the aggregate premium pool for the 2007–08 underwriting year.[57] Pure risk premium is the basic building block for determining the aggregate premium pool and represents the direct cost of settling claims. As shown in table 4.1, the net claims cost represented 44 per cent of the aggregate premium pool for the 2007–08 underwriting year.[58]

The ACCC found that insurers maintained the methodology used in previous underwriting years. In most cases, insurers estimated the total losses arising from claims notified in the year, projected payments based on assumed claims frequencies and average claims costs and then discounted based on an assumed pattern of payments to allow for expected investment income. Insurers estimated that the cost of claims was expected to increase at a rate greater than normal wage inflation.

The other method used by one actuary for setting the pure risk premium was to set it at the level of the insurer's aggregate retention point of its stop loss reinsurance program. That is, they estimated that the pure risk premium would be the cost of all claims that had to be paid before the reinsurance program began to pay for claims beyond the insurer's retention level.

The ACCC found that the stated approaches were all considered sound.

5.3.3 Expenses

The ACCC considered the amount of expenses incorporated into the aggregate premium pool for the 2007–08 underwriting year. Table 4.1 shows that the expenses represented 26 per cent of the aggregate premium pool for the 2007–08 underwriting year.

All aggregate premium pool estimates included an allowance for expenses, which was determined to be actuarially justified.

Two insurers revised their operations by transferring the MDO service function. One transferred the function from the MDO to the insurer while another transferred the function from the insurer to the MDO. In both cases, the servicing costs were recognised and appropriate allowances for insurance company expenses were incorporated in the aggregate premium pool.

57 The 2007 calendar year in the case of AMIL.

58 The net claims costs is the expected ultimate claims cost net of recoveries received or expected to be received, including those from the Australian Government, under the high cost claims scheme, the run-off cover scheme and the UMP support scheme.

5.3.4 Reinsurance expenses

The ACCC considered the reinsurance expenses incurred by insurers to assess whether the reinsurance program was used effectively to minimise the insurer's risk exposure and the extent to which the cost of reinsurance was considered in premium rates recommended by the actuary. Table 4.1 shows that reinsurance expenses represented 14 per cent of the aggregate premium pool.

All medical indemnity insurers used reinsurance programs for the 2007–08 underwriting period to manage the risks inherent in their portfolio. Most insurers used a combination of excess of loss and stop loss reinsurance to manage their risk exposure.[59] The attachment points for excess of loss reinsurance and the aggregate retention for stop loss reinsurance adopted by insurers varied across the industry due to individual circumstances. All insurers factored the total cost of reinsurance into the premiums charged to medical practitioners.[60]

The ACCC acknowledges that the trade-off between the net cost of reinsurance and the level of risk that the insurer is willing to undertake is ultimately a business decision for the insurer. The ACCC notes that, similar to last year's report, one insurer's reinsurance arrangements for the 2007–08 underwriting year reflected its assessment that one component of its potential reinsurance program would have been ineffective in reducing risk given the premium being asked by the reinsurer. The effect of this change was that the insurer has increased its potential loss in the event of adverse claims experience; however, this increase in volatility is managed by holding a greater amount of capital.

5.3.5 Surplus

The ACCC considered the component of each insurer's aggregate premium pool that represented a surplus. The surplus component is generally designed to:

- build the capital needed to achieve the target level set by the Australian Prudential Regulation Authority (APRA)[61, 62]
- build the additional capital needed as a result of risks underwritten in 2007–08 to maintain total capital at, or above, the level required by APRA
- maintain a contingency (or prudential) margin over and above the actuary's central estimate of the outstanding claims liability to increase the probability that the pure risk premium is adequate to meet the cost of claims
- provide a surplus (profit) to the insurer.

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59 'Excess of loss' is a form of reinsurance that indemnifies a reinsured against claims in excess of an agreed amount (known as the attachment point) and the reinsurer pays the loss in excess of this amount up to an agreed limit. In addition, there may be an aggregate limit for all claims assumed by the reinsurer. Stop loss reinsurance is where the reinsurer is obliged to cover, up to a limit, any part of the total annual loss burden that exceeds an aggregate retention.

60 In some cases the reinsurance program covered risk incurred as a result of IBNR claims resulting from cover provided by the parent MDO. A portion of the reinsurance premium was then charged to the MDO.

61 As discussed in chapter 2 the change from medical indemnity being offered by discretionary mutuals to authorised insurers from 1 July 2003 resulted in medical indemnity providers being required to maintain a minimum level of capital to support their insurance business. In recognition of the significance of this change, APRA introduced special transition arrangements that allowed medical indemnity providers to meet the target capital levels by 30 June 2008.

62 The ACCC understands that APRA has targeted 150 per cent minimum capital requirement (MCR) as the expected level of capital to be held by medical indemnity insurers.

Table 4.1 shows that the amount of surplus in the aggregate premium pool has decreased over the past four underwriting years, from 35 per cent in 2003–04 to 16 per cent in 2007–08.

The decrease in the amount of the aggregate premium pool represented by surplus reflects the fact that insurers initially used the surplus to build capital to APRA's target level of 150 per cent of minimum capital requirement (MCR) and, as insurers' capital levels approach or pass this, or their own internal target[63], a significant surplus is no longer needed.

For the 2007–08 underwriting period the ACCC found that all insurers had generated sufficient capital to satisfy APRA's target MCR and did not need to include the significant surplus loading built into previous years' premiums.

Most insurers included a loading in their premiums for additional capital. This capital was built into premiums for one of two reasons—to maintain their capital at a level sufficient to continue to meet or exceed APRA's target capital after taking into account the additional risks underwritten in 2007–08, or to maintain a contingency margin.

Other mechanisms such as premium rebates were also employed for returning surplus capital to policyholders.

The ACCC took into account the long-term pricing goals as well as the overall capital position of the insurer when determining the actuarial justification of this insurer's current year premiums.

No insurer explicitly included a surplus in premiums for the purpose of making a profit. While some insurers have the ability to pay a dividend to the parent entity (the MDO), MDOs operate on a not-for-profit-basis as 'mutuals' owned and operated by members and therefore would not have the incentive, or the mechanism, to make and distribute any profit.

63 The ACCC understands that while APRA has targeted 150 per cent MCR as the expected level of capital to be held by the five MDO-owned insurers, all insurers have set internal targets higher than this amount.

5.3.6 Recommended relativities and cross-subsidisation

The ACCC examined the premium rate relativities across the various risk specialties that were recommended by the actuary to the insurer's board.

The ACCC found that most insurers had undertaken extensive analysis of the premium relativities across specialties. Insurers typically examined historical frequency and average size by specialty. The ACCC found that cross-subsidisation between specialties was common across insurers and that in some cases significant variance between the technical and actual relativities existed. While insurers indicated that they were moving to unwind these cross-subsidies, many indicated that this was a long-term process and potentially not all cross-subsidies would be removed for a variety of reasons, including commercial factors as well as data limitations. All insurers identified and quantified cross-subsidies between risk specialties.[64]

The ACCC also examined the premium relativities applied across broad income bands. Similar to the analysis done for specialties, insurers generally examined these rates by comparing the risk relativities between income bands. Cross-subsidies exist between income bands and again some insurers indicated a desire to unwind these. But generally made only limited changes to income banding relativities in 2007–08.

The ACCC found that, given that premium relativities between specialties and income bands were examined and commented on, and cross-subsidies were identified and where possible quantified, the relativities adopted were actuarially justified.

The ACCC's assessment of the actuarial and commercial justification of premium relativities between jurisdictions is considered in chapter 7.

5.3.7 Government reforms

The ACCC examined the effect of the Australian Government's medical indemnity reforms (in particular, HCCS and ROCS) and Commonwealth, state and territory tort law reform on costs and premiums, which were identified as having the main impact on claims costs (and therefore premiums). The extent to which insurers had considered these measures when determining premiums varied across the industry.

The high cost claims scheme

The high cost claims scheme (HCCS) was introduced to address the issue of high-cost claims for medical incidents. It was designed to reduce the potential cost of large claims to insurers, and is expected to affect premiums in two ways. First, it is expected to reduce the pure risk premium component of premiums because the Australian Government will pay 50 per cent of high cost

64 Cross-subsidisation between current and retired insureds has now been formalised by the introduction of ROCS, which provides automatic free insurance cover to doctors for death, disability, maternity and retirement (doctors aged 65 or over or who have left the workforce for three or more years). The scheme is funded by a percentage charged on the total premium pool of medical indemnity providers, which in turn is passed on to the premiums charged to current financial medical practitioners.

claims above a threshold amount.[65] Second, the scheme is expected to reduce the amount of reinsurance needed to cover the total cost of high cost claims. These effects will, to some degree, be interdependent depending on the attachment points of each insurer's reinsurance program.

All insurers took into account the full amount of expected HCCS recoveries in determining the pure risk premium for the 2007–08 underwriting year. Three insurers indicated that they had factored the full effect of the HCCS into their 2007–08 reinsurance programs. As noted in previous reports, the rationale of the remaining two insurers for not factoring the HCCS into the reinsurance program differed.

The ACCC continues to take the view that because the rationale for not taking the HCCS fully into account in the reinsurance program appears to be unwillingness by some reinsurers to fully reflect the benefits of the Australian Government's scheme, the aggregate premium pool of these insurers is actuarially justified. Importantly, both insurers fully took HCCS recoveries into account in establishing their pure risk premium.

Run-off cover scheme

The run-off cover scheme (ROCS) was introduced to provide secure cover for medical practitioners who retire, die, become permanently disabled, take maternity leave or leave the workforce for three years or more. The scheme covers claims by these medical practitioners, with the cost funded by a charge on current members. This scheme is expected to affect premiums by taking claims from these medical practitioners off the insurers' books, thereby reducing the pure risk premium. However, premiums will increase by the amount the Australian Government charges to cover the cost of this scheme.

All insurers commented on the effect of ROCS on 2007–08 premiums. Four insurers indicated that they expected to make recoveries from ROCS on claims costs resulting from notifications received in the 2006–07 underwriting year. Although the level of recoveries varied between insurers, none expected recoveries of the same order as the ROCS levy imposed on final premiums.

