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Australian Competition & Consumer Commission

Medical indemnity insurance

SECOND MONITORING REPORT

Medical indemnity insurance

Second monitoring report

December 2004

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Contents

Abbreviations

ABS	Australian Bureau of Statistics
ACCC	Australian Competition and Consumer Commission
AMA	Australian Medical Association
AMIL	Australasian Medical Insurance Limited
APRA	Australian Prudential Regulation Authority
ASIC	Australian Securities and Investment Commission
AWE	average weekly earnings
GP	general practitioner
GST	Goods and Services Tax
HCCS	high cost claims scheme
HIC	Health Insurance Commission
HPIA	Health Professionals Insurance Australia Pty Ltd
IBNR	incurred but not reported
IAAust	Institute of Actuaries of Australia
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
MIPS	Medical Indemnity Protection Society Limited
MPSTas	Medical Protection Society of Tasmania
MISS	medical indemnity support scheme
PIICA	Professional Indemnity Insurance Company Australia Pty Limited
PSS	premium support scheme
QDM	Queensland Doctors' Mutual Pty Ltd
ROCS	run-off cover scheme
UMP	United Medical Protection Limited

Glossary of terms

Term	Meaning
claims expense	all payments made in the current year on claims arising from current and prior notification years, as well as any adjustments to outstanding claims provisions across the period
claims-incurred cover	the insurer agrees to indemnify the policyholder 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	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 prior policy 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 earlier years, this is typically a cheaper product to underwrite than claims-incurred cover.
claims frequency	the ultimate number of claims by notification year expressed as a proportion of the total number of indemnified members
combined ratio	the sum of the loss ratio and the expense ratio showing whether the sum of expenses (claims expenses and other expenses) is less than or exceeds premium revenue for the year
excess	an amount of the loss that will be paid by the insured party before the insurer pays the claim
expense ratio	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)	claims arising from incidents or losses that have occurred but are yet to be reported to the insurer
indemnified members	the number of members which 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 employer indemnified
long-tail class	a class of insurance in which there may be a delay of many years before a claim is reported and/or paid
loss ratio	the total claims expense in a year as a proportion of premium revenue for that year
medical defence organisation (MDO)	a not-for-profit mutual organisation created and owned by medical practitioners to provide a range of services to members, including indemnity (indemnity was only able to be offered by MDOs prior to 1 July 2003)

minimum capital requirement (MCR)	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
pure risk premium	the amount of premium that is required to purely meet the cost of expected medical indemnity claims and associated costs
notification year	the year in which the insurer is notified of a claim or an incident which may potentially give rise to a claim
personal injury or death claim	a claim relating to an incident that results in the injury or death of a third party individual
premium revenue	the amount of gross written premium that is 'earned' during the period, earned being the proportion of risk covered
reinsurance	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 expenses	the amount of premium revenue ceded to reinsurers for reinsurance during a period
reinsurance ratio	the reinsurance expense as a proportion of premium revenue for that year
retroactive cover	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 prior to joining that provider. This type of cover typically applies to claims-made cover
return on net assets	emerging surplus expressed as a percentage of the total net assets held over the period
run-off cover	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	all claims costs that the insurer expects will eventually be paid for claims arising in a given notification year
ultimate number of claims	the total number of notifications that the insurers expect will eventually become claims and be paid

underwriting performance	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	the year in which an insurance policy was issued
excess of loss reinsurance	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 an attachment point) for each and every claim. There may also be an aggregate limit in respect of all claims assumed by the reinsurer

Summary

Background

In May 2002 the largest medical indemnity provider in Australia, United Medical Protection (UMP), 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.

ACCC's monitoring role

In October 2002 the Prime Minister announced that the Australian Competition and Consumer Commission (ACCC) would monitor medical indemnity premiums to assess whether they are actuarially and commercially justified.

To undertake this task, the ACCC asked the five current providers of medical indemnity insurance to private medical practitioners 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 five current providers of medical indemnity insurance are Australasian Medical Insurance Limited (AMIL), Health Professionals Insurance Australia Pty Ltd (HPIA), MDA National Insurance Pty Ltd (MDANI), Medical Insurance Australia Pty Ltd (MIA) and Professional Indemnity Insurance Company Australia Pty Ltd (PIICA).

This is the second of three annual monitoring reports to be produced by the ACCC for the Australian Government.

Findings of the first monitoring report

On 23 February 2004 the Australian Government released the ACCC's first medical indemnity insurance monitoring report, which examined the actuarial and commercial justification of premiums for the 2003–04 underwriting period.

The report concluded that the premiums charged by four of the five medical indemnity providers in 2003–04 were actuarially justified on the basis that the overall premium pool of each insurer was adequate to cover projected costs. The ACCC was unable to determine if premiums of the remaining provider (HPIA) were actuarially justified because of a lack of information it provided about its assumptions and supporting analysis.

With regard to the commercial justification of premiums, the report concluded that the premiums set by all five medical indemnity providers were considered to be commercially justified.

Background to the medical indemnity insurance industry

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.

These arrangements changed on 1 July 2003 when the Australian Government, as a part of its medical indemnity industry reform package, brought the industry under a 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 assessment methodology

The ACCC's methodology focused on how premiums were derived by the five medical indemnity providers from an actuarial and commercial perspective.

The ACCC's assessment of the actuarial justification of premiums considers the technical actuarial aspects of pricing. It examines the process adopted by medical indemnity providers 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 recent medical indemnity and tort law reforms).

The ACCC's assessment of the commercial justification of premiums considers the ability of medical indemnity providers to meet their commercial obligations to key stakeholders. It examines the impact on premium rates of APRA's minimum capital regulatory requirements that medical indemnity providers need to 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.

Assessment of the actuarial justification of medical indemnity premiums

The ACCC found that premiums were considered to be actuarially justified for all five medical indemnity providers.

The ACCC found that the overall premium pool of each insurer was actuarially justified. It was evident that insurers made extensive use of actuaries in preparing liability assessments, pricing reports, funding plans and financial forecasts.

In each case the construction of the recommended premium pool was considered to be soundly based and incorporated all major cost implications for the pricing of medical indemnity insurance. Each insurer adopted an overall premium pool at least equal to the

actuary's recommended premium pool, with any divergence attributable to the use of more up-to-date information.

While the overall premium pools were determined to be actuarially justified for all insurers, two issues arose during the ACCC's examination of some insurers' overall premium pool:

- The depth to which factors other than the pure risk premium (such as expenses, the reinsurance program and premium surplus) were examined by the actuary.
- The level of detail to which assumptions underlying the actuary's analysis were provided in medical indemnity providers reports.

The ACCC notes that the Institute of Actuaries of Australia (IAAust) is currently developing medical indemnity premium guidelines, which may assist actuaries addressing these issues in future pricing reports.

The ACCC's analysis regarding specialty premium rates showed that most insurers conducted detailed analysis on premium relativities between specialties. In the majority of cases, insurers indicated a desire to unwind existing cross-subsidisation between specialties but were unable to do so this year due to a range of factors. However, the ACCC still found these rates to be considered actuarially justified because the extent of cross-subsidisation was understood and quantified and the overall premium pool was expected to be achieved.

Assessment of the commercial justification of medical indemnity premiums

The ACCC found that, in the current market environment, premiums set by the five insurers were considered to be commercially justified.

As at 30 June 2004 all insurers reported that they were in a strong solvency position. This has been achieved well ahead of forecasts based on 2002–03 and 2003–04 financial projections—partially as a result of significant surpluses emerging from the 2003–04 underwriting period. This strong solvency position has meant that the capital position of all insurers is significantly above the minimum capital requirements of APRA. Indeed, two insurers have indicated that they are no longer building capital in the 2004–05 underwriting year.

It is noted, however, that two other insurers identified emerging surpluses lower than previously forecast. To increase their level of capital over a specified target level the parent entities injected capital in 2003–04. These capital injections were sufficient to make up for the lower than expected results as well as put both insurers in a capital position stronger than initially forecast.

The premiums written in the 2004–05 underwriting year are generally expected to continue to build or maintain this strong position for all insurers, which will assist in ensuring that they have the financial capacity to continue underwriting medical indemnity insurance.

1. Introduction

1.1 Background

In May 2002 the largest medical indemnity provider in Australia, United Medical Protection (UMP), 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 certain high-risk procedures like obstetrics.[1] In response to this crisis, the Australian Government started to introduce a framework of reforms to ensure a viable and ongoing medical indemnity insurance market.[2]

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 and appendix A.

As part of the reform framework, the Prime Minister announced that the Australian Competition and Consumer Commission (ACCC) would monitor medical indemnity premiums to assess whether they are actuarially and commercially justified.[3] This report is the second of three ACCC reports to the Australian Government arising from this role.

1.2 Ministerial request

On 19 November 2002 the Treasurer, the Hon. Peter Costello MP, wrote to the ACCC about this new role. The Treasurer indicated that the measures announced by the Australian Government intended to place the medical indemnity insurance industry on a commercial basis. The measures also aimed to ensure that medical practitioners, particularly those in high risk disciplines, would be provided with appropriate cover. He also expressed the government's concern that the market develops in a viable manner, with industry participants correctly provisioning for the risks that they underwrite.

The Treasurer 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]

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1 Parliament of the Commonwealth of Australia, Medical Indemnity Bill 2002, Revised explanatory memorandum, 2002, p. 4.

2 The Hon. John Howard MP, Prime Minister, 'A new medical indemnity insurance framework', 23 October 2002.

3 ibid.

4 *The Prices Surveillance Act 1983* was repealed on 1 March 2004 when the main provisions in this Act 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. At the time of this report there were five such insurers:

- Australasian Medical Insurance Limited (AMIL)
- Health Professionals Insurance Australia Pty Ltd (HPIA)
- MDA National Insurance Pty Ltd (MDANI)
- Medical Insurance Australia Pty Ltd (MIA)
- Professional Indemnity Insurance Company Australia Pty Ltd (PIICA).

Medical indemnity insurance is also offered by a number of commercial insurers to other medical professionals who practice 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.

1.4 Approach to monitoring

The ACCC established a framework for assessing the actuarial and commercial justification of medical indemnity premiums.

In assessing the **actuarial** justification of premiums, the ACCC considers the technical actuarial aspects of pricing. It examines the process adopted by medical indemnity providers 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 medical indemnity providers to meet their commercial obligations to key stakeholders. It assesses the impact on premium rates of APRA's minimum capital regulatory requirements that medical indemnity providers need to 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.

[5] Parliament of the Commonwealth of Australia, Medical Indemnity (Prudential Supervision and Product Standards) Bill 2002, revised explanatory memorandum, 2002, p. 6.

The ACCC's analysis covers the five medical indemnity providers in Australia that offer insurance to private medical practitioners. In mid-2004 the ACCC requested a range of quantitative and qualitative information from these entities about their premium setting arrangements, cost structures and the impact of various government reforms (including tort reforms) on their operations.[6] Details of the ACCC's information request can be found at appendix C.

This report examines premiums set by medical indemnity providers for the underwriting period from 1 July 2004 to 30 June 2005, except for UMP/AMIL which has an underwriting period from 1 January 2004 to 31 December 2004. The ACCC has specifically not adjusted UMP/AMIL's calendar year results to financial year except where otherwise noted.

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

1.5 Qualifications

The ACCC's analysis is based on information supplied by each of the five insurers. The ACCC has relied on the information provided by insurers rather than performing an independent verification of their information or actuarial advice. 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's analysis, particularly regarding its assessment of individual insurers' information, could not be disclosed in this report.

It should also be noted that, due to the significant regulatory reforms of the medical indemnity industry, some applicable terms have changed in this report. References to 'medical indemnity providers' refer to medical defence organisations (MDOs) pre-1 July 2003 and medical indemnity insurers post-1 July 2003. Similarly, although MDOs historically charged members a subscription rather than a premium, this report refers to the pre-1 July 2003 subscription as premium.

1.6 Previous report

On 23 February 2004 the Australian Government released the ACCC's first medical indemnity insurance monitoring report, which examined the actuarial and commercial justification of premiums for the 2003–04 underwriting period.

The report concluded that the premiums charged by four of the five medical indemnity providers in 2003–04 were actuarially justified on the basis that the overall premium pool of each insurer was considered to be adequate to cover projected costs. It also found that although insurers adopted specialty premium rates that were different to the recommended technical rates, these were considered actuarially justified as the overall premium pool was still expected to be achieved.

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[6] Some of the information required by the ACCC is also collected by APRA in its role of overseeing the prudential framework governing the medical indemnity industry from 1 July 2003.
The ACCC aligned its information requirements as much as possible to those of APRA in an effort to minimise duplication costs for insurers. However, the ACCC's role in medical indemnity insurance is one of price monitoring. Therefore while the information required by both the ACCC and APRA was broadly consistent, in some cases the ACCC was required to request more detailed information.

The ACCC was unable to determine if premiums of the remaining provider (HPIA) were actuarially justified because of a lack of information it provided about its assumptions and supporting analysis.

The report found that all five medical indemnity providers were raising capital through premiums to enable them to meet the 30 June 2008 capital requirements set by APRA.

With regard to the commercial justification of premiums, the report concluded that the premiums set by all five medical indemnity providers were considered to be commercially justified.[7] This assessment recognised the need for insurers to raise adequate capital to ensure that they can continue to underwrite medical indemnity insurance.

1.7 Report outline

This report contains six chapters and three 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 the Australian Government reforms to medical indemnity insurance current as at 1 July 2004.

Chapter 4 examines historical trends in costs, premiums and the financial performance of the industry between 1997–98 and 2003–04.

Chapter 5 presents the ACCC's findings regarding the actuarial justification of medical indemnity premiums charged for the 2004–05 underwriting period by the five current medical indemnity providers.

Chapter 6 presents the ACCC's findings regarding the commercial justification of medical indemnity premiums charged for the 2004–05 underwriting period by the five current medical indemnity providers.

Appendix A provides further detail of the Australian Government reforms. It outlines the development of the reform package from its initial form to its current state.

Appendix B outlines the tort law reforms introduced by respective Australian, state and territory governments up to 30 June 2004.

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

[7] The ACCC's assessment of the commercial justification of premiums extended to HPIA. As a starting base for the analysis it was assumed that the premium information supplied by HPIA was actuarially justified, despite the ACCC being unable to verify this.

2. Overview of the medical indemnity industry

2.1 Introduction

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 characteristics of the medical indemnity industry both pre-reform and post-reform with a particular focus on any changes in the industry since December 2003.

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

2.2 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.[8]

2.2.1 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.

There are a number of different types of liability insurance, 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.[9] In the case of medical indemnity insurance, the professional being insured is the medical practitioner—indemnity coverage

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8 Insurance Council of Australia, Background Paper No.7 to the HIH Royal Commission, 'A Profile of the General Insurance Industry', November 2001, p. 3.

9 ibid, p. 26.

reduces their exposure to financial losses arising from personal injury actions brought against them as a result of the performance of their professional duties.

2.2.1 Medical malpractice

Malpractice insurance is another name for professional indemnity insurance, but this title has generally been reserved for the medical professions.[10] Although medical indemnity insurance provides similar protection to that for other professionals, the nature of medical malpractice claims against medical practitioners will generally differ from claims against other professionals.

Accountants, lawyers, investment advisers and valuers, for example, are usually sued for 'economic loss', that is, loss of past and/or future income occurring as a result of advice provided. Claims against architects and engineers often relate to 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 as a result of 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 represents a major portion of overall claims costs.

2.2.2 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 the tort law reforms have reduced limitation periods somewhat, 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.[11]

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[10] Insurance Council of Australia, *Submission to Ministerial Forum, addressing the issues in professional indemnity insurance*, March 2002, p. 1.

[11] Parliament of the Commonwealth of Australia, Medical Indemnity (Prudential Supervision and Product Standards) Bill 2002, Revised explanatory memorandum, 2002, p. 8.

2.2.3 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.[12] 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 medical indemnity provider after the practitioner ceases practice (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.[13] Claims-made cover is standard within the broader general insurance industry in respect of professional indemnity insurance contracts.

Claims-made cover is different to claims-incurred cover because in respect of the former, the incident must have occurred **and** the claim must have been notified to the indemnity provider in the period of coverage. This means that for claims-made cover the medical practitioner is not covered for past incidents that are notified to the indemnity provider after the practitioner ceases practicing medicine or moves to another indemnity provider.[14]

2.3 Characteristics of the industry—pre 1 July 2003

Before 1 July 2003, medical indemnity cover was traditionally offered by medical defence organisations (MDOs), which operated on a not-for-profit basis as 'mutuals' owned and operated by members. MDOs offered indemnity protection to medical practitioners as part of a range of services to their members.[15]

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

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12 ibid, p. 8.

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

14 Where a medical practitioner is indemnified on a 'claims-made' basis, this may necessitate the purchase of what is known as 'run-off' or 'retrospective' 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. Retrospective cover allows the insured to notify the insurer of an incident that occurred before the current period of cover.

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

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

- Medical Defence Association of South Australia (MDASA)
- Medical Defence Association of Victoria (MDAV)
- MDA National (MDAN)[16]
- Medical Indemnity Protection Society (MIPS)
- Medical Protection Society of Tasmania (MPSTas)
- Queensland Doctors Mutual (QDM)[17]
- UMP

The above MDOs operated mainly along state lines[18] and were outside the prudential framework regulated by the Australian Prudential Regulation Authority (APRA). 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. These captives were established primarily to provide reinsurance cover to the parent MDO.

2.4 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. As such, the MDOs applied to APRA to make their captive insurers fully authorised to conduct insurance business.

The five authorised insurers that currently provide medical indemnity insurance in Australia are:

- Australasian Medical Insurance Limited (AMIL)—writing insurance for members of UMP
- Health Professionals Insurance Australia Pty Ltd (HPIA)[19]—writing insurance for members of MIPS and MPSTas
- MDA National Insurance Pty Ltd (MDANI)—writing insurance for members of MDAN

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

17 QDM has subsequently merged with MIPS on 22 July 2004.

18 The first monitoring report found that the MDO with the largest market share in each state was:
- New South Wales/Australian Capital Territory—UMP
- Victoria—MDAV
- Queensland—UMP
- South Australia—MDASA
- Western Australia—MDAN
- Tasmania—MPSTas
- Northern Territory—UMP

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

19 HPIA (and previously supplied QDM before it merged with MIPS).

- Medical Insurance Australia (MIA)—writing insurance for members of MDASA
- Professional Indemnity Insurance Company Australia Pty Ltd (PIICA)—writing insurance for members of MDAV.

Since 1 July 2003 medical indemnity providers have continued the tradition of providing insurance primarily in their home states as follows:

- UMP—New South Wales
- MIA—South Australia
- HPIA—Victoria
- PIICA—Victoria
- MDANI—Western Australia

However, the extent to which this occurs differs between insurers, with some writing just over half of their business in their home state, while others write closer to 90 per cent in their home state. There appears to be a trend developing for medical indemnity providers to supply more insurance beyond their home states than in previous years and the medical indemnity market is no longer strictly state-based.

2.4.1 Market shares

The number of indemnity 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 memberships of medical indemnity providers will typically be higher due to the inclusion of members for whom medical indemnity providers are not required to meet claims, that is, student and employer indemnified.

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

Chart 2.1 shows the percentage of the total number of indemnified[20] members in Australia with each medical indemnity provider based on the most recently available data provided by the medical indemnity insurers for 2002–03[21] and 2003–04.[22]

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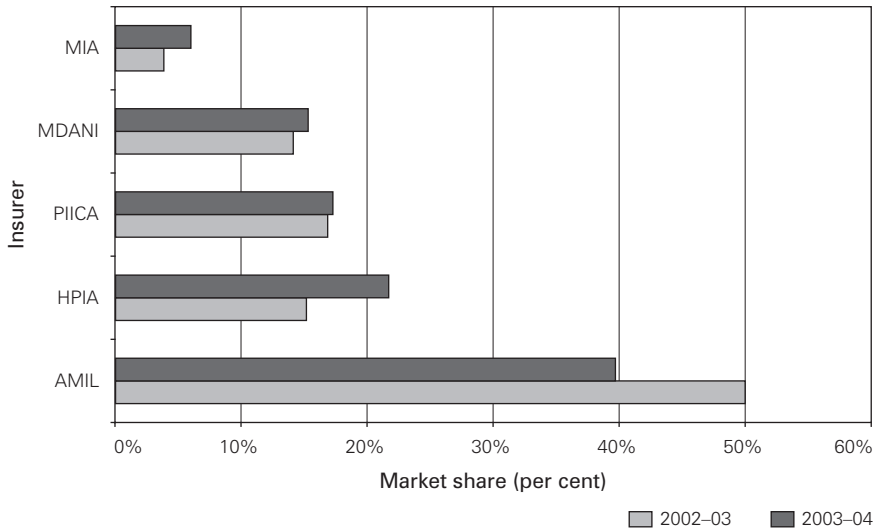
[20] Where possible the ACCC has excluded membership numbers that relate to non-indemnified members such as students or practitioners who are employer indemnified.

