March 2007

Australian Competition & Consumer Commission

Medical indemnity insurance

FOURTH MONITORING REPORT

Medical indemnity insurance

Fourth monitoring report

March 2007

Australian
Competition &
Consumer
Commission

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Abbreviations

ABS	Australian Bureau of Statistics
ACCC	Australian Competition and Consumer Commission
AMIL	Australasian Medical Insurance Limited
APRA	Australian Prudential Regulation Authority
ASIC	Australian Securities and Investment Commission
AWE	average weekly earnings
ECS	exceptional claims scheme
GP	general practitioner
GST	goods and services tax
HCCS	high cost claims scheme
HIC	Health Insurance Commission
IBNR	incurred but not reported
IAAust	Institute of Actuaries Australia
Invivo	Invivo Medical Pty Ltd
MCR	minimum capital requirement
MDAN	MDA National Pty Ltd
MDANI	MDA National Insurance Pty Ltd
MDASA	Medical Defence Association of South Australia Limited
MDAV	Medical Defence Association of Victoria Limited
MDAWA	Medical Defence Association of Western Australia
MDO	medical defence organisation
MIA	Medical Insurance Australia Pty Ltd
MIGA	Medical Insurance Group Australia
MIPS	Medical Indemnity Protection Society Limited
MIPSI	MIPS Insurance Pty Ltd
MPSTas	Medical Protection Society of Tasmania
MISS	medical indemnity subsidy scheme
PIICA	Professional Indemnity Insurance Company Australia Pty Limited

PSS	premium support scheme
QBE	QBE Insurance (Australia) Limited
QDM	Queensland Doctors' Mutual Pty Ltd
ROCS	run-off cover scheme
UMP	United Medical Protection Limited (as referred to in legislation)
United	United Medical Protection Limited

Glossary of terms

claims expense	all payments made in the year on claims arising from that and previous notification years, as well as any adjustments to outstanding claims provisions across the year
claims-incurred cover	the insurer agrees to indemnify the policy holder for any valid claims arising from incidents that occur during the coverage period, with a claim able to be lodged at any time in the future
claims-made cover	the insurer agrees to indemnify all claims arising from incidents notified during the policy period, so long as the incident occurred during the current period, or any previous periods in which the policyholder has held continuous claims-made cover with the insurer up to and including the current period, or to an earlier retroactive date. Due to the more limited period the insurer is 'on risk', especially in early years, this is typically a cheaper product to underwrite than claims-incurred cover
claims frequency	the ultimate number of claims expected by year of notification expressed as a proportion of the total number of Medicare services provided in the corresponding year
combined ratio	the sum of the loss ratio and the expense ratio showing whether the sum of expenses (claims expenses and other expenses) is lower or higher than premium revenue for the year
excess of loss reinsurance	the direct insurer carries all individual losses incurred in each individual claim up to a certain limit, and the reinsurer pays the loss in excess of this amount (known as the attachment point) for each and every claim. There may also be an aggregate limit for all claims assumed by the reinsurer
expense ratio	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 and 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 that are 'at risk', that is, those members for whom the medical indemnity provider may be required to pay a claim (the measure excludes those non-indemnified members such as students and 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
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
medical defence organisation (MDO)	a not-for-profit mutual organisation created and owned by medical practitioners to provide various services to members, including indemnity (indemnity was only able to be offered by MDOs before 1 July 2003)
medical indemnity provider	an organisation that provides liability insurance, either as an insurer or as an authorised representative of an insurer, that indemnifies medical practitioners for financial loss arising from actions brought against them as a result of the performance of their professional duties.
notification year	the year in which the insurer is notified of a claim or an incident that may potentially give rise to a claim
personal injury or death claim	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
pure risk premium	the amount of premium needed just to meet the cost of expected medical indemnity claims and associated costs
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 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 net of tax 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

Summary

Background

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

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

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

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

ACCC's monitoring role

In October 2002 the Prime Minister, the Hon. John Howard, announced that the Australian Competition and Consumer Commission (ACCC) would monitor medical indemnity premiums on an annual basis to assess whether they are actuarially and commercially justified. On 16 March 2005 the Australian Government asked the ACCC to extend its monitoring to examine, to the extent possible, the actuarial and commercial justification of premiums within each jurisdiction in more detail. On 29 May 2006, the Australian Government asked the ACCC to continue to examine the actuarial and commercial justification of medical indemnity premiums, including within jurisdictions, for a further three years and that the ACCC extend its monitoring to include the new entrant to medical indemnity insurance, Invivo.

The ACCC asked the six 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 six current providers of medical indemnity insurance are Australasian Medical Insurance Limited (AMIL), Invivo Medical Pty Ltd (Invivo), MDA National Insurance (MDANI), Medical Insurance Australia Pty Ltd (MIA), MIPS Insurance Pty Ltd (MIPSI) and Professional Indemnity Insurance Company Australia Pty Ltd (PIICA).

Qualifications

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

Findings of previous ACCC medical indemnity insurance monitoring reports

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

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

ACCC assessment methodology

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

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

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

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

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

This report is the first to include information on Invivo. Invivo is a corporate authorised representative of QBE Insurance (Australia) Limited. In this report 'Invivo's premiums' refers to premiums paid to Invivo for the purchase of a QBE professional indemnity policy.

Assessment of the actuarial justification of medical indemnity premiums

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

MDO-owned insurers

The ACCC found that the aggregate premium pool of each insurer was actuarially justified. It was evident that insurers made extensive use of actuaries in premium 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 aggregate premium pool after considering advice from the actuary.

One issue that arose in relation to the aggregate premium pool of the five MDO-owned insurers was the actuaries' consideration of the expense, reinsurance and surplus components. The ACCC found that while all actuaries' considered these components to various extents, some continued to rely on the insurer to determine some or all of these components and did not independently examine these components in light of past experience and the actuaries' understanding of the insurers' operations and capital management policies. The ACCC encourages all actuaries to examine these components independently rather than rely on the advice of insurers.

The ACCC analysis of specialty premium rates found that all insurers conducted detailed analysis on the risk relativities between specialties. Similar to previous monitoring reports, the ACCC found that insurers generally cited the unwinding of existing cross-subsidisation between specialties as an

objective but noted that this was a long-term process and potentially not all cross-subsidies would be removed for a variety of reasons, including commercial factors as well as data limitations. However, the ACCC found these rates and the relativities for income bands to be actuarially justified because the extent of cross-subsidisation was understood and, where possible, quantified.

The ACCC analysis of the impact of government reforms on premiums includes an examination of Australian Government medical indemnity reports (including the high cost claims scheme and the run-off cover scheme), and Commonwealth, state and territory tort law reforms. The ACCC found that all insurers factored in the HCCS and ROCS in their premium determination and most insurers took full account of the HCCS in their reinsurance programs. The two insurers that did not reflect the HCCS in their reinsurance program did so because of an unwillingness of reinsurers to fully reflect the full benefits of the scheme in their reinsurance pricing and structure. Importantly, both insurers fully took the HCCS recoveries into account in establishing their pure risk premium. The majority of insurers took tort law reform into account in setting their aggregate premium pools for 2006–07.

Invivo

The ACCC also conducted separate analysis on Invivo's 2006–07 premiums and found them to be actuarially justified. This included an examination of the methodology used by Invivo to set premiums (payable to QBE), a comparison of actual premium rates with the actuary's recommended premium rates and an assessment of the impact of specific government reforms on premiums.

Assessment of the commercial justification of medical indemnity premiums

The ACCC found that, in the current market environment, the premiums set by all six medical indemnity providers were considered to be commercially justified.

MDO-owned insurers

The net asset position of all insurers as at 30 June 2006 was an improvement on the strong position observed as at 30 June 2005. The degree to which the net asset position had improved depended on the circumstances of individual insurers. The position of three insurers as at 30 June 2005 was such that they no longer intended to build capital into premiums for the 2005–06 underwriting year. The stronger results as at 30 June 2006 meant that four insurers no longer needed to build capital through premiums in the 2006–07 underwriting year.

The ACCC notes that one insurer continued its practice of not incorporating sufficient capital within its insurance premiums to maintain its net asset to MCR ratio. To compensate for this, the insurer's parent entity is scheduled to make a capital injection in 2006–07 as well as further injections in future years. The ACCC found that while this may not be a viable long-term strategy, 2006–07 premiums for this insurer were still commercially justified because the injections were appropriately budgeted for and had MDO board approval.

Invivo

The ACCC examined the commercial justification of Invivo's premiums separately by examining the business plan presented to QBE and supporting financial projections.

The ACCC found that based on this analysis Invivo's premiums for the 2006–07 underwriting year were commercially justified.

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

The ACCC found that jurisdictional premium relativities were considered to be actuarially and commercially justified for all six medical indemnity providers.

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

For the commercial justification of premium relativities, the ACCC considered the extent to which relativities recommended by actuaries were adopted in final premium rates as well as the level of cross-subsidisation in the premium relativities. The ACCC found that that in some instances recommendations were not adopted in final premium rates due to a lack of reliable claims experience in some jurisdictions. However, the ACCC found that while no medical indemnity provider explicitly cross-subsidised between jurisdictions, cross-subsidies may exist due to the lack of reliable claims experience data. The relativities adopted were considered to be commercially justified.

1 Introduction

1.1 Background

In May 2002 the largest medical indemnity provider in Australia, United Medical Protection (United), was placed into provisional liquidation resulting in a potential lack of indemnity cover for many doctors. At the same time, medical practitioners were experiencing significant increases in subscriptions charged across all medical indemnity providers. In extreme cases, medical practitioners were paying over a third of their incomes for indemnity cover, while others left the profession or ceased some high-risk procedures like obstetrics.[2] In response to this crisis, the Australian Government introduced a framework of reforms to ensure a viable and ongoing medical indemnity insurance market.[3]

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, the Hon. John Howard, announced that the Australian Competition and Consumer Commission would monitor medical indemnity premiums to assess whether they are actuarially and commercially justified.[4] This report is the fourth ACCC report to the Australian Government arising from this role.

1.2 Ministerial request

On 19 November 2002 the Treasurer, the Hon. Peter Costello, wrote to the ACCC about this new role. The Treasurer indicated that the measures announced by the Australian Government were 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. The Treasurer also expressed the government's concern that the market should develop in a viable manner, with industry participants correctly provisioning for the risks they underwrite.

On 16 March 2005 the Hon. Mal Brough, then the Minister for Revenue and Assistant Treasurer, asked the ACCC to extend the scope of its third monitoring report on medical indemnity insurance to examine, to the extent possible, the actuarial and commercial justification of premiums within each jurisdiction in more detail.

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

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

4 ibid.

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*.[5] On 29 May 2006 the Minister for Revenue and Assistant Treasurer, the Hon. Peter Dutton, wrote to the ACCC requesting that it continue to examine the actuarial and commercial justification of medical indemnity premiums, including within jurisdictions, for a further three years and that the ACCC extend its monitoring to include the new entrant to medical indemnity insurance, Invivo.

1.3 Scope of report

The ACCC's monitoring role is limited to medical indemnity insurance written in Australia by medical indemnity providers that indemnify medical practitioners (that is, doctors) working in the private health sector. During the period covered by this report there were six medical indemnity providers:

- Australasian Medical Insurance Limited (AMIL)
- Invivo Medical Pty Ltd (Invivo)
- MDA National Insurance Pty Ltd (MDANI)
- Medical Insurance Australia Pty Ltd (MIA)
- MIPS Insurance Pty Ltd (MIPSI)
- Professional Indemnity Insurance Company Australia Pty Ltd (PIICA).[6]

This report is the first to include information on Invivo. Invivo is a corporate authorised representative of QBE Insurance (Australia) Limited. In this report 'Invivo's premiums' refers to premiums paid to Invivo for the purchase of a QBE professional indemnity policy.

Medical indemnity insurance is also offered by some other commercial insurers to medical professionals who practise in the private health sector, such as hospital and ancillary staff (including nurses and other medical staff). Medical practitioners who practise in the Australian public health sector are generally indemnified against medical malpractice by the relevant state-based public sector insurer for the work they perform in the public health system.[7] They do not need to take out their own private medical indemnity insurance to cover this work.

1.4 Approach to monitoring

In assessing the actuarial justification of premiums the ACCC considers the technical actuarial aspects of pricing. It examines the process adopted by 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.

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

6 As the MDO parent entities of the insurers are no longer able to sell insurance under the Australian Government's reform package, the ACCC has generally not examined their operations or membership pricing.

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

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 how premium rates were affected by the Australian Prudential Regulation Authority's minimum capital regulatory requirements that the medical defence organisation (MDO) owned medical indemnity providers must achieve in order to reach a fully capitalised position by 30 June 2008, as well as broader commercial obligations such as solvency targets and emerging surplus levels. The ACCC's assessment framework is discussed further in chapter 6.

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

The ACCC's analysis covered the six medical indemnity providers in Australia that offer insurance to private medical practitioners. In mid-2006 the ACCC requested a range of quantitative and qualitative information from these entities about their premium-setting arrangements, cost structures and the effect of various government reforms (including tort reforms) on their operations.[8] Details of the ACCC's information request can be found in appendix B.

This report examines premiums set by medical indemnity providers for the underwriting period of 1 July 2006 to 30 June 2007, except for United/Australasian Medical Insurance Limited, which has an underwriting period of 1 January 2006 to 31 December 2006. The ACCC has specifically not adjusted United/AMIL's calendar year results to the financial year except where otherwise noted.

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

1.5 Qualifications

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

8 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 close as possible to those of APRA in an effort to minimise duplication costs for these 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 requested more detailed information.

It should also be noted that, the use of some terms have changed for this report. References to 'medical indemnity providers' now refers to an organisation that provides liability insurance, either as an insurer or as an authorised representative of an insurer, that indemnifies medical practitioners for financial loss arising from actions brought against them as a result of the performance of their professional duties.

1.6 Previous reports

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

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 aggregate premium pool of each insurer was considered to be adequate to cover projected costs.[9] It also found that, although insurers adopted specialty premium rates that differed from the recommended technical rates, these were considered actuarially justified as the aggregate premium pool was still expected to be achieved.

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

For the commercial justification of premiums, the report concluded that the premiums set by all five medical indemnity providers were considered to be commercially justified.[10] This assessment recognised the need for insurers to raise adequate capital to ensure they can continue to underwrite medical indemnity insurance.

On 16 March 2005 the Australian Government released the ACCC's second medical indemnity insurance monitoring report, which examined the actuarial and commercial justification of premiums for the 2004–05 underwriting period. On 16 February 2006 the Australian Government released the third medical indemnity insurance monitoring report, which examined the actuarial and commercial justification of premiums for the 2005–06 underwriting period.

Both reports concluded that the premiums charged by all five medical indemnity providers in 2004–05 and 2005–06 were actuarially justified. Each found that 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. The reports also found that for both underwriting years each insurer adopted an aggregate premium pool after considering advice from its actuary.

For the commercial justification of premiums both reports considered that, in the current market environment, premiums set by all five insurers were commercially justified, with all insurers reporting they were in a strong solvency position, generally ahead of earlier forecasts.

9 The ACCC was unable to determine whether the premiums of the remaining provider (HPIA, now known as MIPSI) were actuarially justified because it did not provide sufficient information about its assumptions and supporting analysis.

10 The ACCC 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 and commercially justified, despite the ACCC being unable to verify this.

The third monitoring report also found that the jurisdictional premium relativities were considered to be actuarially and commercially justified for the 2005–06 underwriting year. The ACCC found that insurers were restricted in the extent to which an actuarial analysis of jurisdictional relativities could be undertaken due to a lack of reliable claims experience in some jurisdictions and, in the absence of this data, the ACCC considered that the approach used by insurers was actuarially justified. The ACCC also found that the relativities adopted by insurers generally reflected the actuarial advice received and that no insurer explicitly cross-subsidised between jurisdictions. The ACCC considered that the relativities adopted were commercially justified.

1.7 Report outline

This report contains seven chapters and two appendixes.

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

Chapter 3 examines the Australian Government reforms to medical indemnity insurance current up to 1 March 2007.

Chapter 4 examines historical trends in costs, premiums and the financial performance of the industry between 1997–98 and 2005–06.

Chapter 5 presents ACCC findings on the actuarial justification of medical indemnity premiums charged for the 2006–07 underwriting period by the six current medical indemnity providers.

Chapter 6 presents ACCC findings on the commercial justification of medical indemnity premiums charged for the 2006–07 underwriting period by the six current medical indemnity providers.

Chapter 7 presents ACCC findings on the actuarial and commercial justifications of medical indemnity premiums charged in different jurisdictions for the 2006–07 underwriting period by the six current medical indemnity providers.

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

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

2 Overview of the medical indemnity industry

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

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

2.1 What is medical indemnity insurance?

Insurance provides protection against the unfortunate consequence of future events by transferring the risk of possible loss from a person or organisation (the insured) to the insurer. To gain this benefit, the insured pays the insurer a sum of money known as a premium for the cost of insurance.[11]

2.1.1 Liability insurance

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

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

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

Medical indemnity insurance is a type of professional indemnity insurance. Professional indemnity insurance indemnifies professional people for their legal liability to their clients and others relying on their advice and/or services.[12] With medical indemnity insurance, the professional being insured is the medical practitioner—indemnity coverage reduces their exposure to financial losses arising from personal injury actions brought against them as a result of the performance of their professional duties.

11 Insurance Council of Australia, background paper No. 7 to the HIH Royal Commission, 'A Profile of the General Insurance Industry', November 2001, p. 3.

12 ibid., p. 26.

2.1.2 Medical malpractice

Malpractice insurance is another name for professional indemnity insurance, but this term has generally been reserved for the medical professions.[13] Although medical indemnity insurance provides protection similar to that for other professionals, the nature of medical malpractice claims against medical practitioners will generally differ from claims against other professionals.

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

Claims against medical practitioners relate to personal injury or death and are lodged against a medical practitioner 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 represent a major portion of overall claims costs.

2.1.3 Long-tail insurance

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

Depending on the statute of limitations, which varies between each state and territory, medical indemnity claims can be made years after an incident, even if the medical practitioner is no longer practising medicine. Although tort law reforms have reduced limitation periods, this long-tail characteristic continues to place considerable pressure on providers of such cover to be able to identify the likely cost of future claims and build this into their pricing (premium) structures.[14]

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

14 Parliament of the Commonwealth of Australia, Medical Indemnity (Prudential Supervision and Product Standards) Bill 2002, revised explanatory memorandum, p. 8.