The remaining insurer did not build ROCS recoveries into its premiums on the basis that it was not expecting a material level of revenue from this source.

All insurers continue to indicate they are correctly incorporating the ROCS levy into the premiums charged to medical practitioners.

Based on this, the ACCC found that the insurers' consideration of ROCS in determining their premiums for the 2007–08 underwriting year was actuarially justified.

65 The threshold is currently $300 000.

Tort law reform

Commonwealth, state and territory governments have progressively introduced tort law reforms since early 2001 in response to problems perceived in the availability and affordability of public liability and professional indemnity insurance.[66] Many of the reforms deal directly with constraining the number and size of personal injury payouts. As most medical indemnity claims are for personal injury cases, some of these reforms are expected to affect the cost of providing medical indemnity insurance.

All insurers implicitly took tort law reform into account when setting premiums because they adopted assumptions for average claim size and frequency based on past experience that incorporated tort law reform. Insurers generally indicated that the number of claims and average cost of claims had decreased as result of tort law reform.

5.3.8 Conclusion

The ACCC found that premiums were considered to be actuarially justified for all five MDO-owned insurers.

The ACCC examined several factors in its determination of the actuarial justification of premiums, including assessment of the aggregate premium pool, the recommended relativities for each classification (including specialty and income bands) and the impact of specific government reforms on premiums.

The ACCC found that the aggregate premium pool of each insurer was actuarially justified. It was evident that insurers had made extensive use of actuaries in premium liability assessments, in most pricing reports, funding plans and financial forecasts. In each case it was considered that the construction of the recommended premium pool was soundly based and incorporated all major cost implications for the pricing of medical indemnity insurance. Most insurers adopted an aggregate premium pool after considering advice from the actuary. One insurer set the premium pool on commercial grounds that were later supported by actuarial advice.

The ACCC analysis of specialty premium rates found that all insurers conducted detailed analysis on the risk relativities between specialties or relied on recent risk relativity analysis. As in previous monitoring reports, the ACCC found that insurers generally cited the unwinding of existing cross-subsidisation between specialties as an objective. The ACCC noted that this was a long-term process and potentially not all cross-subsidies would be removed for a variety of reasons, including commercial factors as well as data limitations. However, the ACCC still found these rates and the relativities for income bands to be actuarially justified because the extent of cross-subsidisation was understood and, where possible, quantified.

66 The effect of tort law reform on costs and premiums in public liability and professional indemnity insurance is discussed in more detail in the Australian Government publication, *Available and affordable—Improvements in liability insurance following tort law reform in Australia*, December 2006, available free online at www.treasury.gov.au.

The ACCC's analysis of the impact of government reforms on premiums includes an examination of Australian Government medical indemnity reforms (including HCCS and ROCS) and Commonwealth, state and territory tort law reforms. The ACCC found that all insurers appropriately considered HCCS and ROCS into their premium determinations and most insurers took full account of HCCS in their reinsurance programs.

Although two insurers did not reflect HCCS in their reinsurance program because of the unwillingness of their reinsurers to fully reflect the full benefits of the scheme, both insurers fully took HCCS recoveries into account when establishing their pure risk premium. All insurers, either implicitly or explicitly, also took tort law reform into account in setting their aggregate premium pools for 2007–08.

5.4 Analysis—QBE

As described in section 5.3 the five MDO-owned insurers price by establishing an aggregate premium pool and then determining risk relativities for insureds based on their jurisdiction, specialty and income. In contrast, QBE's pricing approach is different, with premiums established on a 'bottom-up' rather than 'top-down' approach.

This difference in approach meant that the ACCC's analysis of QBE had to be reported on separately to the five MDO-owned insurers.

5.4.1 Ratings process

As identified in the fourth report the method employed by QBE in constructing premiums was based on calculating individual premiums for each specialty. The process used included an analysis of the ultimate claims frequency and average claims size by specialty, including an assessment of the impact of reinsurance and government reforms. Using this analysis QBE forecast gross premiums payable to it by including the following components:

- claim frequency
- average claims cost
- reinsurance costs
- expenses (including administration, brokerage and interest)
- profit.

As a new medical indemnity underwriter, QBE's limited claims experience does not provide a statistically significant volume of claims for deriving or adjusting premium rates. Premium levels and adjustments to 2006 rates for the 2007 calendar year were based on analysis of available market information and identified issues that were considered by QBE actuaries likely to affect premiums. Differential premiums were applied in each jurisdiction also based on analysis of available industry data.

5.4.2 Government reforms

The high cost claims scheme

As noted above, HCCS is expected to reduce premiums two ways: first, by reducing the pure risk premium component, as the Australian Government meets 50 per cent of the excess above a threshold amount of the cost of individual large claims and, second, the scheme is expected to reduce the amount of reinsurance needed to cover the total cost of high-cost claims.

QBE examined the effect of HCCS on its pure risk premium and took into account the full amount of expected HCCS recoveries. Further, QBE's reinsurance program was designed to reinsure only the risk net of HCCS recoveries.

The run-off cover scheme

ROCS is expected to affect premiums by taking claims from medical practitioners who retire, die, become permanently disabled or permanently leave the workforce for three years or more off the insurers' books, thereby reducing the pure risk premium.

QBE did not explicitly take any ROCS recoveries into account in estimating its claims costs because its pricing methodology prices risks individually.

Tort law reform

As tort law reform predominantly deals with constraining the number and size of personal injury cases, it is expected to affect the cost of providing medical indemnity insurance because most medical indemnity claims relate to personal injury. QBE took into account tort law reform during the process of establishing its final average claims costs by specialty.

5.4.3 Conclusion

The ACCC found that QBE's 2007 premiums were actuarially justified. This analysis recognised that this is only QBE's second year of underwriting medical indemnity insurance and therefore it had limited claims experience available. The ACCC's assessment included revisiting the original methodology used to set premiums that compared scheduled premium rates with the actuary's recommended premium rates. It also involved an assessment of the impact of specific government reforms on premiums and changes in rates based on emerging experience and other identified issues.

5.5 Conclusion

The ACCC found that premiums were considered to be actuarially justified for the five MDO-owned insurers.

The ACCC found that the aggregate premium pool of each insurer was actuarially justified. In most cases the construction of the recommended premium pool was considered to be soundly based and reflected consideration of detailed advice from the actuary.

The ACCC's analysis of specialty premium rates found that all insurers either conducted detailed analysis on the risk relativities between specialties or relied on recent analysis. As in previous monitoring reports, the ACCC found that insurers generally cited the unwinding of existing cross-subsidies between specialties as an objective, but noted that this was a long-term process and potentially not all cross-subsidies would be removed for a variety of reasons, including commercial factors as well as data limitations. No major realignment of rates was conducted for 2007–08. However, the ACCC still found these rates and the relativities for income bands to be actuarially justified because the extent of cross-subsidisation was understood and, where possible, quantified.

The ACCC found that all insurers appropriately considered HCCS and ROCS into their premium determination and most insurers took full account of HCCS in their reinsurance programs. The two insurers that did not reflect HCCS in their reinsurance program did so because of an unwillingness of reinsurers to fully reflect the full benefits of the scheme in their reinsurance pricing and structure. Importantly, both insurers took HCCS recoveries into full account when establishing their pure risk premium. All insurers took tort law reform into account in setting their aggregate premium pools for 2007–08.

The ACCC also conducted separate analysis on QBE's premiums and found them to be actuarially justified.

6 Commercial justification of medical indemnity premiums

This chapter presents Australian Competition and Consumer Commission (ACCC) findings on the commercial justification of medical indemnity premiums charged for the 2007–08 underwriting period by insurers to private medical practitioners.[67]

The ACCC analysis examines the commercial justification of premiums at an industry level by identifying a number of issues common to medical indemnity pricing across the industry.

The ACCC findings regarding the commercial justification of medical indemnity premiums charged within each jurisdiction for 2007–08 are discussed in chapter 7.

6.1 Qualifications

The ACCC analysis is based on information supplied by each of the insurers. The ACCC relied on the information provided by insurers rather than performing an independent verification. As the medical defence organisation parent entities of insurers are no longer able to sell insurance, the ACCC has generally not examined their operations or membership pricing. For the MDO-owned insurers, this analysis only examined the premiums charged by each insurer for primary medical indemnity insurance and specifically excluded any examination of ancillary policies or the subscription charged by the MDO.

In preparing this report it was necessary for the ACCC to maintain the confidentiality of information provided by individual insurers. Accordingly some quantitative aspects of the ACCC analysis, particularly in relation to its assessment of individual insurer's information, could not be disclosed in this report.

6.2 Assessment methodology

The ACCC's assessment of the commercial justification of premiums considers whether each insurer's current premiums and pricing strategies would be sustainable in a viable and ongoing commercial market.

Fiscally responsible insurers examine the financial impact of pricing decisions on their operations by preparing business plans that describe how they intend to manage their business. They also prepare detailed corporate plans on the financial effect (including on the income statement and balance sheet) of the business plan on their overall corporate strategies. This type of analysis is necessary to ensure that insurers are capital-compliant with the Australian Prudential Regulation Authority's targeted capital level by 30 June 2008, as their pricing decisions in the current underwriting period will affect their financial position at the end of the transition period.[68]

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67 On 1 July 2007 AIL commenced operation as a medical indemnity insurer as a result of the merger of the parent MDO entities of the Australasian Medical Insurance Limited and the Professional Indemnity Insurance Company Australia Pty Limited. In this report the ACCC will be assessing the commercial justification of premiums, set by AMIL and PIICA prior to the merger which is the 2007 calendar year for AMIL and the 2007–08 financial year for PIICA. In addition the ACCC has analysed consolidated information supplied by Avant Insurance Limited for PIICA and AMIL.

68 The Australian Prudential Regulation Authority established a scheme for transitional arrangements whereby providers have up to five years from 1 July 2003 to 30 June 2008 to comply with these minimum capital requirements. APRA required all medical indemnity providers intending to use the transitional period to build the required minimum capital to provide it with a funding plan indicating how this capital was going to be raised over the transitional period.