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

[22] AMIL membership numbers relate to the previous calendar year, that is, membership for the 2003 calendar year has been recorded against the financial year ending 30 June 2004. The ACCC understands AMIL membership levels are assessed in August of each calendar year and therefore this allocation is expected to have no material impact on market shares.

Chart 2.1 Medical indemnity provider indemnity members—2002–03[23] and 2003–04



Source: Derived by ACCC from membership data for all medical indemnity providers

The largest medical indemnity provider is AMIL, with approximately 40 per cent of all indemnified members in Australia in 2003–04. HPIA is the next largest with 22 per cent, followed by PIICA with 17 per cent, MDANI with 15 per cent and MIA with 6 per cent.

These market shares have changed significantly since 2002–03 for some insurers. AMIL's share of indemnified members fell by 10 per cent, most of which was gained by HPIA and MIA.[24]

2.4.2 Regulatory arrangements

Since 1 July 2003 it is a legislative requirement that medical indemnity insurance be provided in the form of an insurance contract between an authorised insurer and medical practitioner.[25,26] This means that authorised insurers are unable to offer discretionary, unlimited indemnity protection. This change effectively extended APRA's prudential supervision to encompass medical indemnity because all medical indemnity insurers must therefore comply with APRA's prudential standards that apply to general insurance. These requirements include:

- compliance with APRA's liability valuation standards, which mandates the appointment of an approved actuary who estimates the liabilities and risk margin

[23] Results for 2002–03 may not be directly comparable to that shown in the first ACCC monitoring report due to revised data.

[24] The decrease in market share for AMIL may be a result of it being in provisional liquidation from May 2002, with some medical practitioners moving to other insurers, and AMIL restricted to only being able to renew business.

[25] In the case of UMP/AMIL, contractual insurance has been offered since 1 January 2003.

[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.

- 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]

For the existing medical indemnity insurers, APRA has 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 (MCR).[28] From 1 July 2008 all medical indemnity providers must be fully capitalised.

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

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.

ASIC also 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 requirement 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. Run-off cover provides medical practitioners leaving practice with protection against claims arising from prior incidents.[29]

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27 An insurer's minimum capital requirement (MCR) is determined to have regard to 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 APRA's website.

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

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

3. Government reforms of medical indemnity insurance

3.1 Introduction

In 2002 rising medical indemnity insurance premiums and the provisional liquidation of the largest provider, UMP, 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 reforms current as at 1 July 2004.

3.2 Medical indemnity reform by the Australian Government

The government's medical indemnity reform package was developed throughout 2002 and announced in full on 23 October 2002. Since then, the government has outlined a series of modifications as well as introducing additional measures. This chapter examines only those reforms that were implemented and in force as at 1 July 2004. These reforms are particularly relevant because medical indemnity providers would, in many cases, need to consider the effect of these reforms on their price setting arrangements for the 2004–05 underwriting year (this is discussed in more detail in chapter 5). For completeness, the development of the reform package from its inception to its current form is outlined in detail in appendix A.

The reforms include the:

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

3.2.1 Exceptional claims scheme

The exceptional claims scheme[30] was introduced to address medical practitioners' concerns that their personal financial assets may be exposed to the risk of large awards and settlements in excess of their insurance contract limit. This is known as the 'blue sky' issue.[31]

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30 The exceptional claims scheme is contained in the *Medical Indemnity Amendment Act 2003*, Schedule 2, which commenced 5 December 2003.

31 Before 1 July 2003 medical indemnity insurance was offered on a discretionary basis, which allowed the medical indemnity provider to provide unlimited cover at its discretion with no cap on the amount of damages it would pay. However, the introduction of legally enforceable medical indemnity insurance contracts from 1 July 2003 meant that the contractual liability of the insurer had to be capped at a specific amount of damages, thereby exposing the personal financial assets of the medical practitioner to the risk of having to meet the cost of large awards for damages in excess of the cap.

Under the exceptional claims scheme, the government assumes liability for 100 per cent of any damages payable against a medical practitioner that exceed the insurance contract limit, so long as the medical practitioner has cover to at least the threshold. The specified level of cover was $20 million for claims notified under medical indemnity insurance contracts from 1 July 2003.[32]

The threshold reflects the maximum level of cover offered by medical indemnity providers to medical practitioners. It will be reviewed to ensure that medical indemnity providers offer the highest level of insurance cover that can be backed by reinsurance and, conversely, if reinsurers reduce insurance contract limits the threshold will be reduced accordingly.[33]

Claims that arise from the treatment of public patients in public hospitals are exempt from this scheme. However, it does cover claims that arise from medical practitioners accompanying Australian sporting teams and cultural groups overseas.[34] The scheme will operate for a minimum of three years and will be reviewed to assess whether it remains necessary in light of state and territory tort reform and claims trends.

3.2.2 Run-off cover scheme

The run-off cover scheme (ROCS)[35] was introduced in response to medical practitioners' concerns about their ability to pay for run-off cover when they leave the workforce and are no longer earning an income.[36]

Under ROCS, a charge known as the ROCS support payment is imposed on medical indemnity providers and subsequently incorporated into each medical practitioner's annual insurance premium during their working life. Upon leaving the workforce, the ROCS will cover the types of claims that a medical practitioner's last insurance contract covered without further payment. Medical practitioners are therefore no longer required to fund their own run-off cover when they stop work because a proportion of their insurance premium is effectively paid into the scheme during their working life.

The ROCS support payment is calculated as 8.5 per cent of the medical indemnity providers' premium income for a 12 month period (9.5625 per cent for UMP/AMIL).[37] These rates apply from 2004 to 2008.

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32 To account for UMP members who were covered by contracts with a $15 million limit between 1 January 2003 to 30 June 2003, the threshold for those contracts written in this period is $15 million.

33 House of Representatives Official Hansard, second reading of Medical Indemnity Bill 2003, The Hon. Tony Abbott MP, Minister for Health and Ageing, 6 November 2003, p. 2293.

34 This is a recent inclusion that is contained in the Medical Indemnity Amendment Regulations 2004 (No.2), which commenced on 5 December 2003.

35 ROCS is contained in the *Medical Indemnity Legislation Amendment (Run-off Cover Indemnity and Other Measures) Act 2004*, the majority of which commenced 1 July 2004, and the *Medical Indemnity (Run-off Cover Support Payment) Act 2004*, which commenced 1 July 2004.

36 Before 1 July 2003 medical practitioners generally obtained medical indemnity cover on a claims-incurred basis meaning that all claims for incidents while they were practising would be covered even after they retired. Those practitioners who were covered by claims-made cover during this period were usually offered 'free' retirement cover or offered it for a low one-off payment (the true cost of this cover was usually built into normal premiums). However, after 1 July 2003 cover has been almost always offered on a claims-made basis and, due to the contractual nature of insurance, doctors who retired would have had to continue to pay annual premiums to a medical indemnity provider to ensure cover. As such, doctors were concerned about the availability and affordability of retirement cover as well as their ability to 'pre-fund' that cover during their working lives.

37 AMIL is charged an additional 1.0625 per cent to make up for the shortfall in funding that would otherwise result from AMIL not making a contribution for the period 1 July to 31 December 2004 because it operates on a calendar year basis.

ROCS applies to claims notified on or after 1 July 2004 that are made against:

- medical practitioners aged 65 or more who permanently retire from the workforce
- medical practitioners who retire prematurely due to permanent disability
- medical practitioners on maternity leave
- medical practitioners who have permanently left the workforce for a continuous period of three or more years
- deceased medical practitioners (provided that a claim can still be made against the doctor's estate)
- medical practitioners who are determined by regulation to be eligible.

3.2.3 UMP support scheme (formerly the IBNR scheme)[38]

Following the government's consideration of the Medical Indemnity Policy Review Panel's report at the end of 2003, the UMP support payment was introduced to replace the IBNR scheme.[39,40] The panel expressed concern that present medical practitioners and patients continued to make payments to compensate for past under-funding.

The government therefore agreed that it would fund three quarters of UMP's IBNR liability estimated at approximately $460 million.[41] The remaining quarter is to be met by the UMP support payment from those medical practitioners who were members of UMP at 30 June 2000.

The UMP support payment is payable for a maximum of six years and no medical practitioner will make a payment after the 2008–09 financial year. Medical practitioners who were members of UMP for less than six years need only make payments for the number of years they were members, and no medical practitioner will pay more than was originally required under the previous IBNR scheme. An 18-month moratorium on IBNR levy payments over $1000 is in place until 31 December 2004 and will impact on payment calculations for the first two years of the scheme.[42] Payment calculations for the last four years will be unaffected.

The UMP support payment will be calculated as the lesser of:

- the amount of the medical practitioner's former IBNR levy
- 2 per cent of the medical practitioner's gross Medicare billable income from the preceding 12 months
- $5000.

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38 UMP was the only medical indemnity provider to participate fully in the scheme.

39 The Australian Government initially announced the IBNR scheme to help medical indemnity providers fund their unfunded IBNR liabilities. The scheme was to be financed by a levy on the members of those medical indemnity providers that held unfunded liabilities. Appendix A provides more detail on this scheme.

40 The UMP scheme is contained in the *Medical Indemnity Legislation Amendment (Run-off Cover Indemnity and Other Measures) Act 2004* the majority of which commenced 1 July 2004 and the *Medical Indemnity (Run–off Cover Support Payment) Act 2004*, which commenced 1 July 2004.

41 Medical Indemnity Policy Review Panel, *Affordable, Secure and Fair—Report to the Prime Minister*, 10 December 2003, p. 2.

42 In response to doctors' concerns over the impact of the IBNR levy, on 3 October 2003 the government agreed to an 18-month moratorium on IBNR levy payments above $1000 per year, to be in place until 31 December 2004.

Based on this, the maximum payment a medical practitioner will pay in 2003–04 is $1000. In 2004–05 it is $3000 and from 2005–06 onwards it is $5000 per year.[43] The UMP support payment can be paid via a medical practitioner's medical indemnity provider so that the cost is incorporated into the premium subsidy scheme.

Medical practitioners can apply for an exemption from the UMP support payment if they fall under one of the exemption categories, including:

- medical practitioners who earn less than $5000 per year
- medical practitioners who did not practice before 30 June 2000
- medical practitioners who are aged over 65 or turn 65 on or before 30 June of the contribution year
- medical practitioners who were impaired on or before 30 June of the contribution year, which has resulted in a continuing inability to work in a medical profession.[44]

3.2.4 High cost claims scheme

The high cost claim scheme (HCCS)[45] was introduced by the government to reduce the cost of large claims to insurers and thereby stabilise medical indemnity premiums.

Under this scheme, the government will reimburse medical indemnity providers 50 per cent of all claims above the $300 000 threshold up to a medical practitioner's limit of insurance. The HCCS does not extend to incidents that occur outside of Australia or to the treatment of public patients in public hospitals.

3.2.5 Premium support scheme

The premium support scheme (PSS)[46] was introduced to replace the medical indemnity subsidy scheme (MISS),[47] which provided premium subsidies specifically to neurosurgeons, obstetricians, procedural GPs and GP registrars undertaking procedural training.

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

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43 See www.hic.gov.au/providers/resources/programs_services/indemnity/exempt_fact_sheet.pdf

44 ibid.

45 The high cost claims scheme is contained in the *Medical Indemnity Act 2002*, which commenced on 1 January 2003, the Medical Indemnity Amendment Regulations 2003 (No. 2), Schedule 2 which commenced on 22 October 2003, and the Medical Indemnity Amendment Regulations 2004 (No. 1), Schedule 1 which commenced on 1 January 2004. HCCS applies to a threshold of $2 million for all claims between 1 January 2003 to 21 October 2003, $500 000 for all claims between 22 October 2003 and 31 December 2003, and $300 000 for all claims from 1 January 2004 onwards.

46 PSS was enacted under section 43(1) of the *Medical Indemnity Act 2002*, which commenced 17 June 2004.

47 MISS was contained in the Medical Indemnity Subsidy Scheme 2003, which commenced 20 June 2003 and applied to indemnity payments made on or after 1 January 2003 until 30 June 2004. PSS replaced MISS from 1 July 2004.

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
- medical practitioners who have applied for and have been deemed to be eligible for the MISS—the subsidy is calculated as the greater of that under MISS or PSS
- special category members[48]—the subsidy is 80 per cent of the total cost to the member for the premium period of the member's gross indemnity costs.

3.3 Tort law reform

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.[49] 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.

Appendix B contains a detailed summary of the tort reform initiatives introduced by respective state and territory governments up to 30 June 2004.

[48] A special category member is a member who:
- no longer practices as a doctor
- no longer derives a private medical income from practicing as a doctor
- practices 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)
- has a liability in a premium period for run-off cover or retro-active cover and does not at any time have a contract of insurance providing medical indemnity cover with any other medical indemnity provider.

[49] The impact of tort law reform on costs and premiums of public liability and professional indemnity insurance is subject to a separate monitoring role by the ACCC. See ACCC reports *Public liability and professional indemnity insurance—monitoring report*, July 2003, January 2004 and July 2004.

4. Historical costs, premiums and financial performance in medical indemnity insurance

4.1 Introduction

The Australian Government asked the ACCC to monitor medical indemnity premiums to assess whether they are actuarially and commercially justified. To do this, the ACCC requested a range of information from the five current medical indemnity providers about their costs and pricing strategies.

In the first monitoring report this information was also used to determine historical trends in the costs associated with providing medical indemnity insurance to 30 June 2002. The ACCC also examined trends in premiums charged for indemnity protection. The historical financial performance of the medical indemnity industry was also examined.

This chapter updates those findings of the first monitoring report to include information up to 2003–04.[50,51]

4.2 Costs of medical indemnity insurance

The ACCC examined the cost components of the five insurers' total premium pools for the 2003–04 and 2004–05 underwriting years. Table 4.1 shows the percentage of the actuarially recommended[52] aggregate premium pool for each cost category and is presented as an average estimate based on the responses across insurers.

Table 4.1 Components of actuarially recommended aggregate premium pool—medical indemnity—2003–04 and 2004–05 underwriting years

Components	Percentage of premium charged by insurers 2003–04	2004–05
Expected surplus[53]	36	26
Net claims costs[54]	32	36
Reinsurance expenses	17	16
Underwriting and general expenses	15	22
Total premium pool	**100**	**100**

Source: Derived by ACCC from data for all five medical indemnity insurers.

Note: Table represents required actuarially determined premium pool and does not include statutory third party collections such as stamp duty, GST or the ROCS levy.

50 With the exception of section 4.2 and section 4.3 all analysis contained in this chapter includes UMP/AMIL results on a financial year basis.

51 In some instances the results for this report for historical years may be different to that reported in the first report generally due to revised data.

52 The difference between the actuarially recommended premium pool and the actual premium pool is discussed in more detail in section 5.4.1.

53 The expected surplus was typically raised for the purpose of capital accumulation or maintenance. This is discussed in more detail in section 5.4.6.

54 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 HCCS, ROCS or UMP support scheme.

The table shows that for the 2004–05 underwriting year the net cost of claims was the largest component of the premium pool at 36 per cent. Expected surplus represented 26 per cent, underwriting and general expenses 22 per cent and reinsurance expenses 16 per cent.

These proportions differ somewhat to those for the 2003–04 underwriting year, when expected surplus represented 36 per cent of the premium pool, net claims costs 32 per cent and underwriting and general expenses only 15 per cent.

4.3 Trends in medical indemnity claims

The cost of claims is the most significant driver of premiums in medical indemnity insurance.[55]

This section examines the major cost component of medical indemnity insurance by examining historical trends in ultimate claims costs, frequency of claims, and the average size of claims:[56]

- *Ultimate claims costs by notification year*—the ultimate costs of claims[57] expected to be met by medical indemnity providers by year of notification[58]
- *Claim frequency*—the ultimate number of claims expected by year of notification expressed as a proportion of the total number of indemnified members[59] in the corresponding underwriting year.[60]
- *Average size of claims*—the ultimate expected[61] average size of claims arising from a given notification year that will eventually be settled.

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55 The analysis of claims only extends to 2002–03. This is because at the time of preparing this analysis the information for 2003–04 was not available.

56 UMP records notifications by calendar year, not financial year. The ACCC considered it inappropriate to adjust these figures without knowledge of claim notification patterns. Data based on UMP's calendar years has therefore been allocated to the following financial year, i.e. the 2002 calendar year has been allocated to the 2002–03 financial year. This creates a six-month lag for UMP data compared with other indemnity providers.

57 Ultimate claims costs refers to all claims 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—the ultimate cost includes all payments made for claims to date as well as all those expected future payments yet to be made. Both past payments and future expected payments are in nominal dollars for the years in which they were made/are expected to be made. It should also be noted that due to ultimate claims costs and numbers being based largely on expectations which can change from year to year, data contained within this section may not be directly comparable with that shown in the first monitoring report.

58 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 the insurer.

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

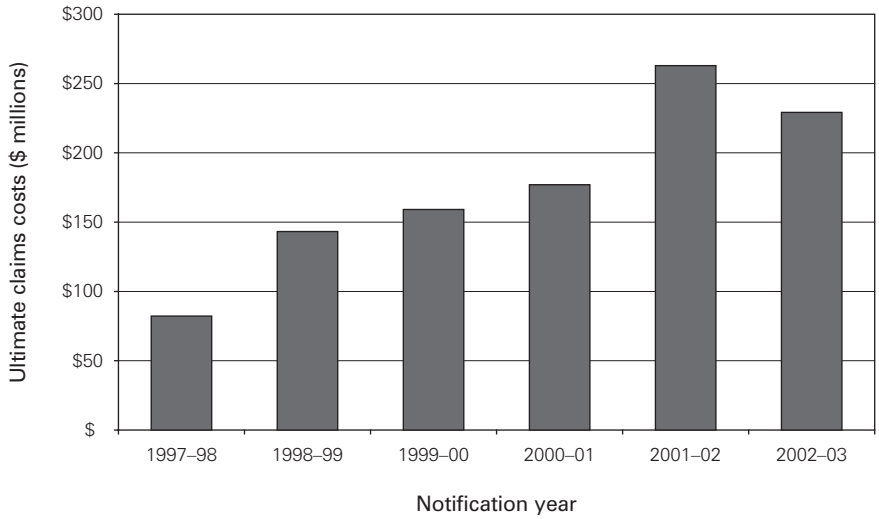
60 Notification year will generally correspond with underwriting year because membership is usually taken on a financial year basis.

61 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 subject to uncertainty, the average claim size for any given notification year will be an **expected** average size, until all claims have been settled for that year.

4.3.1 Ultimate claims costs

Chart 4.1 shows the trend in ultimate claims costs[62] for claims notified between 1997–98 and 2002–03.

Chart 4.1 Ultimate claims costs by year of notification—1998–99 to 2002–03



Source: Derived by ACCC from data for all medical indemnity providers.[63]

The ultimate cost of claims expected by year of notification increased between 1997–98 and 2001–02 from $82 million to $263 million. However, in 2003 the ultimate cost of claims decreased by 13 per cent to $229 million.

In summary:

The ultimate cost of claims by year of notification increased significantly between 1997–98 and 2001–02 before decreasing by 13 per cent in 2002–03.