2.1.4 Types of indemnity coverage

Traditionally medical indemnity cover was provided to medical practitioners on a claims-incurred (sometimes referred to as 'incidents-occurring') basis. Claims-incurred cover provides indemnity for valid claims arising from incidents that occur during the period of cover, with a claim able to be lodged at any time in the future.[15] 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.[16] Claims-made cover is standard within the broader general insurance industry for professional indemnity insurance contracts.

Claims-made cover is different to claims-incurred cover because, for the former, the incident must have occurred and the claim must have been notified to the indemnity provider during the period of coverage. This means that for claims-made cover, the medical practitioner is not covered for past incidents notified to the indemnity provider after the practitioner ceases practicing medicine or moves to another indemnity provider.[17]

2.2 Characteristics of the industry—pre-1 July 2003

Before 1 July 2003 medical indemnity cover was traditionally offered by medical defence organisations, which operated on a not-for-profit basis as 'mutuals' (i.e. owned and operated by its members). MDOs offered indemnity protection to medical practitioners as part of a range of services to their members.[18]

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

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

- Medical Defence Association of South Australia Limited (MDASA)
- Medical Defence Association of Victoria Limited (MDAV)

15 ibid., p. 8.

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

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

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

- MDA National Pty Ltd (MDAN)[19]
- Medical Indemnity Protection Society Limited (MIPS)
- Medical Protection Society of Tasmania (MPSTas)
- Queensland Doctors Mutual Pty Ltd (QDM)[20]
- United Medical Protection Limited (United).

The above MDOs operated mainly along state lines[21] and were outside the prudential framework regulated by the Australian Prudential Regulation Authority. Although MDOs were not insurance companies authorised by APRA to conduct insurance business, they did have some associations with authorised insurers. Before 1 July 2003 all MDOs operating in Australia had access to subsidiary or 'captive' insurance companies, which were established primarily to provide reinsurance cover to the parent MDO.

2.3 Characteristics of the industry—post-1 July 2003

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

The six authorised providers of medical indemnity insurance in Australia are:

- Australasian Medical Insurance Limited (AMIL)—writing insurance for members of United
- Invivo Medical Pty Ltd (Invivo)—is the corporate authorised representative of QBE Insurance (Australia) Limited and has the exclusive arrangement to distribute and manage QBE's professional indemnity insurance covering medical practitioners
- MIPS Insurance Limited (MIPSI)—writing insurance for members of MIPS and MPSTas (and previously to QDM before it merged with MIPS)
- MDANI—writing insurance for members of MDAN
- Medical Insurance Australia Pty Ltd (MIA)—writing insurance for members of MDASA
- Professional Indemnity Insurance Company Australia Pty Limited (PIICA)—writing insurance for members of MDAV.

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

20 QDM subsequently merged with MIPS on 22 July 2004.

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

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

Since 1 July 2003 most medical indemnity providers have continued the tradition of providing insurance primarily in their home states. However, the extent to which this occurs differs between providers, with some writing just over a third of their business in their home state and others writing 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 the past, and the medical indemnity market is no longer strictly state based.

Invivo commenced operations in November 2005 and currently has offices in Sydney and Brisbane. While it initially focused on United members, who are largely concentrated in New South Wales and Queensland, media reports have indicated that it may seek to acquire other insurers' membership, including in other jurisdictions.[22]

2.3.1 Market shares

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

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

The ACCC has specifically excluded Invivo from its analysis of market share because it provided policy holder numbers on the condition of confidentiality.

Chart 2.1 shows the percentage of the total number of indemnified[23] members in Australia with each medical indemnity provider based on the most recently available data provided for 2002–03[24], 2003–04, 2004–05 and 2005–06.[25]

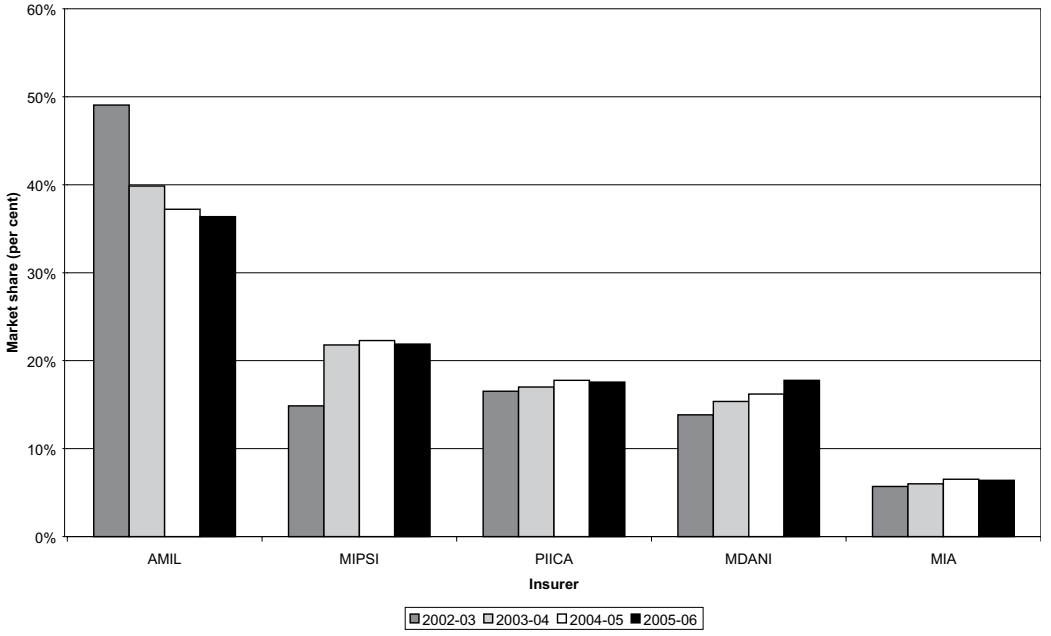
22 Adam Cresswell, 'Rivalry for Doctor Cover intensifies', *The West Australian*, 3 December 2005, p 29.

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

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

25 AMIL membership numbers relate to the previous calendar year—that is, membership for the 2005 calendar year has been recorded against the financial year ending 30 June 2006. The ACCC understands that AMIL membership levels are assessed in August each calendar year and therefore this allocation is expected to have no material effect on market shares.

Chart 2.1 Medical indemnity provider indemnity members, 2002–03 to 2005–06[26]



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

The largest medical indemnity provider is AMIL, which had approximately 36 per cent of all indemnified members in Australia in 2005–06. AMIL's market share has been falling since 2002–03; however, the rate of decline has slowed in recent years. MIPSI, PIICA and MIA's market share remained relatively stable in 2005–06, while MDANI continued to gain market share.

2.3.2 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 the medical practitioner.[27] This means that authorised insurers are unable to offer discretionary unlimited indemnity protection. This change extended APRA's prudential supervision to encompass medical indemnity insurance because it required all medical indemnity insurers to comply with APRA's prudential standards that apply to general insurance.

26 Results may not be directly comparable to those shown in previous reports due to revised data.

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

These requirements include:

- compliance with APRA's liability valuation standards, which mandates the appointment of an approved actuary who estimates the liabilities and risk margin
- having risk management systems, including pricing and underwriting control mechanisms
- holding a minimum level of capital based on an assessment of identified risks (but subject to a minimum of $5 million)[28]
- regular provision of data and reports.

APRA has established a scheme for transitional arrangements for the five MDO-owned insurers whereby providers have up to five years from 1 July 2003 to 30 June 2008 to comply with these minimum capital requirements (MCR).[29] From 1 July 2008 these medical indemnity providers must be fully capitalised.

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

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

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

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

- the minimum cover limit that an insurer may offer or provide to a medical practitioner is $5 million
- the contract must provide an offer for retroactive and run-off cover for otherwise uncovered prior incidents.[30]

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.

28 An insurer's minimum capital requirement is determined by having 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 the APRA website (www.apra.gov.au).

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

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

3 Government reforms of medical indemnity insurance

In 2002 rising medical indemnity insurance premiums and the provisional liquidation of the largest provider, United Medical Protection Limited (United), led to significant problems of affordability and availability of medical indemnity insurance for private medical practitioners. In response to these problems the Australian Government introduced a series of reforms aimed at ensuring a viable and ongoing medical indemnity insurance market. This chapter examines those medical indemnity reforms including reviews of these reforms up to 1 March 2007.

3.1 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. The government has subsequently outlined a series of modifications as well as introducing additional measures. This chapter examines reforms and reviews of these reforms that have been implemented and/or completed as at 1 March 2007. The reforms up to 1 July 2006 are particularly relevant because medical indemnity providers would often need to consider the effect of these reforms on their price setting arrangements for the 2006–07 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 and reviews of these reforms include the:

- exceptional claims scheme (ECS)
- run-off cover scheme (ROCS)
- IBNR and UMP support schemes
- high cost claims scheme (HCCS)
- premium support scheme (PSS)
- changes to the medical indemnity package resulting from a review of competitive neutrality
- the review of the medical indemnity package by the medical indemnity policy review panel.

3.1.1 Exceptional claims scheme

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

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

There is no sunset clause for ECS, although it can be ended by regulation. It is anticipated that the scheme will be reviewed from time to time in close consultation with the medical profession and insurers to determine if it remains necessary in light of state and/or territory tort law reform and claims trends.[31]

3.1.2 Run-off cover scheme

ROCS 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.[32]

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, ROCS will cover the types of claims that a medical practitioner's last insurance contract covered without further payment.[33] 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 United/Australasian Medical Insurance Limited).[34] These rates apply from 2004 to 2008.

ROCS applies to claims notified on or after 1 July 2004 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 determined by regulation to be eligible.

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31 Medical Indemnity Policy Review Panel, *Achieving stability and premium affordability in the Australian medical indemnity marketplace*, February 2007, p. 4.

32 ROCS is contained in the *Medical Indemnity Legislation Amendment (Run-off Cover Indemnity and Other Measures) Act 2004* and the *Medical Indemnity (Run-off Cover Support Payment) Act 2004*. Before 1 July 2003 medical practitioners generally obtained medical indemnity cover on a claims-incurred basis, which meant that all claims for incidents while they were practising would be covered even after they retired. Practitioners with 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 typically 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.

33 ROCS initially mirrored the cover of the insurance contract held by the medical practitioner at the time of the incident. However, the *Medical Indemnity Amendment Act 2006* removed the requirement for the medical practitioner to have held indemnity cover at the time of the incident, which means that ROCS mirrors the terms and conditions of the medical practitioner's last pre-retirement contract.

34 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.

3.1.3 High cost claims scheme

HCCS was introduced by the government to reduce the cost of large claims to insurers and thereby stabilise medical indemnity premiums.[35]

Under this scheme, the government will reimburse medical indemnity providers 50 per cent of all claims above the $300 000 threshold up to the medical practitioner's limit of insurance.[36] HCCS does not extend to incidents that occur outside of Australia or to the treatment of public patients in public hospitals.[37]

3.1.4 Premium support scheme

PSS was introduced to replace the medical indemnity subsidy scheme (MISS), which provided premium subsidies specifically to neurosurgeons, obstetricians, procedural general practitioners (GPs) and GP registrars undertaking procedural training.[38]

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.

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 been deemed eligible for MISS—the subsidy is calculated as the greater of that under MISS or PSS
- special category members—the subsidy is 80 per cent of the total cost to the member for the premium period of the member's gross indemnity costs.[39]

35 HCCS is contained in the *Medical Indemnity Act 2002*, Schedule 2 of the Medical Indemnity Amendment Regulations 2003 (No. 2) and Schedule 1 of the Medical Indemnity Amendment Regulations 2004 (No. 1).

36 The HCCS threshold was initially $2 million for claims notified between 1 January and 21 October 2003, it was then reduced to $500 000 for claims notified between 22 October and 31 December 2003, before being reduced to the current $300 000 threshold for all claims notified after 1 January 2004.

37 The *Medical Indemnity Legislation Amendment (Run-off Cover Indemnity and Other Measures) Act 2004* received Royal Assent on 23 June 2004. Among other things, the Act amended the HCCS provisions contained in the *Medical Indemnity Act 2004*, to enable payments for high-cost claims to be made once the medical indemnity provider **becomes aware** of a claim or an incident against a medical practitioner. This brings the scheme into line with the claims-made insurance policies written by medical indemnity providers.

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

39 A special category member is a member who:

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

3.1.5 IBNR and UMP support schemes

Under the IBNR indemnity scheme[40] the Australian Government funds IBNR liabilities of participating medical indemnity providers that held unfunded IBNR liabilities at 30 June 2002. Following an assessment of all medical indemnity providers' liabilities by the Australian Government Actuary, United (known in the scheme as UMP) is the only provider participating in this scheme.

To fund payments under the IBNR scheme the Australian Government introduced the IBNR contribution scheme to collect contributions from medical practitioners and other health professionals who were members of medical indemnity providers that participated in the IBNR scheme. As United was the only participating member, the IBNR contribution scheme was renamed the UMP support scheme.[41]

The scheme as originally announced was designed to be revenue neutral for the government, with United's then members reimbursing the full cost over time through an annual levy.

However, the Medical Indemnity Policy Review Panel's report, provided to the Australian Government at the end of 2003, expressed concern that present medical practitioners and patients had to make payments to compensate for past under-funding.

The government agreed that it would fund around three-quarters of United's IBNR liability as it emerged. The remaining quarter is to be met by the UMP support payment from medical practitioners who were members of United at 30 June 2000.[42]

After this the UMP support payment was payable for a maximum of six years and no medical practitioner would make a payment after the 2008–09 financial year. Medical practitioners who were members of United for fewer than six years needed to make payments only for the number of years they were members, and no medical practitioner would pay more than was originally required under the previous IBNR scheme.

An 18-month moratorium on IBNR levy payments above $1000 until 31 December 2004 affected payment calculations for the first two years of the scheme.[43] Payment calculations for the last four years were to be unaffected, with the UMP support payment calculated as the lesser of:

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

In May 2005, as part of the Australian Government's response to the *Review of Competitive Neutrality in the Medical Insurance Industry*, the government reduced the UMP support payment further.

40 The IBNR indemnity scheme is contained in the *Medical Indemnity Act 2002*.

41 The UMP support scheme is contained in the *Medical Indemnity Act 2002*.

42 The Health Insurance Commission (HIC), now known as Medicare Australia, reported in its 2002–03 annual report that the total IBNR liability was $498.5 million; in the 2003–04 annual report, the valuation was reported as $259.5 million; in the 2004–05 annual report, $245 million; and in the 2005–06 annual report, $208 million. These reductions were due to a combination of factors including favourable claims experience and transferring some liability to HCCS and ROCS.

43 In response to doctors' concerns over the effect 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.

The UMP support payment scheme has been amended to reduce the extent and duration of payments required by medical practitioners. Under the new arrangements, members' payments will be reduced by $1000 annually. The number of contribution years will also be reduced from six to four years.

The maximum amount that members will pay for the final contribution years will be the lesser of:

- $4000
- the amount by which the applicable percentage of the member's annual subscription for the base year exceeds $1000, or
- two per cent of their gross medical income in excess of $50 000.

Medical practitioners can also 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 practise 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.

3.1.6 Competitive neutrality review

On 4 November 2004 United announced that its licensed insurer, Australasian Medical Insurance Limited (AMIL), would make significant reductions in premiums for 2005. United suggested that a number of factors had a major impact on its premiums, including the loyalty of its members, medical indemnity reforms and extensive tort law reform in most Australian states and territories.[44]

However, other medical indemnity providers argued that specific Australian Government assistance to United, in the form of the IBNR scheme (under which United was the only participating member), had helped it to reduce its premiums.

On 7 December 2004 the Hon. Tony Abbott, the Minister for Health and Ageing, and the Hon. Mal Brough, then Minister for Revenue and Assistant Treasurer, announced that the government would commission an independent review of competitive neutrality in the medical indemnity insurance market.

Under the terms of reference of the review each form of government assistance and any resulting competitive advantages were to be examined. Should any competitive advantage be determined, the review was to identify and evaluate options to restore competitive neutrality.

The review reported to the government on 15 March 2005, and the report and the government's response to its recommendations were subsequently released on 13 May 2005. The review found that the specific assistance given to United through the IBNR scheme had resulted in a competitive advantage. The review suggested that this competitive advantage arose because the government had taken over all United's legacy commitments, allowing it, unlike other medical indemnity providers, to concentrate only on the future.

44 United Medical Protection, 'Premiums to drop as AMIL exceeds APRA's minimum capital requirements', press release, 4 November 2004.

The review also found that AMIL's pricing was well below its competitors and that this was the result of a much more bullish view of the future impacts of tort law reform. However, it then alleged that it was extremely unlikely that United could take such a view prudentially if it did not have the comfort of knowing that the Australian Government had assumed its legacy obligations for IBNR claims.

The review recommended that to redress the balance it would be necessary for United to make a series of regular payments to compensate the Australian Government for assuming its obligations.

The Australian Government accepted these recommendations on 13 May 2005 and indicated that the payments it would receive from United would be used to reduce the payments doctors make under the UMP support scheme.

On 16 June 2005 the Australian Government introduced legislation to bring these changes into effect. The *Medical Indemnity (Competitive Advantage Payment) Act 2005* and the *Medical Indemnity Legislation Amendment (Competitive Neutrality) Act 2005* impose the competitive neutrality payment on United, provide for the administrative arrangements and modify aspects of the UMP support payment. These Acts came into operation on 1 July 2005.

The competitive advantage payment was defined as a percentage of the outstanding net IBNR exposure of the insurer's participating medical defence organisation at 30 June in the previous financial year multiplied by the MDO's unfunded IBNR factor.[45] The percentage for each of the 10 contribution years from 1 July 2005 was to be prescribed in regulations made on or after the start of the contribution year and was not to be greater than 15 per cent.[46]

United accounted for the net present value of $59 million of the expected competitive advantage payment liability in its 2004–05 accounts. In 2005–06 United agreed on a settlement with the Australian Government of $56 million, and paid this in full in the 2005–06 year.

The UMP support payment scheme was also amended to reduce the extent and duration of payments required by medical practitioners (see section 3.1.5).

3.1.7 Medical indemnity policy review panel

In late 2005 the Australian Government announced the establishment of the Medical Indemnity Policy Review Panel.