In examining the commercial justification of premiums, the ACCC compared for the five MDO-owned insurers:

- The financial projections contained in their initial funding plans as provided to APRA to make use of the transition period for building the capital to APRA-targeted capital (referred to as '2002–03 projections').
- The revised financial projections prepared in 2003–04, 2004–05, 2005–06 and 2006–07 (referred to respectively as '2003–04 projections', '2004–05 projections', '2005–06 projections' and '2006–07 projections'). These projections are typically updated each year to take into account more recent data and developments.[69]
- The actual financial position as at 30 June 2004, 30 June 2005, 30 June 2006 and 30 June 2007 based on annual reporting data provided to APRA (referred to as 'actual results').[70]

Comparing these sets of data allows the ACCC to examine how insurers' financial position forecasts have changed over the five years and whether forecasts for 2007–08 were based on insurers' recent experiences.

The ACCC examined several key indicators in making its assessment of the commercial justification of premiums, including:

- solvency[71]—the current and forecast net asset position of insurers to assess levels of solvency
- emerging surplus—the emerging and forecast levels of surplus loading in premium and whether this was sufficient to achieve the insurers' targeted solvency and capital requirements
- minimum capital requirement coverage and capital targets—current and forecast levels of MCR coverage to examine whether capital targets would be met
- return on net assets—current and forecast return on net assets
- underwriting performance—the emerging and forecast underwriting performance in terms of the loss, expense, reinsurance and combined ratios (defined in section 6.3.5).

The ACCC's ability to report on the commercial justification of QBE's premiums for the 2007–08 underwriting year was limited because of data constraints surrounding the company. This is because QBE:

- has limited historical information specific to medical indemnity insurance
- is a large insurer that underwrites significant volumes of professional indemnity insurance business other than medical indemnity[72] so it is difficult to disaggregate Queensland Insurance (Australia) Limited's medical indemnity insurance results from its other professional indemnity business.

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69 These revised projections were updated at different times depending on the insurer. The ACCC endeavoured to use the most recent projections up to 30 June of each year.

70 The actual results for 2006–07 include annual reporting data for PIICA and AMIL as AIL only commenced operation on 1 July 2007.

71 Solvency is a measure of whether an insurance company has sufficient assets (capital, surplus, reserves and so on) to meet all liabilities (the cost of claims and all other expenses).

72 The MDO-owned insurers only underwrite medical indemnity insurance, whereas the Queensland Insurance (Australia) Limited (QBE) underwrites medical indemnity insurance as well as a range of commercial and personal lines of insurance.

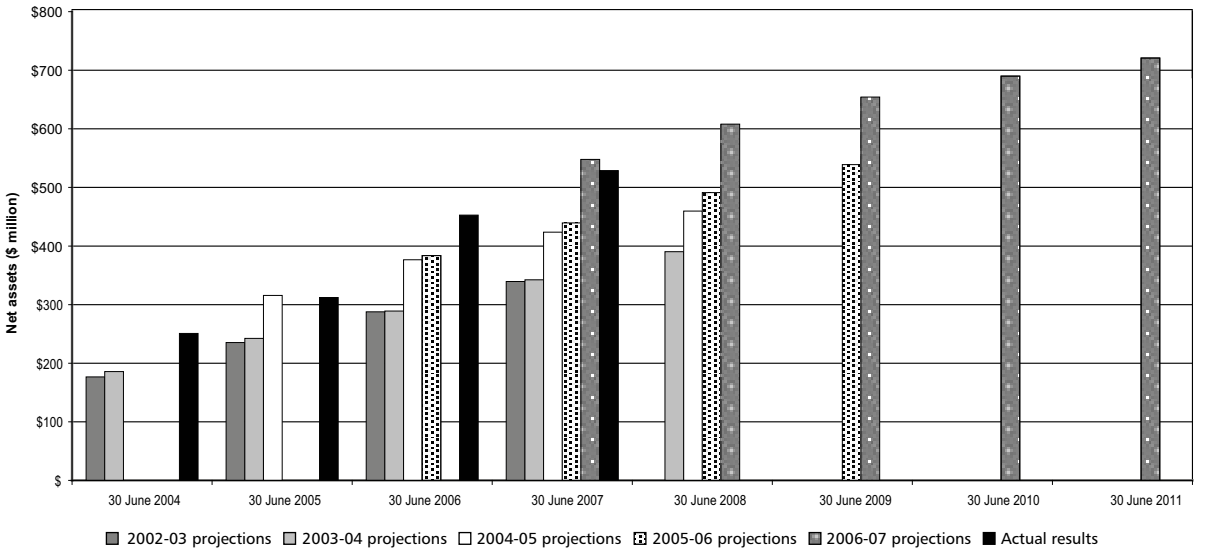
The ACCC has not included QBE's data in the industry analysis contained in chapter 6; however, it has separately examined the commercial justification of QBE's premiums by examining Invivo's financial projections and how these are consolidated within QBE's professional indemnity insurance business.

6.3 Analysis—MDO-owned insurers

6.3.1 Solvency targets

The ACCC assessed insurers' actual solvency levels as at 30 June 2004 to 30 June 2007 and compared these against the projections of solvency based on the five projection years between 2002–03 and 2006–07. These levels are shown in chart 6.1.

Chart 6.1 Net assets: actual results 30 June 2004 to 30 June 2007 and projections 2002–03 to 2006–07



Source: derived by ACCC from MDO-owned insurers.

Chart 6.1 shows that the 2002–03 projections originally forecast that the net assets of the medical indemnity industry would increase from $177 million to $339 million between 30 June 2004 and 30 June 2007. These forecast positions improved when subsequently revised in later projections. The 2006–07 projections forecast the net asset position to grow from $548 million at 30 June 2007 to $721 million at 30 June 2011.

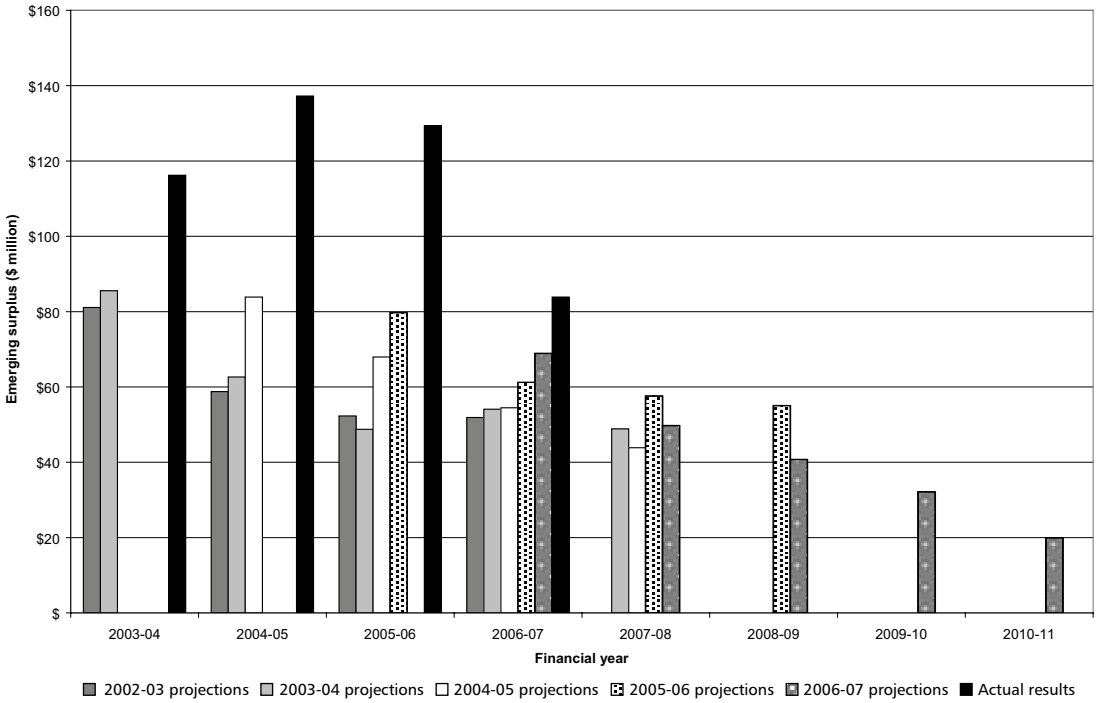
As at 30 June 2007 the industry was in a strong solvency position with total assets exceeding total liabilities by $529 million. This was a significant improvement on the actual result observed at 30 June 2006 of $453 million.

The net asset position of all insurers as at 30 June 2007 was also an improvement on their actual results as at 30 June 2006. However, the degree to which the net asset position had improved depended on the circumstances of individual insurers.

6.3.2 Emerging surplus

The ACCC assessed the actual emerging surplus as at 30 June 2007 and compared this against the emerging surplus forecast in the five projection years between 2002–03 and 2006–07.[73] This is shown in chart 6.2.

Chart 6.2 Emerging surplus: actual position 2003–04 to 2006–07 and projections 2002–03 to 2006–07



Source: derived by ACCC from MDO-owned insurers.

The chart shows that based on the 2002–03 projections the level of emerging surplus was forecast to decrease from $81 million in 2003–04 to $52 million in 2006–07. A declining emerging surplus is also reflected in all five projection sets. The emerging surplus predicted in the 2006–07 projections is $69 million in 2006–07, falling to $20 million in 2010–11. As these surpluses are typically used by insurers to build and maintain capital, the levels of emerging surplus would be expected to reduce once sufficient capital has been raised to meet insurers' targets.