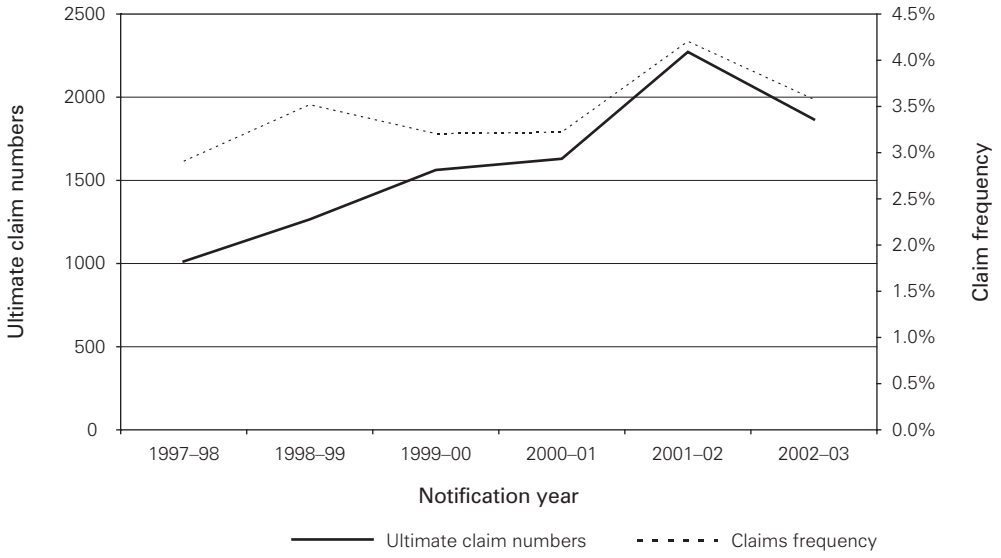
4.3.2 Claims frequency

Chart 4.2 shows the ultimate number of claims expected to be met by insurers for each notification year between 1998–99 and 2002–03, and the corresponding claims frequency by number of indemnified members.

62 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.

63 It should be noted that the analysis of the ultimate cost of claims in the first monitoring report included information from four medical defence organisations, whereas the current analysis includes information for all medical indemnity providers that were active in the market in each year.

Chart 4.2 Ultimate claim numbers and claims frequency by year of notification—1998–99 to 2002–03



Source: Derived by ACCC from data for all medical indemnity providers.

The ultimate number of claims rose from 1013 in 1997–98 to 1630 in 2000–01 (an increase of 61 per cent) before rising sharply to 2272 in 2001–02 (an increase of 39 per cent). The ultimate number of claims decreased by 18 per cent in 2002–03 to 1867. The observed trend is similar to that for the ultimate cost of claims as shown in chart 4.1.

Claims frequency generally followed a similar trend to the ultimate number of claims, particularly since 1999–00. The claims frequency increased from 2.9 per cent in 1997–98 to 3.5 per cent in 1998–99. It subsequently decreased to 3.2 per cent in 1999–00 before rising to 4.2 per cent by 2001–02. In 2002–03 it fell to 3.6 per cent.

The significant increase in claims frequency observed in 2001–02 may be attributable to claims being 'brought forward' before the introduction of tort law reform. The introduction of tort law reform can result in many claims that may otherwise have been lodged several years later being 'brought forward' and lodged with courts in order to have the pre-reform legislation apply to the claim. This has the effect of creating a 'spike' in the number of claims before the reforms coming into effect.

In summary:

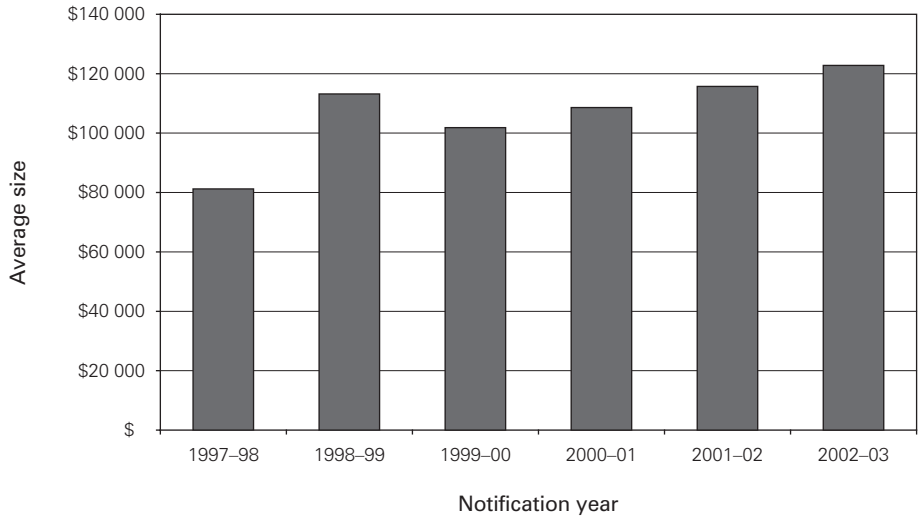
The ultimate number of claims showed a similar trend to ultimate claims costs, increasing by 124 per cent between 1997–98 and 2001–02 before decreasing by 18 per cent in 2002–03.

The frequency of claims by year of notification increased from 2.9 per cent to 4.2 per cent between 1997–98 and 2001–02, before decreasing to 3.6 per cent in 2002–03.

4.3.3 Average size of claims

Chart 4.3 shows the trend in the ultimate average size of claims expected by notification year between 1997–98 and 2002–03.[64]

Chart 4.3 Ultimate average claim size by year of notification—1997–98 to 2003–04



Source: Derived by ACCC from data for all medical indemnity providers.

This chart shows that the average size of claims increased between 1997–98 and 2002–03 from approximately $81 000 to approximately $123 000.

In summary:

The average size of claims by year of notification increased between 1997–98 and 2001–02 and continued to increase in 2002–03.

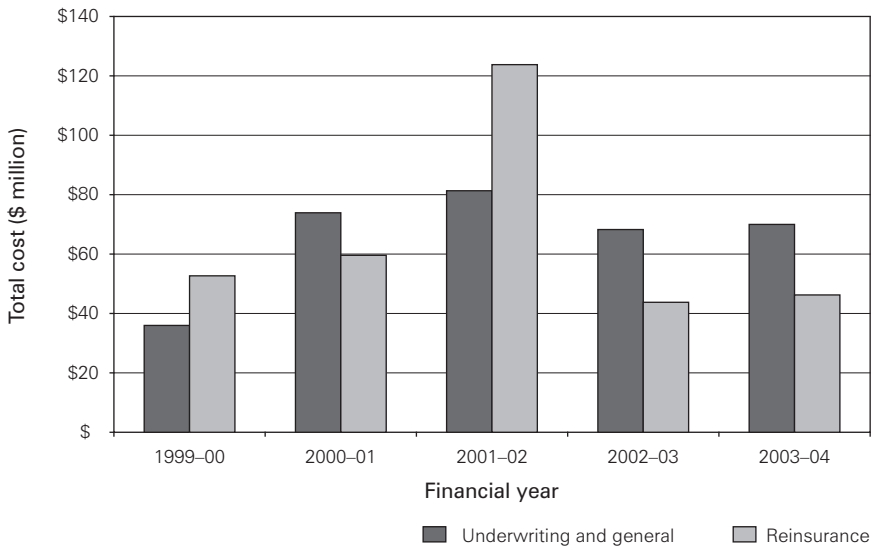
4.4 Trends in other expenses

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.

[64] Because the calculation of the ultimate cost of claims takes into account both past payments and expected future payments these estimates in more recent years are still largely uncertain. This is because expected future payments is based on an actuarial estimate of all unfinalised notifications. Therefore this estimate may change as experience emerges, resulting in the average cost of claims becoming greater or less for each notification year.

Chart 4.4 shows reinsurance and underwriting and general expenses for the years 1999–00 to 2003–04.

Chart 4.4 Reinsurance expense and underwriting and general expenses—1999–00 to 2003–04



Source: Derived by ACCC from data for five medical indemnity providers.

Underwriting and general expenses increased from $36 million in 1999–00 to $81 million in 2000–01 before decreasing to $68 million in 2002–03. Underwriting and general expenses rose marginally in 2003–04 to $70 million.

Reinsurance expenses increased from $53 million in 1999–00 to $60 million in

2000–01, before increasing markedly to $124 million in 2001–02. Reinsurance expenses then fell significantly to $44 million in 2002–03, before increasing marginally to $46 million in 2003–04.[65]

In summary:

Underwriting and general expenses increased substantially in 2000–01 and have remained relatively stable since then.

Reinsurance expenses rose significantly in 2001–02, but fell to below 1999–00 levels in 2002–03 and 2003–04.

[65] The financial report of one insurer noted that it had substantially altered its reinsurance arrangements in 2003–04 resulting in a positive reinsurance expense. This was because its rearrangements meant that there was a decrease in the amount of reinsurance expense expected to be paid to its reinsurers. In the above analysis the ACCC removed the effect of this change in reinsurance arrangements and only considered the reinsurance expense actually incurred for the year.

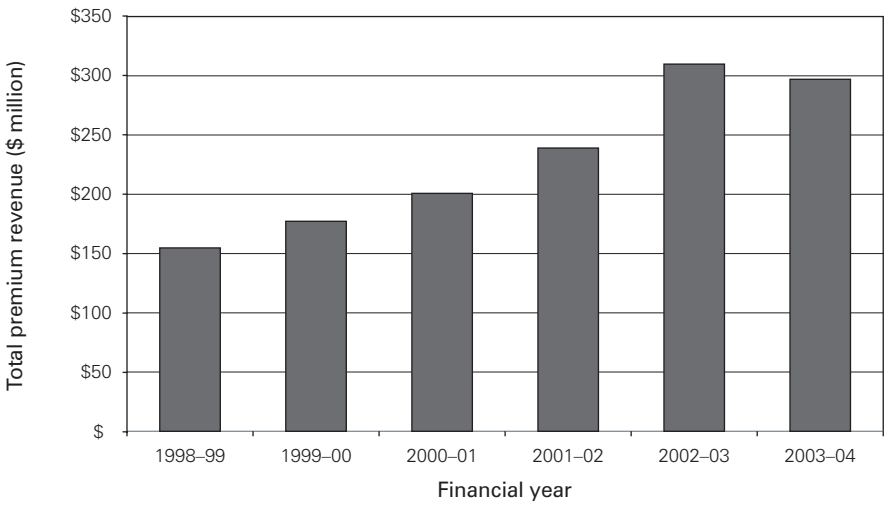
4.5 Trends in premiums

The ACCC examined medical indemnity premiums by examining trends in total premium revenue and the average premium. The average premium is the total premium revenue earned per financial year divided by the total number of indemnified policy holders for that year, in real terms.[66]

4.5.1 Total premium revenue

Chart 4.5 shows the trend in the total gross premium revenue[67] by underwriting year for the period 1998–99 to 2003–04.

Chart 4.5 Total gross premium revenue by underwriting year—1998–99 to 2003–04



Source: Derived by ACCC from data for five medical indemnity providers.
Excludes call revenue.[68]
Excludes all statutory third party collections including GST and stamp duty.[69]

The total gross premium revenue doubled from $155 million in 1998–99 to $310 million in 2002–03. In 2003–04 total premium revenue fell by 4 per cent to $297 million.[70]

In summary:

Total premium revenue rose by 100 per cent between 1998–99 and 2002–03, before decreasing by 4 per cent in 2003–04.

66 Adjusted using the average weekly earning index (AWE) published by the Australian Bureau of Statistics (ABS) (catalogue number 6302.0).

67 Premium revenue is earned premium, that is, the total amount of gross written premium that is earned during the period, earned being that proportion of risk covered by the policy that has expired at the end of the reporting period.

68 Before MDOs were regulated from 1 July 2003, a call was a request by MDO's 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.

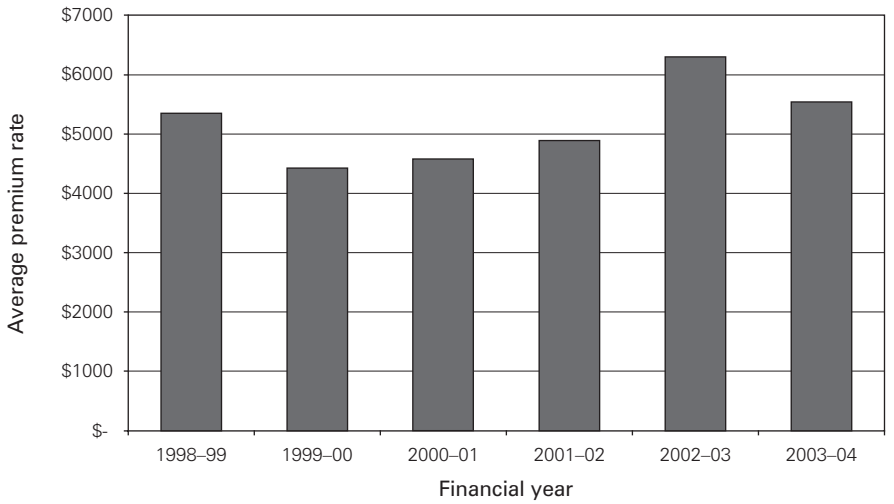
69 The ROCS levy is not included as this is not applicable until 2004–05 premiums.

70 The fall in the gross premium revenue in 2003–04 may reflect the move by some insurers from claims-incurred policies (which are typically more expensive) to 1st year claims-made policies (which are typically cheaper than mature claims-made policies and claims-incurred policies).

4.5.2 Average premium

Chart 4.6 shows the historical trend in the average premium payable by members of medical indemnity providers. This average gives an indication of the trend in real premiums payable by all indemnified medical practitioners between 1998–99 and 2003–04.

Chart 4.6 Average premium—real terms—1998–99 to 2003–04



Source: Derived by ACCC from data for five medical indemnity providers.

Notes: Data is shown in real terms adjusted to 30 June 2004 values using the AWE index published by the ABS rates exclude third party statutory collections such as GST and stamp duty.

The average premium decreased by 17 per cent in real terms from $5359 in 1998–99 to $4434 in 1999–00 before increasing by around 3 per cent in 2000–01, 7 per cent in 2001–02, and 29 per cent in 2002–03 to $6311. Real average premiums fell by 12 per cent in 2003–04 to $5549.[71, 72]

In summary:

The average premium decreased by 12 per cent in 2003–04 having increased over the prior three years.

[71] The fall in the average premium rate in 2003–04 may reflect the move by some insurers from claims-incurred policies (which are typically more expensive) to 1st year claims-made policies (which are typically cheaper than mature claims-made policies and claims-incurred policies).

[72] Results shown in chart 4.6 may not be directly comparable to that shown in the first ACCC monitoring report due to revised data.

[73] The ACCC examined the financial performance of the MDO group (i.e. the parent MDO as well as the licensed authorised insurer) to ensure consistency over the historical time period. However, this will mean the results are not directly comparable with those contained in chapter 6, which examined medical indemnity insurers in isolation.

4.6 Trends in financial performance

The ACCC examined the underwriting performance of medical defence organisations[73] to determine the performance of the industry over five years between 1999–00 and 2003–04.

Although the medical indemnity industry operates on a not-for-profit basis, underwriting performance indicates whether the industry is expected to make a surplus, break even, or make a loss on its activities.[74]

The analysis is based on an assessment of several ratios using data on a financial year basis sourced from annual reports produced by MDOs:

- *Loss ratio*—the total claims expense attributable to the financial year[75] on claims arising from that or prior years as a proportion of premium revenue.
- *Expense ratio*—the sum of all underwriting and general expenses (excluding reinsurance expenses) as a proportion of premium revenue.
- *Reinsurance ratio*—the reinsurance expense as a proportion of gross premium revenue.
- *Combined ratio*—the sum of the loss ratio 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.[76]

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

Ratios were constructed on an aggregate basis using data provided by five of the seven MDOs active in the market throughout the period. The ACCC considers the results to be representative of the performance of the industry as a whole.[77]

The indicators of underwriting performance are examined on financial year basis[78] and include not only the expenses incurred in the year, but also changes in provisions held for expenses arising from underwriting activities of prior years but expected to be paid in future years. Adjustments to claims provisions, reinsurance recovery provisions or other expense provisions can affect the actual results observed in a financial year. As such, the ratios in any one year may not accurately reflect the results achieved by insurers from underwriting activities in that year.

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74 It should be noted that this excludes its financial year investment returns.

75 Claims expenses include all payments made in the current year on claims arising from current and prior notification years, as well as adjustments to outstanding claims reserves across the period. As these reserves are held on an inflated and discounted basis, the claims expense in a given period will also be on an inflated and discounted basis.

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

77 As the ratios are constructed using aggregated data they represent the average performance of the industry as a whole and do not necessarily reflect the performance of individual medical indemnity providers.

78 As opposed to on an incident or notification year basis which examines the premiums written in one year against all the expenses that are expected to be incurred as a direct result of writing that premium.

For example, an insurer may increase its claims provisions in a particular year based on its expectations at that time. This will have the effect of increasing claims costs and thus result in a higher loss ratio for that year (therefore leading to a higher combined ratio). Should that insurer subsequently revise down its expectations for those claims attributable to that prior year, and release a portion of its claims provisions, the resulting benefit will be reported as a lower loss ratio in the current year, not the year that the reduction in claims provisions are attributable to.

It should also be noted that due to these indicators being on a financial year basis they are not directly comparable with those indicators prepared on an underwriting year or notification year basis.

4.6.1 Loss ratio

The loss ratio can be calculated gross or net of reinsurance costs and recoveries:

- the gross loss ratio is calculated as claims expenses[79] per financial year divided by gross premium revenue earned in the corresponding financial year
- the net loss ratio takes reinsurance recoveries[80] out of claims expenses and takes reinsurance expenses away from gross premium revenue.

Table 4.2 shows the gross and net loss ratios for 1999–00 to 2003–04.

Table 4.2 Gross and net loss ratio—1999–00 to 2003–04[81]

	Gross loss ratio	Net loss ratio
1999–00	156	89
2000–01	84	136
2001–02	84	148
2002–03	52	49
2003–04	45	12

Source: Derived by ACCC from data for five medical indemnity providers.

The table shows that the gross loss ratio decreased from 156 per cent in 1999–00 to 84 per cent in 2000–01 and 2001–02. It then decreased over the next two years to 45 per cent in 2003–04. The net loss ratio showed a different trend, increasing from 89 per cent in 1999–00 to 148 per cent in 2001–02, then decreasing significantly to 49 per cent in 2002–03 and again to 12 per cent in 2003–04.

[79] Claims expenses are comprised of total claims payment in the year, added to the change in outstanding claims reserves over the year. As previously noted, claims expenses are recorded on an inflated and discounted basis. This calculation is similar to that used to calculate premium revenue, where the premiums received in the year are added to the change in premium reserves over the year to arrive at premium revenue.

[80] Similar to claims expenses, reinsurance recoveries revenue is comprised of the actual reinsurance recoveries received in the year, added to the change in the outstanding reinsurance recoveries over the year.

[81] The ACCC has explicitly excluded abnormal expense items related to IBNR claims expenses included in total claims expenses for 1999–00 ($65 million) and 2001–02 ($475 million). This is because these claims expenses do not relate specifically to the claims expense of that particular year but are an abnormal accounting item relating to prior years' claims expense.

The significant fluctuations observed in the net loss ratio reflects variations in both the reinsurance premiums paid by the industry as well as the recoveries received and expected. Typically it would be expected that the net loss ratio would be higher than the gross loss ratio because, where reinsurance is priced on an appropriate technical basis, total reinsurance recoveries could be expected to be lower than reinsurance expenses, except in the event of a total catastrophic loss. The table shows that this relationship does not always hold. This will especially be the case in more recent years where the HCCS recoveries may be included in other recoveries, and therefore total recoveries (including those from reinsurance, other sources and the HCCS) may be higher than the amount paid for reinsurance.

The reductions in both the gross and the net loss ratios in 2003–04 are partially due to one insurer significantly revaluing its outstanding claims reserves. This insurer's actuarial valuation of the ultimate settlement cost of claims notified and not yet notified that have yet to be settled was significantly reduced, resulting in a positive claims expense for the year. That is, the claims settlements that were paid out that year were less than the release of reserves attributable to the revaluation of the outstanding claims.[82] When this insurer's results are excluded the gross and net loss ratios for 2003–04 are 99 and 18 per cent, respectively.[83]

4.6.2 Expense ratio

The expense ratio can also be calculated gross and net of reinsurance expenses. The gross expense ratio is calculated as underwriting and general expenses per financial year divided by the gross premium revenue in that year. The net expense ratio is underwriting and general expenses divided by net premium revenue (gross premium revenue less reinsurance expenses).