The panel's role was to evaluate the effectiveness of the Australian Government's current package of medical indemnity measures, including the:

- PSS
- HCCS
- ECS
- IBNR scheme
- ROCS
- UMP support program.

45 United's unfunded IBNR factor is 1.

46 The percentage for the contribution year beginning 1 July 2005 was set at 4.55 per cent.

The Minister for Health and Ageing released the panel's report on 22 February 2007. The panel found that considerable progress had been made in achieving the objectives of improved affordability and sustainability in the medical indemnity marketplace. It concluded that there is general satisfaction with, and acceptance of, the package among doctors and insurers. The panel therefore recommended against any material amendments to the current package of medical indemnity measures.[47]

3.2 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. Many of the reforms deal directly with constraining the number and size of personal injury payouts. As most medical indemnity claims are related to personal injury cases, some of these reforms are expected to have an impact on the cost of providing medical indemnity insurance.

The major reforms to tort law include the introduction of:

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

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

47 Medical Indemnity Policy Review Panel, *Achieving stability and premium affordability in the Australian medical indemnity marketplace*, February 2007, p. 2.

4 Trends in costs and premiums in medical indemnity insurance

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 six current medical indemnity providers about their costs and pricing.

The ACCC used this information to determine trends in the costs associated with providing medical indemnity insurance to 30 June 2006 and trends in premiums charged for indemnity protection.[48, 49]

The ACCC has not included Invivo within the historical trend analysis contained in this chapter because it is a start-up operation and as such has only current information on costs and premiums, which is analysed in chapters 5, 6 and 7.

4.1 Cost components of medical indemnity insurance

The ACCC examined the cost components of the five medical defence organisation (MDO)-owned insurers'[50] total premium pools for the four underwriting years between 2003–04 and 2006–07. Table 4.1 shows the percentage of the actuarially recommended aggregate premium pool for each cost category, which is presented as an average estimate based on the responses across insurers.

48 With the exception of section 4.1, section 4.2 and chart 4.7, all analysis contained in this chapter includes United/Australasian Medical Insurance Limited (AMIL) results on a financial year basis.

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

50 Table 4.1 examines only the actuarially recommended aggregate premium pool for the five MDO-owned medical indemnity providers and does not include information on Invivo. This is because Invivo prices on a 'bottom up' basis, as opposed to establishing a premium pool and determining relativities based on specialty, jurisdiction or income. Invivo's pricing methodology is discussed in further detail in section 5.4.1.

Table 4.1 Components of actuarially recommended aggregate premium pool: 2003–04 to 2006–07

	2003–04	2004–05	2005–06	2006–07
Expected surplus[51]	36	26	21	19
Net claims costs[52]	32	36	40	45
Reinsurance expenses	17	16	14	13
Underwriting and general expenses	15	22	25	23
Total premium pool	100	100	100	100

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

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

The table shows that for the 2006–07 underwriting year the net cost of claims was the largest component of the premium pool at 45 per cent. Expected surplus represented 19 per cent, underwriting and general expenses 23 per cent and reinsurance expenses 13 per cent.

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

4.2 Trends in medical indemnity claims

The cost of claims is the most significant driver of premiums in medical indemnity insurance. This section examines the major cost component of medical indemnity insurance by examining trends in the following indicators[53]:

- ultimate claims costs by notification year—the ultimate costs of claims[54] expected to be met by medical indemnity providers by year of notification[55]

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

52 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 HCCS, ROCS or the UMP support scheme.

53 For the fourth monitoring report the ACCC specifically requested that insurers provide the total number of claims (including incidents likely as well as open and closed claims), the total amount of claims paid to date and the actuarial outstanding claims liability (inflated but undiscounted) as at 30 June 2006. This ensured that insurers provided information to the ACCC on a consistent basis. Due to differing data sources the results shown in section 4.2 may not be directly comparable with that shown in previous monitoring reports.

54 'Ultimate cost of claims' 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, so until all notifications for that year have been finalised, the ultimate cost includes all payments made for claims to date as well as all those expected future payments. Both past payments and future expected payments are in nominal dollars for the years in which they were/are expected to be made. Due to ultimate claims costs and numbers being largely based on expectations, which can change from year to year, data contained within this section may not be directly comparable with that shown in earlier reports.

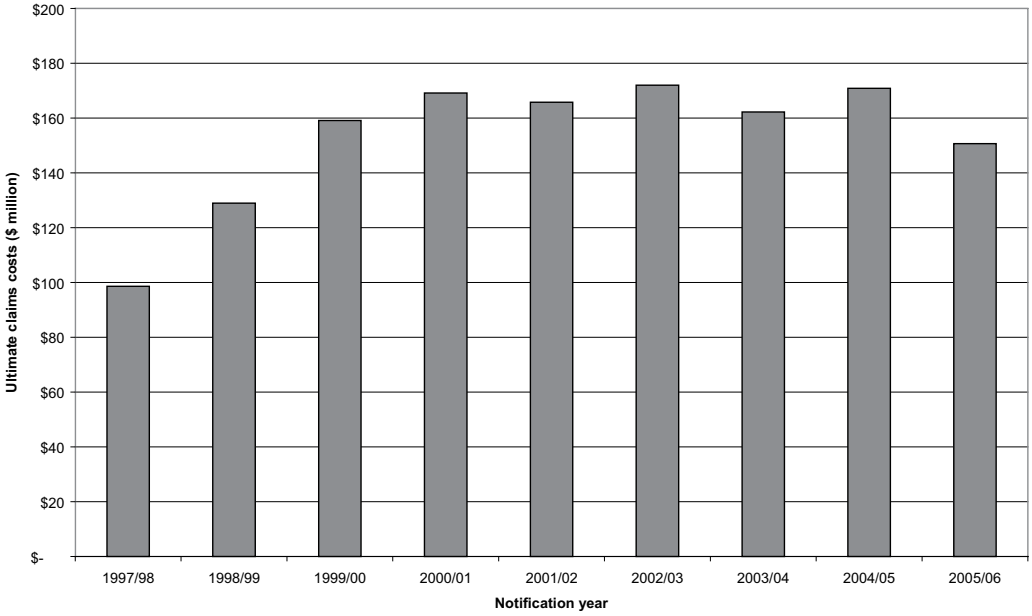
55 The notification year is the year in which an insurer is either notified of an incident occurring or, where no prior notification has been made, when a claim is lodged with an insurer.

- claim frequency—the ultimate number of claims expected by year of notification expressed as a proportion of the total number of Medicare services provided[56] in the corresponding year
- average size of claims—the ultimate expected[57] average size of claims arising from a given notification year that will eventually be settled.

4.2.1 Ultimate claims costs

Chart 4.1 shows the trend in ultimate claims costs[58] for claims notified between 1997–98 and 2005–06.

Chart 4.1 Ultimate claims costs by year of notification: 1997–98 to 2005–06



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

The ultimate cost of claims expected by year of notification increased between 1997–98 and 2000–01 from $99 million to $169 million. The ultimate cost of claims then remained largely constant over the next four years to 2004–05 before falling in 2005–06 to $151 million.

56 In previous reports claims frequency was derived by expressing the number of claims as a proportion of membership for the corresponding underwriting year. Due to potentially inconsistent definitions of membership for earlier years, the ACCC has adopted the number of claims per 100 000 Medicare services as a more consistent measure of claims frequency over time.

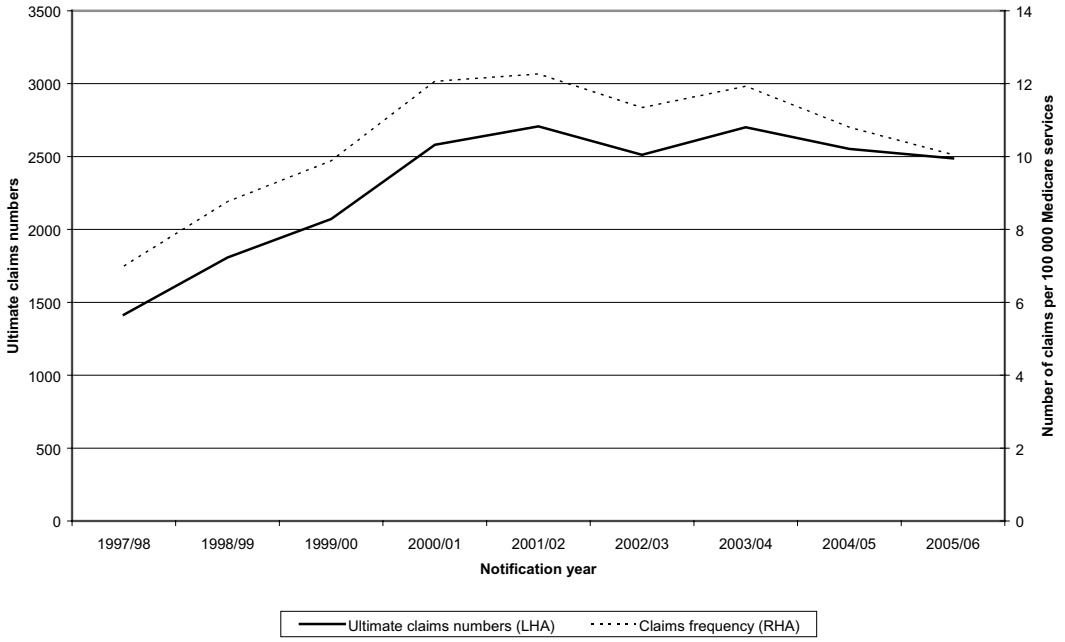
57 The ultimate cost of claims is based on an insurer's past payments as well as a reasonable estimate of future expected payments on unfinalised claims. As this estimate of future expected payments is uncertain, the average claim size for any given year will be an **expected** average size, until all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

58 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.

4.2.2 Claims frequency

Chart 4.2 shows the ultimate number of claims expected to be met by insurers for each notification year between 1997–98 and 2005–06, and the corresponding claims frequency in terms of the number of claims per 100 000 Medicare services provided.

Chart 4.2 Ultimate claim numbers and claims frequency by year of notification: 1997–98 to 2005–06



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

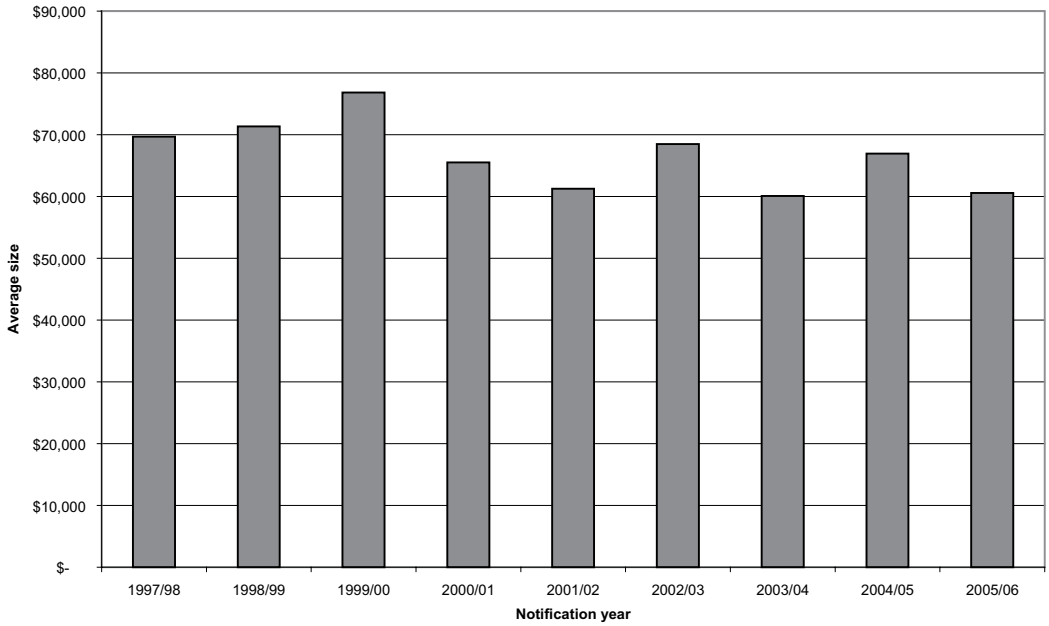
The ultimate number of claims increased by 91 per cent between 1997–98 and 2000–01 (from 1415 to 2707). The ultimate number of claims remained relatively constant over the next four years with 2487 claims in 2005–06.

Claims frequency has followed a largely similar trend to the ultimate number of claims. The number of claims per 100 000 Medicare services increased from 7 to 12 between 1997–98 and 2001–02. The claims frequency then fluctuated marginally in 2002–03 and 2003–04 before falling to a low of 10 claims per 100 000 Medicare services in 2005–06.

4.2.3 Ultimate 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 2005–06.[59]

Chart 4.3 Ultimate average size of claims by year of notification: 1997–98 to 2005–06



Source: Derived by ACCC from data for all medical indemnity providers, excluding Invivo

The ultimate average size of claims increased by 10 per cent between 1997–98 and 1999–2000, from $69 697 to $76 818. The ultimate average cost of claims fell to $65 526 in 2000–01; it fluctuated around that level over the next five years and then dropped to $60 574 in 2005–06.

Individual insurers experience did not necessarily reflect the industry trend, with some insurers showing a strong upward trend in the ultimate average size of claims. However, the results shown in chart 4.3 reflect the ultimate average size of claims incurred across the industry.

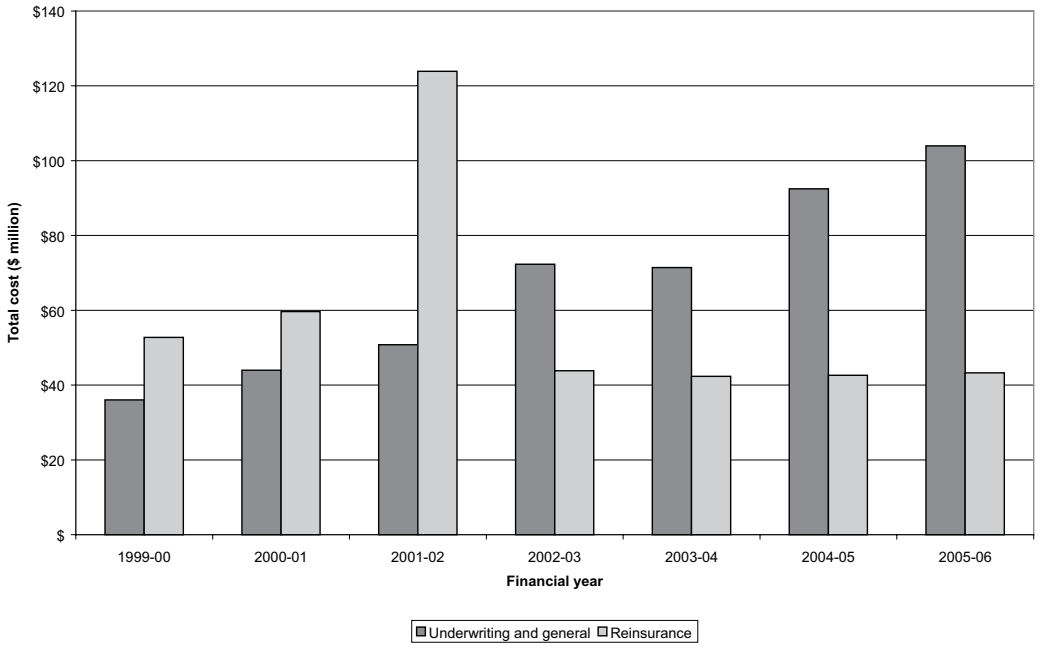
59 Because the calculation of the ultimate cost of claims takes into account both past payments and expected future payments estimates of the ultimate cost of claims in more recent years is still largely uncertain. This is because expected future payments are based on an actuarial estimate of all unfinalised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

4.3 Trends in other expenses

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

Chart 4.4 shows reinsurance expense and underwriting and general expenses for the years 1999–2000 to 2005–06.

Chart 4.4 Reinsurance expense and underwriting and general expenses: 1999–2000 to 2005–06



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

Note: One insurer's reinsurance cost as sourced from its annual report has been adjusted based on information provided directly by that insurer.[60]

Underwriting and general expenses increased in almost all years, from $36 million in 1999–2000 to $104 million in 2005–06.

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

Reinsurance expenses increased from $53 million in 1999–2000 to $60 million in 2000–01, before increasing markedly to $124 million in 2001–02.[61] Reinsurance expenses then fell significantly to $44 million in 2002–03 and remained constant at this level over the following three years, with reinsurance expenses in 2005–06 at $43 million.

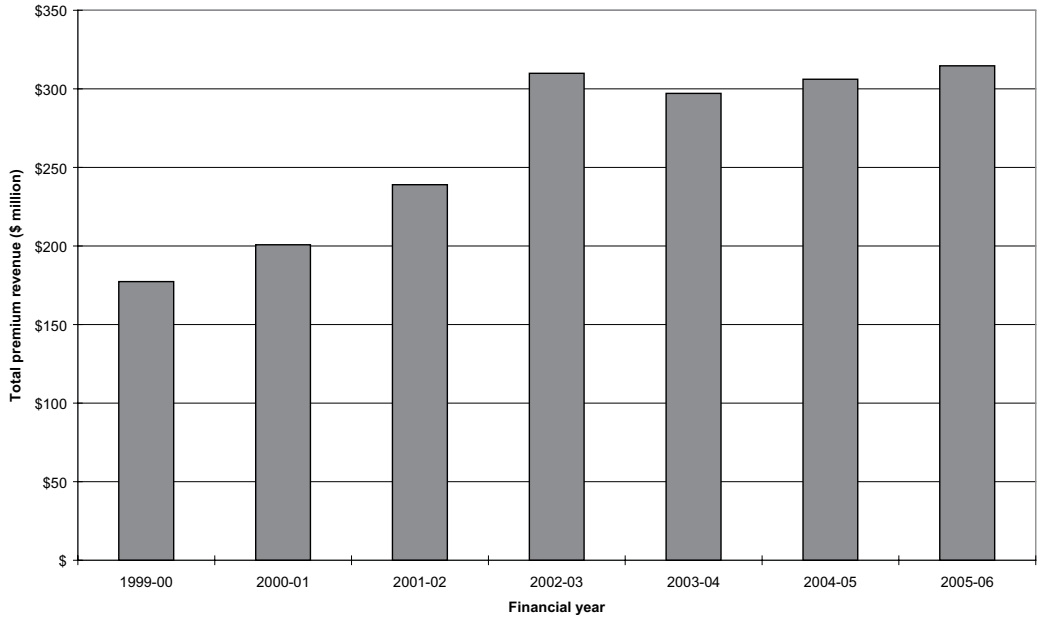
4.4 Trends in premiums

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 policyholders for that year in real terms.[62]

4.4.1 Total premium revenue

Chart 4.5 shows the trend in the total gross premium revenue [63] by underwriting year for the period 1999–2000 to 2005–06.