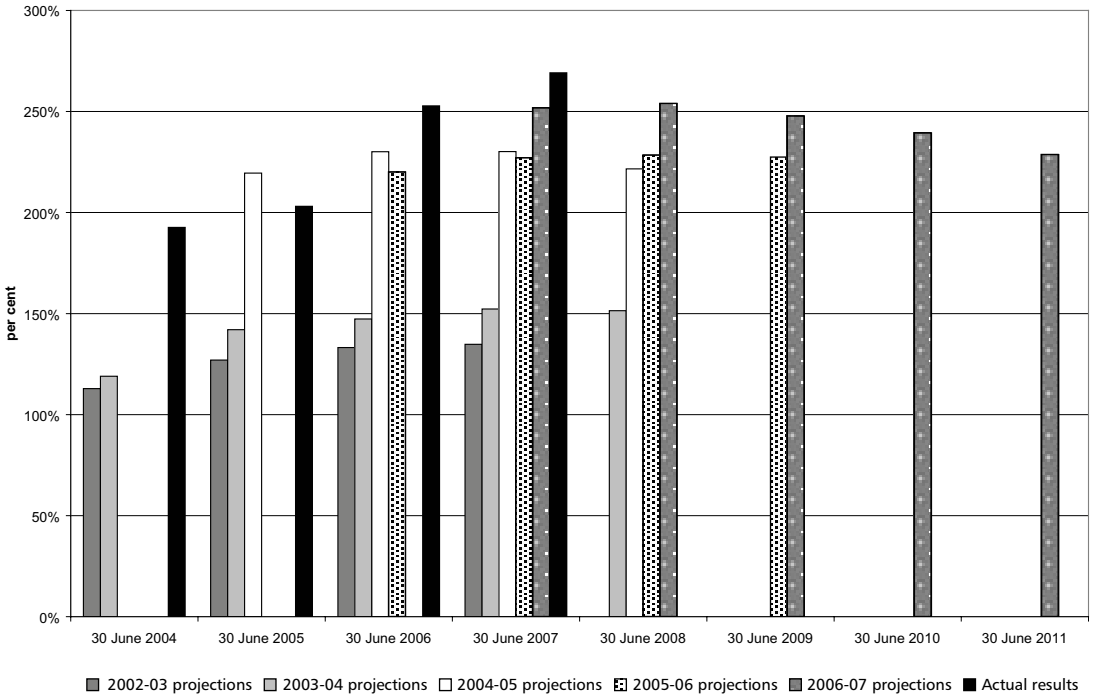
73 The ACCC has adjusted one insurer's 2004–05 actual results on advice from that insurer to remove the impact of a reporting discrepancy in that year.

The medical indemnity industry achieved an emerging surplus of $84 million in 2006–07, which was somewhat higher than projected but represented a significant reduction from the actual result observed in 2005–06.

6.3.3 MCR cover and capital targets

The ACCC assessed the actual financial position of the MDO-owned medical indemnity insurers as at 30 June 2007 and compared this against the financial position forecast in the five projection years between 2002–03 and 2006–07. The ACCC examined the net asset[74] to MCR ratio as an indicator of financial position, as shown in chart 6.3.

Chart 6.3 Net assets to MCR ratio: actual position 2003–04 to 2006–07 and projections 2002–03 to 2006–07



Source: Derived by ACCC from MDO-owned insurers.

The chart shows that the 2002–03 projections forecast the medical indemnity insurance industry to have a net asset position equal to 113 per cent of MCR at 30 June 2004, rising to 135 per cent by 30 June 2007. The 2003–04 projections were also broadly consistent with the 2002–03 projections; however, the three other projection sets forecast a significantly higher net asset-to-MCR ratio over the same period. The 2006–07 projections forecast the MCR coverage to be 252 per cent at

74 For the analysis in section 6.3.3, the net asset position is, where possible, based on the APRA-determined capital base of the insurers. The APRA determined capital base is used by APRA to gauge compliance with the MCR.

30 June 2007 and then gradually decreasing from this level in the period through until 30 June 2011.

The actual net asset to MCR ratio of the medical indemnity industry at 30 June 2007 of 269 per cent was higher than all prior projections.

As at 30 June 2007 all insurers significantly exceeded the target 150 per cent MCR coverage required by APRA and are also projected to satisfy this target capital level by 30 June 2008.[75]

The ACCC notes that, as for the 2006–07 underwriting year, one insurer did not incorporate sufficient capital within its insurance premiums to maintain its net asset-to-MCR ratio. To compensate for this, the insurer's parent entity is scheduled to make a capital injection in 2007–08, as well as further injections in future years.

Capital injections from the parent entity are generally a more efficient method of raising capital than a loading in insurance premiums[76]; further, it is also a more efficient way to utilise otherwise unused capital in not-for-profit organisations, such as MDOs.[77]

However, while capital injections funded through a combination of subscriptions and unused capital from the MDO may allow the insurer to meet its internal target capital levels in the short to medium term, it may not be sustainable on a long-term basis. This is because all unused capital in the MDO will eventually be transferred and any capital injections will need to be funded purely though the MDO's annual surplus (profit), potentially leading to an increase in subscription levels.

Notwithstanding this, the ACCC found, after taking into account that capital injections are appropriately budgeted for and have MDO board approval, that this insurer's pricing was commercially justified.

75 APRA's transitional arrangements enable medical indemnity providers to build capital up to APRA's targeted capital level by 30 June 2008.

76 Raising capital through insurance premiums incurs a 10 per cent goods and services tax, stamp duty (which varies depending on the jurisdiction) and an 8.5 per cent run-off cover scheme (ROCS) levy. Income tax is also charged on profit at 30 per cent.

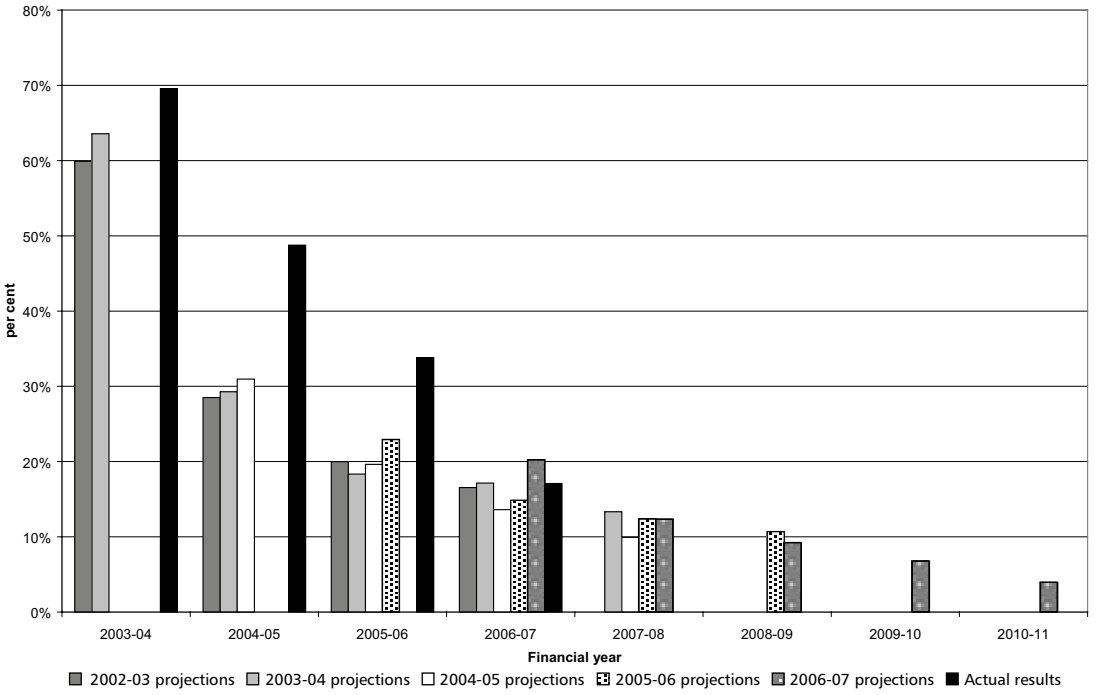
Alternatively, subscriptions raised through the parent MDO do not incur stamp duty or the ROCS levy and, as they operate as not-for-profit organisations, only incur income tax on investment returns.

77 MDOs are not subject to the same prudential requirements as licensed insurers and as such have a lesser statutory obligation to hold free capital.

6.3.4 Return on net assets

The ACCC assessed the returns of the MDO-owned medical indemnity insurers relative to their net asset position and compared these against the five projection years between 2002–03 and 2006–07. This is shown in chart 6.4.

Chart 6.4 Return on net assets: actual position 2003–04 to 2006–07 and projections 2002–03 to 2006–07



Source: derived by ACCC from MDO-owned insurers.

Chart 6.4 shows that the 2002–03 projections forecast the return on net assets to decrease from 60 per cent in 2003–04 to 17 per cent in 2006–07. This trend of a decline in the return of net assets was reflected in all five projections sets. In 2006–07 the projected return on net assets was forecast to continue to decline from 20 per cent in 2006–07 to 4 per cent in 2010–11.

The return on net assets is projected to decrease because insurers initially raised significant surpluses to fund capital requirements when their asset bases were low, but, once those capital targets are achieved, the required surplus will reduce.[78]

The actual return on net assets of 17 per cent for 2006–07 was around the level predicted in projections. The downwards trend in the actual results was also consistent with the projections.

78 This is further influenced by the fact that the net asset position of insurers increases as they approach their capital targets.

6.3.5 Underwriting performance

The ACCC examined the underwriting performance in the following terms:

- Loss ratio—the total claims expense attributable to each financial year on claims arising from that or previous years as a proportion of gross premium revenue.[79]
- Expense ratio—the sum of all underwriting and general expenses (excluding reinsurance expenses) as a proportion of gross premium revenue.
- Reinsurance ratio—the reinsurance expense as a proportion of gross premium revenue.
- Combined ratio—the sum of the loss and the expense ratio. A combined ratio less than 100 per cent indicates that a company makes an underwriting surplus (i.e. premiums more than cover the cost of claims and operating expenses). A ratio greater than 100 per cent indicates that the company has an underwriting loss.[80]

The ACCC examined gross ratios, which show performance of the industry before the effect of reinsurance, to assess the underlying profitability of the insurers. Net ratios were also examined to assess the performance of that part retained by the insurers. Any difference between the gross and the net ratio highlights the effect of reinsurance on the insurers.