Table 4.3 shows the gross and net expense ratios for 1999–00 to 2003–04.

Table 4.3 Gross and net expense ratio—1999–00 to 2003–04

	Gross expense ratio	Net expense ratio
1999–00	20	29
2000–01	37	52
2001–02	34	71
2002–03	22	26
2003–04	24	25

Source: Derived by ACCC from data for five medical indemnity providers.

The table shows that the gross expense ratio increased from 20 per cent in 1999–00 to 37 per cent in 2000–01, remaining relatively constant (at 34 per cent) in 2001–02. The ratio then fell to 22 per cent in 2002–03 and remained around that level (at 24 per cent) in 2003–04. This trend is consistent with data on underwriting and general expenses shown in chart 4.4.

[82] United Medical Protection, Annual Review 2003–04, p. 19.

[83] The net loss ratio result was still quite favourable, mainly due to significant reinsurance and other recoveries in that year.

The net expense ratio increased from 29 per cent in 1999–00 to 52 per cent in 2000–01 and increased again to 71 per cent in 2001–02.[84] Similar to the gross expense ratio the net expense ratio fell substantially in 2002–03 to 26 per cent and remained stable in 2003–04 at 25 per cent.

Although the aggregate gross and net expense ratios were virtually unchanged in 2003–04 compared to 2002–03, this was not the case for all insurers—for some expenses relative to premium revenue rose, while for others expenses fell relative to premium revenue.

4.6.3 Reinsurance ratio

The reinsurance ratio is calculated as reinsurance expenses divided by gross premium revenue. It is calculated as a separate ratio because reinsurance is a different type of expense to underwriting and general expenses in that it is somewhat discretionary, and because it is a major component of total expenses.

Table 4.4 shows the reinsurance ratio for 1999–00 to 2003–04.

Table 4.4 Reinsurance ratio—1999–00 to 2003–04

	Reinsurance ratio
1999–00	30
2000–01	30
2001–02	52
2002–03	14
2003–04	5

Source: Derived by ACCC from data for five medical indemnity providers.

The table shows that the reinsurance ratio was constant at 30 per cent in 1999–00 and 2000–01 before increasing to 52 per cent in 2001–02.[85] The reinsurance ratio then fell to 14 per cent in 2002–03 and again to 5 per cent in 2003–04.

However, as noted in footnote 65, the financial report of one insurer noted that it had substantially altered its reinsurance arrangements in 2003–04, resulting in a positive reinsurance expense. This was because its rearrangements meant that there was a decrease in the amount of reinsurance expense expected to be paid to its reinsurers. If the effect of this reduction is removed from the above analysis so that only the actual reinsurance expense incurred for the year is considered the reinsurance ratio for 2003–04 is 16 per cent.

[84] The increase in the net expense ratio in 2001–02 was caused by an increase in reinsurance premiums paid that year, which resulted in lower net premium revenue.

[85] The increase occurred across all of the five medical indemnity providers, albeit at different rates. Although the reasons behind this are not entirely clear, they may relate to either changes in the amount of reinsurance cover sought by the medical indemnity providers, and/or increases in the reinsurance premiums payable for a given level of cover.

4.6.4 Combined ratio

The gross combined ratio is calculated by adding together the gross loss ratio and the gross expense ratio, and indicates underlying profitability before considering the impact of the form and cost of the adopted reinsurance program.

The net combined ratio is the sum of the net loss ratio and the net expense ratio, and shows the underwriting performance of insurers after taking into account the outcome of their reinsurance activities.[86]

Table 4.5 shows the gross and net combined ratios for 1999–00 to 2003–04.

Table 4.5 Gross and net combined ratio—1999–00 to 2003–04[87]

	Gross combined ratio	Net combined ratio
1999–00	176	118
2000–01	120	189
2001–02	118	219
2002–03	74	75
2003–04	68	37

Source: Derived by ACCC from data for five medical indemnity providers.

The gross combined ratio fell from 176 per cent in 1999–00 to 120 per cent in 2000–01 and remained stable in 2001–02 (at 118 per cent). The gross combined ratio then decreased to 74 per cent in 2002–03 and again marginally in 2003–04 to 68 per cent.

The net combined ratio showed a different trend, increasing from 118 per cent in 1999–00 to 219 per cent in 2001–02 before decreasing to 75 per cent in 2002–03 and again to 37 per cent in 2003–04.

The ACCC's first report found that all five medical indemnity insurers were building surpluses into their 2003–04 premiums to build capital to meet the minimum capital requirements of APRA. Therefore the combined ratios for 2003–04 would be expected to be below 100 indicating an underwriting surplus.

Further, as noted previously, the combined ratios are calculated on a financial year basis and therefore include not only the expenses incurred in the year but also changes in provisions held for expenses expected to arise from underwriting activities of prior years. Substantial adjustments to claims provisions, reinsurance recovery provisions or other expense provisions will therefore affect the actual results observed in a financial year. In this particular case the loss ratios and reinsurance ratios were heavily influenced by changes in provisions by one insurer, therefore the combined ratios for 2003–04 are not indicative of the financial performance of MDOs from medical indemnity insurance written in 2003–04.

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86 In cases where the combined ratio is not equal to the sum of its component ratios, this is because of rounding.

87 The ACCC has explicitly excluded abnormal expense items related to IBNR claims expenses included in total claims expenses for 1999–00 ($65 million) and 2001–02 ($475 million). This is because these claims expenses do not relate specifically to the claims expense of that particular year but are an abnormal accounting item relating to prior years claims expense.

In summary:

The gross combined ratio declined from 176 per cent in 1999–00 to 118 per cent in 2001–02, before decreasing to 74 per cent in 2002–03 and 68 per cent in 2003–04. The improvement in 2003–04 is largely due to a change in the claims provisions by one insurer.

The net combined ratio was substantially lower than the gross combined ratio in 2003–04. However, the treatment of the HCCS recoveries in financial reports appears to have affected these results.

4.7 Conclusion

Based on the data provided by medical indemnity providers, the ACCC found that:

- the surplus component (which is primarily being used to build capital) of the 2004–05 premium pool is lower than that observed in 2003–04
- the ultimate cost of claims by year of notification reduced in 2002–03, as did the frequency of the ultimate number of claims; however, the ultimate average claim size continued to increase in 2002–03
- in 2003–04 the average premium (based on the aggregate premium pool) decreased by 12 per cent in real terms, although this appeared to reflect the move to writing cheaper claims made policies by some insurers
- the financial performance of the industry improved in 2003–04, although this may be overstated due to a change in the circumstances of one insurer.

5. Actuarial justification of medical indemnity premiums

5.1 Introduction

This chapter presents the ACCC's findings regarding the actuarial justification of medical indemnity premiums charged for the 2004–05 underwriting period[88] by the five current medical indemnity providers to private medical practitioners.

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.

Chapter 6 discusses the ACCC's findings regarding the commercial justification of medical indemnity premiums charged for 2004–05.

5.2 Qualifications

The ACCC's analysis is based on information supplied by each of the five insurers and their affiliated MDOs. The ACCC relied on the information provided by insurers rather than performing an independent verification. This analysis only examined the premiums charged by the medical indemnity insurer and specifically excludes any examination of 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 in relation to its assessment of individual insurer's information, could not be disclosed in this report.

5.3 Assessment methodology

The ACCC's review of the actuarial justification of premiums considers the process adopted by the 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 recent medical indemnity and tort reforms) have been considered in setting prices.

Specifically, the ACCC examined:

- 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 professional standards (such as existing standards related to disclosure of information to enable another actuary to reproduce results)
    - the method employed by the actuary to construct the aggregate premium pool, associated premium relativities, the assumptions adopted and the rigour associated with those assumptions

[88] 2004 calendar year in the case of AMIL.

    - the extent to which the insurer's board adopted the actuary's recommended premium rates
    - the degree to which the recommended actuarial premium pool detailed in the pricing report is 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 that is required purely 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 not likely to be known for a number of years after the premium has been set (see section 2.2.3). 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, the projected rate of claims cost increases, legal costs, discount rate, and the projected growth rate of membership numbers and profile
- Expenses—the expenses 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 and the basis of cost allocation across membership categories
- Reinsurance expenses—the amount of premium ceded to reinsurers for reinsurance during a period. Factors considered include:
    - whether or not 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
    - an assessment of expected recoveries compared to premiums
- Surplus[89]—the surplus of funds that is expected to emerge after reinsurance costs, the cost of claims and administration expenses are deducted from premium revenue. For medical indemnity providers, these funds are typically used to meet and maintain MCR 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 amounts required for each purpose
    - quantifying the impact on premiums of any allowance for the surplus

[89] In the *Medical indemnity insurance—monitoring report—December 2003* the ACCC examined surplus in terms of capital and profit. This report looks at an expanded definition of surplus which includes capital accumulation, capital maintenance, building contingency margins into claims costs, and profit.

- Recommended rates/relativities—the premium rate and/or price relativities across various risk specialties that are recommended by the actuary to the insurer's board. Factors considered include:
  - the extent of the analysis to confirm or modify risk specialties
  - 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
- Government reforms—the impact of measures arising from the Australian Government's medical indemnity package and relevant tort law reform initiatives introduced by Commonwealth, state and territory governments on costs and premiums. The ACCC requested specific commentary on the following government initiatives:
  - High cost claims scheme (HCCS)—medical indemnity providers 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.
  - Premium subsidy scheme (PSS)—medical indemnity providers were asked to comment on how the premium subsidy arrangements had impacted on actual premium rates charged.
  - Run-off cover scheme (ROCS)—medical indemnity providers 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. Providers were also asked to outline the principal for allocating the cost of ROCS to each membership category.
  - Tort law reform—medical indemnity providers 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. Where no consideration of the effect of tort reforms on costs and premiums was given, this was to be noted.

5.4 Detailed analysis

5.4.1 Ratings process

Based on the information provided by insurers, the ACCC found that the method employed in constructing the overall premium pool was generally consistent across medical indemnity providers. In most cases, insurers estimated the overall premium pool required by establishing the estimated cost of claims, reinsurance costs, administration expenses plus an additional margin for capital growth or maintenance.

In general the methodology adopted by medical indemnity providers to establish their overall premium pools was based on sound actuarial techniques. Further, the results were generally supported by other reports prepared by the insurer.

All insurers relied on the premium pool estimates prepared by the actuary—however, most modified the pool to reflect updated information not considered by the actuary at the time of preparing their report. In all cases the actual premium pool was at least equal to the actuarial target premium pool.

On this basis the ACCC found that the ratings process used and the overall premium pool adopted by all five medical indemnity providers was considered actuarially sound.

The ACCC notes that in some cases actuaries were only used in establishing the pure risk premium component and relied on the insurer to determine the amount required for the other components of the overall premium pool. The ACCC recognises that there are limitations on the extent to which actuaries can assess the appropriateness of components of premiums based on insurers' projections, such as administration expenses, reinsurance expenses and capital requirements. However, it may be prudent for actuaries to consider how these recommendations compare with past experience and their understanding of the insurers' operations in their pricing reports.

Further to this the ACCC notes that the Institute of Actuaries of Australia (IAAust) is currently formulating medical indemnity premium guidelines, which may assist actuaries in determining what issues should to be covered off in their pricing reports to insurers and the depth to which each issue should be dealt with.

5.4.2 Pure risk premium

The basic building block for determining the overall premium pool is the pure risk premium, which represents the direct cost of settling claims. 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. These insurers estimated that the cost of claims were expected to increase at a rate greater than normal wage inflation.

In some cases, the actuary set the pure risk premium 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 and, in most cases, the assumptions were supported by the analysis conducted in the most recent actuarial assessment of insurers' outstanding claims liabilities.

The ACCC notes that in some cases the reasoning behind the assumptions adopted was not sufficiently documented when determining the pure risk premium. However, as noted above, the IAAust's production of medical indemnity premium guidelines may assist actuaries in determining the detail to which assumptions need to be explained.

5.4.3 Expenses

The ACCC examined the amount of expenses that were incorporated into premiums for 2004–05. As indicated in table 4.1, expenses represented, on average, approximately 22 per cent of the premium pool across insurers.

All overall premium pool estimates included an allowance for expenses and this was determined to be actuarially justified.

However, the ACCC notes that in some cases the actuary relied solely on information provided by the insurer in their determination of this component of the premium pool. The ACCC recognises that there are limitations on the extent to which actuaries can assess the appropriateness of the expenses component of premiums based on insurers' projections. However, it may be prudent for actuaries to consider how these recommendations compare with past experience and their understanding of the insurers' operations. As noted above, the release of the medical indemnity premium guidelines by the IAAust may address the issue of the extent to which the actuary must determine the reasonableness of expenses.

5.4.4 Reinsurance expenses

The ACCC examined the reinsurance expenses incurred by insurers to assess several factors including whether or not the reinsurance program was used effectively to minimise the insurer's risk exposure.

All medical indemnity insurers used reinsurance programs for the 2004–05 period to manage the risks inherent in their portfolio. They all used a combination of 'excess of loss' and 'stop loss' reinsurance to manage their risk exposure.[90] 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.[91]

The ACCC examined the expected net cost of reinsurance and found that generally all insurers expected reinsurance recoveries to be considerably less than the value of the premiums ceded to the reinsurer. A similar result was found for the 2003–04 underwriting year.

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 to determine.

However, once insurers are fully capitalised those insurers that develop a greater risk appetite may potentially stand to gain significant cost savings as a result of a lower net cost of reinsurance. These savings may result in lower premiums for medical practitioners. However, it should also be noted that while any reduction in the level of reinsurance obtained may lower reinsurance costs, the insurer will be potentially exposed to greater claims costs.

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90 Excess of loss reinsurance is where the direct insurer carries all individual losses incurred for each individual claim or event up to a certain limit and the reinsurer pays the loss in excess of this amount (known as an attachment point) up to an agreed limit. In addition there may be an aggregate limit in respect of all claims assumed by the reinsurer.
Stop–loss reinsurance is where 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.

91 In some cases the reinsurance program covered IBNR claims for cover provided by the parent MDO. In these cases a portion of the reinsurance premium was charged to the MDO.

The ACCC also notes that following on from the significant withdrawal of capital in the reinsurance market in recent years (e.g. following on from the expected losses resulting from the terrorist attacks on the World Trade Centre in the United States of America) the cost of reinsurance has increased. However, should the market begin to recover from these events and capital levels are rebuilt then insurers may be able to achieve a better net cost of reinsurance which could also lead to lower premiums for medical practitioners.[92]

5.4.5 Recommended rates/relativities

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 medical indemnity providers had undertaken extensive analysis of the premium relativities across specialties. Some insurers conducted new analysis on relativities between specialties for the 2004–05 underwriting year, while others updated previous analysis to incorporate recent developments (including new specialties).

With regard to the relativities between jurisdictions the ACCC found that most insurers were unable to accurately determine state-based premium relativities due to a lack of reliable state-based claims experience. Most insurers therefore made relatively simplistic estimates and included a flat loading or discount on premiums for medical practitioners outside the insurer's home state. In the absence of reliable state-based claims experience this approach is still considered to be actuarially sound.

5.4.6 Surplus

The ACCC examined the component of insurers overall premium pool that provided a surplus, which is designed to:

- build the capital required to meet APRA's MCR[93]
- build additional capital necessary to maintain the MCR as a direct result of premiums written in 2004–05
- 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 provision is adequate to meet the cost of claims
- provide a surplus (profit) to the insurer.

The ACCC's first monitoring report found that all five insurers sought to raise capital through surplus loadings in their 2003–04 premiums so as to meet APRA's MCR. Approximately 36 per cent of their overall premium pool for the 2003–04 underwriting

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92 The ACCC was unable to accurately compare reinsurance costs between the 2003–04 and 2004–05 underwriting periods due to the circumstances surrounding reinsurance arrangements changing significantly. First, reinsurance costs may have changed as a result of changes made to the HCCS. Similarly, some insurers have changed both the manner in which they obtain reinsurance and the levels of reinsurance obtained. Therefore it is difficult to determine the extent to which any change in price is a result of either of the above factors or the result of obtaining reinsurance on more favourable terms.

93 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 by 30 June 2008.

period was surplus primarily for the purpose of building the capital necessary to meet APRA's MCR.

For the 2004–05 underwriting period the ACCC found that two medical indemnity providers indicated they had now satisfied the solvency requirements and, as such, no longer needed to build their MCR through premium loadings. The remaining medical indemnity providers continued to build capital loadings into their overall premium pools primarily to meet APRA's MCR. As a result, these insurers continued to raise capital through profits retained after GST, stamp duty, the ROCS levy, and income tax payments.[94]

The two insurers that had reached their MCR still 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 sufficient level so as to continue to meet APRA's MCR after taking into account the additional risks underwritten in 2004–05, and to maintain a contingency margin.

No insurer explicitly included a surplus in premiums for the purpose of making a profit.

The ACCC notes that in some cases the actuary relied on information provided by the insurer in their determination of the surplus component of the premium pool. As noted above, the release of the medical indemnity premium guidelines by the IAAust may address the issue of the extent to which the actuary is expected to examine levels of projected surplus.

5.4.7 Government reforms

The ACCC examined the effect of the Australian Government's medical indemnity reforms (in particular, the HCCS, the ROCS and the PSS) and Commonwealth, state and territory tort law reform on costs and premiums.

The ACCC found that the extent to which these measures had been considered by insurers in determining premiums varied across the industry.

The high cost claim scheme (HCCS)

The HCCS was introduced to address the issue of high cost claims related to medical incidents. It was designed to reduce the potential cost of large claims to insurers, and is expected to impact on premiums in two ways. First, it would be expected to impact premiums by reducing the pure risk premium component as the Australian Government would pay 50 per cent of high cost claims. Second the scheme is expected to reduce the amount of reinsurance required to cover the total cost of high cost claims. These impacts will, to some degree, be interdependent depending on the attachment points of each insurer's reinsurance program.

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[94] The ACCC noted in its first monitoring report that this may **not** be the most efficient method of raising capital when compared to capital injections from existing shareholders or share offers to new parties. This is because capital raised through a loading in premiums would incur 10 per cent GST, between 5 and 10 per cent stamp duty (depending on the jurisdiction), and 8.5 per cent ROCS levy. Income tax is also charged on profit at 30 per cent. As a result, every $1 of capital loading in premiums converts to between $0.52 and $0.55 (depending on the level of stamp duty) of capital.

All insurers examined the impact of the HCCS on their pure risk premium. Four insurers estimated expected recoveries from the scheme for high cost claims and took 100 per cent of these expected HCCS recoveries into account when determining their pure risk premium. The remaining insurer estimated expected recoveries from the scheme, but only took 50 per cent of these into account when determining its pure risk premium.

The reason provided was that the legislation applying the HCCS initially outlined that the scheme would apply when a medical indemnity provider becomes aware of a claim against a medical practitioner. Applying the scheme in this manner would mean that potentially only formal demands for monetary compensation would be covered by the scheme. However, medical practitioners claims made insurance policies cover all potential claims notified to the insurer, even those that have not matured into formal demands for monetary compensation. There may be a delay therefore between when a claim is notified and covered by an insurer, and when it is notified and covered by the HCCS. Thus, if 100 per cent of the HCCS recoveries were taken into account and the scheme was unwound before those high cost claims notified to an insurer had the potential to mature, a portion of the insurer's high cost claims would be unfunded.

In terms of factoring the HCCS into reinsurance programs, three insurers indicated that they had taken full account of the scheme when establishing their reinsurance arrangements for 2004–05. The remaining two insurers did not. The reason, similar to that outlined above, was that due to some uncertainty concerning the longevity of the scheme they were unwilling to be potentially unreinsured and risk being underfunded.