Chart 4.5 Total gross premium revenue by underwriting year: 1999–2000 to 2005–06



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

Note: Excludes call revenue.[64]

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

62 Adjusted to 30 June 2006 values using the average weekly earnings index published by the Australian Bureau of Statistics (catalogue number 6302.0).

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

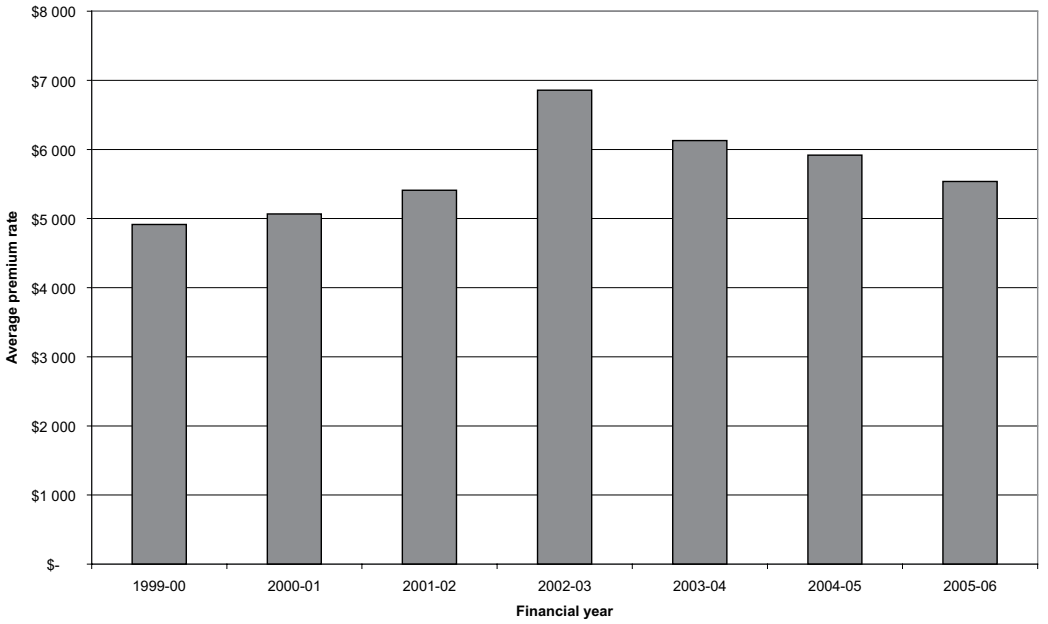
64 Before medical defence organisations were regulated from 1 July 2003, a 'call' was a request by MDOs for additional funding from members to cover current or anticipated future shortfalls. To ease the burden on members, MDOs generally gave members the option of taking several years to pay the amount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

The total gross premium revenue rose significantly, from $177 million in 1999–2000 to $310 million in 2002–03. The total gross premium revenue fell marginally in 2003–04 to $297 million before rising marginally over the next two years to $315 million in 2005–06.

4.4.2 Average premium

Chart 4.6 shows the average premium in real terms paid by medical indemnity insurance policy holders. This average gives an indication of the trend in real premiums payable by all indemnified medical practitioners between 1999–2000 and 2005–06.

Chart 4.6 Average premium—real terms: 1999–2000 to 2005–06



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

Notes: Data is shown in real terms adjusted to 30 June 2006 values using the average weekly earnings (AWE) index published by the Australian Bureau of Statistics (ABS).

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

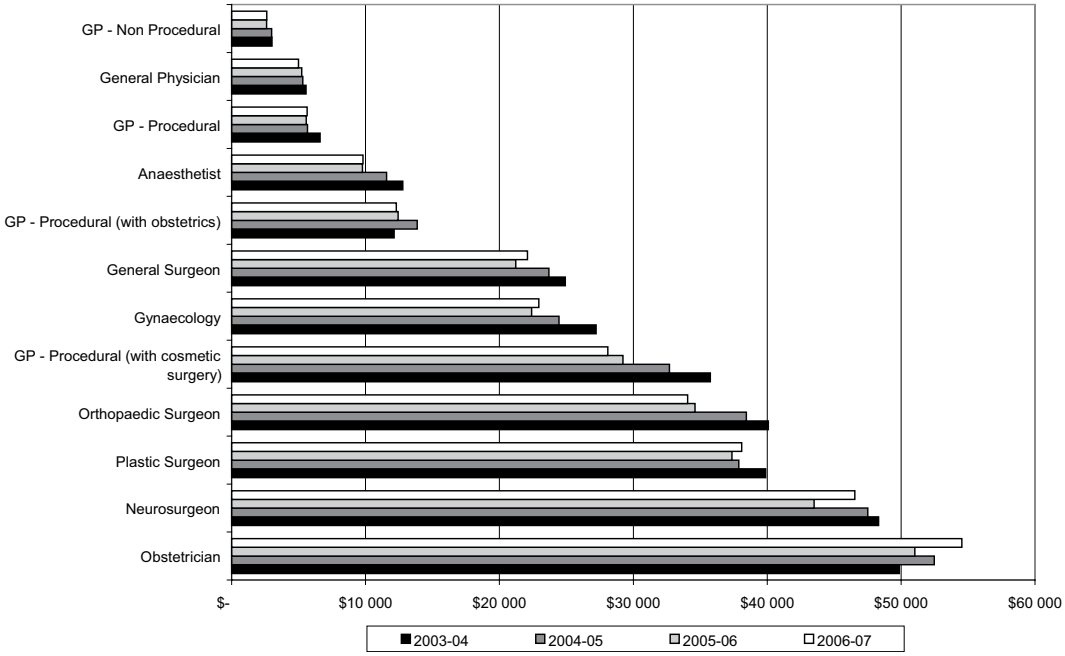
The average premium increased steadily between 1999–00 and 2001–02, from $4914 to $5410 (representing an increase of 10 per cent), before increasing sharply in 2002–03 to $6857 (representing an increase of 27 per cent). The average premium then fell over the next three years to a low of $5537 in 2005–06. The average premium fell by 6 per cent in 2005–06 when compared to premiums in 2004–05.

Medical practitioners who practise relatively more complex medical procedures are likely to face a higher risk of medical negligence claims being made against them than ones who perform less

complex procedures. The complexity of medical procedures is also a key determinant of the size of medical negligence claims. Because levels of risk vary with specialties so do the premiums charged by all medical indemnity insurers for different types of specialties.

To understand the relativities that apply between certain specialties, the ACCC obtained information from insurers on the gross written premiums and membership for individual specialties for the underwriting years between 2003–04 and 2006–07.[65] This information allowed the ACCC to examine the average written premium for selected specialties across the four underwriting years to determine the relativities between specialties as well as any changes in those relativities.

Chart 4.7 Average premium by specialty—real terms: 2003–04 to 2006–07



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

Notes: Data is shown in real terms adjusted to 30 June 2006 values using the AWE index published by the ABS. For 2006–07 data has been discounted to 30 June 2006 values using estimates of AWE for 2006–07 based on historical trends.

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

65 The ACCC asked insurers to provide gross written premium and membership numbers as at a specific date in the 2006–07 underwriting year to allow insurers to provide the data prior to the end of the underwriting year. However, because the majority of insurance is underwritten at the beginning of the underwriting year, the data should provide a reasonable estimate of the full year's results.

Chart 4.7 shows that the average written premium in real terms for the selected specialties varied between $2624 for a non-procedural GP to $54 535 for an obstetrician in 2006–07.[66, 67]

The annual change in average written premiums in 2006–07 compared to 2005–06 was generally an increase across the specialties ranging from 0.4 per cent for anaesthetists to 7 per cent for obstetricians and neurosurgeons. Four specialties, however, experienced decreases in average premiums:

- procedural general practitioners (GPs) with obstetrics (1 per cent)
- orthopaedic surgeons (2 per cent)
- procedural GPs with cosmetic surgery (4 per cent)
- general physicians (5 per cent).

Chart 4.7 also shows the change in the average written premium for the selected specialties between 2003–04 and 2006–07. In real terms the average written premium for most selected specialties generally decreased over the period; over the four years these decreases ranged from 4 per cent for neurosurgeons and plastic surgeons to 23 per cent for anaesthetists. However, two specialties experienced increases in the average premium over the period—average premiums for procedural GPs with obstetrics increased by 1 per cent, while obstetricians' premiums rose by 9 per cent.

This analysis may be influenced by differing characteristics of the membership for each specialty. Some specialties may include differing mixes of non-mature claims-made membership[68], different income levels and different jurisdictions.[69] All these factors may influence the average written premium for reasons other than specialty relativities.

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

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

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

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

5 Actuarial justification of medical indemnity premiums

This chapter presents the findings of the ACCC regarding the actuarial justification of medical indemnity premiums charged for the 2006–07 underwriting period[70] by the six 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.

The ACCC's findings regarding the actuarial justification of medical indemnity premiums charged within each jurisdiction for 2006–07 are discussed in chapter 7.

5.1 Qualifications

The ACCC's analysis is based on information supplied by each of the six medical indemnity providers (including Invivo). The ACCC relied on the information provided by medical indemnity providers rather than performing an independent verification. As the medical defence organization (MDO) parent entities of medical indemnity providers are no longer able to sell insurance, the ACCC has generally not examined their operations, or membership pricing. ACCC analysis only examined the premiums charged by each medical indemnity provider for primary medical indemnity insurance and specifically excluded any examination of ancillary policies, allied health care professionals or the subscription charged by the MDO.

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

5.2 Assessment methodology

5.2.1 Five MDO-owned insurers

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

70 The 2005 calendar year in the case of Australasian Medical Insurance Limited (AMIL).

Specifically, the ACCC examined the following:

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

- examining the purpose for building a surplus into premiums and the appropriateness of the amount needed for each purpose
- quantifying the effect on premiums of any allowance for the surplus.

- Recommended rates/relativities—the premium rate and/or price relativities for each classification used, including specialty and income band relativities. Factors considered include:
  - the method of derivation of relativities across classifications, including the extent of the analysis to confirm or modify risk classifications
  - quantifying cross-subsidies and incorporation of board policy in the recommended rates
  - comparing the actuary's recommended premium relativities against the actual premium rates charged by the insurer, with insurers being asked to explain material differences.

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

- Government reforms—the impact of measures arising from the Australian Government's medical indemnity package and relevant tort law reforms introduced by Commonwealth, state and territory governments on costs and premiums. The ACCC requested specific commentary on the following government initiatives:
  - HCCS—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.
  - 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.
  - 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. When no consideration of the effect of tort law reforms on costs and premiums was given, this was to be noted.

5.2.2 Invivo

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

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

- Ratings process—the method used by Invivo's actuary to determine premium rates. The factors considered by the ACCC include the:

- extent to which premium rates are based on sound actuarial principles and professional standards
- method employed by the actuary to construct the individual premiums for each specialty, the assumptions adopted and the rigour associated with those assumptions
- actuary's inclusion of reasonable allowance for expense, reinsurance and surplus loadings in individual premiums
- extent to which the insurer adopted the actuary's recommended premium rates.

- Government reforms—the impact of measures arising from the Australian Government's medical indemnity package and relevant tort law reforms introduced by Commonwealth, state and territory governments on costs and premiums. The ACCC requested specific commentary on the following government initiatives:
  - HCCS—the ACCC's analysis examined the degree of influence this scheme has had on the calculation of recommended premium rates, estimated claims cost reductions, as well as any allowances made for changes in the level and cost of reinsurance and Invivo's capital requirements.
  - ROCS—the ACCC's analysis examined the degree of influence this scheme has had on the calculation of recommended premium rates, estimated claims cost reductions, as well as any allowances made for changes in the level and cost of reinsurance and Invivo's capital requirements.
  - Tort law reform—the ACCC's analysis examined the effect of tort reforms on the premium setting arrangements. This included specific commentary of the effect on costs, premiums, assumptions and the methodology employed.

Due to differences in the monitoring methodology for Invivo and the other insurers, the ACCC's analysis of the actuarial justification of Invivo's premium is discussed separately in section 5.4.

5.3 Analysis—MDO-owned insurers

5.3.1 Ratings process

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

In general the methodology adopted by these insurers to establish their aggregate premium pools was based on sound actuarial techniques. Further, the results were generally supported by other reports and advices prepared in relation to the insurers operations.

In all cases, the insurer determined the actual premium pool after considering advice from the actuary.

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

The Institute of Actuaries of Australia (IAAust) has now finalised its *Professional Standard on Financial Condition Reports* (PS 305) for general insurers, which encompasses medical indemnity insurers. This standard requires the actuary to consider the adequacy of premiums, as well as to outline, consider and comment on material issues arising from the insurers' pricing processes. The actuary must also consider whether expected future profitability arising from the assessment of premium adequacy is in line with an insurer's plans.

This retrospective consideration of premium adequacy and profits will take effect for financial condition reports effective from 30 June 2006, which means that this analysis can be used for the 2007–08 pricing process.[71]

The ACCC continues to encourage actuaries to assess the adequacy of the aggregate premium pool, including all individual components, based on the actuary's understanding of past experience and their understanding of the insurers' overall operations in their pricing reports.

5.3.2 Pure risk premium

The ACCC considered the pure risk premium component of the aggregate premium pool for the 2006–07 underwriting year. Pure risk premium is the basic building block for determining the aggregate premium pool and represents the direct cost of settling claims. As shown in table 4.1, the net claims cost represented 45 per cent of the aggregate premium pool for the 2006–07 underwriting year.[72]

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

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

The ACCC found that the stated approaches were all considered sound and the assumptions were consistent with, where appropriate, the analysis conducted in the most recent or updated actuarial assessments of insurers' outstanding claims liabilities.

71 The 2007 calendar year in the case of AMIL.

72 The net claims costs is the expected ultimate claims cost net of recoveries received or expected to be received, including those from the Australian Government, under the high cost claims scheme (HCCS), run-off cover scheme (ROCS) and the incurred but not reported (IBNR) scheme in respect of incidents notified in the period of cover.

5.3.3 Expenses

The ACCC considered the amount of expenses incorporated into the aggregate premium pool for the 2006–07 underwriting year. Table 4.1 shows that the expenses represented 23 per cent of the aggregate premium pool for the 2006–07 underwriting year.

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

Previous reports have noted that some actuaries' consideration of the expense component of the aggregate premium pool in pricing reports relied solely on information provided by the insurer. This continued to be that case for some insurers in the 2006–07 underwriting year. As discussed in section 5.3.1, the ACCC believes that actuaries would be prudent to consider how the insurer's recommendations compare with past experience and the actuaries' understanding of the insurer's operations and outline this within their pricing reports.

5.3.4 Reinsurance expenses

The ACCC considered the reinsurance expenses incurred by insurers to assess whether the reinsurance program was used effectively to minimise the insurer's risk exposure and the extent to which the cost of reinsurance was considered in premium rates recommended by the actuary. Table 4.1 shows that that reinsurance expenses represented 13 per cent of the aggregate premium pool.

All medical indemnity insurers used reinsurance programs for the 2006–07 underwriting period to manage the risks inherent in their portfolio. Most insurers used a combination of 'excess of loss' and 'stop loss' reinsurance to manage their risk exposure.[73] 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.[74]

The ACCC examined the expected net cost of reinsurance[75] and found that generally all insurers expected reinsurance recoveries to be considerably less than the value of premiums ceded to the reinsurer, similar to previous years.[76]

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. In this regard the ACCC notes that one insurer significantly altered its reinsurance arrangements for the 2006–07 underwriting year based on its assessment that one component of its potential reinsurance

73 'Excess of loss' reinsurance is where the direct insurer carries all individual losses incurred in respect of each individual claim or event up to a certain limit and the reinsurer pays the loss in excess of this amount (known as the 'attachment point') up to an agreed limit. In addition, there may be an aggregate limit for all claims assumed by the reinsurer. 'Stop loss' reinsurance is where the reinsurer is obliged to cover any part of the total annual loss burden that exceeds an aggregate retention, with the retention being defined as either a percentage of annual premium or a fixed sum.

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

75 The net cost of reinsurance is the reinsurance premium less any reinsurance recovery expected.

76 The ACCC was unable to accurately compare reinsurance costs between the current and previous underwriting periods because the circumstances surrounding reinsurance arrangements changed significantly. Some insurers 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 cost is a result of this or the result of obtaining reinsurance on more favourable terms.

program was deemed to be ineffective in reducing risk in relation to the premium being asked by the reinsurer. The effect of this change was that the insurer has increased its potential loss in the event of adverse claims experience; however, this increase in volatility is managed by holding a greater amount of capital.

The ACCC found this approach to be actuarially justified because the actuary considered the effect of both placing and not placing parts of the reinsurance program on the net claims cost as well as the financial implications relating to its prudential requirements.

5.3.5 Surplus

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

- build the capital needed to achieve the target level set by the Australian Prudential Regulation Authority (APRA)[77, 78]
- build the additional capital needed as a result of risks underwritten in 2006–07 to maintain total capital at, or above, the level required by APRA
- maintain a contingency (or prudential) margin over and above the actuary's central estimate of the outstanding claims liability to increase the probability that the pure risk premium is adequate to meet the cost of claims
- provide a surplus (profit) to the insurer.

Table 4.1 shows that the amount of surplus in the aggregate premium pool has decreased over the past four underwriting years, from 36 per cent in 2003–04 to 19 per cent in 2006–07.

The decrease in the amount of the aggregate premium pool represented by surplus reflects the fact that insurers initially used the surplus to build capital to APRA's target level of 150 per cent of minimum capital requirement (MCR) and, as insurers' capital levels approach or pass this, or their own internal target[79], a significant surplus is no longer needed.

For the 2006–07 underwriting period the ACCC found that four medical indemnity providers indicated that, as they had now satisfied their internal solvency targets, they did not need to include the significant surplus loading built into previous years' premiums. The remaining medical indemnity provider continued to build capital loadings into its aggregate premium pools predominantly to meet APRA's capital target.[80]

77 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.