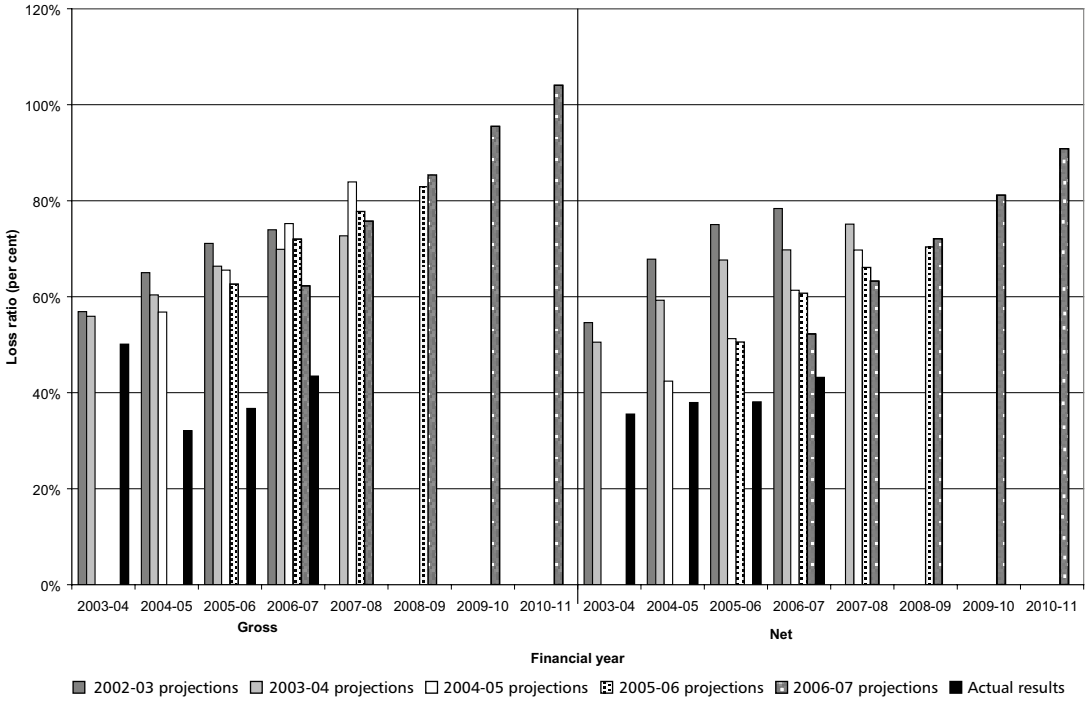
79 As the loss ratio for the financial year includes any loss or surplus for prior underwriting years, this measure does not necessary provide a good indicator of the profitability of the current underwriting year.

80 Analysis of underwriting performance may not necessarily be indicative of an insurer's overall profitability because of the exclusion of investment income.

Loss ratio

Chart 6.5 shows the gross and net loss ratios for the five MDO-owned insurers based on five years of financial projections of insurers. It also shows the actual loss ratios for 2003–04 to 2006–07.

Chart 6.5 Gross and net loss ratio: actual position 2003–04 to 2006–07 and projections 2002–03 to 2006–07



Source: derived by ACCC from MDO-owned insurers.

The chart shows that the 2002–03 projections forecast that the gross loss ratio would rise from 57 per cent in 2003–04 to 74 per cent in 2006–07. Subsequent projections also forecast increasing loss ratios. The 2006–07 projections forecast the gross loss ratio increasing from 62 per cent in 2006–07 to 104 per cent in 2010–11. The direction of projections for the net loss ratios was also similar to that observed for the gross loss ratios.

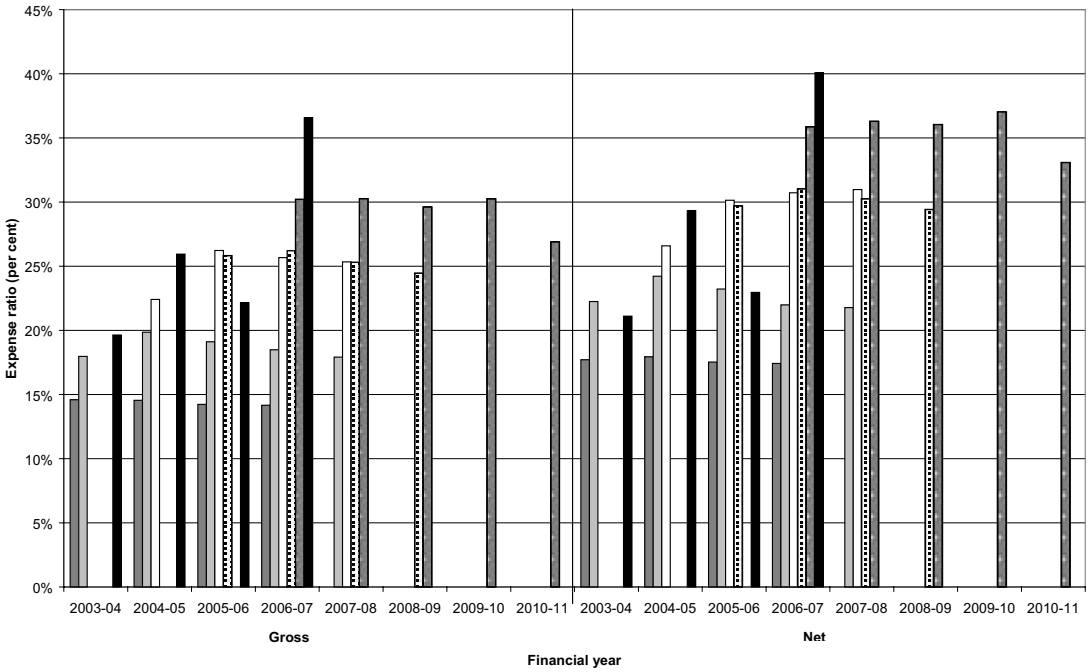
The actual result for the gross and net loss ratios in 2006–07 of 43 per cent was significantly lower than all projections. This trend is similar to that observed for 2003–04, 2004–05 and 2005–06. Actual loss ratios have been lower than projections because of actual premium income generally being higher than projections and actual claims costs generally being lower than projections.

However, while the actual results have been lower than projections, the upward trend in the net loss ratio is broadly consistent with the trend observed in all projections.

Expense ratio

Chart 6.6 shows the gross and net expense ratios for the five MDO-owned insurers based on the 2002–03 to 2006–07 financial projections of insurers. It also shows the actual expense ratios from 2003–04 to 2006–07.[81, 82]

Chart 6.6 Gross and net expense ratio: actual position 2003–04 to 2006–07 and projections 2002–03 to 2006–07



Source: derived by ACCC from MDO-owned insurers.

The chart shows that based on 2002–03 projections the gross expense ratio was forecast to be between 14 and 15 per cent between 2003–04 and 2006–07, while the net expense ratio was forecast to be between 17 and 18 per cent. The 2004–05 and 2005–06 projections are higher than earlier projections, reflecting higher than forecast actual results in 2003–04 and 2004–05. The 2006–07 projections are higher than previous projections for both the gross and net expense ratio, with forecasts from 2006–07 to 2010–11 ranging between 27 and 30 per cent and 33 and 37 per cent respectively.

The actual results for the gross and net expense ratios in 2006–07 of 37 and 40 per cent were higher than projected. However, the industry results observed do not reflect the individual experience of all insurers and mainly reflected abnormal increases in expenses by some insurers.

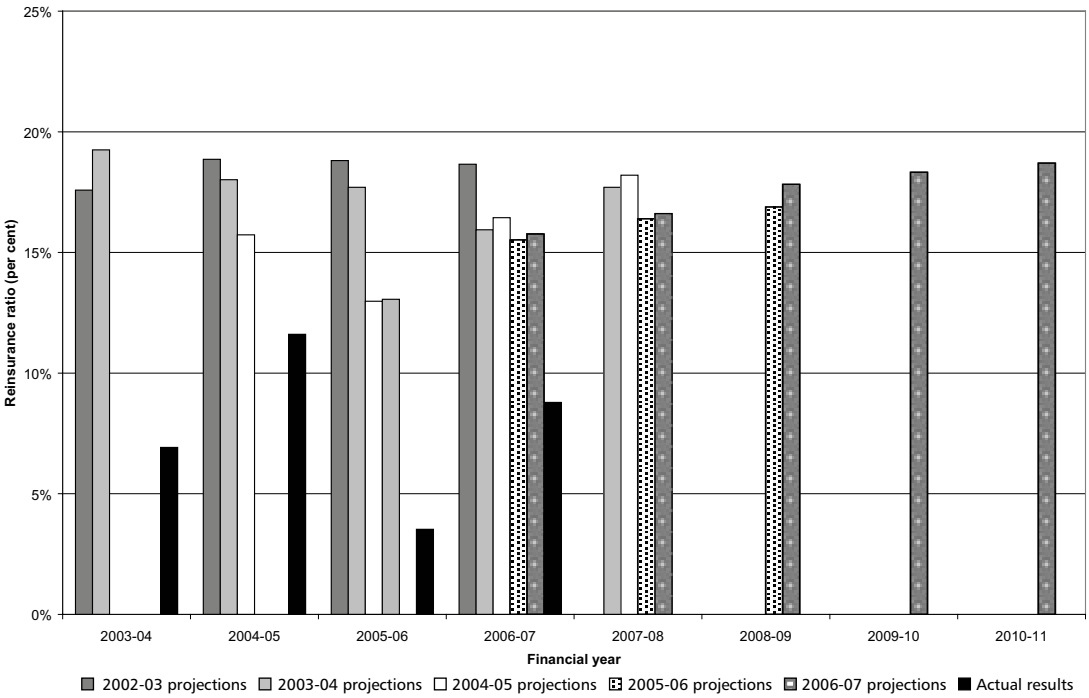
81 The ACCC has adjusted one insurer's 2004–05 actual results on advice from that insurer to remove the impact of a reporting discrepancy in that year.

82 The ACCC has adjusted one insurer's actual expense ratios to remove some APRA-approved transfers.

Reinsurance ratio

Chart 6.7 shows the reinsurance ratio for the five MDO-owned insurers based on five years of financial projections of insurers. It also shows the actual reinsurance ratio for 2003–04 to 2006–07.