However, on 23 June 2004 the *Medical Indemnity Legislation Amendment (Run-off Cover Indemnity and Other Measures) Act 2004* received royal assent. Among other things, the Act amended the HCCS provisions contained in the *Medical Indemnity Act 2004*, such that the scheme would make a payment for high cost claims where the medical indemnity provider becomes aware of a claim (i.e. received a formal demand for monetary compensation), **or becomes aware of an incident**, against a medical practitioner. This means that the scheme operates on the same basis as the claims made insurance policies written for medical practitioners, and insurers could therefore be guaranteed of payment of all claim notification even if the scheme was wound down. This change took effect retrospectively from 1 January 2003, thereby encompassing all claims under the HCCS.

The ACCC considers that the overall premium pool of those insurers that did not take the HCCS into account in their pure risk premium and/or their reinsurance arrangements are still actuarially justified. This is because the changes to the operation of the scheme were not in place until after reinsurance arrangements and pricing decisions had been finalised. However, the ACCC notes that the certainty of the scheme may now result in these insurers receiving windfall gains where the HCCS pays for claims that it was not expected to, or where these payments are received in addition to full reinsurance recoveries.

The ACCC would expect all insurers to take the HCCS fully into account in determining both their pure risk premium as well as their reinsurance arrangements for 2005–06 premiums.

Run-off cover scheme (ROCS)

The ROCS was introduced to provide secure cover for medical practitioners who retire, die, become permanently disabled, or permanently leave the workforce for three years or more. The scheme will cover claims by these medical practitioners and the cost will be funded by a charge on current members. This scheme would be expected to impact on 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.

The majority of insurers expected to make recoveries from the ROCS for liabilities arising from the current underwriting period and took these into account when setting their pure risk premium.[95] All insurers correctly incorporated the ROCS levy into the premiums charged to medical practitioners.

The ACCC considers that the insurers' consideration of the ROCS in determining their premiums for 2004–05 was actuarially justified.

Premium subsidy scheme (PSS)

The PSS was introduced to assist all eligible medical practitioners with the cost of their medical indemnity insurance, by providing a subsidy to medical practitioners whose income exceeded a determined threshold. As this subsidy is designed to be taken into account on the final premium determined by the medical indemnity provider, the actuary would **not** be expected to take this scheme into account when determining the overall premium pool or specialty risk relativities.

Insurers indicated that the scheme was not taken into account when determining either the overall premium pool or the speciality risk relativities.

Tort law reform

Since early 2001 tort law reforms have been introduced progressively by Commonwealth, state and territory governments in response to perceived problems in the availability and affordability of public liability and professional indemnity insurance.[96] 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.

Most insurers noted that tort law reform was expected to have some effect on claims costs, and in some cases evidence of this was currently emerging. However, the majority of insurers indicated that as the true extent of these reforms was currently unknown, they were unlikely to take these reforms into account in determining their pure risk premium until further experience emerged and presented measurable and consistent trends. However, all insurers continued to make allowances for lower claims costs as a result of changes to the discount rate across most states and territories.

One insurer had conducted detailed analysis on the expected impact of tort law reforms on premiums. This insurer outlined in detail the estimated impact of legislative changes on claims costs that it had allowed for in determining its pure risk premium.

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[95] AMIL writes premiums on a calendar year basis and as this scheme took effect from 1 July 2004 AMIL did not take ROCS into account in setting its 2004 premiums.

[96] The impact of tort law reform on costs and premiums in public liability and professional indemnity insurance is subject to a separate monitoring role by the ACCC. See ACCC reports *Public liability and professional indemnity insurance—monitoring report*, July 2003, January 2004 and July 2004.

The ACCC considers the premiums of those insurers that took a more cautious view of tort law reform as actuarially justified. However, the ACCC expects these insurers to extend their assessments of the impact of these reforms on the cost of claims in preparation for setting 2005–06 premiums, once more claims experience has emerged.

5.4.8 Cross-subsidisation

The ACCC examined cross-subsidisation between risk specialties and the extent to which cross-subsidies were quantified by insurers.[97]

The ACCC found that cross-subsidisation was a common feature in the medical indemnity industry, with the exception of one insurer which stated that there were no longer any major subsidies across its rates. All other insurers indicated that although they currently had cross-subsidies between specialties in their premium rates they had a policy of unwinding these. However, the extent to which this was able to be put into practice in the 2004–05 underwriting period varied. Some insurers indicated that while they had planned to unwind the subsidies this underwriting period, this did not happen for a variety of reasons.

All insurers whose premiums relativities included cross-subsidies between classes identified these subsidies and attempted to quantify them.

The ACCC notes however, that unwinding cross-subsidies and moving premiums towards their technical rates, to the extent that this is possible, would also be considered actuarially justified as long as this action was clearly identified. Moving specialty premiums towards their technical rates would result in more transparent pricing, which may assist medical indemnity providers in retaining membership for those specialties that are currently net subsidisers.

5.5 Conclusion

The ACCC found that premiums were considered to be actuarially justified for all five medical indemnity providers.

Two main aspects of insurers' pricing strategies were considered. First, the ACCC assessed whether or not the overall premium pools of the insurers were expected to be adequate to cover expected costs. Second, it assessed whether specialty premium rates were determined using actuarially sound methods.

The ACCC found that the overall premium pool of each insurer was actuarially justified. It was evident that insurers made extensive use of actuaries in preparing liability assessments, pricing reports, funding plans and financial forecasts. In each case the construction of the recommended premium pool was considered to be soundly based and incorporated all major cost implications for the pricing of medical indemnity insurance. Each insurer adopted an overall premium pool at least equal to the actuary's recommended premium pool, with any divergence attributable to the use of more up to date information.

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[97] Cross subsidisation between current and retired members has now been formalised by the introduction of the run-off cover scheme (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). This scheme is funded by a percentage charged on the total premium pool of medical indemnity providers, which is in turn passed on to the premiums charged to current financial medical practitioners.

While the overall premium pools were determined to be actuarially justified for all insurers, two issues arose during the ACCC's examination of some insurers' overall premium pool:

- the depth to which factors other than the pure risk premium (such as expenses, the reinsurance program and premium surplus) were examined by the actuary
- the level of detail to which assumptions underlying the actuary's analysis were provided in medical indemnity providers' reports.

The ACCC notes, however, that the IAAust is currently developing medical indemnity premium guidelines, which may assist actuaries addressing these issues in future pricing reports.

The ACCC's analysis regarding specialty premium rates showed that most insurers conducted detailed analysis on premium relativities between specialties. In the majority of cases, insurers indicated a desire to unwind existing cross-subsidisation between specialties but most were unable to do so this year due to a range of factors. However, the ACCC still found these rates to be considered actuarially justified because the extent of cross-subsidisation was understood and quantified and the overall premium pool was expected to be achieved.

6. Commercial justification of medical indemnity premiums

6.1 Introduction

This chapter presents the ACCC's findings regarding the commercial justification of medical indemnity premiums charged for the 2004–05 underwriting period[98] by the five current medical indemnity providers to private medical practitioners.

This 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.

6.2 Qualifications

The ACCC's analysis is based on information supplied by each of the five insurers and their affiliated MDOs. The ACCC relied on the information provided by insurers rather than performing an independent verification. This analysis only examined the premiums charged by the medical indemnity insurer and specifically excludes any examination of the subscription charged by the MDO.[99]

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 regarding its assessment of individual insurer's information, could not be disclosed in this report.

6.3 Assessment methodology

The ACCC's assessment of the commercial justification of premiums considers whether the insurers' 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 statement of financial performance and statement of financial position) of the business plan on their overall corporate strategies. This type of analysis is necessary to ensure that insurers are capital compliant with APRA's MCR by 30 June 2008, as their pricing decisions in the current underwriting period will impact their financial position at the completion of the transition period.

98 2004 calendar year in the case of AMIL.

99 This means that the results contained in this chapter are not directly comparable with the results contained in chapter 4, which examined the MDO entity as a whole (i.e. both the MDO and the authorised medical indemnity insurer).

In examining the commercial justification of premiums, the ACCC compared three sets of information for medical indemnity providers:

- The financial projections contained in their initial funding plans as provided to APRA to make use of the transition period for building the MCR (referred to as 2002–03 projections).[100]
- The most recent revised financial projections, which take into account more recent data and developments (referred to as 2003–04 projections).[101]
- The financial position as at 30 June 2004 based on quarterly reporting data provided to APRA (referred to as actual 2003–04 position).[102]

Comparing these three sets of data allows the ACCC to examine how insurers' financial position forecasts have changed and whether forecasts for 2003–04 have been achieved based on actual data for 2003–04.

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

- Solvency[103]—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 premiums and whether this was sufficient to achieve the medical indemnity providers' targeted solvency and capital requirements
- MCR coverage and capital targets—current and forecast levels of MCR coverage to examine whether capital targets would be met
- Returns on net assets—current and forecast returns on net assets
- Underwriting performance—the emerging and forecast underwriting performance in terms of the loss ratio, expense ratio, reinsurance ratio and combined ratio. These ratios were defined in section 4.6.

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100 APRA required all medical indemnity providers who intended 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 transition period. This funding plan was typically provided to APRA in mid-2003. It should be noted that due to differences in the time period specified by insurers when submitting these funding plans the financial projections period analysed by the ACCC has been limited to 2003–04 to 2006–07.

101 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 2004.

102 APRA's reporting requirements require quarterly reporting forms to be provided within four weeks of the end of the reporting period, annual reporting forms are required to be provided within three to four months. Due to these timing constraints the ACCC relied on the reporting forms provided for the June quarter 2004, while this data may be different to that provided in the annual reporting forms, the difference is not expected to be material.

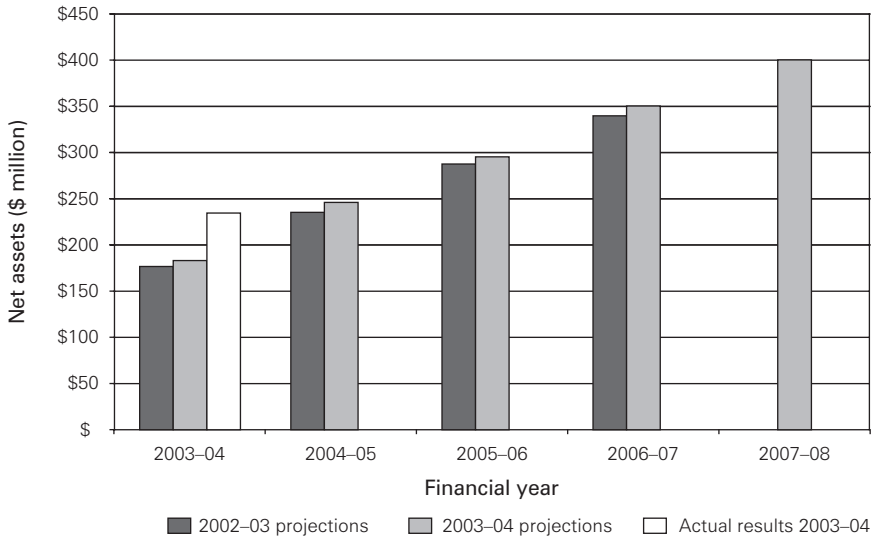
103 Solvency is a measure of whether an insurance company has sufficient assets (capital, surplus, reserves etc.) to meet all liabilities (the cost of claims and all other expenses).

6.4 Detailed analysis

6.4.1 Solvency targets

The ACCC assessed medical indemnity providers' actual solvency levels for 2003–04 and compared these against the 2002–03 and 2003–04 projections of solvency. This is shown in chart 6.1.

Chart 6.1 Net assets—2003–04 actual position and 2002–03 and 2003–04 projections



Source: Derived by the ACCC from data for all five medical indemnity insurers

As at 30 June 2004 the industry was in a strong solvency position with total assets significantly exceeding total liabilities. Further, the majority of medical indemnity providers' solvency position at 30 June 2004 was greater than anticipated in 2002–03 and 2003–04 projections.

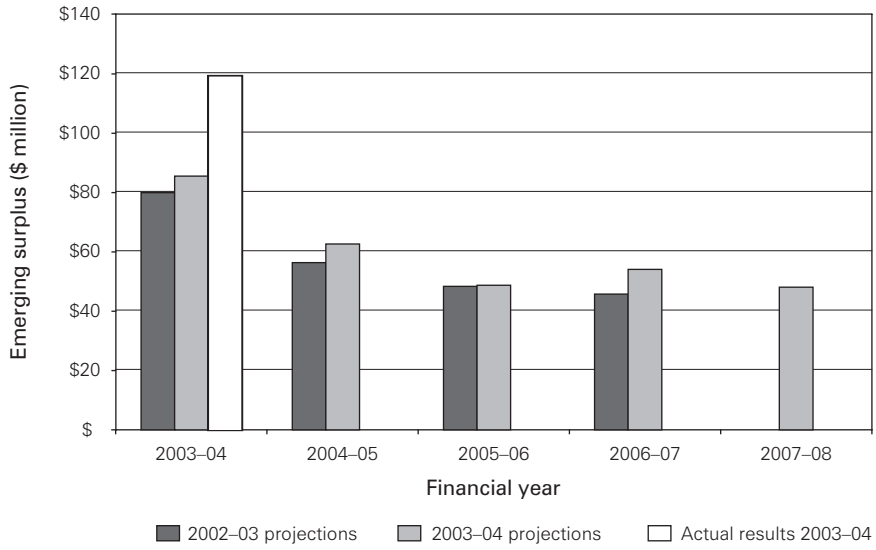
Chart 6.1 shows that the 2002–03 net asset projections for the medical indemnity industry was originally forecast to improve from $177 million to $340 million between 2003–04 and 2006–07. These forecast positions improved when subsequently revised in 2003–04 to $183 million and $351 million (increasing again in 2007–08 to $400 million).

As at 30 June 2004 the medical indemnity industry had actually reported that net assets exceeded both the 2002–03 and 2003–04 projections for 2003–04 and had attained a net asset position of $235 million, 33 per cent above 2002–03 forecasts and 28 per cent above 2003–04 forecasts.

6.4.2 Emerging surplus

The ACCC assessed the actual emerging surplus of the medical indemnity industry as at 30 June 2004 and compared this against the emerging surplus forecast in the 2002–03 and 2003–04 financial projections. This is shown in chart 6.2.

Chart 6.2 Emerging surplus—2003–04 actual position and 2002–03 and 2003–04 projections



Source: Derived by the ACCC from data for all five medical indemnity insurers

Chart 6.2 shows that based on the 2002–03 projections the level of emerging surplus was forecast to decrease from $80 million in 2003–04 to $46 million in 2006–07.[104] The 2003–04 projections raised these forecasts marginally.

However, the 2003–04 actual position showed the medical indemnity industry achieved an emerging surplus of $119 million, significantly higher than that forecast (49 per cent higher than the 2002–03 projections and 38 per cent higher than the 2003–04 projections).

The extent to which the emerging surplus for 2003–04 exceeded forecasts varied between insurers. Two insurers realised an emerging surplus lower than initially forecast.[105] As a result, both insurers received a capital injection from their parent company to assist in meeting their capital targets for the period.

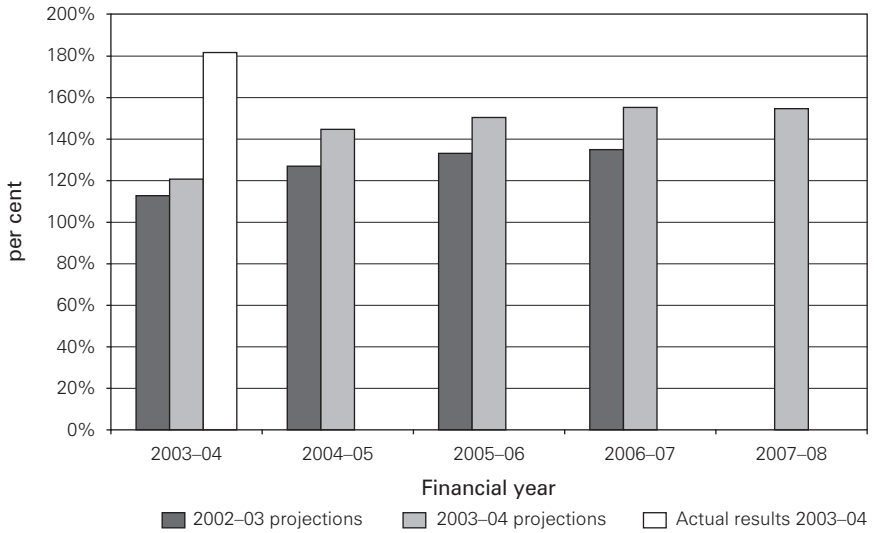
6.4.3 MCR coverage and capital targets

The ACCC assessed the actual financial position of the medical indemnity industry as at 30 June 2004 and compared this against the financial position forecast in the 2002–03 and 2003–04 financial projections. The ACCC examined the net asset to MCR ratio as an indicator of financial position, as shown in chart 6.3.

[104] As these surpluses are typically used by medical indemnity providers to build and maintain capital, the levels of emerging surplus would be expected to reduce once sufficient capital had been raised to meet insurers' targets.

[105] It should be noted that this does not mean that these insurers did not realise a surplus but rather that the surplus realised was lower than initially forecast.

Chart 6.3 Net asset to MCR ratio—2003–04 actual position and 2002–03 and 2003–04 projections



Source: Derived by the ACCC from data for all five medical indemnity insurers

Chart 6.3 shows that the 2002–03 projections forecast the medical indemnity industry to have a net asset position equal to 113 per cent of MCR in 2003–04, rising to 135 per cent by 2006–07.[106] The 2003–04 revised projections forecast net assets to equal 121 per cent of MCR in 2003–04 rising to 155 per cent in 2006–07 (and remaining at this level in 2007–08).

The actual position of the medical indemnity industry at 30 June 2004 was significantly higher than both the 2002–03 and 2003–04 projections, with net assets equal to 182 per cent of MCR.

All insurers exceeded their initial capital targets outlined to APRA in their funding plans (2002–03 projections), and all insurers exceeded or came close to meeting their revised capital targets (based on 2003–04 projections).[107]

The revised 2003–04 financial projections indicated that three insurers would continue to build their capital position further above their current net asset to MCR ratio, with the capital raised through a surplus loading built into premiums (this is discussed in detail in section 5.4.6). However, the ACCC notes that these projections were prepared before the strong results for 2003–04 became available and as such the need to continue building capital past the 2004–05 underwriting year is likely to be somewhat reduced.

Those insurers that have reached their target level of capital will need to maintain that level going forward. The ACCC notes that one insurer's 2003–04 forecasts expects an erosion of its solvency position and to maintain its desired capital adequacy two separate capital injections from the parent entity may be required in future years. While these potential capital

[106] These forecasts differ marginally to those included in the ACCC's first monitoring report due to one insurer's 2002–03 projections being adjusted to allow comparison with the 2003–04 projections and 2003–04 actual results.

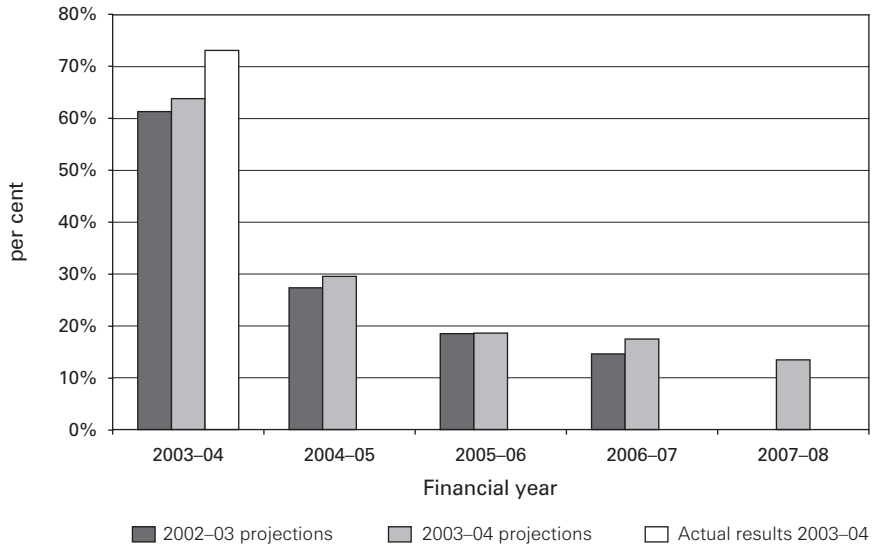
[107] As noted in section 6.4.2 this position was realised with the assistance of capital injections from parent entities for two insurers.

injections would ensure the solvency position is maintained in the short to medium term, the capital maintenance strategy of the insurer may need to be reviewed in the longer term.