78 The ACCC understands that APRA has targeted 150 per cent minimum capital requirement (MCR) as the expected level of capital to be held by the five MDO-owned insurers.

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

80 The ACCC has noted in previous monitoring reports 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 of the level of stamp duty) of capital.

The medical indemnity providers with capital that had reached or exceeded APRA's or their own higher internal target capital levels 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 level sufficient to continue to meet or exceed APRA's target capital after taking into account the additional risks underwritten in 2006–07, or to maintain a contingency margin.

One insurer included a capital component in its aggregate premium pool that would increase its capital levels beyond its internal target levels. This was done to smooth premium increases over a four-year period. Capital levels for the insurer were at levels sufficient to enable it to decrease premiums in the current underwriting year, but this would mean that future underwriting years would require premium increases to maintain capital adequacy. While this meant that in the short-term this insurer increased its capital by an amount greater than required, its capital adequacy was expected to return to its internal target level by the end of the four-year period.

The ACCC determined that while this approach may not be desirable for consumers in the short term, premium decreases in the current underwriting year followed by significant increases in following years would not be beneficial for industry stability or consumers' perception of the state of the industry. The ACCC took into account the long-term pricing goals as well as the overall capital position of the insurer when determining the actuarial justification of this insurer's current year premiums.

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

The ACCC noted in previous monitoring reports that in some cases the actuary relied on information provided by the insurer in their determination of the surplus component of the premium pool. This continued to be the case for some insurers in the 2006–07 underwriting year. The ACCC believes it would be prudent for actuaries to consider how the insurer's recommendations compare with their understanding of the insurer's capital and funding objectives and outline this within their pricing reports.

5.3.6 Recommended relativities and cross-subsidisation

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

The ACCC found that most medical indemnity providers had undertaken extensive analysis of the premium relativities across specialties. Insurers typically examined historical frequency and average size by specialty. The ACCC found that cross-subsidisation between specialties was common across medical indemnity providers and that in some cases significant variance between the technical and actual relativities existed. While insurers indicated that they were moving to unwind these cross-subsidies, many indicated that this was a long-term process and potentially not all cross-subsidies would be removed for a variety of reasons, including commercial factors as well as data limitations. All insurers identified and quantified cross-subsidies between risk specialties.[81]

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

The ACCC also examined the premium relativities applied across broad income bands. Similar to the analysis done for specialties, insurers generally examined these rates by comparing the risk relativities between income bands. Cross-subsidies exist between income bands and again some insurers indicated a desire to unwind these but generally made only limited changes to income banding relativities in 2006–07.

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

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

5.3.7 Government reforms

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

The high cost claims scheme

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

All insurers took into account the full amount of expected HCCS recoveries in determining the pure risk premium for the 2006–07 underwriting year. Three insurers indicated that they had factored the full effect of the HCCS into their 2006–07 reinsurance programs. As noted in the ACCC's third monitoring report, the rationale of the remaining two insurers for not factoring the HCCS into the reinsurance program differed.

One insurer stated that it had not factored HCCS into its reinsurance program because the reinsurer was not prepared to make appropriate allowances for HCCS recoveries in setting the reinsurance program. This insurer indicated that it would be better off financially by placing its reinsurance program without taking HCCS into account.

The second insurer placed its reinsurance program in the same manner as for 2005–06 by reinsuring the full amount of all high-cost claims, but then allowing for a mechanism through which 50 per cent of HCCS recoveries accrue directly to its reinsurers in exchange for a discount on the reinsurance premium. The remaining 50 per cent of HCCS recoveries accrue directly to the insurer because not all reinsurers would agree to the above arrangements.

The ACCC noted in its third monitoring report that by not factoring HCCS recoveries into reinsurance programs, insurers have the potential to 'double dip'. That is, should a high-cost claim arise, they may recover the full amount of that claim from the reinsurer (depending on their position within the reinsurance program) and then receive an additional recovery of 50 per cent of the claim amount above the HCCS threshold. In effect this means insurers could recover more than the actual claim amount.

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

Run-off cover scheme

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

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

The remaining insurer did not build ROCS recoveries into its premiums but rather assumed that the net impact on it would be a nil cost as full recovery of all eligible claims could be received from ROCS.

All insurers correctly incorporated the ROCS levy into the premiums charged to medical practitioners.

Based on this, the ACCC found that the insurers' consideration of ROCS in determining their premiums for the 2006–07 underwriting year was actuarially justified.

Tort law reform

Commonwealth, state and territory governments have progressively introduced tort law reforms since early 2001 in response to problems perceived in the availability and affordability of public liability and professional indemnity insurance.[82] Many of the reforms deal directly with constraining the number and size of personal injury payouts. As most medical indemnity claims are for personal injury cases, some of these reforms are expected to affect the cost of providing medical indemnity insurance.

Only one insurer did not take tort law reform into account when setting premiums for 2006–07, suggesting that while reforms may affect its claims costs, because of the structure of its reinsurance program, the benefits would likely be seen by its reinsurers.

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

The remaining four insurers implicitly took tort law reform into account when setting premiums because they adopted assumptions for average claim size and frequency based on past experience that incorporated tort law reform. While generally these insurers indicated that claim numbers had decreased post-tort law reform, most opted for a cautious approach in directly attributing this to tort law reform.

5.3.8 Conclusion

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

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

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

An issue relating to the aggregate premium pool of the five MDO-owned insurers was the actuaries' consideration of the expense, reinsurance and surplus components. The ACCC found that while all actuaries considered these components to various extents, some continued to rely on the insurer to determine some or all of these components and did not independently examine these components in light of past experience and the actuaries' understanding of the insurers' operations and capital management policies. The ACCC would encourage all actuaries to independently examine these components rather than rely on the advice of insurers.

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

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

As mentioned earlier, two insurers did not reflect HCCS in their reinsurance program because of the unwillingness of their reinsurers to fully reflect the full benefits of the scheme in their reinsurance

pricing and structure. Importantly, both insurers fully took the HCCS recoveries into account when establishing their pure risk premium. The majority of insurers took tort law reform into account in setting their aggregate premium pools for 2006–07.

5.4 Analysis—Invivo

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

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

5.4.1 Ratings process

The method employed by Invivo in constructing premiums was based on calculating individual premiums for each specialty. The process used included an analysis of the ultimate claims frequency and average claims size by specialty, including an assessment of the impact of reinsurance and government reforms. Using this analysis Invivo established gross premiums payable to QBE Insurance (Australia) Limited by including the following components:

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

The ACCC has compared Invivo's estimates for the above components of individual premiums with the respective components of the five MDO-owned insurers shown in table 4.1 and found them to be broadly similar. The ACCC also examined the extent to which Invivo adopted the actuary's recommended premium rates and found them to be not inconsistent.

5.4.2 Government reforms

The high cost claims scheme

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

Invivo examined the effect of HCCS on its pure risk premium and took into account the full amount of expected HCCS recoveries. Further, Invivo's reinsurance program was designed to reinsure only 50 per cent of the cost of high cost claims, with the other 50 per cent coming from HCCS recoveries.

The run-off cover scheme

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

Invivo did not take any ROCS recoveries into account in estimating its claims costs because of its pricing methodology, which prices risks individually. Because it is not estimating the total cost of claims for all insureds, some of which may be covered by ROCS, it does not need to factor either the recoveries or the levy into its pricing assumptions. This is because the scheme will operate on a cost neutral basis to the insurer.

Tort law reform

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

5.4.3 Invivo conclusion

The ACCC found that Invivo's premiums were considered to be actuarially justified. This determination was based on an examination of its ratings process, and the impact of specific government reforms on premiums.

5.5 Conclusion

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

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

One issue that arose in relation to the aggregate premium pool was the actuaries' consideration of the expense, reinsurance and surplus components. The ACCC found that while all actuaries considered these components to various extents, some continued to rely on the insurer to determine some or all of these components. The ACCC would encourage actuaries to examine these components in terms of past experience and their understanding of the insurers' operations and capital management policies and objectives in future pricing reports.

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

The ACCC found that all insurers factored HCCS and ROCS into their premium determination and most insurers took full account of HCCS in their reinsurance programs. The two insurers that did not reflect HCCS in their reinsurance program did so because of an unwillingness of reinsurers to fully reflect the full benefits of the scheme in their reinsurance pricing and structure. Importantly, both insurers took the HCCS recoveries into full account when establishing their pure risk premium. The majority of insurers took tort law reform into account in setting their aggregate premium pools for 2006–07.

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

6 Commercial justification of medical indemnity premiums

This chapter presents the findings of the ACCC regarding the commercial justification of medical indemnity premiums charged for the 2006–07 underwriting period[83] by the six current medical indemnity providers to private medical practitioners.

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

The ACCC findings regarding the commercial justification of medical indemnity premiums charged within each jurisdiction for 2006–07 are discussed in chapter 7.

6.1 Qualifications

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

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

6.2 Assessment methodology

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

Fiscally responsible insurers examine the financial impact of pricing decisions on their operations by preparing business plans that describe how they intend to manage their business. They also prepare detailed corporate plans on the financial effect (including on the income statement and balance sheet) of the business plan on their overall corporate strategies. This type of analysis is necessary to ensure that insurers are capital compliant with the Australian Prudential Regulation Authority's targeted capital level by 30 June 2008, as their pricing decisions in the current underwriting period will affect their financial position at the end of the transition period.[84]

83 The 2006 calendar year in the case of Australasian Medical Insurance Limited (AMIL).

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

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

- The financial projections contained in their initial funding plans as provided to the Australian Prudential Regulation Authority to make use of the transition period for building the capital to APRA-targeted capital (referred to as '2002–03 projections').
- The revised financial projections prepared in 2003–04, 2004–05 and 2005–06 (referred to respectively as '2003–04 projections', '2004–05 projections' and '2005–06 projections'). These projections are typically updated each year to take into account more recent data and developments.[85]
- The actual financial position as at 30 June 2004, 30 June 2005 and 30 June 2006 based on annual reporting data[86] provided to APRA (referred to as 'actual results').

Comparing these sets of data allows the ACCC to examine how insurers' financial position forecasts have changed over the four years and whether forecasts for 2005–06 were based on actual data for 2005–06.

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

- solvency[87]—the current and forecast net asset position of insurers to assess levels of solvency
- emerging surplus—the emerging and forecast levels of surplus loading in premium and whether this was sufficient to achieve the medical indemnity providers' targeted solvency and capital requirements
- minimum capital requirement coverage and capital targets—current and forecast levels of MCR coverage to examine whether capital targets would be met
- return on net assets—current and forecast return on net assets
- underwriting performance—the emerging and forecast underwriting performance in terms of the loss, expense, reinsurance and combined ratios, which are defined in section 6.3.5.

The ACCC's ability to report on the commercial justification of Invivo's premiums for the 2006–07 underwriting year was limited because of data constraints surrounding the company. This is because Invivo is:

- a start-up organisation, so historical information is not available

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

86 APRA's reporting requirements require quarterly reporting forms to be provided within four weeks of the end of the reporting period, as opposed to annual reporting forms which are required to be provided within three to four months. In previous reports the ACCC has used quarterly data for the most recent year due to timing constraints.

In the third monitoring report the ACCC relied on quarterly reporting data for the 2004–05 actual results provided to APRA, due to timing constraints. With the availability of annual reporting data the ACCC has updated these results in the current monitoring reports. This may mean that the results between the third monitoring report and this report may not be directly comparable due to changes made to the final audited annual returns.

Due to the timing of the government's requests for the ACCC to continue monitoring, the ACCC has been able to use annual data for the actual results as at 30 June 2006 in this report.

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

- affiliated with a large insurer that underwrites insurance other than medical indemnity[88] so it is difficult to disaggregate its medical indemnity insurance results from other professional indemnity business.

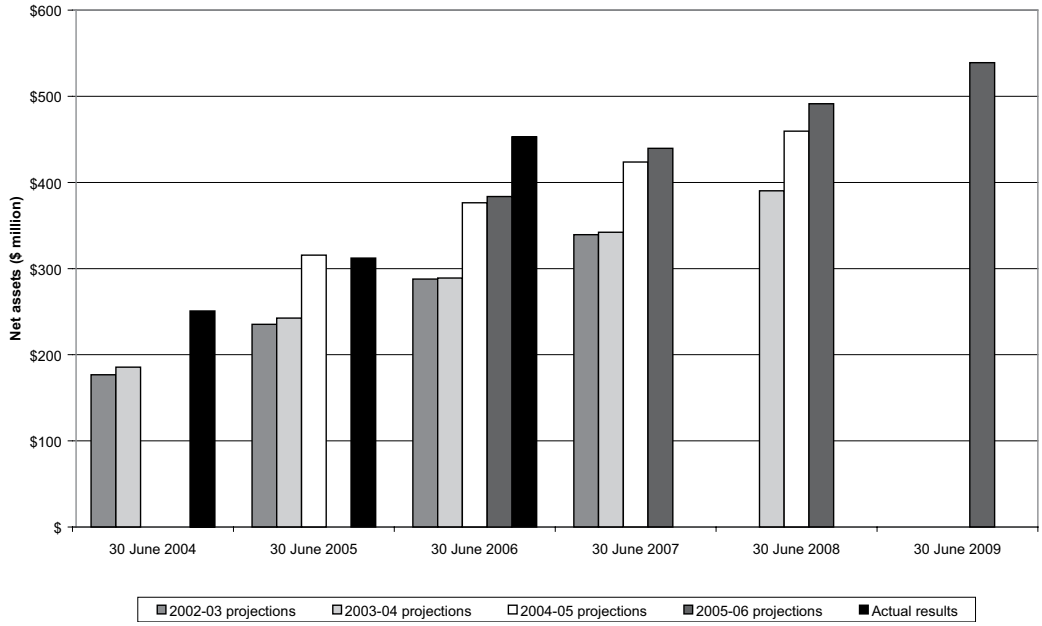
The ACCC has not included Invivo's data in the industry analysis contained in chapter 6; however, it has separately examined QBE's medical indemnity premiums and Invivo's financial plans to determine the commercial justification of its 2006–07 premiums.

6.3 Analysis—MDO-owned insurers

6.3.1 Solvency targets

The ACCC assessed medical indemnity providers' actual solvency level as at 30 June 2004 to 30 June 2006 and compared these against the projections of solvency based on the four projections years between 2002–03 and 2005–06. This is shown in chart 6.1.

Chart 6.1 Net assets: 30 June 2004, 30 June 2005 and 30 June 2006 actual position and 2002–03, 2003–04, 2004–05 and 2005–06 projections



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

88 The MDO-owned insurers only underwrite medical indemnity insurance, whereas QBE underwrites medical indemnity insurance as well as a range of commercial and personal lines of insurance.

Chart 6.1 shows that the 2002–03 projections originally forecast that the net assets of the medical indemnity industry would increase from $177 million to $340 million between 30 June 2004 and 30 June 2007. These forecast positions improved when subsequently revised in 2003–04, 2004–05 and 2005–06. The 2005–06 projections forecast the net asset position to grow from $384 million at 30 June 2006 to $539 million at 30 June 2009.

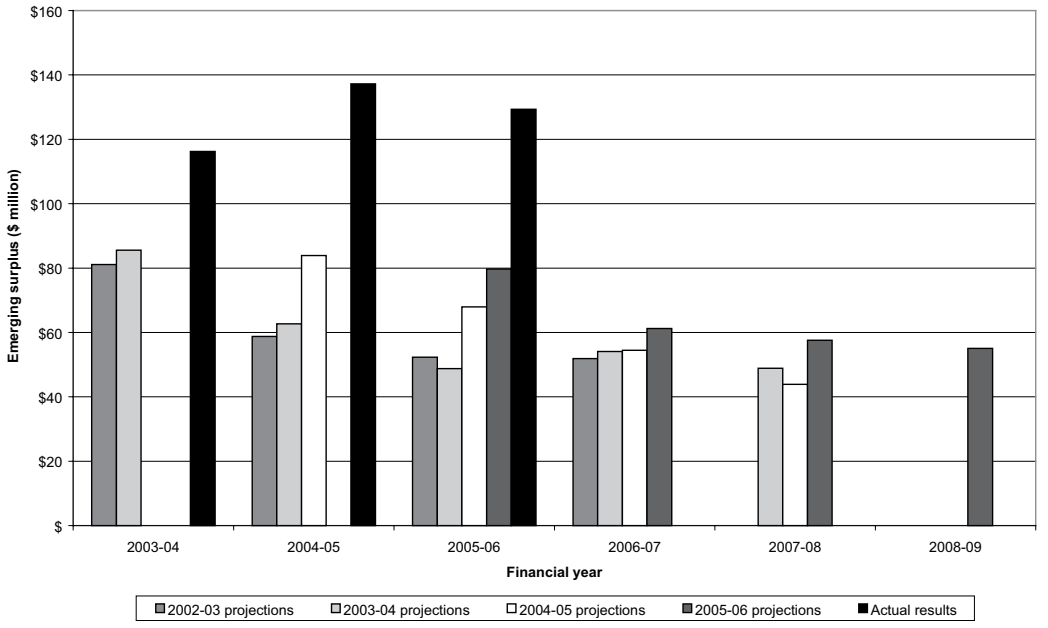
As at 30 June 2006 the industry was in a strong solvency position with total assets exceeding total liabilities by $453 million. This was a significant improvement on the actual result observed at 30 June 2005 of $312 million. Further, the solvency position at 30 June 2006 was greater than anticipated in all projections.

The degree to which the net asset position improved depended on the circumstances of individual insurers. The position of three insurers at 30 June 2005 was such that they no longer intended to build capital into premiums for the 2005–06 underwriting year. The stronger results as at 30 June 2006 meant that four insurers no longer needed to build capital through premiums in the 2006–07 underwriting year.

6.3.2 Emerging surplus

The ACCC assessed the actual emerging surplus for 2003–04, 2004–05 and 2005–06 and compared this against the emerging surplus forecast in the four projection years between 2002–03 and 2005–06.[89] This is shown in chart 6.2.