Chart 6.7 Reinsurance ratios: actual position 2003–04 to 2006–07 and projections 2002–03 to 2006–07



Source: derived by ACCC from MDO-owned insurers.

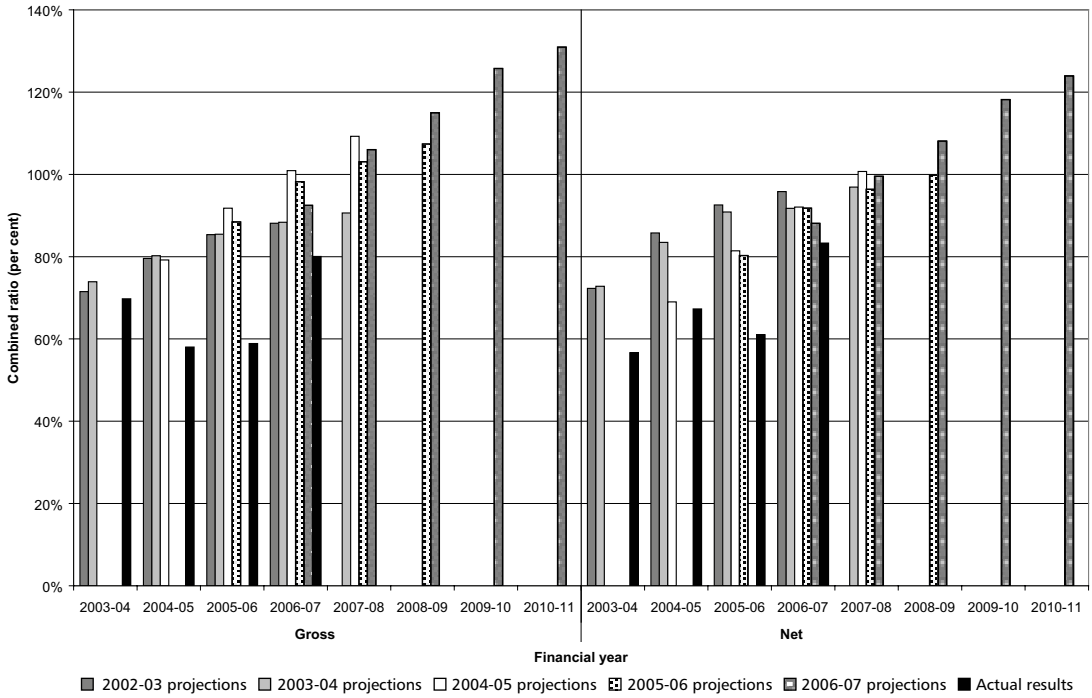
The chart shows that based on 2002–03 projections the reinsurance ratios were forecast to be between 18 and 19 per cent between 2003–04 and 2006–07. The 2003–04 projections were similar to the 2002–03 forecasts over the same period. Revised projections were generally consistent with the 2002–03 projections with a few exceptions. The 2006–07 projections forecast the reinsurance ratio to remain relatively stable between 2006–07 and 2010–11 with forecasts ranging between 16 and 19 per cent.

The actual reinsurance ratio for the industry of 9 per cent for 2006–07 was lower than projected. This mainly reflected lower than forecast reinsurance expenses experienced by some insurers.

Combined ratio

Chart 6.8 shows the gross and net combined ratios for the five MDO-owned insurers based on projections from 2002–03 to 2006–07 provided by insurers. It also shows the actual combined ratios for 2003–04 to 2006–07.[83]

Chart 6.8 Gross and net combined ratio: actual position 2003–04 to 2006–07 and projections 2002–03 to 2006–07



Source: derived by ACCC from MDO-owned insurers.

The chart shows that the 2002–03 projections forecast the gross combined ratio to increase from 72 per cent in 2003–04 to 88 per cent in 2006–07, and the net combined ratio to increase from 72 per cent to 96 per cent for the same period. This general movement is also reflected in subsequent projections. The 2006–07 projections forecast the gross combined ratio to increase from 92 per cent in 2006–07 to 131 per cent in 2010–11, and the net combined ratio to increase from 88 per cent to 124 per cent for the same period.

As noted in section 6.3.2, insurers have been raising significant surpluses to fund capital requirements. However, this is projected to decrease as insurers' capital bases increase as they approach APRA or internal capital targets. Combined ratios are therefore projected to increase, because insurers expect to generate lower levels of surplus as capital targets are reached.

83 The ACCC has adjusted one insurer's actual combined ratios to remove some APRA-approved transfers.

The projected gross and net combined ratios from 2007–08 to 2010–11 are generally just under or over 100 per cent. A combined ratio greater than 100 per cent indicates that an insurer is making a loss on its underwriting activities. However, it should be noted that a combined ratio exceeding 100 per cent may still be profitable for an insurance business once investment income is taken into account.

The actual results observed for 2006–07 show that the gross combined and net combined ratios of 80 and 83 per cent respectively were somewhat lower than prior projections for these ratios.

6.3.6 QBE

As discussed in section 6.2, data limitations meant that QBE was excluded from the general industry analysis contained in this chapter.

The ACCC examined the commercial justification of QBE's premiums by examining Invivo's financial projections and how these are consolidated within QBE's professional indemnity insurance business.

Based on this analysis, the ACCC found that QBE's premiums for the 2007 underwriting year were commercially justified.

6.4 Conclusion

The ACCC found that, in the current market environment, the premiums set by the MDO-owned insurers (which included consolidated information supplied by AIL for PIICA and AMIL) were commercially justified.

The net asset position of all insurers as at 30 June 2007 was an improvement on the strong position observed as at 30 June 2006. However, the degree to which the net asset position had improved depended on the circumstances of individual insurers.

The ACCC notes that one insurer continued its practice of not incorporating sufficient capital within its insurance premiums to maintain its target ratio of capital to net assets. To compensate for this, the insurer's parent entity is scheduled to make a capital injection in 2007–08, as well as further injections in future years. The ACCC found that, while this may not be a viable long-term strategy, 2007–08 premiums for this insurer were still commercially justified because the injections were appropriately budgeted for and had MDO board approval.

The ACCC also conducted separate analysis on QBE's 2007 premiums and found them to be commercially justified.

7 Actuarial and commercial justification of medical indemnity premiums within each jurisdiction

This chapter presents findings of the Australian Competition and Consumer Commission (ACCC) regarding the actuarial and commercial justification of medical indemnity premiums charged for the 2007–08 underwriting period[84] within each jurisdiction by the six authorised providers of medical indemnity insurance to private medical practitioners as at 30 June 2007.

7.1 Qualifications

In preparing this analysis it was necessary for the ACCC to maintain confidentiality of information provided by individual insurers. As noted in section 2.3, medical indemnity providers have largely continued the tradition of providing insurance primarily in their home states.[85] Because of this, some quantitative aspects of the ACCC analysis of the jurisdictional premiums could not be disclosed in this report.

7.2 Background

7.2.1 Findings of previous ACCC monitoring reports

In its first and second monitoring reports, the ACCC assessment of the actuarial and commercial justification of premiums examined the determination of the aggregate premium pool and, to a lesser extent, the relativities applied to that pool for individual specialties, jurisdictions and income bands.

The ACCC's third and fourth monitoring report separately examined the actuarial and commercial justification of jurisdictional relativities. Both these reports found that jurisdictional premium relativities were considered actuarially and commercially justified for all monitored insurers; however, insurers were restricted in their analysis by a lack of reliable claims experience in some jurisdictions.

For the fifth monitoring report, the ACCC has again separately examined the actuarial and commercial justification of jurisdictional relativities.

7.2.2 Pricing medical indemnity insurance by jurisdiction

To understand how jurisdictional relativities are derived and applied, it is important to understand the overall process adopted by insurers when determining individual premiums.

The pricing process typically adopted by the five MDO-owned insurers involves each insurer determining the aggregate premium pool. The aggregate premium pool typically includes:

84 The 2007 calendar year in the case of AMIL and QBE.

85 As noted in section 2.3, some insurers now have more than half of their membership outside of their home state. However, the home state still generally represented the largest proportion of their membership base.

- the expected net cost of claims covered by the individual insurance policies issued in the current underwriting period, **plus**
- an appropriate risk margin on the expected claims costs, which is intended to reflect the uncertainty in the expected claims costs, **plus**
- expenses expected to be incurred in respected of business written in the current underwriting period, **plus**
- the gross cost of reinsurance for the current underwriting period, **plus**
- future expenses required to administer claims arising in future years, **less**
- investment income earned on premiums until the date of payment of claims and expenses.

Once an insurer has determined the aggregate premium pool, it will determine the risk relativities. As with other types of insurance, the risk profile of the insured is an important determinant when setting individual premium rates. Typically the higher the risk profile of the medical practitioner, the higher the premium considered necessary to cover the cost of expected future claims.

Medical indemnity insurers typically base the risk profile of the medical practitioner according to several factors for ratings purposes:

- Medical specialty—medical practitioners who practise relatively more complex medical procedures are likely to face a higher risk of medical negligence claims being made against them than ones who perform less complex procedures. The complexity of medical procedures is also a key determinant of the size of medical negligence claims. Because of this, medical indemnity insurers will group medical specialties together, based on their risk for rating purposes. The level of grouping varies across medical indemnity insurers, with some recording relatively few groups and others incorporating almost 100 specialty groups in their relativity pricing.
- Income band/gross billing level—premium relativities are also determined on the basis of income/gross annual billings generated by the medical practitioner. Insurers regard this as a crude but equitable way to assess the relative amounts of clinical practise undertaken and therefore the risk the insurer is exposed to.
- Jurisdiction in which a practice is located—the location of a doctor's clinical practice also influences the premium relativity. This may reflect the different legislative requirements between jurisdictions, as well as the claims experience the insurer holds in different jurisdictions. Insurers apply the jurisdictional relativities to premiums by applying a loading or a discount to their premiums in their home jurisdiction.

In some instances, such as when insurers have a small membership in some categories, it can be difficult to accurately determine ratings factors for medical speciality, income bands or jurisdictional relativities because of a lack of statistically robust claims experience on which to base relativities.