6.4.4 Return on net assets

The ACCC assessed the returns of medical indemnity providers relative to the net asset position and compared these against the 2002–03 and 2003–04 forecasts. This is shown in chart 6.4.

Chart 6.4 Return on net assets—2003–04 actual position and 2002–03 and 2003–04 projections



Source: Derived by the ACCC from data for all five medical indemnity insurers

The chart shows that the 2002–03 projected return on net assets was forecast to decrease from approximately 61 per cent in 2003–04 to 15 per cent in 2006–07.[108] This forecast was marginally increased in the 2003–04 projections.

Initially insurers are raising significant surpluses to fund the capital requirements while the asset base is low. The return on net assets is projected to decrease as insurers' capital base increases. Once the capital targets are achieved the required surplus reduces leading to a reduction in the return on net assets.

The actual result for 2003–04 was higher than both projections at 73 per cent.

[108] These forecasts differ marginally to those included in the ACCC's first monitoring report due to one insurer's 2002–03 projections being adjusted to allow comparison with the 2003–04 projections and 2003–04 actual results.

6.4.5 Underwriting performance

The ACCC examined the underwriting performance in terms of the loss ratio, the expense ratio, the reinsurance ratio and the combined ratio. These terms were defined in section 4.3.4.[109]

Loss ratio

Table 6.1 shows the gross and net loss ratios based on the 2002–03 and the 2003–04 financial projections of insurers for the industry. It also shows the actual loss ratios for 2003–04.

Table 6.1 Gross and net loss ratio—2003–04 actual and 2002–03 and 2003–04 projections

	2002–03 projections		2003–04 projections		Actual results	
	Gross	Net	Gross	Net	Gross	Net
2003–04	57	55	56	51	36	35
2004–05	65	68	60	59		
2005–06	71	75	66	68		
2006–07	74	79	70	70		
2007–08			74	76		

Source: Derived by the ACCC from data for all five medical indemnity insurers

The table shows that the gross and the net loss ratios based on 2002–03 projections were forecast to rise from 57 and 55 per cent respectively in 2003–04 to 74 and 79 per cent respectively in 2006–07. The gross and net loss ratios based on 2003–04 projections were similar, rising from 56 and 51 per cent respectively to 70 per cent each respectively in 2006–07 (rising again to 74 and 76 per cent respectively in 2007–08).

The actual loss ratios for 2003–04 were significantly lower than anticipated with a gross loss ratio of 36 per cent and a net loss ratio of 35 per cent.

These results, however, were not reflected across all insurers. Some insurers had only a marginal improvement on their forecasts or no change at all. One insurers' actual loss ratio for 2003–04 was worse that originally anticipated, whereas the actual results for two insurers were significantly better than their financial projections.

It should be noted that, as outlined in section 4.6.1, one insurer has noted that the decrease in its claims expense for 2003–04 reflects a reduction in the valuation of the ultimate settlement cost of claims notified in prior years due to more favourable claims experience following recent tort law reform.

[109] The underwriting performance based on 2002–03 forecasts differs marginally to that included in the ACCC's first monitoring report due to one insurer's 2002–03 projections being adjusted to allow comparison with the 2003–04 projections and 2003–04 actual results.

Expense ratio

Table 6.2 shows the gross and net expense ratios based on the 2002–03 and the 2003–04 financial projections of insurers for the industry. It also shows the actual expense ratios for 2003–04.

Table 6.2 Gross and net expense ratio—2003–04 actual and 2002–03 and 2003–04 projections

	2002–03 projections		2003–04 projections		Actual results	
	Gross	Net	Gross	Net	Gross	Net
2003–04	15	18	18	22	19	21
2004–05	15	18	20	24		
2005–06	14	18	19	23		
2006–07	14	17	18	22		
2007–08			18	22		

Source: Derived by the ACCC from data for all five medical indemnity insurers

The table 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 2003–04 projections revised these forecasts to between 18 and 20 per cent gross, and 22 to 24 per cent net. The actual results for 2003–04 of 19 per cent gross expense ratio and 21 per cent net expense ratio were in line with the revised projections.[110]

Reinsurance ratio

Table 6.3 shows the reinsurance ratio for the industry based on the 2002–03 and the 2003–04 financial projections of insurers. It also shows the actual reinsurance ratio for 2003–04.

Table 6.3 Reinsurance ratio—2003–04 actual and 2002–03 and 2003–04 projections

	2002–03 projections	2003–04 projections	Actual results
2003–04	18	19	8
2004–05	19	18	
2005–06	19	18	
2006–07	19	16	
2007–08		18	

Source: Derived by the ACCC from data for all five medical indemnity insurers

[110] These results do not reflect the individual circumstances of all insurers. However, the majority of insurers' actual expense ratios for 2003–04 were higher than the expense ratios based on their 2002–03 and 2003–04 forecasts.

The table shows that based on 2002–03 projections the reinsurance ratio was forecast to be between 18 and 19 per cent between 2003–04 and 2006–07. The revised 2003–04 projections were not substantially different.

However, the actual reinsurance ratio for the industry for 2003–04 was significantly lower than both the 2002–03 and 2003–04 projections at 8 per cent.[111]

Combined ratio

Table 6.4 shows the gross and net combined ratios based on the 2002–03 and the 2003–04 financial projections of insurers for the industry. It also shows the actual combined ratios for 2003–04.

Table 6.4 Gross and net combined ratio—2003–04 actual and 2002–03 and 2003–04 projections

	2002–03 projections		2003–04 projections		Actual results	
	Gross	Net	Gross	Net	Gross	Net
2003–04	72	72	74	73	55	56
2004–05	80	86	80	83		
2005–06	85	93	85	91		
2006–07	88	96	88	92		
2007–08			92	98		

Source: Derived by the ACCC from data for all five medical indemnity insurers

The table shows that based on 2002–03 projections the gross and net combined ratios were forecast to increase from 72 per cent each respectively in 2003–04 to 88 and 96 per cent respectively in 2006–07. The revised 2003–04 projections did not differ substantially from the earlier projections.

The gross and net combined ratios based on 2003–04 actual results are significantly below the forecast values, that is, the financial performance of the industry was better than expected.

However, as noted above, the industry result is not representative of the experience of all insurers. While some insurers' actual results for 2003–04 showed more favourable experience than initially forecast, others showed worse experience. The source of this deterioration in experience relative to earlier projections differed between insurers—one insurer experiencing higher claims costs relative to premiums than initially forecast and another experiencing both higher claims costs and higher expenses relative to premiums.

[111] These results for the industry do not reflect the individual experience of all insurers. Some insurers' reinsurance ratios based on actual results for 2003–04 were higher than that forecast based on 2002–03 and 2003–04 projections. Other insurers achieved a reinsurance ratio equal to or close to their projections. One insurer achieved a better than forecast reinsurance ratio, however, this was due to changes in their reinsurance circumstances as opposed to achieving better reinsurance experience (see also section 4.6.3).

6.5 Conclusion

The ACCC found that, in the current market environment, premiums set by the five insurers were considered to be commercially justified.

As at 30 June 2004 all insurers reported that they were in a strong solvency position. This strong solvency position has been achieved well ahead of forecasts based on 2002–03 and 2003–04 financial projections—partially as a result of significant surpluses emerging from the 2003–04 underwriting period. This strong solvency position has meant that the capital position of all insurers is significantly above the MCR of APRA. Indeed, two insurers have indicated that they are no longer building capital in the 2004–05 underwriting year.[112]

It is noted, however, that two other insurers identified emerging surpluses lower than previously forecast. To increase their level of capital over a specified target level the parent entities injected capital in 2003–04. These capital injections were sufficient to make up for the lower than expected results as well as put both insurers in a capital position stronger than initially forecast.

The premiums written in 2004–05 are generally expected to continue to build or maintain this strong position for all insurers, which will assist in ensuring that they have the financial capacity to continue underwriting medical indemnity insurance.

[112] Based on financial projections prepared in 2003–04 the remaining three insurers indicated that they would continue to build their capital position above their current net asset to MCR ratio, with the capital raised through a surplus loading built into premiums. However, these projections may have been prepared before the strong results for 2003–04 became available and, as such, the need to continue to build capital past the 2004–05 underwriting year is likely to be somewhat reduced.

Appendixes

A. Medical indemnity reforms as at 30 June 2004

A.1 Background

In May 2002 the largest medical indemnity provider in Australia, UMP, was placed into provisional liquidation resulting in a potential lack of indemnity cover for many medical practitioners. 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 certain high-risk procedures like obstetrics.[113] In response to this crisis, the government started to introduce a framework of reforms to ensure a viable and ongoing medical indemnity insurance market.[114]

The government's long-term medical indemnity reform package has been outlined in a series of announcements. The initial package was developed throughout 2002 and announced in full on 23 October 2002. The government has subsequently announced a series of modifications as well as additional measures to the reform package. The development of the reform package from its initial form to its current state is discussed in detail below.

A.2 Government measures announced on 1 May 2002

In response to the provisional liquidation of UMP/AMIL, the government announced the UMP guarantee on 1 May 2002.[115]

A.2.1 UMP guarantee

The UMP guarantee provided temporary assistance to UMP/AMIL to allow it to continue operating. This guarantee covered the obligation of UMP/AMIL to pay any unfunded amount properly payable in respect of a claim in the period 29 April 2002 to 30 June 2002 under a current or past policy. It also covered incidents that occurred between 29 April 2002 and 30 June 2002.

A.3 Government measures announced on 31 May 2002

On 31 May 2002 the Prime Minister announced an enhancement to the UMP guarantee as well as the introduction of a new scheme to fund currently unfunded IBNRs.[116]

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113 Parliament of the Commonwealth of Australia, Medical Indemnity Bill 2002, revised explanatory memorandum, 2002, p. 4.

114 The Hon. John Howard MP, Prime Minister, 'A new medical indemnity insurance framework', 23 October 2002.

115 Senator the Hon. Kay Patterson, then Minister for Health and Ageing, 'Statement on UMP/AMIL by Senator Patterson', 1 May 2002.

116 The Hon. John Howard MP, Prime Minister, 'Medical Indemnity Insurance', 31 May 2002.

A.3.1 UMP guarantee

The government extended the UMP guarantee by six months to cover claims notified between 29 April 2002 and 31 December 2002 under an existing or renewed claims-made policy. The government's guarantee enabled the provisional liquidator of UMP/AMIL to renew policies on a claims-made basis for the period until 31 December 2002 and to continue to meet claims notified before 29 April 2002 and properly payable between 1 July 2002 and 31 December 2002.

A.3.2 IBNR scheme

The government announced the IBNR scheme as a measure to help medical indemnity providers fund their unfunded liabilities. The IBNR scheme would also fund the extension of the UMP guarantee.

The IBNR scheme would apply to liabilities that were currently unfunded and could not be adequately provided for by the medical indemnity providers. The scheme would be financed through a levy on medical practitioners that were members of the relevant medical indemnity providers, and could be paid over an extended period.

A.4 Medical indemnity reform package announced on 23 October 2002

The Prime Minister announced the new medical indemnity insurance reform package on 23 October 2002. This package included:[117]

- a further extension of the UMP guarantee
- further details of the IBNR scheme
- premium subsidies for high risk specialties
- a high cost claims scheme (HCCS)
- bringing medical indemnity insurance under the general insurance regulatory framework
- various health industry-specific measures.

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[117] The legislative framework for this package includes the:

- *Medical Indemnity Act 2002*
- *Medical Indemnity (IBNR Indemnity) Contribution Act 2002*
- *Medical Indemnity (Enhanced UMP Indemnity) Contribution Act 2002*
- *Medical Indemnity (Consequential Amendments Act) 2002*.

These Acts commenced on 1 January 2003.
The *Medical Indemnity (Financial Assistance—Binding Commonwealth Obligation) Act 2002* and *Medical Indemnity (Prudential Supervision and Product Standards) Act 2003* were subsequently added to this package and commenced on 2 December 2002 and 1 July 2003 respectively.

A.4.1 UMP guarantee

The government extended the term of the UMP guarantee by a further year until 31 December 2003. This provided the provisional liquidator with time to fully explore options for restructuring the business, and for other measures to take effect.[118] The extension of the guarantee meant that amounts payable by UMP/AMIL between 29 April 2002 to 31 December 2003 for claims notified or finalised before 29 April 2002 were covered. The UMP guarantee would also cover amounts payable in respect of claims notified in the period 29 April 2002 to 31 December 2003, whenever the claim is finalised (including after 31 December 2003).

A.4.2 IBNR scheme

The government announced further details of the IBNR scheme.[119] The IBNR scheme was designed to fund medical indemnity providers' IBNR liabilities that were unfunded as at 30 June 2002, with funding to begin in early 2003.

The scheme was to be funded by a levy on medical practitioners that was calculated according to the extent of the medical indemnity providers' unfunded IBNR liabilities. However, in any year, the amount of the levy would not be more than the levy amount paid in the first year and an exemption would apply to the estates of deceased members, members who retired before 31 December 2001 and student members as at 30 June 2000.

A.4.3 Premium subsidies

The government announced it would provide a premium subsidy to ensure practitioners undertaking high-risk specialties such as obstetricians, neurosurgeons and procedural GPs (most of whom work in rural and regional areas) could afford medical indemnity insurance.[120]

The subsidy was designed to be equal to 50 per cent of the difference between the cost of the premiums plus the IBNR levy[121] (if applicable) and the corresponding cost for gynaecologists, general surgeons and non-procedural GPs in the relevant state and territory. For neurosurgeons, in light of the particularly high costs that some face, the subsidy was to increase to 80 per cent on the part of their premium that exceeded $50 000.

A.4.4 High cost claims scheme (HCCS)

The government announced the introduction of the HCCS to lower premiums by reducing the potential cost of large claims to insurers.[122]

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118 The Hon. John Howard MP, Prime Minister, media release, 'A new medical indemnity insurance framework', 23 October 2002.

119 The IBNR scheme is contained in the *Medical Indemnity (IBNR Indemnity) Contribution Act 2002*, which commenced 1 January 2003.

120 This subsidy is contained in the *Medical Indemnity Act 2002*, which commenced 1 January 2003.

121 This levy represents the cost of the Australian Government's IBNR scheme that was to be met by contributions levied on practitioners who were members of the medical indemnity providers that held unfunded IBNR liabilities.

122 The HCCS is contained in the *Medical Indemnity Act 2002*, which commenced 1 January 2003.

Under the HCCS the government agreed to reimburse medical indemnity providers, on a per claim basis, 50 per cent of the insurance payout greater than $2 million for claims notified on or after 1 January 2003. The HCCS did not apply to those payouts related to the provision of public hospital services or that were otherwise covered by state and territory governments.

A.4.5 Medical indemnity regulatory framework

From 1 July 2003[123] medical indemnity providers were to be placed within a regulatory framework to encourage a more commercially sustainable focus in providing insurance by service providers.[124] First, medical indemnity providers were required to become 'authorised' insurers and therefore be subject to a range of prudential safeguards enforced by APRA that aim to mitigate insolvency risks. For example, medical indemnity providers must maintain capital at a level specified by APRA as part of its minimum capital requirements (MCR). For those insurers that did not have this level of funding at the outset (1 July 2003 or 1 January 2003 in the case of AMIL), transitional provisions were put into place until 30 June 2008.

Medical indemnity insurance was also required to be offered to practitioners in a contract of insurance, rather than as 'discretionary assistance', so as to facilitate prudential supervision and increased certainty.

Second, the *Medical Indemnity (Prudential Supervision and Product Standards) Act 2003* specified minimum product standards to be administered by the Australian Securities and Investment Commission (ASIC). These standards commenced on 1 July 2003 and included:

- minimum cover limits
- offers of retroactive and run-off cover for claims-made cover.[125]

Finally, authorised providers of medical indemnity cover were required to submit data to the Australian Government, including to the Health Insurance Commission (HIC) and APRA.

A.4.6 Various industry-specific measures

The government also outlined its support for additional industry measures that focused on quality and safety improvement for doctors, such as improving clinical risk management, reducing adverse events and improving patient safety. These measures intended to benefit the provision of health services and were expected to have flow-on effects to medical indemnity insurance in the long-term.[126]

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123 AMIL (the authorised insurer of UMP) was fully regulated by APRA from 1 January 2003.

124 The placement of medical indemnity providers under a regulatory framework is outlined in the *Medical Indemnity (Prudential Supervision and Product Standards) Act 2003*, which commenced 1 July 2003.

125 Offers for run-off cover and retroactive cover must comply with the requirements set out in s. 24 of the *Medical Indemnity (Prudential Supervision and Product Standards) Act 2003*, including the requirement that the premium to be paid on the policy is reasonable.

126 An example is the National Open Disclosure Standard developed by the Australian Council for Safety and Quality in Health Care. This standard aims to encourage greater openness with regards to adverse events, to ensure that action is taken to uncover the causes of the event, and to put in place systems to prevent similar events from occurring again.

A.5 Government measures announced on 19 March 2003

The government announced further details of its reform package on 19 March 2003, including adjustments to premium subsidies and reforms to the way retirement cover is to be offered.[127]

A.5.1 Premium subsidies

To preserve obstetrician services in rural and regional areas, the government announced that it would increase the financial support provided to these obstetricians. The premium subsidy increased from 50 per cent to 80 per cent of the difference between the cost of premiums plus the contribution to the IBNR Scheme (if applicable) and the corresponding cost for gynaecologists in the same income band in the relevant state or territory.[128]

A.5.2 Retirement cover

Some medical practitioners had expressed concerns about the availability and affordability of retirement cover and their ability to continue to 'pre-fund' the cover during their working life. In response, the government announced details of minimum interim retirement cover requirements whereby medical indemnity providers must offer retirement cover to medical practitioners ceasing practice in 2003–04.[129] Medical indemnity providers must also offer retirement cover (on the same terms and conditions) on an annual renewable basis for at least six years from 2003–04.

Regarding medium to longer term retirement cover arrangements, the government indicated that it wanted to ensure that medical practitioners have access to arrangements where they do not have to pay material premiums after they retire. Therefore in consultation with medical indemnity providers and the medical profession, the government announced it would examine various options, including continued market provision underpinned by minimum retirement cover standards and a government guaranteed statutory retirement cover scheme funded by medical practitioners.

A.6 Government measures announced on 23 May 2003

On 23 May 2003 the Prime Minister announced the exceptional claims scheme (referred to as the blue sky scheme), which aimed to allow medical practitioners to continue to practise with increased certainty about claims costs above their medical indemnity insurance cover limit.[130]

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127 The Hon. John Howard MP, Prime Minister, 'A new medical indemnity insurance framework: further measures', 19 March 2003.

128 This premium subsidy is contained in the *Medical Indemnity Subsidy Scheme 2003*, which commenced 20 June 2003 and applied to indemnity payments made on or after 1 January 2003.

129 These minimum requirements are contained in the Medical Indemnity (Prudential Supervision & Product Standards) Amendment Regulations 2003 (No.1), which commenced 1 July 2003.

130 The Hon. John Howard MP, Prime Minister, 'Medical indemnity: certainty for doctors', 23 May 2003.

A.6.1 Exceptional claims scheme

After the introduction of medical indemnity insurance contracts that capped the insurer's contractual liability, medical practitioners expressed concern that their personal financial assets could be potentially exposed to large awards and settlements in excess of the contract limit. This issue is commonly referred to as the 'blue sky' issue.

In response, the government announced its plans to implement the exceptional claims scheme. This scheme would assume liability for 100 per cent of any damages payable against a medical practitioner that exceeded a specified level of cover provided by that medical practitioner's medical indemnity provider. The specified level of cover was $20 million for claims notified under medical indemnity insurance contracts from 1 July 2003.[131]

The exceptional claims scheme would be funded by an ex-post charge imposed on the medical indemnity provider who insured the medical practitioner against whom the damages are payable. The government would review the scheme after three years to determine whether it remains necessary given state and territory tort reform and claims trends.