Chart 6.2 Emerging surplus: 2003–04, 2004–05 and 2005–06 actual position and 2002–03, 2003–04, 2004–05 and 2005–06 projections



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

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

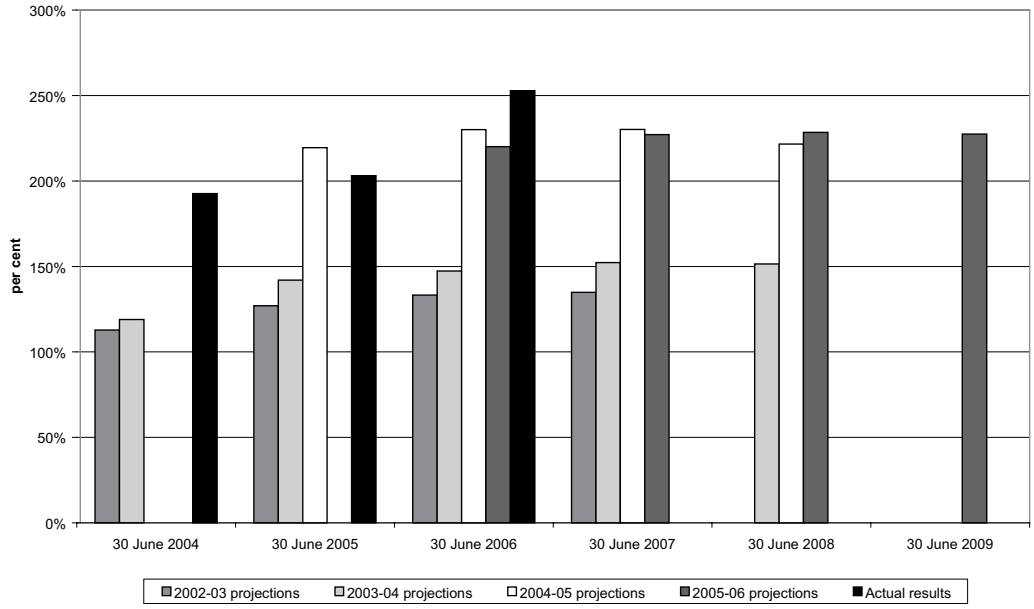
The chart shows that based on the 2002–03 projections the level of emerging surplus was forecast to decrease from $81 million in 2003–04 to $52 million in 2006–07. A declining emerging surplus is also reflected in the 2003–04, 2004–05 and 2005–06 projections. The emerging surplus predicted in the 2005–06 projections is $80 million in 2005–06, falling to $55 million in 2008–09. 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 has been raised to meet insurers' targets.

The medical indemnity industry achieved an emerging surplus of $129 million in 2005–06, significantly higher than that forecast in all four sets of projections. This primarily resulted from higher premium and investment income in 2005–06 than was forecast in previous periods. Although at significantly higher levels to that forecast, the surplus did, however, reduce in 2005–06.

6.3.3 MCR coverall and capital targets

The ACCC assessed the actual financial position of the MDO-owned medical indemnity insurers as at 30 June 2006 and compared this against the financial position forecast in the four projection years between 2002–03 and 2005–06. The ACCC examined the net asset[90] to MCR ratio as an indicator of financial position, as shown in chart 6.3.

Chart 6.3 Net asset to MCR ratio: 30 June 2004, 30 June 2005 and 30 June 2006 actual position and 2002–03, 2003–04, 2004–05 and 2005–06 projections



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

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

The chart shows that the 2002–03 projections forecast the medical indemnity industry to have a net asset position equal to 113 per cent of MCR at 30 June 2004, rising to 135 per cent by 30 June 2007. The 2003–04 projections were also broadly consistent with the 2002–03 projections; however, the 2004–05 and 2005–06 projections forecast a significantly higher net asset to MCR ratio over the same period. The 2005–06 projections forecast the MCR coverage to be 220 per cent at 30 June 2006 and remaining around this level until 30 June 2009.

The 2005–06 projections generally had all insurers maintaining their MCR coverage at or near the 30 June 2006 projected level through to 30 June 2009, suggesting that most insurers expected only to raise capital for the purposes of maintaining target capital levels.

The actual net asset to MCR ratio of the medical indemnity industry at 30 June 2006 of 253 per cent was significantly higher than all projections.

As at 30 June 2006 all but one insurer significantly exceeded the target 150 per cent MCR coverage required by APRA[91]; further, all these insurers exceeded, or were only marginally below, their 2005–06 projections.

The remaining insurer whose net asset to MCR ratio was below that required by APRA was above its 2005–06 revised projections and expected to meet the APRA target in the 2006–07 year.

The ACCC notes that, as for the 2005–06 underwriting year, one insurer did not incorporate sufficient capital within its insurance premiums to maintain its net asset to MCR ratio. To compensate for this, the insurer's parent entity is scheduled to make a capital injection in 2006–07, as well as further injections in future years.

Capital injections from the parent entity are generally a more efficient method of raising capital than a loading in insurance premiums[92]; further, it is also a more efficient way to utilise otherwise unused capital in not-for-profit organisations, such as MDOs.[93]

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

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

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

92 Raising capital through insurance premiums incurs 10 per cent goods and services tax, between 5 and 10 per cent stamp duty (depending on the jurisdiction), and 8.5 per cent run-off cover scheme (ROCS) levy. Income tax is also charged on profit at 30 per cent. As a result, every $1 of capital loading in premiums coverts to between $0.52 and $0.55 (depending on the level of stamp duty) of capital.

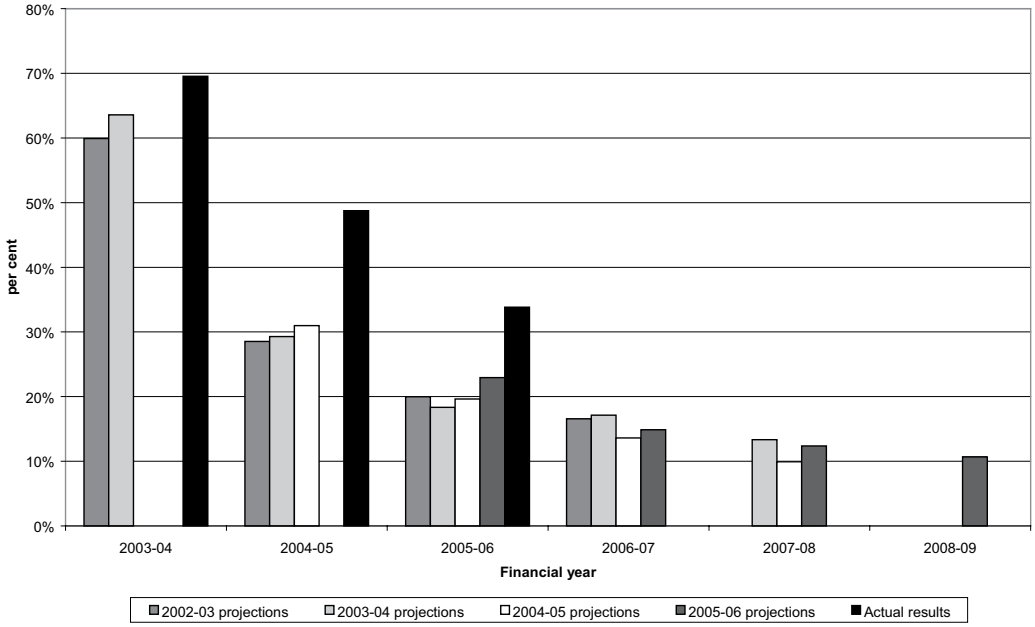
Alternatively, subscriptions raised through the parent MDO do not incur stamp duty or the ROCS levy, and, as they operate as not for profit organisations, only incur income tax on investment returns.

93 MDOs are not subject to the same prudential requirements as the licensed insurer and as such have a lesser need to hold free capital.

6.3.4 Return on net assets

The ACCC assessed the returns of the MDO-owned medical indemnity insurers relative to their net asset position and compared these against the four projection years between 2002–03 and 2005–06. This is shown in chart 6.4.

Chart 6.4 Return on net assets: 2003–04, 2004–05 and 2005–06 actual position and 2002–03, 2003–04, 2004–05 and 2005–06 projections



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

Chart 6.4 shows that in 2002–03 the projected return on net assets was forecast to decrease from 60 per cent in 2003–04 to 17 per cent in 2006–07. This trend of a decline in the return of net assets was also reflected in the 2003–04, 2004–05 and 2005–06 projections. In 2005–06 the projected return on net assets was forecast to continue to decline from 23 per cent in 2005–06 to 11 per cent in 2008–09.

The return on net assets is projected to decrease because insurers initially raised significant surpluses to fund capital requirements when their asset bases were low, but, once those capital targets are achieved, the required surplus reduces.[94]

The actual returns on net assets of 70 per cent for 2003–04, 49 per cent for 2004–05 and 34 per cent for 2005–06 were higher than all projections and generally reflect insurers reaching APRA's MCR requirements earlier than projected. The downwards trend in the actual results, however, was consistent with the projections.

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

6.3.5 Underwriting performance

The ACCC examined the underwriting performance in terms of the:

- Loss ratio—the total claims expense attributable to each financial year on claims arising from that or previous years as a proportion of premium revenue.[95]
- 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 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.[96]

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

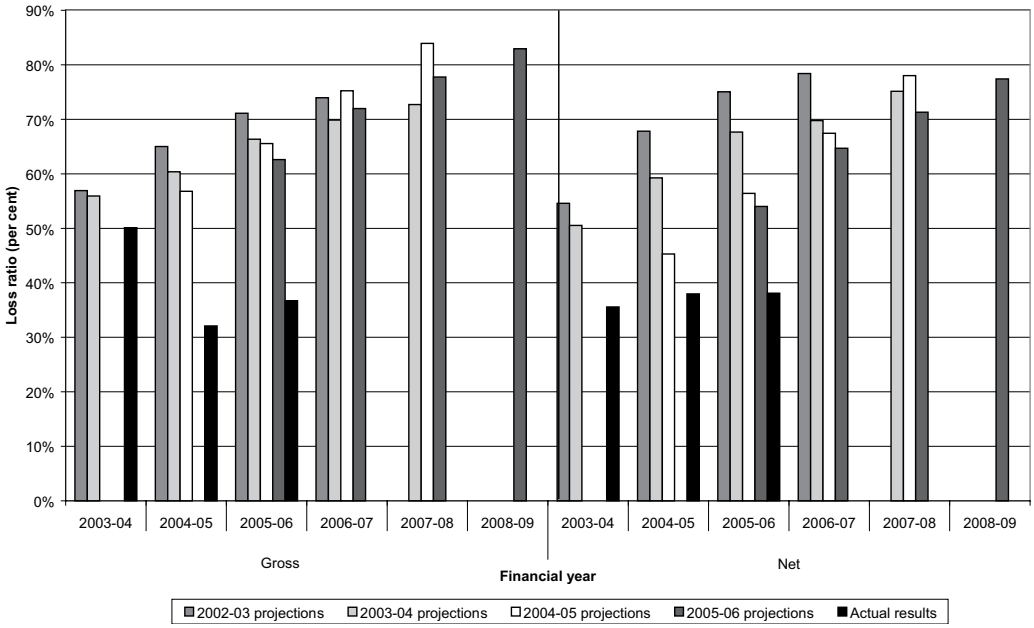
Loss ratio

Chart 6.5 shows the gross and net loss ratios for the five MDO-owned insurers based on the 2002–03, 2003–04, 2004–05 and 2005–06 financial projections of insurers. It also shows the actual loss ratios for 2003–04, 2004–05 and 2005–06.

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

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

Chart 6.5 Gross and net loss ratio: 2003–04, 2004–05 and 2005–06 actual position and 2002–03, 2003–04, 2004–05 and 2005–06 projections



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

The chart shows that the 2002–03 projections forecast the gross loss ratio to rise from 57 per cent in 2003–04 to 74 per cent in 2006–07. Subsequent projections also forecast increasing loss ratios, although the magnitude of the increase has generally been decreasing in subsequent projections. The 2005–06 projections forecast the gross loss ratio increasing from 63 per cent in 2005–06 to 83 per cent in 2008–09. The direction of projections for the net loss ratios was also similar to that observed for the gross loss ratios.

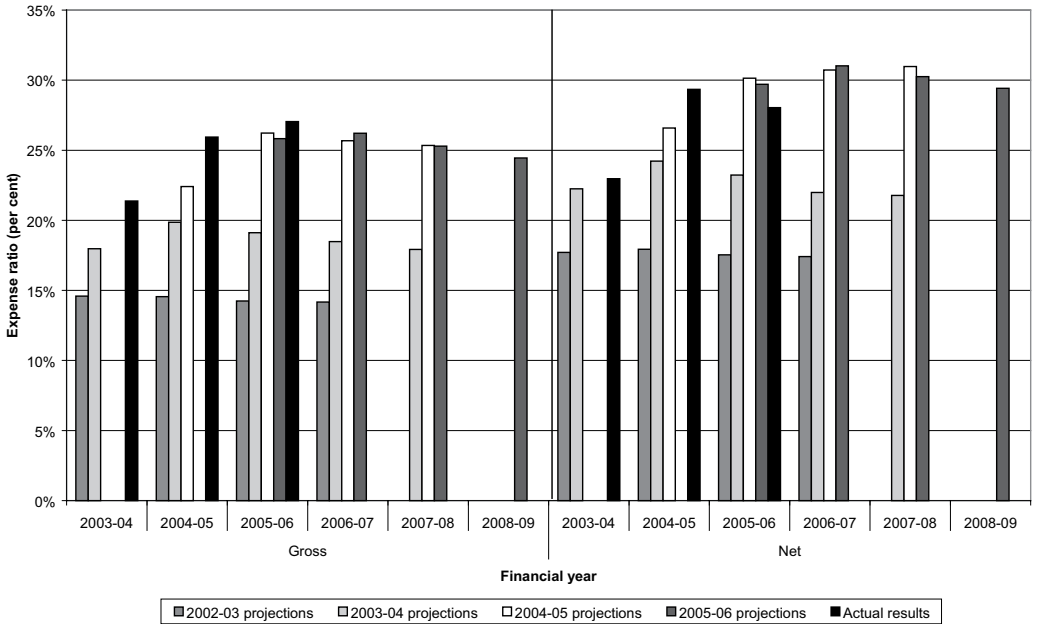
The actual result for the gross and net loss ratio in 2005–06, of 37 and 38 per cent respectively, is significantly lower than all projections. This trend is similar to that observed for 2003–04 and 2004–05. Actual loss ratios have been lower than projections as a result of actual premium income generally being higher than projections and actual claims costs generally being lower than projections.

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

Expense ratio

Chart 6.6 shows the gross and net expense ratios for the five MDO-owned insurers based on the 2002–03, 2003–04, 2004–05 and 2005–06 financial projections of insurers. It also shows the actual expense ratios for 2003–04, 2004–05 and 2005–06.[97]

Chart 6.6 Gross and net expense ratio: 2003–04, 2004–05 and 2005–06 actual position and 2002–03, 2003–04, 2004–05 and 2005–06 projections



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

The chart shows that based on 2002–03 projections the gross expense ratio was forecast to be between 14 and 15 per cent between 2003–04 and 2006–07, while the net expense ratio was forecast to be between 17 and 18 per cent. The 2004–05 and 2005–06 projections are higher than earlier projections, reflecting higher than forecast actual results in 2003–04 and 2004–05. The 2005–06 projections are in line with the 2004–05 projections for both the gross and net expense ratio, with forecasts ranging between 24 and 26 per cent and 29 and 31 per cent respectively between 2005–06 and 2008–09.

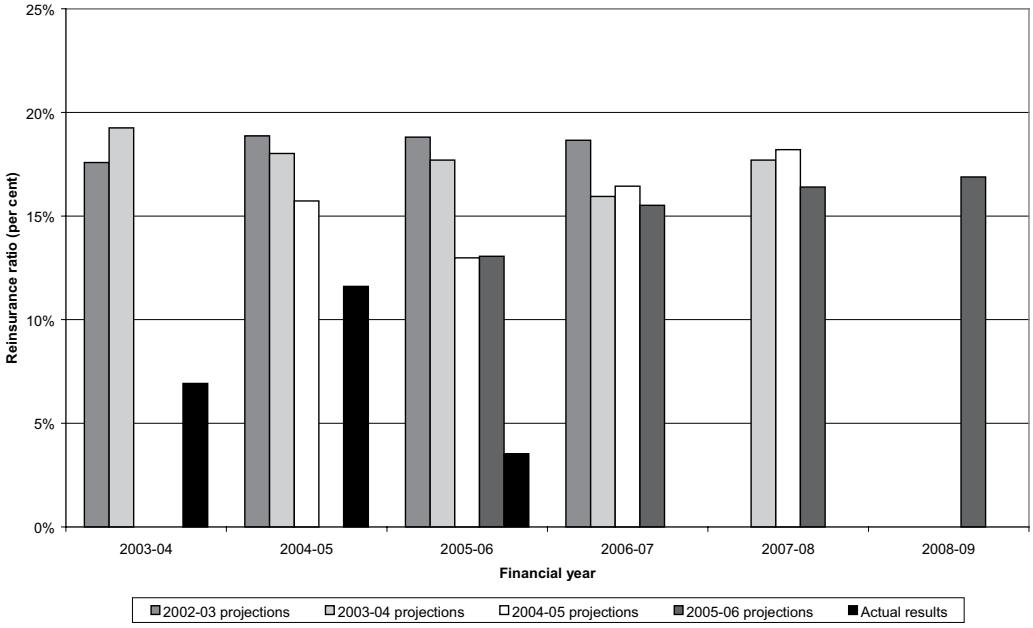
The actual gross expense ratio in 2005–06 of 27 per cent was marginally higher than the 2004–05 and 2005–06 projections, while the net expense ratio of 28 per cent was marginally lower than the projections for 2004–05 and 2005–06.

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

Reinsurance ratio

Chart 6.7 shows the reinsurance ratio for the five MDO-owned insurers based on the 2002–03, 2003–04, 2004–05 and 2005–06 financial projections of insurers. It also shows the actual reinsurance ratio for 2003–04, 2004–05 and 2005–06.

Chart 6.7 Reinsurance ratio: 2003–04, 2004–05 and 2005–06 actual position and 2002–03, 2003–04, 2004–05 and 2005–06 projections



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

The chart shows that based on 2002–03 projections the reinsurance ratios were forecast to be between 18 and 19 per cent between 2003–04 and 2006–07. The 2003–04 projections were similar to the 2002–03 forecasts over the same period. Revised projections were generally consistent with the 2002–03 projections with a few exceptions. The 2005–06 projections forecast the reinsurance ratio to increase marginally over the period from 13 per cent in 2005–06 to 17 per cent in 2008–09.