While QBE's pricing methodology[86] differs from that outlined above for the five MDO-owned insurers, it determines jurisdictional relativities based on available industry data. This is why the ACCC has considered QBE's jurisdictional relativities in conjunction with the industry, as opposed to preparing a separate analysis as was done in chapters 5 and 6.

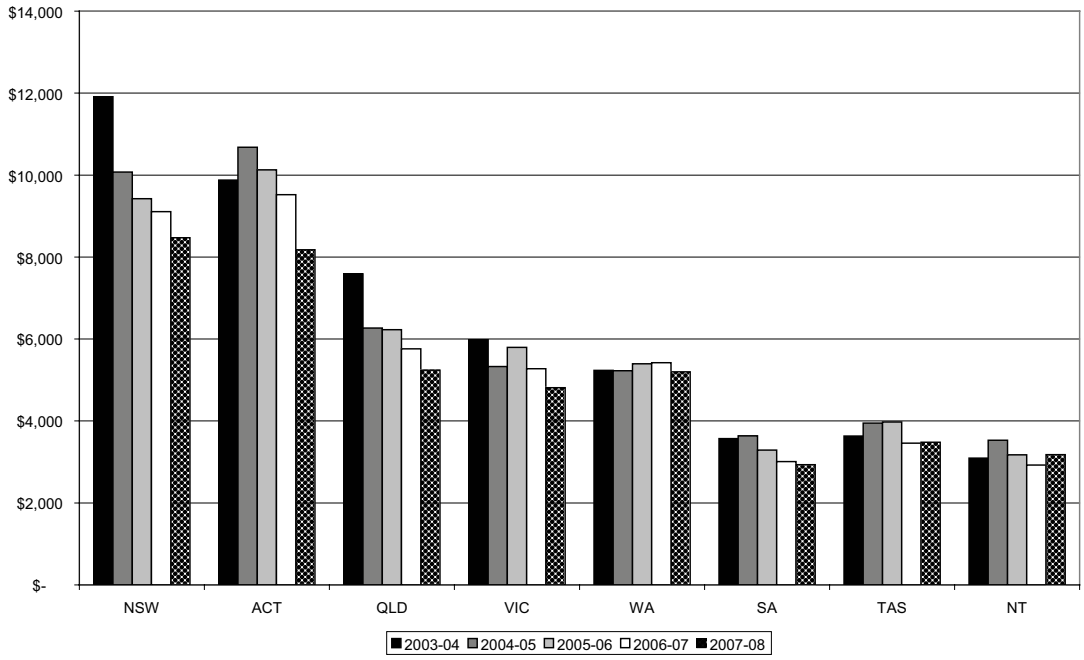
86 QBE's pricing methodology is described in detail in section 5.4.1.

7.2.3 Premium relativities

To obtain an understanding of the actual relativities applied between jurisdictions the ACCC obtained information from the five MDO-owned insurers[87] on the gross written premium and membership numbers by individual jurisdiction for the underwriting years 2003–04 to 2007–08.[88] This information allowed the ACCC to examine the average written premium in each jurisdiction across the four underwriting years to determine the relativities between jurisdictions as well as any changes in those relativities.

Chart 7.1 shows the average written premium of the five MDO-owned insurers by jurisdiction in real terms across the five years.[89, 90]

Chart 7.1 Average written premium in real terms—by jurisdiction: 2003–04 to 2007–08



Source: derived by ACCC from MDO-owned insurers.

87 The ACCC was also provided with information on QBE's gross written premium and policy holder numbers; however, as this data was only available for two underwriting years, it has not been incorporated in the ACCC's historical analysis of jurisdictional premiums.

88 The ACCC asked insurers to provide the gross written premium and membership numbers at a specific date in the 2007–08 underwriting year to allow insurers to provide data prior to the end of the underwriting year. However, because the majority of insurance is written at the beginning of the underwriting year, the data should provide a reasonable estimate of the full year's results.

89 The ACCC prepared the average written premium analysis by jurisdiction by examining the average written premium of each of the five MDO-owned medical indemnity providers and then averaging the result across all five. As noted in section 2.3, medical indemnity providers have largely continued the tradition of providing insurance primarily in their home states. Because of this, presenting a weighted average written premium by jurisdiction may lead to the results being driven by individual insurers within their home states. The ACCC deemed the methodology adopted necessary to maintain confidentiality of data.

90 The average written premium by jurisdiction is presented on a real basis to reflect the impact of inflation with nominal premiums adjusted to 30 June 2007 values using the average weekly earnings index published by the Australian Bureau of Statistics (catalogue number 6302.0).

Chart 7.1 shows that real average written premium in 2007–08 is highest in New South Wales and the Australian Capital Territory and lowest in Tasmania, South Australia and the Northern Territory. The chart also shows that in 2007–08 real average written premium decreased in a majority of jurisdictions ranging from 3 per cent in South Australia to 14 per cent in the Australian Capital Territory. In Tasmania and the Northern Territory real average written premium increased in 2007–08 by 1 per cent and 9 per cent respectively.

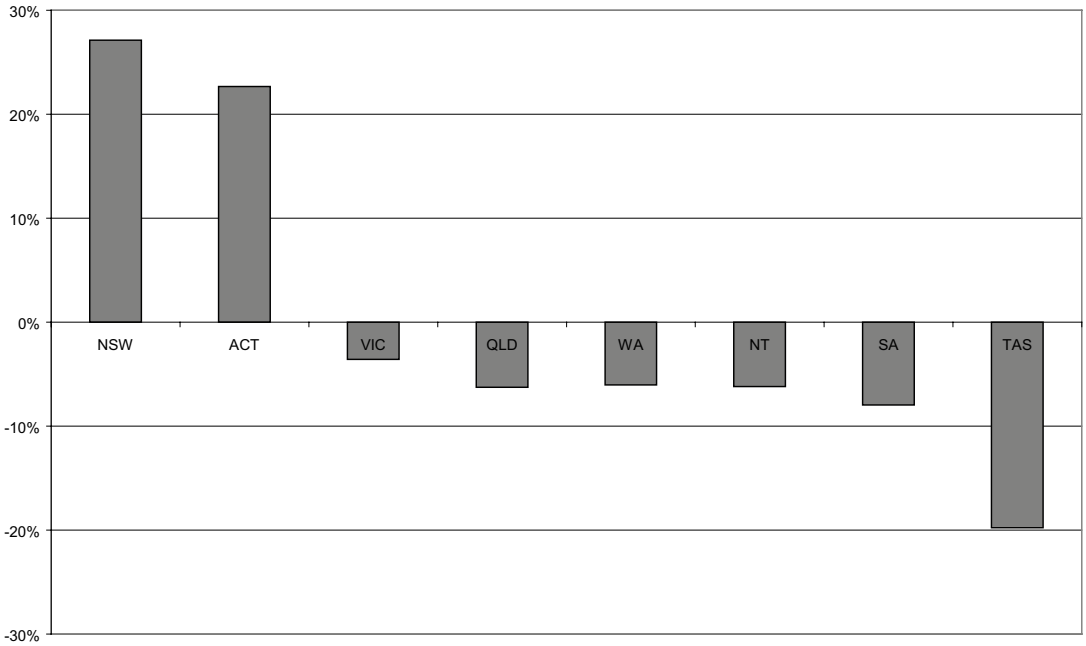
This analysis may be influenced by differences in the medical practitioner membership between jurisdictions. For example, some jurisdictions may have a higher proportion of low risk specialties, which may lead to those jurisdictions having a lower comparable average written premium. Further, some jurisdictions may have more medical practitioners on non-mature claims-made policies[91], resulting in these jurisdictions having a lower comparable average written premium.

The ACCC also examined the observed jurisdictional premium relativities used by the six authorised insurers (including QBE) for the 2007–08 underwriting year by examining the premium rates actually set across jurisdictions. Specifically, the ACCC compared all equivalent mature claims-made premium categories (including specialties and income bands) between the home state of each insurer and other jurisdictions.

As noted previously, insurers apply the jurisdictional relativities to premiums by applying a loading or discount to premiums in their home jurisdiction. As each insurer generally had a different home jurisdiction to which other jurisdictions were compared, the ACCC compared each jurisdiction's premium relativity to the average premium relativities by jurisdiction across all insurers. Chart 7.2 shows the average industry observed jurisdiction relativities for all insurers (including QBE) for the 2007–08 underwriting year.

91 Under a claims-made policy the insurer agrees to indemnify all claims arising from incidents notified during the policy period, as long as the incident occurred during the current period or any prior periods in which the policyholder has held continuous claims-made cover with the insurer up to, and including, the current period. Due to the more limited period the insurer is 'on-risk', this product is discounted during the earlier years until the policy becomes 'mature', which is typically four to five years.

Chart 7.2 Average observed jurisdictional relativity: 2007–08



Source: derived by ACCC from all medical insurers (including QBE).

Chart 7.2 shows that New South Wales and the Australian Capital Territory had the highest jurisdictional relativity (at 27 and 23 per cent), while Tasmania has the lowest (at –20 per cent). The relativities for the remaining jurisdictions ranged between –4 per cent and –8 per cent.

Jurisdictional relativities exist because, for a variety of procedural and social reasons, the level of common-law awards and settlements varies between states.[92] As claims costs is one of the largest components of premiums, this will be a significant driver of premium differences between jurisdictions.

Despite the different methodologies adopted in chart 7.1 and chart 7.2, the results are similar—New South Wales and the Australian Capital Territory have the highest relativities while Tasmania and South Australia have the lowest relativities. The remaining jurisdictions showed some differences between the analyses, which may result from chart 7.1 being influenced by different proportions of specialties and claims-made membership in each jurisdiction.

92 IAAust, submission to the Public Liability Forum, March 2002, p. 9.

7.3 Actuarial and commercial justification of premium relativities by jurisdiction

The ACCC examined the actuarial and commercial justification of the jurisdictional relativities applied for the 2007–08 underwriting year by the six current insurers, including QBE, which were operating as at 30 June 2007.