A.7 Government measures announced on 3 October 2003

A.7.1 IBNR scheme

In response to medical practitioners' concerns over the impact of the IBNR levy, the government met with industry representatives on 3 October 2003.[132] The government subsequently agreed to an 18-month moratorium on IBNR levy payments above $1000 per year, to be in place until 31 December 2004.[133]

A.8 Government measures announced on 10 October 2003

On 10 October 2003, after further discussions with the Australian Medical Association (AMA), the Minister for Health and Ageing, the Hon. Tony Abbott MP, announced enhancements to the medical indemnity insurance reform package.[134] These enhancements included changes to the HCCS and IBNR scheme. Further details of the exceptional claims scheme (the blue sky scheme) were also announced.

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131 To account for UMP members who were covered by contracts with a $15 million limit for claims notified from 1 January 2003 to 30 June 2003, the threshold for this period was $15 million.

132 The Hon. Tony Abbott MP, Minister for Health and Ageing, 'Statement at Royal Prince Alfred Hospital', 3 October 2003.

133 Those doctors who had already paid a levy in excess of $1000 a year were to receive a refund and new levy notices would be issued once the medical indemnity policy review had taken place.

134 The Hon. Tony Abbott MP, Minister for Health and Ageing, 'New medical indemnity arrangements', 10 October 2003.

A.8.1 High cost claims scheme (HCCS)

The government agreed to reimburse medical indemnity providers, on a per claim basis, 50 per cent of claims above a $500 000 threshold up to a medical practitioner's limit of insurance.[135] This new threshold applied to all claims notified on or after 22 October 2003.

A.8.2 IBNR scheme

The government announced that the following would be exempt from the IBNR levy:

- medical practitioners employed by public hospitals or where their private medical income is returned to those hospitals
- medical practitioners aged 65 and over, regardless of practice income
- medical practitioners who need to retire early because of disability or permanent injury
- medical practitioners and their estates with an IBNR levy liability due in the year of their death.

These exemptions commenced from 15 August 2003.[136]

A.8.3 Exceptional claims scheme

In the process of implementing the exceptional claims scheme, the government undertook to treat claims under the exceptional claims scheme on a claims-incurred rather than a claims-made basis.[137] By treating claims on a claims-incurred basis, the scheme would apply to all incidents that occurred during the operation of the scheme. The scheme became effective from 5 December 2003.[138]

A.9 Government measures announced on 16 October 2003

A.9.1 Medical indemnity policy review

On 16 October 2003 the government announced a review into the medical indemnity insurance reform process to be undertaken by the Medical Indemnity Policy Review Panel. The panel was to report to the Prime Minister by 10 December 2003 on ways to ensure that medical indemnity arrangements in Australia:

- are financially sustainable, transparent and comprehensible to all parties
- provide affordable, comprehensive and secure cover for all medical practitioners

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135 The new HCCS limit is contained in the Medical Indemnity Amendment Regulations 2003 (No. 2), schedule 2 which commenced 22 October 2003.

136 The changes to the IBNR scheme are contained in the Medical Indemnity Amendment Regulations 2003 (No. 1), schedule 1, commenced 15 August 2003.

137 The Hon. Tony Abbott MP, Minister for Health and Ageing, 'New medical indemnity arrangements', 10 October 2003.

138 The exceptional claims scheme is contained in the *Medical Indemnity Amendment Act 2003*, schedule 2 which commenced 5 December 2003.

- enable Australia's medical workforce to provide care and continue to practice to its full potential
- safeguard the interests of the consumers and the community.[139]

The panel was directed by the government to consider a number of specific issues, including:

- the impact of current and proposed reforms and measures
- barriers that make it difficult for medical practitioners to provide certain and confident treatment
- overseas experience in medical indemnity insurance
- the IBNR levy and its application.

The government appointed a panel that consisted of six non-government members including a lawyer experienced in insurance issues, a financial expert and four doctors. The Hon. Tony Abbott MP, Minister for Health and Ageing, chaired the panel which was assisted by a secretariat drawn from the government taskforce on medical indemnity insurance.[140]

A.10 Government measures announced on 17 December 2003

The Medical Indemnity Policy Review Panel provided its recommendations to the government on 10 December 2003.[141] On 17 December 2003 the government announced that it would adopt the recommendations outlined below.

A.10.1 High cost claims scheme (HCCS)

On the panel's recommendation, the government extended the HCCS to cover 50 per cent of all claims above a $300 000 threshold up to a medical practitioner's limit of insurance. These regulations applied to claims notified on or after 1 January 2004.[142]

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139 The Hon. Tony Abbott MP, Minister for Health and Ageing, 'The new medical indemnity policy review panel', 16 October 2003.

140 The panel consisted of the following members: The Hon. Tony Abbott MP, Minister for Health and Ageing, Senator the Hon. Helen Coonan, then Minister for Revenue and Assistant Treasurer, Dr Bill Glasson, Federal President of the AMA, Dr Andrew Pesce, Chairman of the AMA's medical indemnity taskforce, Associate Professor Don Sheldon, Chairman of the Council of Procedural Specialists, Nancy Milne, Partner Clayton Utz, Dr Susan Page, President of the Rural Doctors' Association of NSW and John Phillips, former Deputy Governor of the Reserve Bank of Australia.

141 Medical Indemnity Policy Review Panel, *Affordable, Secure and Fair—Report to the Prime Minister*, 10 December 2003.

142 Changes to the HCCS are contained in the Medical Indemnity Amendment Regulations 2004 (No. 1), schedule 1 which commenced 1 January 2004.

A.10.2 Premium subsidies

The panel recommended that a new medical indemnity premium support scheme be introduced to assist eligible medical practitioners with the cost of their medical indemnity insurance. The scheme would:

- replace the premium subsidy introduced on 23 October 2003[143]
- assist medical practitioners who pay more in total medical indemnity costs than a determined affordability threshold or thresholds
- ensure that no medical practitioners currently receiving a subsidy receive less support under the new arrangements
- provide automatic support to medical practitioners without any application process, with the government support shown separately on premium notices.[144]

On 15 June 2004 the Hon. Tony Abbott MP, Minister for Health and Ageing formulated the *Premium Support Scheme 2004*[145] (PSS) in line with these recommendations. The PSS would apply to the following:

- medical practitioners with gross indemnity costs that 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)
- medical practitioners who have applied for and have been deemed to be eligible for the initial premium subsidy (the subsidy is calculated as the difference between the old subsidy and the new subsidy)
- special category members[146] (the subsidy the higher of the subsidies under either the MISS or PSS).

A.10.3 UMP support payment (formerly the IBNR scheme)[147]

The IBNR levy was described by the panel as a major concern for medical practitioners in concept and in form. Many medical practitioners argued that it was unfair for the government to expect present patients and medical practitioners to continue to make payments to compensate for past under-funding.[148] For these reasons, the government accepted the panel's recommendation to introduce the UMP support payment to replace the IBNR contribution payment.

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143 The initial premium subsidy only applied to neurosurgeons, obstetricians, procedural GPs and GP registrars undertaking procedural training.

144 Medical Indemnity Policy Review Panel, *Affordable, Secure And Fair—Report to the Prime Minister,* 10 December 2003, p. 19.

145 This scheme was enacted under s. 43(1) of the *Medical Indemnity Act 2002* which commenced 17 June 2004.

146 A special category member is a member who either:
- no longer practices as a doctor
- no longer derives a private medical income from practicing as a doctor
- practices 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).

In addition to this, a special category member is one who 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.

147 UMP was the only medical indemnity provider to participate fully in the scheme.

148 Medical Indemnity Policy Review Panel, *Affordable, Secure And Fair—Report to the Prime Minister*, 10 December 2003.

The new arrangements for the UMP support payment[149] provide that:

- the length of time a medical practitioner has to make payments is linked to the period the medical practitioner belonged to UMP before 30 June 2000
- no medical practitioner will make a payment after the 2008–09 financial year
- medical practitioners who earn less than $5000 in any year will not make a contribution in the following year.

The UMP support payment is calculated as the lesser of a medical practitioner's initial IBNR levy, two per cent of a medical practitioner's gross income from medical practice, or $5000. The government also decided to retain the 18-month moratorium on IBNR levy payments over $1000. Therefore if a medical practitioner's annual contribution for 2003–04 would have been over $1000 the medical practitioner is only required to pay $1000 so that the maximum annual contribution for 2003–04 would be capped at $1000.

Finally, medical practitioners can pay their UMP support payment through their medical indemnity provider, therefore incorporating the cost as part of the premium subsidy scheme.

A.10.4 Further work

The panel also suggested that a working party be developed in 2005 to evaluate the effectiveness of these new arrangements.

A.11 Government measures announced on 13 May 2004

On 13 May 2004 the government announced further details on retirement cover, as well as changes to the HCCS and exceptional claims scheme.

A.11.1Retirement cover

In response to the medical indemnity policy review panel's recommendation for a run–off reinsurance vehicle, the government introduced the run-off cover scheme (ROCS) on 13 May 2004 to come into effect from 1 July 2004.[150]

ROCS is intended to provide secure insurance cover for the following:

- medical practitioners aged 65 or more who are permanently retired
- medical practitioners aged 65 or more who retire early due to disabilities
- medical practitioners on maternity leave
- medical practitioners who have permanently left the workforce for three years or more

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149 These are contained in the *Medical Indemnity (IBNR Indemnity) Contribution Amendment Act 2004* which commenced 24 March 2004 and Medical Indemnity Amendment Regs 2004 (No. 2) which commenced 1 July 2004.

150 This scheme is contained in the *Medical Indemnity Legislation Amendment (Run-off Cover Indemnity and Other Measures) Act 2004* the majority of which commenced 1 July 2004 and the *Medical Indemnity (Run-off Cover Support Payment) Act 2004* which commenced 1 July 2004.

- medical practitioners who are deceased, provided that a claim can still be made against the medical practitioner's estate
- medical practitioners who are in another group determined by regulation to be eligible.[151]

Under ROCS, medical practitioners are guaranteed medical indemnity insurance without having to pay insurance premiums after retirement. The cost of the scheme will be funded by a ROCS support payment paid by medical indemnity providers. This payment will be 8.5 per cent of medical indemnity providers' premium income for a 12-month period, except for AMIL where it will be 9.5625 per cent.[152] The scheme will also assume the estimated $40 million cost of liabilities arising from claims that have not yet been notified for an estimated 10 000 medical practitioners who have already retired.[153]

A.11.2 High cost claims scheme (HCCS)

The government also announced changes to the HCCS. In particular, an amendment was made to the circumstances in which a high cost claim would be payable under the scheme. Originally, a medical indemnity provider must have become aware of the claim against the practitioner for it to qualify as a high cost claim.[154] Since the amendment,[155] this requirement has now been broadened so that the medical indemnity provider must become aware of the claim or the incident that led to the claim, even though there may be no formal demand for compensation. The amendment has made the HCCS consistent with the policies offered by medical indemnity providers, and acknowledges that the government will contribute to all high cost claims incidents notified under the scheme before its termination.

A.11.3 Exceptional claims scheme

The government also legislated to improve access to the exceptional claims scheme,[156] which was broadened to provide cover for Australian medical practitioners accompanying Australian sport teams and cultural groups travelling overseas.

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151 *Medical Indemnity Legislation Amendment (Run-off Cover Indemnity and Other Measures) Act 2004*, the majority commenced 1 July 2004.

152 AMIL is charged an additional 1.0625 per cent to make up the shortfall in funding that would otherwise result from AMIL not making a contribution for the period 1 July to 31 December 2004 because it operates on a calendar year basis.

153 The Hon. Tony Abbott MP, Minister for Health and Ageing, 'Final element of medical indemnity legislation', 18 June 2004.

154 *Medical Indemnity Legislation Amendment (Run-off Cover Indemnity and Other Measures) Act 2004*, s. 30(1)(d).

155 These amendments received royal assent on 23 June 2004.

156 The changes to the exceptional claims scheme are contained in the Medical Indemnity Amendment Regulations 2004 (No. 2) which commenced 5 December 2003.

B. Tort reforms as at 30 June 2004

B.1 Introduction

This appendix outlines the tort reforms relating to medical indemnity that the Commonwealth, state and territory governments have introduced up to 30 June 2004.

B.2 Initiatives announced by governments that were introduced as at 30 June 2004

B.2.1 Australian Government

The *Taxation Laws Amendment (Structured Settlements and Structured Orders) Act 2002* was introduced into Commonwealth Parliament on 6 June 2002, and commenced upon royal assent on 19 December 2002. It amended the *Income Tax Assessment Act 1997*, the *Income Tax Assessment Act 1936*, the *Income Tax (Transitional Provisions) Act 1997* and the *Life Insurance Act 1995*. The amendments provide an income tax exemption for annuities and certain deferred lump sums paid under structured settlements to seriously injured people.

The Trade Practices Amendment (Personal Injuries and Death) Bill 2003 was introduced into Parliament on 27 March 2003. The Bill is intended to prevent individuals or the ACCC from bringing actions for damages for personal injuries or death resulting from contraventions of Division 1 of Part V of the *Trade Practices Act 1974*. The Bill passed the House of Representatives on 25 June 2003 and was amended by the Senate before being passed on 1 December 2003. The House of Representatives subsequently did not accept the Senate amendments on 2 December 2003. The Senate in turn has insisted on these amendments in a message to the House on 11 February 2004. As at 30 June 2004, the Bill was yet to be finalised and had not passed the Senate.

The *Trade Practices Amendment (Personal Injuries and Death) Act (No. 2) 2004* was introduced into Parliament on 19 February 2004, and commenced on royal assent on 13 July 2004. This Act seeks to amend Commonwealth legislation in an attempt to ensure that a nationally consistent approach is taken so that limitation periods and caps on damages arising from personal injury or death apply consistently across Australia.

This Act:

- sets a general limitation period of three years since the date of discoverability for personal injury claims
- establishes exceptions to this general rule including death or injury from smoking or other tobacco products and a long-stop period of 12 years after the act or omission that caused the death or injury
- caps the maximum amount of damages for non-economic loss at $250 000 (indexed to CPI)
- provides that the maximum amount of damages for non-economic loss is only to be awarded in a most extreme case

  enables the court to refer to earlier decisions of the court or other courts to establish an appropriate award

- limits personal injury damages for gratuitous attendant care services
- limits the amount of damages for economic loss due to the loss of employer superannuation contributions
- determines when interest on damages is payable
- does not award exemplary or punitive damages for personal injury claims.

These amendments apply to contraventions of Part IVA, Division 1A or 2A of Part V, or Part VA of the *Trade Practices Act 1974* that occur after this Act commences.

B.2.2 New South Wales

The *Health Care Liability Act 2001* was introduced into NSW Parliament on 19 June 2001, and commenced on royal assent on 5 July 2001. Part 3 commenced on 1 January 2002.[157] This act in its current form provides that a person will not be able to practise as a medical practitioner unless the person is covered by approved medical indemnity insurance.

The *Civil Liability Act 2002* was introduced into NSW Parliament on 28 May 2002, received royal assent 18 June 2002 and has been in force retrospectively since 20 March 2002.

This Act:

- caps the maximum amount of damages for non-economic loss at $350 000 (indexed to AWE)
- establishes a 15 per cent threshold of impairment for damages for non-economic loss according to a sliding scale
- caps the maximum amount of loss for damages for economic loss at three times the rate of AWE
- does not award exemplary or punitive damages for personal injury claims
- limits recovery for gratuitous attendant care
- requires the claimant to prove realistic future earnings
- applies a discount rate of five per cent or as per regulations
- does not award interest on damages for non-economic loss or gratuitous attendant care services
- allows damages claims under the *Compensation to Relatives Act 1987* to be reduced to incorporate contributory negligence of the deceased person
- limits legal cost claims to the greater of $10 000 or 20 per cent of damages less than $100 000
- imposes new requirements on lawyers and penalties that apply to unmeritorious claims and defences
- provides for costs to be awarded on an indemnity basis if incurred after a failure to accept an offer of compromise.

157 The following provisions have since been repealed: Part 2 Divisions 1– 4 sections 5–18, Part 4 sections 26 and 27, section 28, section 35, Schedule 1. The provisions that have been repealed are now generally covered by similar provisions in the *Civil Liability Act 2002* and the *Civil Liability Amendment (Personal Responsibility) Act 2002*.

The *Civil Liability Amendment (Personal Responsibility) Act 2002* was introduced into NSW Parliament on 23 October 2002 and received royal assent on 28 November 2002. The Act commenced on 6 December 2002 with the exception of parts of schedules 1[1], 1[4] and 1[5]. Schedules 1[1] and 1[4] commenced on 10 January 2003 and the remaining amendments not in force as at 10 November 2004 are the proportionate liability provisions.

This Act:

- allows waivers and voluntary assumption of risk
- provides a defense against civil liability for professionals so that a professional does not breach a duty arising from providing professional service if it is established that a professional acted in a way that is widely accepted by peer professional opinion
- excludes civil liability for failure to take reasonable care in respect of a risk, or to warn of a risk, that a reasonable person would consider to be an inherent obvious risk
- excludes volunteers and 'good Samaritans' acting in good faith from civil liability
- provides for structured settlements
- ensures that an apology does not amount to an admission of liability
- limits claims for nervous shock
- limits damages for injuries suffered by a person while intoxicated
- limits liability for injury or death or damage to property resulting from self-defence or arising from criminal conduct
- sets new limitation periods for personal injury cases.

B.2.3 Queensland

The *Personal Injuries Proceedings Act 2002* was introduced into the Queensland Parliament on 30 June 2002, received royal assent on 20 June 2002 and commenced retrospectively from 18 June 2002.

This Act:

- prescribes procedures for quick resolution for personal injury claims
- provides a requirement for the mandatory early notification of claims following an injury or the appearance of symptoms
- requires exchange of information such as medical reports to facilitate early settlement and avoid costly litigation
- sets out restrictions on legal advertising including the prohibition of 'no win no fee' advertising
- limits the amount of legal costs that can be awarded in specified circumstances with no legal costs to be paid for claims under $30 000 and legal costs of $2500 for claims between $30 000 and $50 000
- ensures that an apology does not amount to an admission of liability
- limits compensation for economic loss to three times the rate of AWE
- excludes jury trials in personal injury claims

- provides that courts cannot award exemplary, punitive or aggravated damages for personal injury claims
- provides for structured settlements
- excludes volunteers and 'good Samaritans' acting in good faith from civil liability.

The *Personal Injuries Proceedings Amendment Act 2002* was introduced into Parliament on 30 July 2002 and commenced on royal assent on 29 August 2002. Sections 4 and 8 of this Act commenced on 18 June 2002. This Act provides transitional provisions for the *Personal Injuries Proceedings Act 2002*.

The *Civil Liability Act 2003* was introduced into the Queensland Parliament on 11 March 2003 and received royal assent on 9 April 2003. The Act commenced in three separate stages. On 9 April 2003 parts of chapter 2, chapter 3, chapter 4 and chapter 6 commenced.[158] Chapter 2 part 2 deals with proportional liability and has not commenced however it will commence automatically on 10 April 2005. The remaining provisions of the Act commenced retrospectively on 2 December 2002.

This Act:

- caps the maximum amount of damages for non-economic loss at $250 000
- caps the maximum amount of damages for economic loss at three times the rate of AWE
- provides for structured settlements
- does not award interest on damages for non-economic loss
- does not award exemplary, punitive or aggravated damages for personal injury claims
- provides for contributory negligence and enables the court to reduce damages up to 100 per cent
- provides a defense against civil liability for professionals so that a professional does not breach a duty arising from providing professional service if it is established that a professional acted in a way that is widely accepted by peer professional opinion
- excludes volunteers and 'good Samaritans' acting in good faith from civil liability
- ensures that an apology does not amount to an admission of liability
- excludes civil liability for failure to take reasonable care in respect of a risk, or to warn of a risk, that a reasonable person would consider to be an inherent obvious risk
- imposes limits on the time period for medical practitioners to be notified of potential claims
- requires written notice to be given for medical negligence claims for personal injury within one month of first consulting a lawyer and nine months of discovering the symptoms.