The actual reinsurance ratio for the industry of 4 per cent for 2005–06 was significantly lower than projected. However, the industry results observed do not reflect the individual experience of all insurers. While generally most insurers' actual individual reinsurance ratios were lower than projections, one insurer's ratio was significantly below its projections, which influenced the industry result.

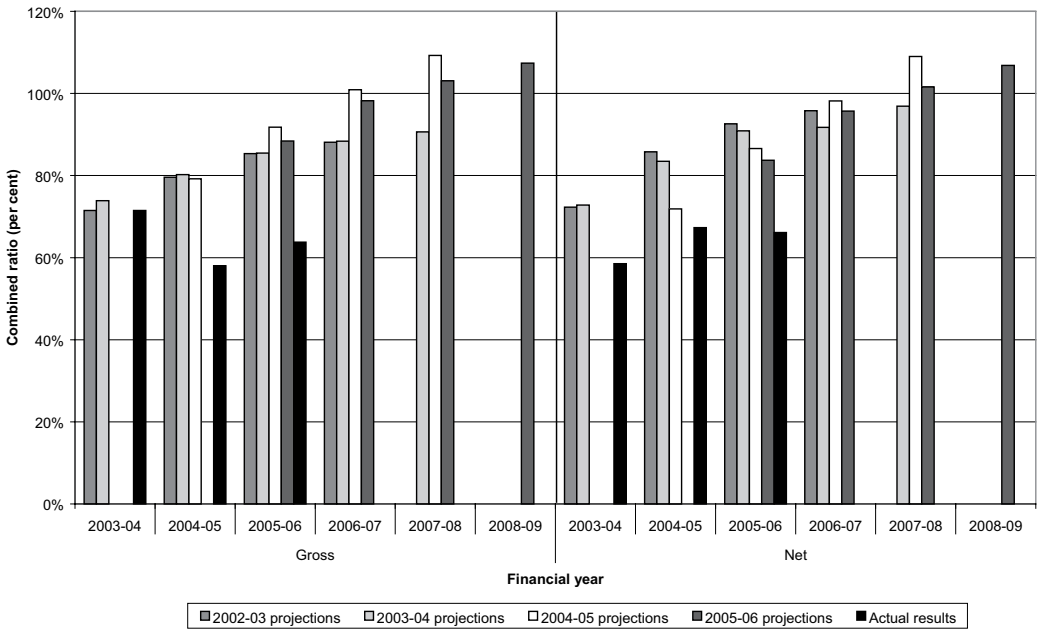
This insurer had previously held a reinsurance contact that had included ongoing adjustment premiums for which it held reserves. As experience developed, the insurer was able to release these reinsurance premium reserves and these releases were allocated to the reinsurance expense

in its actual results. The effect of these reserve releases was that this insurer experienced a positive reinsurance expense in all three years up to, and including, 2005–06, which distorted the actual reinsurance ratio experienced by the industry.

Combined ratio

Chart 6.8 shows the gross and net combined ratios for the five MDO-owned insurers based on the 2002–03, 2003–04, 2004–05 and 2005–06 financial projections of insurers. It also shows the actual combined ratios for 2003–04, 2004–05 and 2005–06.

Chart 6.8 Gross and net combined ratio: 2003–04, 2004–05 and 2005–06 actual position and 2002–03, 2003–04, 2004–05 and 2005–06 projections



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

The chart shows that the 2002–03 projections forecast the gross combined ratio to increase from 72 per cent in 2003–04 to 88 per cent in 2006–07, and the net combined ratio to increase from 72 per cent to 96 per cent over the same period. This general movement is also reflected in the 2003–04, 2004–05 and 2005–06 projections. The 2005–06 projections forecast the gross combined ratio to increase from 88 per cent in 2005–06 to 107 per cent in 2008–09, and the net combined ratio to increase from 84 per cent to 107 per cent over the same period.

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

The 2007–08 and 2008–09 projected gross and net combined ratios observed in the 2004–05 and 2005–06 projections are all over 100 per cent. A combined ratio greater than 100 per cent indicates that an insurer is losing money on its underwriting activities. However, it should be noted that a combined ratio exceeding 100 per cent may still be profitable for an insurance business once investment income is taken into account.

The actual results observed for 2005–06 show that the gross combined and net combined ratios of 64 and 66 per cent respectively were substantially less than all four sets of projections. This trend is generally similar to that observed for 2003–04 and 2004–05. A key driver of the difference between the actual and projected combined ratios is the lower than forecast loss ratios, which have fallen because actual premium income has generally been higher than projections and assessed claims costs have generally been lower than forecast.

6.3.6 Invivo

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

The ACCC examined the commercial justification of Invivo's premiums separately by examining the business plan presented to QBE and supporting financial projections.

Based on this analysis, the ACCC found that Invivo's premiums for the 2006–07 underwriting year were commercially justified.

6.4 Conclusion

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

The net asset position of all insurers as at 30 June 2006 was an improvement on the strong position observed as at 30 June 2005. The degree to which the net asset position had improved depended on the circumstances of individual insurers. The position of three of the insurers as at 30 June 2005 was such that they no longer intended to build capital into premiums for the 2005–06 underwriting year. The stronger results as at 30 June 2006 meant that four insurers no longer needed to build capital through premiums in the 2006–07 underwriting year.

The ACCC notes that one insurer continued its practice of not incorporating sufficient capital within its insurance premiums to maintain its target ratio of capital to net assets. To compensate for this, the insurer's parent entity is scheduled to make a capital injection in 2006–07, as well as further injections in future years. The ACCC found that while this may not be a viable long-term strategy, 2006–07 premiums for this insurer were still commercially justified because the injections were appropriately budgeted for and had MDO board approval.

The ACCC also conducted separate analysis on Invivo's 2006–07 premiums and found them to be commercially justified.

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

This chapter presents the findings of the ACCC regarding the actuarial and commercial justification of medical indemnity premiums charged for the 2006–07 underwriting period[98] within each jurisdiction by the six medical indemnity providers (including Invivo) to private medical practitioners.

7.1 Qualifications

In preparing this analysis it was necessary for the ACCC to maintain confidentiality of information provided by individual medical indemnity providers. As noted in section 2.3, medical indemnity providers have largely continued the tradition of providing insurance primarily in their home states.[99] Because of this, some quantitative aspects of the ACCC analysis of the jurisdictional premiums could not be disclosed in this report.

7.2 Background

7.2.1 Ministerial request

On 16 March 2005 the Hon. Mal Brough, then Minister for Revenue and Assistant Treasurer, asked the ACCC to extend the scope of its third monitoring report on medical indemnity insurance to examine, to the extent possible, the actuarial and commercial justification of premiums within each jurisdiction in more detail. On 29 May 2006 the Hon. Peter Dutton, the Minister for Revenue and Assistant Treasurer, wrote to the ACCC requesting that it continue to examine the actuarial and commercial justification of medical indemnity premiums, including within jurisdictions, for a further three years.

In its first and second monitoring reports, the ACCC assessment of the actuarial and commercial justification of premiums examined the determination of the aggregate premium pool and, to a lesser extent, the relativities applied to that pool for individual specialties, jurisdictions and income bands. In accordance with the Australian Government's request to extend the scope of the monitoring of jurisdictional relativities in more detail, the ACCC examined the actuarial and commercial justification of premium relativities separately from the actuarial and commercial justification of the aggregate premium pool.

The ACCC's third monitoring report found that jurisdictional premium relativities were considered to be actuarially and commercially justified for all five monitored medical indemnity providers; however, insurers were restricted in their analysis by a lack of reliable claims experience in some jurisdictions.

98 The 2006 calendar year in the case of Australasian Medical Insurance Limited (AMIL).

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

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

7.2.2 Pricing medical indemnity insurance by jurisdiction

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

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

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

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

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

- Medical specialty—medical practitioners who practise relatively more complex medical procedures are likely to face a higher risk of medical negligence claims being made against them than ones who perform less complex procedures. The complexity of medical procedures is also a key determinant of the size of medical negligence claims. Because of this, medical indemnity insurers will group medical specialties together, based on their risk for rating purposes. The level of grouping varies across medical indemnity insurers, with some recording relatively few groups and others incorporating almost 100 specialty groups in their relativity pricing.
- Income band/gross billing level—premium relativities are also determined on the basis of income/gross annual billings generated by the medical practitioner. Insurers regard this as a crude but equitable way to assess the relative amounts of clinical practise undertaken and therefore the risk the insurer is exposed to.

- Jurisdiction in which a practicse is located—the location of a doctor's clinical practise also influences the premium relativity. This may reflect the different legislative requirements between jurisdictions as well as the claims experience the insurer holds in different jurisdictions. Insurers apply the jurisdictional relativities to premiums by applying a loading or a discount to their premiums in their 'home' jurisdiction.

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

It is this last relativity—jurisdiction of practice—that the Australian Government has asked the ACCC to examine in more detail.

While Invivo's pricing methodology[100] differs from that outlined above for the five MDO-owned insurers, it determines jurisdictional relativities on a similar basis. This is why the ACCC has considered Invivo's jurisdictional relativities in conjunction with the industry, as opposed to preparing a separate analysis as was done in chapters 5 and 6.

7.2.3 Premium relativities

To obtain an understanding of the actual relativities applied between jurisdictions the ACCC obtained information from the five MDO-owned insurers[101] on the gross written premium and membership numbers by individual jurisdiction for the underwriting years 2003–04 to 2006–07.[102] This information allowed the ACCC to examine the average written premium in each jurisdiction across the four underwriting years to determine the relativities between jurisdictions as well as any changes in those relativities.

Chart 7.1 shows the average written premium of the five MDO-owned insurers by jurisdiction in real terms across the four years.[103, 104]

100 Invivo's pricing methodology is described in detail in section 5.4.1.

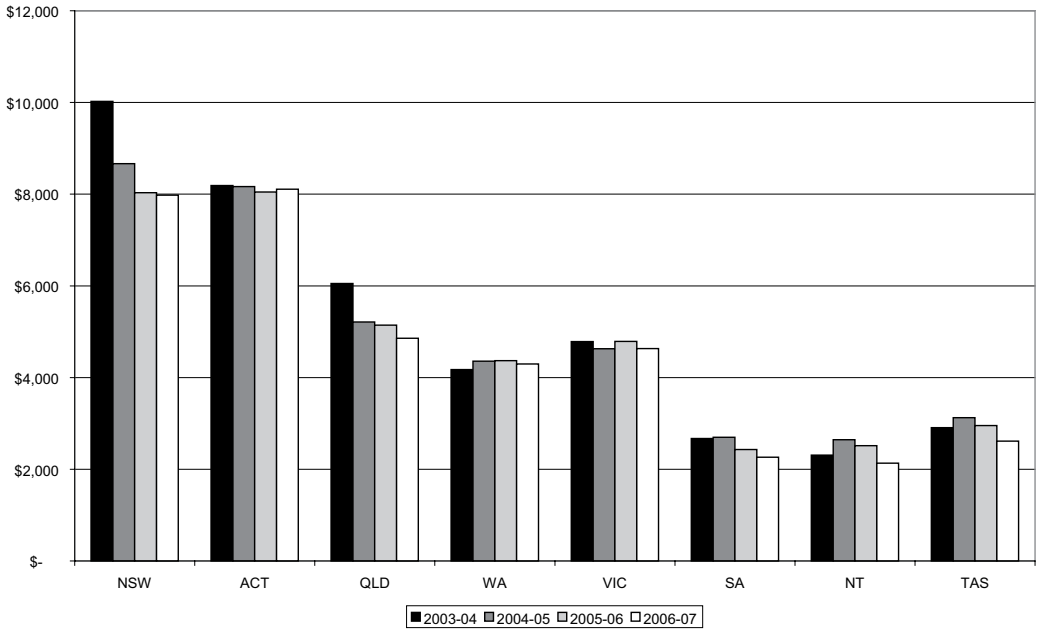
101 The ACCC was also provided with information by Invivo on gross written premium and policy holder numbers for the 2006–07 underwriting year; however, as this data was only available for one underwriting year it has not been incorporated in this monitoring report.

102 The ACCC asked insurers to provide the gross written premium and membership numbers at a specific date in the 2006–07 underwriting year to allow insurers to provide data prior to the end of the underwriting year. However, because the majority of insurance is written at the beginning of the underwriting year, the data should provide a reasonable estimate of the full year's results.

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

104 The average written premium by jurisdiction is presented on a real basis to reflect the impact of inflation with nominal premiums adjusted to 30 June 2006 values. For the 2003–04, 2004–05 and 2005–06 years, premiums were adjusted using the average weekly earning index published by the Australian Bureau of Statistics (catalogue number 6302.0). For 2006–07 average written premiums have been discounted to 30 June 2006 values using estimates of AWE for 2006–07 based on historical trends.

Chart 7.1 Average written premium in real terms—by jurisdiction: 2003–04, 2004–05, 2005–06 and 2006–07



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

Chart 7.1 shows that real average written premium in 2006–07 is highest in New South Wales and the Australian Capital Territory, and lowest in Tasmania, South Australia and the Northern Territory. The chart also shows that in 2006–07 real average written premium decreased in all jurisdictions except the Australian Capital Territory, with the decreases ranging from 1 per cent in New South Wales to 15 per cent in the Northern Territory. In the Australian Capital Territory in 2006–07 premium increased by 1 per cent.

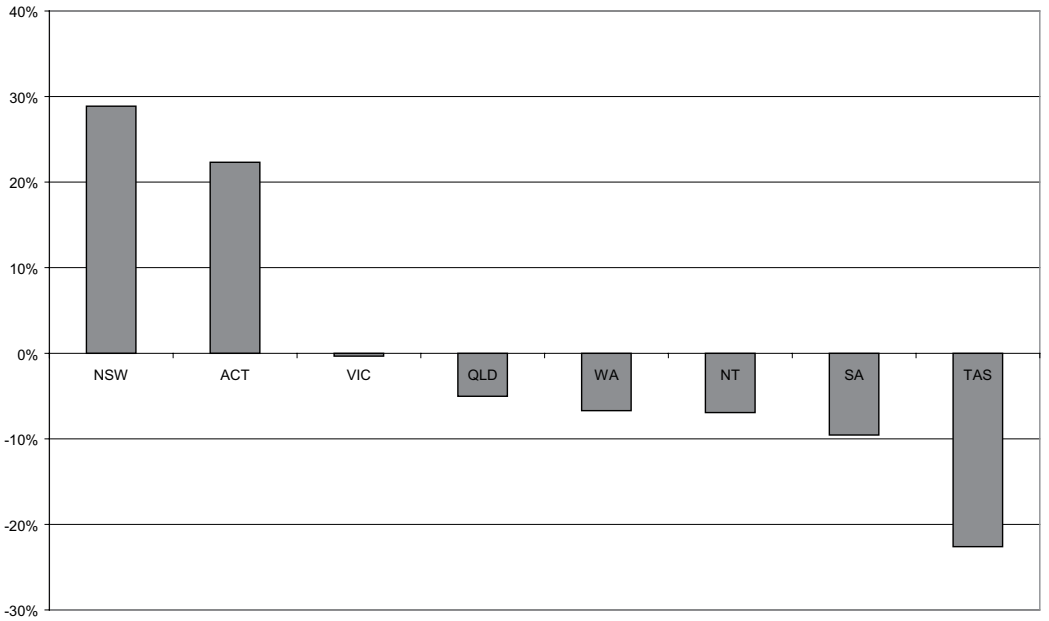
This analysis may be influenced by differences in the medical practitioner membership between jurisdictions. For example, some jurisdictions may have a higher proportion of low risk specialties, which may lead to those jurisdictions having a lower comparable average written premium. Further, some jurisdictions may have more medical practitioners on non-mature claims-made policies[105], resulting in these jurisdictions having a lower comparable average written premium.

The ACCC also examined the observed jurisdictional premium relativities used by the five MDO-owned insurers for the 2006–07 underwriting year by examining the premium rates actually set across jurisdictions. Specifically, the ACCC compared all equivalent mature claims-made premium categories (including specialties and income bands) between the 'home' state of each insurer and other jurisdictions.

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

As noted previously, insurers apply the jurisdictional relativities to premiums by applying a loading or discount to premiums in their 'home' jurisdiction. As each insurer generally had a different home jurisdiction to which other jurisdictions were compared, the ACCC compared each jurisdiction's premium relativity to the average premium relativities by jurisdiction across all insurers. Chart 7.2 shows the average industry observed jurisdiction relativities for the 2006–07 underwriting year.

Chart 7.2 Average observed jurisdictional relativity: 2006–07



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

Chart 7.2 shows that New South Wales and the Australian Capital Territory had the highest jurisdictional relativity (at 29 and 22 per cent), while Tasmania has the lowest (at minus 23 per cent). The relativities for the remaining jurisdictions ranged between zero and minus 10 per cent.

Jurisdictional relativities exist because, for a variety of procedural and social reasons, the level of common law awards and settlements varies between states.[106] As claims costs is one of the largest components of premiums, this will be a significant driver of premium differences between jurisdictions.

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

106 IAAust, Submission to the Public Liability Forum, March 2002, p. 9.

7.3 Actuarial and commercial justification of premium relativities by jurisdiction

The ACCC examined the actuarial and commercial justification of the jurisdictional relativities applied for the 2006–07 underwriting year by all six current medical indemnity providers, including Invivo.

The ACCC found that all insurers who underwrote medical indemnity insurance in 2005–06 undertook analysis before considering whether changes should be made to jurisdictional relativities. However, most medical indemnity providers indicated that their analysis was limited by a lack of reliable claims experience in some jurisdictions. As a result, only one of the insurers that provided medical indemnity insurance in 2005–06 decided to change their existing jurisdictional relativities in the 2006–07 underwriting year.

7.3.1 Actuarial justification of jurisdictional relativities

Methodology

The ACCC examined the actuarial justification of premium relativities for the 2006–07[107] underwriting year. Specifically the ACCC examined the:

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

Extent of the analysis in determining jurisdictional relativities

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

The extent to which this analysis was conducted varied across medical indemnity providers. The majority of medical indemnity providers conducted a detailed analysis by comparing loss ratios for different jurisdictions to derive the jurisdictional relativities for the 2006–07 underwriting year. Other medical indemnity providers generally based their analysis on reviews of detailed jurisdictional analysis prepared in previous years.