The ACCC found that all insurers who underwrote medical indemnity insurance in 2007–08 undertook analysis before considering whether changes should be made to jurisdictional relativities. However, most insurers indicated that their analysis was limited by a lack of reliable claims experience in some jurisdictions. Partly reflecting this data issue, only two of the insurers that provided medical indemnity insurance in 2006–07 decided to change their existing jurisdictional relativities in the 2007–08 underwriting year.

7.3.1 Actuarial justification of jurisdictional relativities

Methodology

The ACCC examined the actuarial justification of premium relativities for the 2007–08[93] underwriting year. Specifically the ACCC examined the:

- extent and level of detail of the analysis to confirm or modify existing relativities
- extent to which insurers took into account tort law reform in setting their jurisdictional relativities.

Extent of the analysis in determining jurisdictional relativities

Insurers generally adopted the same broad process for determining jurisdictional relativities, which involved an examination of historical claims experience within each jurisdiction.

The extent to which this analysis was conducted varied across insurers. The majority of insurers conducted a detailed analysis by comparing loss ratios for different jurisdictions to derive the jurisdictional relativities for the 2007–08 underwriting year. Other insurers generally based their analysis on reviews of detailed jurisdictional analysis prepared in previous years.

As noted in earlier ACCC monitoring reports, insurers, especially smaller insurers, generally experienced some difficulties in accurately determining jurisdictional based premium relativities because of a lack of reliable jurisdictional based claims experience. Therefore, most insurers made relatively simplistic estimates and included a flat loading or discount on premiums for medical practitioners outside their home jurisdictions. All insurers experienced difficulties associated with a lack of reliable jurisdictional based claims experience for some states and territories.

The ACCC has previously determined that the approaches adopted by insurers to determine jurisdictional relativities are actuarially justified given the absence of reliable jurisdictional based claims experience.

93 The 2007 calendar year in the case of AMIL and QBE.

Tort law reform

Only one of the six insurers took into account tort law reform when determining its jurisdictional relativities. The remaining five insurers generally took tort law reform into account in determining their aggregate premium pool as in most cases they had sufficient claims experience only in their home jurisdiction to determine their expectations of tort law reform. The insurer that did take tort law into account indicated that reform in two jurisdictions created a more favourable environment for insurers, which is reflected in its jurisdictional relativities.

7.3.2 Commercial justification of jurisdictional relativities

Methodology

The ACCC examined the commercial justification of premium relativities for the 2007–08[94] underwriting year. Specifically the ACCC examined:

- a comparison of the actuary's recommended jurisdictional relativities with the actual relativities adopted, with insurers being asked to explain material differences
- the quantification of cross-subsidies (as well as the incorporation of board policy) in the recommended relativities.

Adoption of actuarial recommendations

Insurers generally used the approved actuary in the process of determining jurisdictional relativities. However, the timing of the actuary's involvement differed across insurers, with some insurers relying on advice from their actuary to determine and recommend relativities, while one insurer determined relativities in-house and then sought advice on their appropriateness from the actuary. Another insurer made a commercial decision not to review jurisdictional relativities and instead relied on relativity analysis undertaken by its actuary in the 2006–07 underwriting year.

The ACCC found that final relativities, as selected or approved by the actuary, were generally adopted by all insurers in their final rates. However one insurer determined jurisdictional relativities based on previous analysis undertaken by its actuary.

Quantification of cross-subsidies and incorporation of board policy

No insurer specifically quantified cross-subsidies between jurisdictions. However, because of a lack of reliable jurisdictional based claims experience, some cross-subsidies may exist but were not identified. As insurers gain greater experience in new jurisdictions and more technical relativities can be derived, these potential cross-subsidies can be addressed.

Medical indemnity insurers generally did not identify any board policy as justification for the selected jurisdictional relativities. One insurer made a commercial decision not to review cross-subsidies when setting premiums for 2007–08 but, importantly, did not change jurisdictional relativities without actuarial advice. The ACCC did not consider this unreasonable.

94 The 2007 calendar year in the case of AMIL and QBE.

7.4 Conclusion

The ACCC found that jurisdictional premium relativities were considered to be actuarially and commercially justified for the six insurers that were operating as at 30 June 2007.

For the actuarial justification of premium relativities, the ACCC considered the extent of the analysis used to determine the relativities, as well as the extent to which insurers took into account jurisdictional variations in tort law reform. The ACCC found that insurers' analyses were limited because of a lack of reliable claims experience in some jurisdictions. In the absence of this data the ACCC considered the approach used by insurers to be actuarially justified. The lack of reliable claims experience by jurisdiction also affected the ability of insurers to take into account tort law reform in premium relativities.

For the commercial justification of premium relativities, the ACCC considered the extent to which relativities recommended by actuaries were adopted in final premium rates as well as the level of cross-subsidisation in the premium relativities. The ACCC found that that in some instances recommendations were not adopted in final premium rates due to a lack of reliable claims experience in some jurisdictions. The ACCC also noted that one insurer made a commercial decision not to change jurisdictional relativities and relied on previous relativity analysis undertaken when setting premiums for the 2007–08 underwriting year. However, the ACCC found that, while no insurer explicitly cross-subsidised between jurisdictions, cross-subsidies may exist due to the lack of reliable claims experience data. The relativities adopted were considered to be commercially justified.

Appendix A ACCC information request

To fulfil its monitoring requirements, it was necessary for the Australian Competition and Consumer Commission to directly approach medical indemnity providers to request relevant information. In consultation with *am actuaries*, the ACCC developed a uniform information request for the five medical defence organisation-owned insurers to complete.[95]

This appendix briefly describes the nature of the reports and information the ACCC requested from insurers.

A.1 Actuarial pricing report

Insurers generally commissioned actuarial pricing reports for premiums to apply for the 2007–08 underwriting year.[96] These reports provide advice to the insurer on the aggregate premium pool and, in some cases, specialty rates. The ACCC requested a copy of this report.

As there are currently no guidelines on the content or level of detail to be contained in this report, the ACCC outlined the scope and detail it wanted covered in these reports. Specifically, the ACCC requested that the report include additional commentary on two areas.

First, the ACCC requested commentary on the effects (if any) of government reforms on the actuarial assessment performed for the indemnity provider, including but not limited to:

- high cost claims scheme (HCCS)
- run-off cover scheme (ROCS)
- tort law reform enacted in various jurisdictions.

Second, the ACCC requested commentary on the derivation of premium relativities for each classification factor used, including jurisdictional, speciality and income band relativities.

A.2 Actual premium rate report

The ACCC requested a report detailing the actual premiums charged for all forms of indemnity for the 2007–08 underwriting year. If actual premium rates differed from those set out in the actuarial pricing report, the insurer was asked to detail the reasons for these differences. This discussion was to include all relevant commercial and regulatory factors affecting the pricing decisions made by the indemnity provider.

As with the actuarial pricing report, the ACCC asked insurers to comment specifically on any effects of the following government reforms on the actual premium rates being charged:

- HCCS
- ROCS
- tort law reform enacted in various jurisdictions.

95 The ACCC modified its information request for Invivo, which as the authorised representative of QBE, provided information to the ACCC on QBE premiums.

96 One insurer set its premium pool based on commercial considerations. Subsequent supporting actuarial analysis was supplied to the ACCC.

A.3 Membership, premium and claims data

The ACCC also requested the following data from insurers:

Membership data

- Membership numbers by membership category, by jurisdiction, by income band for the 2006–07[97] and 2007–08 underwriting years.

Premium data

- Recommended individual actuarial subscription rates by membership category, by jurisdiction, by income band for the 2007–08 underwriting year.
- Actual subscription rates by membership category, by jurisdiction, by income band for the 2007–08 underwriting year.
- Total gross written premium by membership category, by jurisdiction for the 2006–07[98] and 2007–08 underwriting years.

Claims data

- The total number of claims (including incidents likely as well as open and closed claims), the total amount of claims paid to date and the actuarial outstanding claims liability (inflated but undiscounted) as at 30 June 2006.

A.4 Other information

The ACCC also requested the following information to assist in its monitoring role:

- the most recent financial condition report, which is submitted to the Australian Prudential Regulation Authority on an annual basis and provides a comprehensive overview of the insurer's financial soundness
- copies of financial projections prepared by the authorised insurer in 2006–07 as well as any updates to these projections
- recent annual reports for both the insurer and the MDO group of companies
- a brief outline of any changes to the insurance policies previously offered to medical practitioners for the 2006–07 indemnity period.

97 While information on membership numbers was also provided by insurers for the 2006–07 underwriting year in the context of the previous monitoring request, generally this information was provided at a specific time and may not reflect the actual result for the full year. As such, the ACCC sought revised data where this was available.

98 While information on premium rates was also provided by insurers for the 2006–07 underwriting year in the context of the previous monitoring request, generally this information was provided at a specific time and may not reflect the actual result for the full year. As such, the ACCC sought revised data where this was available.

Appendix B Differences with APRA reports

The Australian Prudential Regulation Authority produces reports from its National Claims and Policies Database which cover professional indemnity and public and product liability insurance. The NCPD reports provide an overview of professional indemnity and public and product liability insurance based on information provided by APRA-regulated general insurers.

It is not possible to directly compare information in the Australian Competition and Consumer Commission and NCPD reports because of differences in the methodologies used to produce the reports. These include that:

- The ACCC and NCPD reports are based on different reference periods. The latest NCPD data is based on the 2006 calendar year whereas the ACCC data is generally presented on a financial year basis.
- The ACCC analysis of premiums includes data from medical defence organisation-owned insurers and its main focus is on insurance for medical practitioners. The NCPD report includes data from all insurers that underwrite medical indemnity and therefore includes other health professionals' insurance premiums (such as optometrists and dentists) that are generally outside the scope of the ACCC's monitoring report.
- Some of the medical indemnity premium information in the ACCC report is provided in real terms with data adjusted using the average weekly earnings index published by the Australian Bureau of Statistics (catalogue number 6302.0). The NCPD data is unadjusted.

These differences will affect the size of average premium calculations in the ACCC and NCPD reports. The trends in the data may also be affected.