[158] The following commenced: ss. 1, 2, ch. 2 pt 1 div. 7, pt 3 div. 2, pt 4, ch.3 pts 2, 4, ss. 53–54 and 56–60, ch. 4 pts 1–2, ch. 5, ch. 6 sch. 1.

B.2.4 Victoria

The *Wrongs and Other Acts (Public Liability Insurance Reform) Act 2002* was introduced into the Victorian Parliament on 12 September 2002, received royal assent on 22 October 2002 and commenced on 23 October 2002. The structured settlement provisions in s. 8 commenced on 14 February 2003 and the volunteer protection provisions in s. 11 commenced on 15 March 2003. The amendments to the *Goods Act 1958* in Part V commenced on 1 May 2003.

This Act:

- caps the maximum amount of damages for non-economic loss at $371 380 (indexed to CPI)
- caps the maximum amount of damages for economic loss at three times the rate of AWE
- sets a discount rate of five per cent with adjustments from time to time to reflect actual real investment returns
- provides for structured settlements
- allows people who are involved in risky activities to waive their right to sue
- requires the court to consider whether a plaintiff may have been affected by alcohol, drugs, or was engaged in a criminal activity when determining a breach of the duty of care
- excludes volunteers and 'good Samaritans' acting in good faith from civil liability
- ensures that an apology does not amount to an admission of liability
- allows for the appointment of a special Insurance Commissioner to the Essential Services Commission, responsible for collecting insurance data to ensure transparency and fairness in pricing premiums.

The *Limitation of Actions Amendment Act 2002* was introduced to Victorian Parliament on 16 October 2002, and commenced on 5 November 2002. It amends the *Limitations of Actions Act 1958* to reduce further the period within which certain actions for damages for personal injuries can be brought from six to three years after injury except for adult disabilities, which remains at six years, except for minors.

The *Wrongs and Limitation of Actions Acts (Insurance Reform) Act 2003* was introduced to Victorian Parliament on 20 May 2003, received royal assent on 16 June 2003 and commenced on 21 May 2003. Sections 3, 17 and 18 have not commenced as at 10 November 2004. The Act amends the *Wrongs Act 1958, Limitations of Actions Act 1958, Building Act 1993*, and the *Accident Compensation Act 1985*.

This Act:

- establishes a 5 per cent threshold of impairment for damages for non-economic loss
- establishes a 10 per cent threshold for psychiatric impairment
- exempts certain circumstances from the thresholds such as loss of a foetus during pregnancy, loss of a breast, or a claim where the fault is intentional and there is intent to cause death, injury, sexual assault or misconduct
- limits recovery of damages for gratuitous attendant care services unless the court is satisfied with a number of requirements

- reduces the statute of limitations from six years to three years for adults from the date that the injury is discovered
- prevents legal action from being taken if the event which caused the injury was over 12 years ago.

B.2.5 South Australia

The *Statutes Amendment (Structured Settlements) Act 2002* was introduced into the South Australian Parliament on 14 August 2002 and commenced on 1 December 2002. This Act amends the Magistrate's District and Supreme Court Acts and permits the use of structured settlement schemes for damages awarded for personal injury.

The *Recreational Services (Limitation of Liability) Act 2002* was introduced on 5 September 2002, received royal assent on 12 September 2002, and commenced on 1 July 2003. It allows for duty of care to be modified by a registered code for providers of high-risk recreational activities. It also provides that after two years the South Australian Economics and Finance Committee must investigate and report to the Parliament on how the Act affects the availability and cost of insurance for providers of recreational services.

The *Wrongs (Liability and Damages for Personal Injury) Amendment Act 2002* was introduced on 14 August 2002, received royal assent on 28 November 2002 and commenced on 1 December 2002.

This Act:

- caps the maximum amount of damages for pain and suffering at $241 500 (indexed to CPI)
- establishes thresholds of seven days impairment or $2750 in medical expenses for damages for non-economic loss and uses a regulated scale of damages related to the severity of injury
- caps the maximum amount of damages for economic loss at $2.2 million
- limits damages for injuries suffered by a person while intoxicated
- excludes awards of damages for injuries suffered by a person engaged in a criminal activity
- excludes volunteers and 'good Samaritans' acting in good faith from civil liability
- ensures that an apology does not amount to an admission of liability.

The *Law Reform (Ipp Recommendations) Act 2003* was introduced to South Australian Parliament on 2 April 2003, received royal assent on 8 April 2004, and commenced on 1 May 2004. It amends the *Wrongs Act 1936*, the *Limitation of Actions Act 1936* and the *Motor Vehicles Act 1959*. In particular, it changes the name of the *Wrongs Act 1936* to the *Civil Liability Act 2003* and incorporates recommendations of the Ipp Review on the law of negligence.

This Act:

- provides general principles for the standard of care
- provides general principles regarding causation
- outlines precautions against risk

- provides the duty of care for mental harm
- excludes the duty to warn another of an obvious risk
- sets the standard of care for professionals and those professing to have a particular skill
- excludes awards of damages for injuries suffered by a person engaged in a criminal activity[159]
- sets the standard of contributory negligence
- establishes a presumption of contributory negligence where the injured person is intoxicated
- excludes volunteers and 'good Samaritans' acting in good faith from civil liability
- prescribes a method to assess damages for non-economic loss in terms of a scale value
- outlines the circumstances when damages for mental harm may be awarded
- excludes interest on damages compensating non-economic or future loss
- excludes damages in respect of gratuitous services
- provides for a lump sum compensation for damages for loss of future earnings or other future losses
- provides a defense against civil liability for a professional so that a professional does not breach a duty arising from providing professional service if it is established that a professional acted in a way that is widely accepted by peer professional opinion.

B.2.6 Western Australia

The *Civil Liability Act 2002* was introduced by the Western Australian Government into Parliament on 14 August 2002, received royal assent on 20 November 2002 and commenced on 1 January 2003.

This Act:

- caps the maximum amount of damages for economic loss at three times the rate of AWE
- sets a threshold for damages for non-economic loss of $12 000
- sets a threshold of $5000 and a cap on damages for gratuitous care (indexed to AWE)
- sets out restrictions on advertising by lawyers of personal injury services
- provides for structured settlements.

The *Volunteers (Protection from Liability) Act 2002* was introduced on 19 June 2002 and commenced upon royal assent on 1 January 2003. It protects volunteers from incurring civil liability when doing voluntary community work. It also provides that community organisations that organise the volunteers' work may incur the civil liability from which volunteers are protected when doing that work.

[159] This replaces previous amendments contained in the *Wrongs (Liability and Damages for Personal Injury) Amendment Act 2002)*.

The *Civil Liability Amendment Act 2003* was introduced to Western Australian Parliament on 20 March 2003 and received royal assent on 30 October 2003. It commenced on 1 December 2003 except for ss. 9 and 14 that relate to proportionate liability. It amends the *Civil Liability Act 2002* and makes a consequential amendment to the *Law Reform (Contributory Negligence and Tortfeasors' Contribution) Act 1947*.

This Act:

- provides general principles for liability for harm caused by the fault of a person
- provides general principles for causation
- provides no liability for recreational activity where there is a risk warning
- allows a waiver of contractual duty of care for recreational activities
- sets the standard of contributory negligence
- establishes a presumption of contributory negligence if a person was intoxicated at the time of injury
- provides that an injured person is presumed to be aware of obvious risk
- excludes a duty of care to warn another person of an obvious risk
- does not exclude liability in connection with a duty to warn of a risk
- sets the standard of care for mental harm
- excludes pecuniary damages for consequential mental harm
- excludes 'good Samaritans' acting in good faith from civil liability
- ensures that an apology does not amount to an admission of liability.

The *Law Reform (Contributory Negligence and Tortfeasors' Contribution) Amendment Act 2003* was introduced into Western Australian Parliament and commenced on royal assent on 17 April 2003. This Act amends the *Law Reform (Contributory Negligence and Tortfeasors' Contribution) Act 1947* and makes changes to reference to claims founded on negligence. It also provides transitional provisions.

The *Civil Liability Amendment Act 2004* commenced on royal assent on 9 November 2004. Part 3 comes into operation immediately after the *Civil Liability Amendment Act 2003*, s. 9 comes into operation. The *Civil Liability Amendment Act 2004* amends the *Civil Liability Act 2002*.

This Act:

- establishes the standard of care for health professionals
- provides a defense against civil liability for professionals so that a professional does not breach a duty arising from providing professional service if it is established that a professional acted in a way that is widely accepted by peer professional opinion.

The *Limitation Bill 2004* was introduced into Western Australian Parliament on 20 October 2004 and at 10 November 2004 is at the second reading stage in the Legislative Council. This Bill changes the common law test in relation to when a cause of action accrues for damages relating to personal injury. Under the current law, a cause of action for a personal injury claim accrues when the injury or disease occurs. However, this Bill would create a new test and a claim would accrue when the person becomes aware that he or she has sustained a not insignificant personal injury or when the first manifestation consistent with the person having sustained a not insignificant personal injury occurs.

This Bill also provides:

- that limitation periods provided for under this Bill apply only to causes of action that accrue on or after the commencement day
- a different limitation period for different causes of action such as asbestos-related disease and the publication of defamatory matter
- a limitation period of six years from injuries sustained in the course of childbirth after the commencement of this Bill
- a default limitation period of six years.

The Limitation Legislation Amendment and Repeal Bill 2004 was introduced at the same time as the Limitation Bill 2004 and makes consequential amendments to this Bill. It also repeals the *Limitation Act 1935* but saves that Act in respect of causes of action which accrued before the commencement day. This Bill is also at the second reading stage in the Legislative Council as at 10 November 2004.

B.2.7 Tasmania

The *Civil Liability Act 2002* was introduced into Tasmanian Parliament on 1 October 2002, received royal assent on 19 December 2002, and commenced on 1 January 2003.

This Act:

- provides that there is a presumption of contributory negligence where the injured person is intoxicated
- excludes awards of damages for injuries suffered by a person engaged in a criminal activity
- ensures that an apology does not amount to an admission of liability
- provides for structured settlements.

The *Civil Liability Amendment Act 2003* implemented recommendations from the Ipp Review. This Act amended the *Civil Liability Act 2002* and the amendments commenced on royal assent on 4 July 2003.

This Act:

- provides general principles for the standard of care
- provides general principles for causation
- excludes the duty to warn another of an obvious risk
- specifies a proactive and reactive duty of a registered medical practitioner to warn of risk
- sets the standard of care for professionals and those professing to have a particular skill
- provides a defense against civil liability for professionals so that a professional does not breach a duty arising from providing professional service if it is established that a professional acted in a way that is widely accepted by peer professional opinion
- sets the standard of contributory negligence for apportioning liability
- makes damages available for loss of future superannuation entitlements

- caps the maximum amount of damages for future economic loss at 4.25 the rate of AWE
- sets a threshold for damages for non-economic loss of $4000 (indexed to CPI)
- provides a formula that applies if the amount of damages for non-economic loss is between $4000 and $20 000 (indexed to CPI)
- allows damages to be awarded for mental or nervous shock
- permits the court to refer to previous court decisions when determining the amount of damages to be awarded for non-economic loss
- provides limitations on damages recoverable for pure mental harm arising from shock
- sets the standard of duty of care for mental harm
- provides the general principles of duty of care for public authorities
- excludes volunteers and 'good Samaritans' acting in good faith from civil liability.

The *Civil Liability Amendment Act 2004* was introduced into Tasmanian Parliament on 7 April 2004 and received royal assent on 9 June 2004. This Act commenced on 4 July 2003 and amends the application of the act and covers the proactive and reactive duty of registered medical practitioners to warn of risk.

The Civil Liability Amendment (Proportionate Liability) Bill 2004 was introduced into parliament on 19 October 2004 and on 17 November 2004 was at the second reading stage in the Legislative Council. This Bill amends the *Civil Liability Act 2002*.

This Bill:

- provides that a defendant who is a concurrent wrongdoer in relation to a claim is limited to an amount reflecting that proportion of the damage or loss claimed
- sets out liability when proceedings involve both an apportionable claim and a claim that is not an apportionable claim
- establishes a duty of the defendant to inform the plaintiff about concurrent wrongdoers.

B.2.8 Australian Capital Territory

The *Civil Law (Wrongs) Act 2002* was introduced into ACT Parliament on 20 August 2002 and was notified in the Government Gazette on 10 October 2002. Sections 1 and 2 of the Act commenced on 10 October 2002 and chapter 10 commenced on 1 January 2003. The remainder of the Act commenced on various dates between 1 November 2002 and 1 July 2003.

This Act:

- provides for structured settlements
- requires courts to determine liability separately from an order of damages
- caps the maximum amount of damages for economic loss at three times the rate of AWE
- excludes volunteers and 'good Samaritans' acting in good faith from civil liability
- establishes new presumptions for contributory negligence

- does not award legal costs in personal injury cases where the damages awarded are $50 000 or less
- provides that the maximum legal costs to be awarded in personal injury cases is the greater of $10 000 or 20 per cent
- prohibits lawyers from prosecuting civil claims when there are no reasonable prospects of success
- establishes a regime for neutral evaluation of cases to resolve disputes more quickly and cheaply.

The *Civil Law (Wrongs) Amendment Act 2003 (No. 2)* was introduced to ACT Parliament on 24 June 2003 and was notified on 8 September 2003. This Act commenced on 9 September 2003 and 8 March 2004 and has been repealed. However, the repeal of an amending law does not affect the continuing operation of the amendments.

It amended the *Civil Law (Wrongs) Act 2002*.

These amendments:

- ensure that an apology does not amount to an admission of liability
- sets the standard of duty of care for mental harm
- provides general principles for the duty of care for negligence
- provides general principles for precautions against risk
- provides general principles for causation
- provides for contributory negligence and enables the court to reduce damages up to 100 per cent
- outlines pre-court procedures for notice of claim, obligations on parties to give documents and information, need for urgent proceedings and expert medical evidence
- permits the court to refer to previous court decisions when determining amounts awarded for non-economic loss
- provides for legal cost arrangements if there is no reasonable prospect of success
- includes mediation as an option along with neutral evaluation of cases
- amends the *Limitation Act 1985* so that the limitation period is three years from the cause of action
- provides a limitation period of six years for injuries to children as a result of provision of health services.

The *Civil Law (Wrongs) (Thresholds) Amendment Bill 2003* was introduced into ACT Parliament on 11 December 2003 but was discharged on 16 October 2004. This Bill proposed to amend the *Civil Law (Wrongs) Act 2002* by restricting the amount awarded for general damages for personal injury resulting from health services provided by a doctor. Specifically, the Bill provided that:

- damages must not be awarded for non-economic loss unless the assessed non-economic loss is $12 001 or more
- if the assessed non-economic loss is at least $12 001 but less than $20 000, the maximum amount of damages for non-economic loss that may be awarded is the amount worked out as follows: (assessed non-economic loss—$12 000) x 2.5.

B.2.9 Northern Territory

The *Personal Injuries (Liabilities and Damages) Act 2003* was introduced into Northern Territory Parliament on 17 October 2002, received royal assent on 18 March 2003 and commenced on 1 May 2003.

This Act:

- caps the maximum damages for economic loss at three times the rate of AWE
- sets a threshold for damages for non-economic loss of five per cent scaling of awards up to a maximum amount of $350 000
- excludes awards of damages for injuries suffered by a person engaged in a criminal activity
- limits liability for contributory negligence
- excludes volunteers and 'good Samaritans' acting in good faith from civil liability
- provides for structured settlements
- ensures that an apology does not amount to an admission of liability.

The *Personal Injuries (Civil Claims) Act 2003* was introduced into the Northern Territory Parliament on 27 February, received royal assent on 29 May 2003 and ss. 1–4, 6, 12–15 and 22 commenced on 1 July 2003. The remaining sections had not yet commenced at 10 November 2004. This Act aims to improve the efficiency of processes for resolving claims for damages for personal injuries and to assist the affordability of those claims. It changes court procedures and legal practitioners' operations, speeds claims processing with compulsory conferencing, and limits recovery of legal costs where court damages are less than earlier settlement offers.

The *Personal Injuries (Liabilities and Damages) Act 2003* was introduced into Parliament on 17 October 2002, received royal assent on 18 March 2003 and commenced on 1 May 2003.

This Act:

- only applies to claims for injuries sustained after the commencement of this Act
- caps the maximum amount of damages that can be awarded for economic loss at three times the rate of AWE
- caps the maximum amount of damages for non-economic loss at $350 000
- provides that damages for pain and suffering are not payable if they are less than $15 000
- imposes limits on compensation for certain kinds of attendant care services
- excludes awards of damages for injuries suffered by a person engaged in a criminal activity
- provides that a person who suffers injuries when intoxicated will be deemed to have contributed to the injuries and have damages reduced by at least 25 per cent
- excludes volunteers and 'good Samaritans' acting in good faith from civil liability
- ensures that an apology is not an admission of liability.

The *Personal Injuries (Liability and Damages) (Consequential Amendments) Act 2003* was introduced into Northern Territory Parliament on 17 October 2002, received royal assent on 18 March 2003 and commenced on 1 May 2003. This Act deals with matters consequential to the *Personal Injuries (Liabilities and Damages) Act 2003*. The main amendment is the repeal of ss. 10 and 10A of the Law Reform (Miscellaneous Provisions) Act dealing with the duty of care owed to trespassers and persons engaged in criminal activities. These provisions now exist in the *Personal Injuries (Liabilities and Damages) Act 2003*.

C. ACCC information request

For the ACCC to fulfil its monitoring requirements, it was necessary to directly approach medical indemnity providers to request relevant information. In consultation with *am actuaries*, the ACCC developed a uniform information request for insurers to complete. This request was similar to that used for the preparation of the first medical indemnity insurance monitoring report. There were some changes and as such the ACCC endeavoured to consult with all insurers before issuing the final requirements.

Where possible, the information request was aligned with APRA's information requirements to reduce the burden on medical indemnity providers. However, the different roles played by APRA and the ACCC regarding medical indemnity insurance meant that the ACCC sought a greater level of detail in some of the reports.

The sections in this appendix briefly describe the nature of the reports and information the ACCC requested from medical indemnity providers.

C.1 Actuarial pricing report

Each medical indemnity provider commissioned actuarial pricing reports for premiums to apply for the 2004–05 underwriting year. These reports provide advice to the medical indemnity provider for the overall 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,[160] the ACCC outlined its desired scope and detail to be covered in these reports. Specifically, the ACCC requested that the report include additional commentary on the effects (if any) of the government reforms on the actuarial assessment performed for the indemnity provider, including but not limited to:

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

C.2 Actual premium rate report

The ACCC requested a report detailing the actual premiums charged for all forms of indemnity for the 2004–05 underwriting year. Where actual premium rates differed from those set out in the actuarial pricing report, the indemnity provider 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.

[160] The ACCC notes that IAAust is currently preparing medical indemnity premium guidelines which may assist actuaries in preparing future reports.

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

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

A request was also made for updates to information obtained in the first information request on historical membership and premium rates.

C.3 Actuarial liability valuation report

The ACCC requested the latest available liability valuation report produced by the indemnity provider's actuary. The latest report was from 30 June 2003. This report was expected to contain commentary on all material issues influencing the assessment of the outstanding claims and the premium liabilities.

In its first monitoring request in 2003 the ACCC indicated that it would seek commentary in future liability valuation reports regarding the impact of government reforms on liabilities. In line with this, the ACCC sought information on the impact of government reforms on the authorised insurer's liability valuation results. The ACCC specifically asked insurers to address the following reforms:

- HCCS
- ROCS (where applicable)
- tort law reform enacted in various jurisdictions.

C.4 Funding plans

The ACCC requested copies of any funding plan updates submitted to APRA for the purpose of applying for exemption from the MCR during the transition period.

The ACCC required both the quarterly and annually prepared funding plan updates to monitor the progress of medical indemnity insurers in meeting their initial funding plan targets. Where this information was not available, the ACCC requested that insurers provide substitute information to allow it to make its assessment.

C.5 Other information

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

- a copy of the insurance policies offered to medical practitioners and details of any changes made since the 2003 indemnity period
- the most recent annual report
- the most recent financial condition report, which is submitted to APRA on an annual basis and provides a comprehensive overview of the insurer's financial soundness.