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

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

107 The 2006 calendar year in the case of Australasian Medical Insurance Limited (AMIL).

Tort law reform

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

7.3.2 Commercial justification of jurisdictional relativities

Methodology

The ACCC examined the commercial justification of premium relativities for the 2006–07[108] underwriting year. Specifically the ACCC examined:

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

Adoption of actuarial recommendations

Medical indemnity providers generally used the approved actuary in the process of determining jurisdictional relativities. However, the timing of the actuary's involvement differed across medical indemnity providers, with some medical indemnity providers relying on advice from their actuary to determine the relativities, while one medical indemnity provider determined relativities in-house and then sought advice on their appropriateness from the actuary. The ACCC does not consider either approach to be more valid because in all cases the actuary was involved at some stage in the process of setting jurisdictional and other relativities.

The ACCC found that final relativities, as selected or approved by the actuary, were not always adopted by medical indemnity providers in their final rates. However, the ACCC understands that where recommendations were not adopted, the rationale for this decision was based on an inability by actuaries to determine jurisdictional based relativities accurately because of a lack of reliable claims experience in some jurisdictions, rather than an explicit desire to cross-subsidise between jurisdictions.

Quantification of cross-subsidies and incorporation of board policy

No medical indemnity provider specifically quantified cross-subsidies between jurisdictions. However, it should be noted that due to a lack of reliable jurisdictional based claims experience, some cross-subsidies may exist but were not identified. As medical indemnity providers gain greater experience in new jurisdictions and more technical relativities can be derived, these potential cross-subsidies can be addressed.

108 The 2006 calendar year in the case of AMIL.

No medical indemnity providers specifically identified any board policy as justification for the selected jurisdictional relativities.

7.4 Conclusion

The ACCC found that jurisdictional premium relativities were considered to be actuarially and commercially justified for all six medical indemnity providers.

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

For the commercial justification of premium relativities, the ACCC considered the extent to which recommended relativities were adopted in final premium rates as well as the level of cross-subsidisation in the premium relativities. In some instances, the ACCC found that recommendations were not adopted in final premium rates because of a lack of reliable claims experience in some jurisdictions. However, the ACCC found that while no medical indemnity provider explicitly cross-subsidised between jurisdictions, cross-subsidies may exist because of a lack of reliable claims experience data. The relativities adopted were considered to be commercially justified.

Appendixes

Appendix A: Medical indemnity reforms as at 31 December 2006

A.1 Background

In May 2002 the largest medical indemnity provider in Australia, United Medical Protection Limited (United), 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.[109] In response to this crisis, the government introduced a framework of reforms to ensure a viable and ongoing medical indemnity insurance market.[110]

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 United/Australasian Medical Insurance Limited (AMIL), the government announced the United Medical Protection Limited (UMP) guarantee on 1 May 2002.[111]

A.2.1 UMP guarantee

The UMP guarantee provided temporary assistance to United/AMIL to allow it to continue its operations. This guarantee covered the obligation of United/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, the Hon. John Howard, announced an enhancement to the UMP guarantee as well as the introduction of a new scheme to fund currently unfunded incurred but not reported (IBNR) matters.[112]

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

110 The Hon. John Howard, Prime Minister of Australia, *A new medical indemnity insurance framework*, press release, 23 October 2002.

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

112 The Hon. John Howard, Prime Minister of Australia, '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 United/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 Incurred but not reported scheme

The government announced the incurred but not reported scheme as a measure to help medical indemnity providers fund their unfunded liabilities; it would also fund the extension of the UMP guarantee. The IBNR scheme would apply to currently unfunded liabilities that could not be adequately provided for by medical indemnity providers. The scheme would be financed through a levy on medical practitioners who 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, the Hon. John Howard, announced the new medical indemnity insurance reform package on 23 October 2002. This package included:

- 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.[113]

A.4.1 UMP guarantee

The government extended the term of the UMP guarantee by a further year until 31 December 2003, which gave the provisional liquidator time to fully explore options for restructuring the business and for other measures to take effect.[114] The extension of the guarantee meant that amounts payable by United/AMIL between 29 April 2002 and 31 December 2003 for claims notified or finalised before

113 The legislative framework for this package included the:
- *Medical Indemnity Act 2002*
- *Medical Indemnity (IBNR Indemnity) Contribution Act 2002*
- *Medical Indemnity (Enhanced UMP Indemnity) 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.

114 The Hon. John Howard, Prime Minister of Australia, *A new medical indemnity insurance framework*, press release, 23 October 2002.

29 April 2002 were covered. The UMP guarantee would also cover amounts payable for claims notified in the period from 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 more details about the IBNR scheme[115], which was designed to fund medical indemnity providers' IBNR liabilities unfunded as at 30 June 2002. Funding was to begin in early 2003, and was to be raised by a levy on medical practitioners 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 specialists undertaking high-risk procedures—such as obstetricians, neurosurgeons and procedural GPs (most of whom work in rural and regional areas)—could afford medical indemnity insurance.[116]

The subsidy was designed to be the equivalent of 50 per cent of the difference between the cost of the premiums plus the IBNR levy [117](if applicable) and the corresponding cost for gynaecologists, general surgeons and non-procedural GPs in the relevant state and territory. In light of the particularly high costs faced by some neurosurgeons, the subsidy was to increase to 80 per cent on the part of their premium in excess of $50 000.

A.4.4 High cost claims scheme

The government announced the introduction of HCCS so as to lower premiums by reducing the potential cost of large claims to insurers.[118]

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

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

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

117 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.

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

A.4.5 Medical indemnity regulatory framework

From 1 July 2003[119], medical indemnity providers were to be placed within a regulatory framework to encourage a more commercially sustainable focus in providing insurance by service providers.[120]

First, medical indemnity providers were required to become 'authorised' insurers, making them subject to a range of prudential safeguards, enforced by the Australian Prudential Regulation Authority, 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 insurers without 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', 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 began on 1 July 2003 and included:

- minimum cover limits
- offers of retroactive and run-off cover for claims-made cover.[121]

Finally, authorised providers of medical indemnity cover were required to submit data to the Australian Government, and to the Health Insurance Commission (HIC)[122] 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.

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.[123]

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

120 The placement of medical indemnity providers under a regulatory framework is outlined in the *Medical Indemnity (Prudential Supervision and Products Standards) Act 2003* which commenced on 1 January 2003.

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

122 Medicare Australia came into operation on 1 October 2005, and now performs all the functions and provides all the services that were provided by the HIC.

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

A.5.1 Premium subsidies

To preserve obstetrician services in rural and regional areas, the government announced 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.[124]

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.[125] 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.

For 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. These included 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, the Hon. John Howard, announced the exceptional claims scheme (ECS) (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.[126]

A.6.1 Exceptional claims scheme

After medical indemnity insurance contracts that capped the insurer's contractual liability were introduced, 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.

124 This premium subsidy is contained in the medical indemnity subsidy scheme, which commenced 20 June 2003 and applied to indemnity payments on or after 1 January 2003.

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

126 The Hon. John Howard, Prime Minister, 'Medical indemnity: Certainty for doctors', 23 May 2003.

In response, the government announced its plans to implement ECS. 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.[127]

A.7 Government measures announced on 3 October 2003

A.7.1 IBNR scheme

In response to medical practitioners' concerns over the effect of the IBNR levy, the government met with industry representatives on 3 October 2003. The government subsequently agreed to an 18-month moratorium on IBNR levy payments above $1000 per year, until 31 December 2004.[128]

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, announced enhancements to the medical indemnity insurance reform package. These enhancements included changes to the high cost claims and IBNR schemes. Further details about ECS were also announced.

A.8.1 High cost claims scheme

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.[129] 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
- deceased medical practitioners and their estates with an IBNR levy liability due in the year of their death.

These exemptions began on 15 August 2003.[130]

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

128 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.

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

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

A.8.3 Exceptional claims scheme

In the process of implementing the ECS, the government undertook to treat claims under the ECS on a claims-incurred rather than a claims-made basis.[131] 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.[132]

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
- enable Australia's medical workforce to provide care and continue to practise to its full potential
- safeguard the interests of the consumers and the community.[133]

The panel was directed by the government to consider various specific issues, including:

- the effect 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.

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.[134] On 17 December 2003 the government announced that it would adopt the recommendations outlined below.

A.10.1 High cost claims scheme

On the panel's recommendation, the government extended 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.[135]

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

132 ECS is contained in the *Medical Indemnity Amendment Act 2003*, Schedule 2, which commenced 5 December 2003.

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

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

135 Changes to HCCS are contained in the Medical Indemnity Amendment Regulations 2004 (No. 1), Schedule 1, which commenced on 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[136]
- 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 receives 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.[137]

On 15 June 2004 the Minister for Health and Ageing formulated the premium support scheme (PSS)[138] in line with these recommendations.

The PSS would apply to:

- medical practitioners with gross indemnity costs above 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[139] (the subsidy is the higher of the subsidies under either the medical indemnity subsidy scheme—MISS—or PSS).

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

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.[140] For these reasons, the government accepted the panel's recommendation to introduce the UMP support payment to replace the IBNR contribution payment.

136 The initial premium subsidy only applied to neurosurgeons, obstetricians, procedural general practitioners and GP registrars undertaking procedural training.

137 Medical Indemnity Policy Review Panel, 'Affordable, Secure and Fair—Report to the Prime Minister'. 10 December 2003, p. 19.

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

139 A special category member is a member who either:
- no longer practises as a doctor
- no longer derives a private medical income from practising as a doctor
- practises as a doctor only in the public sector and has a contract of insurance providing indemnity cover that does not offer indemnity for damages 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.

140 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[141] provide that:

- the length of time a medical practitioner has to make payments is linked to the period the medical practitioner belonged to United 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, had a medical practitioner's annual contribution for 2003–04 been over $1000, the medical practitioner would be required to pay only $1000 so that the maximum annual contribution for 2003–04 would be capped at $1000.

Finally, medical practitioners can pay their UMP support payment via 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 HCCS and ECS.

A.11.1 Retirement 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.[142]

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

141 These are contained in the *Medical Indemnity (IBNR Indemnity) Contribution Amendment Act 2004* and Medical Indemnity Amendment Regulations 2004 (No. 2).

142 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 on 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.[143]

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.[144] 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.[145]

A.11.2 High cost claims scheme

The government also announced changes to 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.[146] Since the amendment[147], 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 prior to its termination.

A.11.3 Exceptional claims scheme

The government also legislated to improve access to ECS[148], which was broadened to provide cover for Australian medical practitioners accompanying Australian sport teams and cultural groups travelling overseas.

A.12 Government measures announced on 7 December 2004

On 4 November 2004 United announced that its licensed insurer, AMIL, would make significant reductions in premiums for 2005. United stated that a number of factors had a major impact on its premiums, including the loyalty of its members, medical indemnity reforms, and extensive tort law reform in most Australian states and territories.[149]

143 *Medical Indemnity Legislation Amendment (Run-off Cover Indemnity and Other Measures) Act 2004*.

144 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.

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

146 Section 30(1)(d) of the.*Medical Indemnity Legislation Amendment (Run-off Cover Indemnity and Other Measures) Act 2004*.

147 The amending legislation received Royal Assent on 23 June 2004.

148 Changes to ECS are contained in the Medical Indemnity Amendment Regulations 2004 (No. 2), which commenced 5 December 2003.

149 United Medical Protection, 'Premiums to drop as AMIL exceeds APRA's minimum capital requirements', press release, 4 November 2004.

However, other medical indemnity providers argued that specific Australian Government assistance to United, in the form of the IBNR scheme (under which United was the only participating member), had helped it reduce its premiums.

On 7 December 2004 the Hon. Tony Abbott, the Minister for Health and Ageing, and the Hon. Mal Brough, then Minister for Revenue and Assistant Treasurer, announced that the government would commission an independent review of competitive neutrality in the medical indemnity insurance market.

The review's terms of reference were to examine each form of government assistance and any resulting competitive advantages. Should any competitive advantage be determined, the review was to identify and evaluate options to restore competitive neutrality.

The review reported to the government on 15 March 2005, and the report and the government's response to the recommendations were subsequently released on 13 May 2005. The review found that the specific assistance given to United through the IBNR scheme has resulted in a competitive advantage. The review suggested that this competitive advantage arose because the government had taken over all United's legacy commitments allowing it, unlike other medical indemnity providers, to concentrate only on the future.

The review also found that AMIL's pricing was well below its competitors and that this was the result of a much more bullish view of the future impacts of tort law reform. However, it then alleged that it is extremely unlikely that United could take such a view prudentially if it did not have the comfort of knowing that the Australian Government had assumed its legacy obligations for IBNR claims.

As such the review recommended that to redress the balance it would be necessary for United to make a series of regular payments to compensate the Australian Government for the assumption of its obligations.

The Australian Government accepted these recommendations on 13 May 2005 and stated that the payments it would receive from United would be used to reduce the payments doctors make under the UMP support scheme.

On 16 June 2005 the Australian Government introduced legislation to bring these changes into effect. The *Medical Indemnity (Competitive Advantage Payment) Act 2005* and the *Medical Indemnity Legislation Amendment (Competitive Neutrality) Act 2005* impose the competitive neutrality payment on United, provide for the administrative arrangements and modify aspects of the UMP support payment. These Acts received Royal Assent on 19 October 2005 and are taken to have commenced on 1 July 2005.

The UMP support payment scheme was amended to reduce the extent and duration of payments required by medical practitioners. Under the new arrangements, UMP support payment members will only need to make payments for a further two contribution years and their payments will be reduced by $1000 annually. The maximum amount that members will pay for the final contribution years will be the lesser of:

- $4000
- the amount by which the applicable percentage of the member's annual subscription for the base year exceeds $1000, or

- 2 per cent of their gross medical income in excess of $50 000.

A.13 Medical Indemnity Legislation Amendment Bill 2005

The Medical Indemnity Legislation Amendment Bill 2005 was introduced to Parliament by the government on 17 February 2005. This legislation was designed to give effect to improvements identified following consultation with the medical indemnity industry, the medical profession and the HIC[150], and amends the *Medical Indemnity Act 2002*, the *Medical Indemnity (Prudential Supervision and Product Standards) Act 2003* and the *Medical Indemnity (Run-Off Cover Support Payment) Act 2004*.

Changes in the legislation were framed to improve the operation of the medical indemnity legislation package, to address minor problems that emerged as the various schemes were implemented.

A.14 Medical Indemnity Legislation Amendment Bill 2006

The Medical Indemnity Legislation Amendment Bill 2006 was introduced to Parliament by the government on 13 September 2006. The legislation is aimed at increasing the level of certainty around the provision of run-off cover for doctors who leave the medical workforce and to simplify the administration of ROCS following concerns raised by medical indemnity insurers and medical practitioners.

The legislation amends the *Medical Indemnity Act 2002* and the *Medical Indemnity (Prudential Supervision and Product Standards) Act 2003*.

The legislation's main change is that medical practitioners who may have had gaps in their medical indemnity cover during their career and who previously would not have been covered under ROCS are now able to be covered by ROCS. The amendment means the terms and conditions of cover provided under ROCS will be equivalent to those of the medical practitioner's last pre-retirement contract.

150 Medicare Australia came into operation on 1 October 2005 and now carries out all the functions and services previously the responsibility of HIC.

Appendix B: ACCC information request

To fulfil its monitoring requirements, it was necessary for the Australian Competition and Consumer Commission to directly approach medical indemnity providers to request relevant information. In consultation with **am actuaries**, the ACCC developed a uniform information request for the five medical indemnity providers (excluding Invivo) to complete.[151]

This information request differs from previous requests due to the ACCC further aligning its information requirements with that of the Australian Prudential Regulation Authority in an effort to minimise compliance costs for medical indemnity providers. Where possible the ACCC is now collecting certain information directly from APRA. However, the different roles played by APRA and the ACCC for medical indemnity insurance has meant that the ACCC continues to need to seek specific information directly from insurers.

This appendix briefly describes the nature of the reports and information the ACCC requested from medical indemnity providers.

B.1 Actuarial pricing report

Each medical indemnity provider commissioned actuarial pricing reports for premiums to apply for the 2006–07 underwriting year. These reports provide advice to the medical indemnity provider on the aggregate premium pool and, in some cases, specialty rates. The ACCC requested a copy of this report.

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

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

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

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

B.2 Actual premium rate report

The ACCC requested a report detailing the actual premiums charged for all forms of indemnity for the 2006–07 underwriting year. If 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.

151 As Invivo had not previously been included in the monitoring program, the ACCC and **am actuaries** undertook discussions with Invivo and QBE Insurance (Australia) Limited to discuss what information was available from both companies which would allow the ACCC to perform its monitoring role. Following these discussions, the ACCC modified its information request to reflect the operational characteristics of Invivo.

This discussion was to include all relevant commercial and regulatory factors affecting the pricing decisions made by the indemnity provider.

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

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

B.3 Membership, premium and claims data

The ACCC also requested the following data from medical indemnity providers:

Membership data

- Membership numbers by membership category, by jurisdiction, by income band for the 2005–06[152] and 2006–07 underwriting years.

Premium data

- Recommended individual actuarial subscription rates by membership category, by jurisdiction, by income band for the 2006–07 underwriting year.
- Actual subscription rates by membership category, by jurisdiction, by income band for the 2006–07 underwriting year.
- Total gross written premium by membership category, by jurisdiction for the 2005–06[153] and 2006 07 underwriting years.

Claim data

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

B.4 Other information

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

- the most recent financial condition report, which is submitted to APRA on an annual basis and provides a comprehensive overview of the insurer's financial soundness
- copies of financial projections prepared by the authorised insurer in 2005–06 as well as any updates to these projections

152 While information on membership numbers were also provided by medical indemnity providers for the 2005–06 underwriting year in the context of the previous monitoring request, generally this information was provided at a specific point in time and may not reflect the actual result for the full year. As such the ACCC sought revised data where this was available.

153 While information on premium rates were also provided by medical indemnity providers for the 2005–06 underwriting year in the context of the previous monitoring request, generally this information was provided at a specific point in time and may not reflect the actual result for the full year. As such the ACCC sought revised data where this was available.

- recent annual reports for both the medical indemnity provider and the MDO group of companies
- a brief outline of any changes to the insurance policies previously offered to medical practitioners for the 2005–06 indemnity period.