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Australian Competition & Consumer Commission

Medical indemnity insurance

THIRD MONITORING REPORT

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Contents

Abbreviations

ABS	Australian Bureau of Statistics
ACCC	Australian Competition and Consumer Commission
AMA	Australian Medical Association
AMIL	Australasian Medical Insurance Limited
APRA	Australian Prudential Regulation Authority
ASIC	Australian Securities and Investment Commission
AWE	average weekly earnings
ECS	exceptional claims scheme
GP	general practitioner
GST	goods and services tax
HCCS	high cost claims scheme
HIC	Health Insurance Commission
HPIA	Health Professionals Insurance Australia Pty Ltd
IBNR	incurred but not reported
IAAust	Institute of Actuaries Australia
MCR	minimum capital requirement
MDAN	MDA National Pty Ltd
MDANI	MDA National Insurance Pty Ltd
MDASA	Medical Defence Association of South Australia Limited
MDAV	Medical Defence Association of Victoria Limited
MDAWA	Medical Defence Association of Western Australia
MDO	medical defence organisation
MIA	Medical Insurance Australia Pty Ltd
MIPS	Medical Indemnity Protection Society Limited
MPSTas	Medical Protection Society of Tasmania
MISS	medical indemnity subsidy scheme
PIICA	Professional Indemnity Insurance Company Australia Pty Limited
PSS	premium support scheme
QDM	Queensland Doctors' Mutual Pty Ltd
ROCS	run-off cover scheme
UMP	United Medical Protection Limited (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 underwriting than claims-incurred cover
claims frequency	the ultimate number of claims by notification year expressed as a proportion of the total number of indemnified members
combined ratio	the sum of the loss ratio and the expense ratio showing whether the sum of expenses (claims expenses and other expenses) is 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
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)
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
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 expenses	the amount of premium revenue ceded to reinsurers for reinsurance during a period
reinsurance ratio	the reinsurance expense as a proportion of premium revenue for that year
retroactive cover	cover purchased to extend the period of incidents for which notifications are covered. This type of cover is purchased from the medical indemnity provider to which the medical practitioner is moving, enabling them to notify their new provider of claims which relate to incidents that occurred prior to joining that provider. This type of cover typically applies to claims-made cover
return on net assets	emerging surplus 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 announced that the Australian Competition and Consumer Commission (ACCC) would monitor medical indemnity premiums for three years 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.

The ACCC asked the five current providers of medical indemnity insurance to private medical practitioners to supply a range of quantitative and qualitative information about their premium setting arrangements, cost structures and the impact of a number of government reforms on their operations for the current underwriting period.

The five current providers of medical indemnity insurance are Australasian Medical Insurance Limited (AMIL), Health Professionals Insurance Australia Pty Ltd (HPIA), MDA National Insurance (MDANI), Medical Insurance Australia Pty Ltd (MIA) and Professional Indemnity Insurance Company Australia Pty Ltd (PIICA).

Findings of the first and second monitoring reports

This is the last of three annual monitoring reports produced by the ACCC for the Australian Government in accordance with the above requests.

The ACCC's first medical indemnity insurance monitoring report, which was released by the Australian Government on 23 February 2004, examined the actuarial and commercial justification of premiums for the 2003–04 underwriting period. The ACCC's second monitoring report was released by the Australian Government on 16 March 2005 and examined the 2004–05 underwriting period.

Both reports found that, overall, the premiums charged by medical indemnity insurers were actuarially and commercially justified.[1]

ACCC assessment methodology

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

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

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

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

1 The ACCC's first monitoring report found that the premiums charged by four of the five medical indemnity providers in 2003–04 were actuarially justified. The ACCC was unable to determine if premiums of the other provider (HPIA) were actuarially justified because of a lack of information it provided about its assumptions and supporting analysis.

Assessment of the actuarial justification of medical indemnity premiums

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

The ACCC found that the aggregate premium pool of each insurer was actuarially justified. It was evident that insurers made extensive use of actuaries in preparing liability assessments, pricing reports, funding plans and financial forecasts. In each case the construction of the recommended premium pool was considered by the ACCC 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 its actuary.

One issue that arose in relation to the aggregate premium pool was the actuaries' consideration of the level of surplus required to build and maintain capital. The ACCC found that actuaries continued to rely on the insurer to determine this component of the aggregate premium pool, and in some cases the insurer did not nominate a desired level of surplus, but instead surplus was the balancing item once the actual premium pool was set. The ACCC notes that the Institute of Actuaries of Australia (IAAust) was developing medical indemnity premium guidelines, and such a guideline would assist actuaries addressing this issue in future pricing reports.

The ACCC's analysis of specialty premium rates found that most insurers conducted detailed analysis on premium relativities between specialties. Insurers generally indicated a desire to unwind existing cross subsidisation between specialties but noted that many practical hurdles limited the extent and speed to which this could be achieved. However, the ACCC still found these rates, and the relativities for income bands, were considered 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 included an examination of Australian Government medical indemnity reforms (such as the high cost claims scheme (HCCS) and the run-off cover scheme (ROCS)), and Commonwealth, state and territory tort law reforms. The ACCC found that all insurers factored the HCCS and ROCS into the determination of their pure risk premium, while most insurers took full account of the HCCS in their reinsurance program. Some insurers indicated that reinsurers were unwilling to fully reflect the benefits of the HCCS in determining the reinsurance program. Nevertheless, the ACCC encourages all insurers to ensure the HCCS is fully taken into account in their reinsurance arrangements for 2006–07 premiums. The majority of insurers indicated they took tort law reform into account in setting their aggregate premium pools for 2005–06. However, the ACCC notes that the level of savings estimated by insurers differed significantly.

Assessment of the commercial justification of medical indemnity premiums

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

The net asset position of all insurers as at 30 June 2005 was an improvement on the strong position observed as at 30 June 2004. The degree to which the net asset position had improved depended on the circumstances of individual insurers. Two insurers were in a position as at 30 June 2004 such that they no longer intended to build capital into premiums for the 2004–05 underwriting year, and this led to the emerging surplus for those insurers falling for 2004–05. The stronger results as at 30 June 2005 meant that an additional insurer no longer needed to build capital through premiums in the 2005–06 underwriting year.

It is noted, however, that as a result of a pricing decision in the 2005–06 underwriting year one of the remaining two insurers has scheduled two separate capital injections from the parent entity in future years. These capital injections are projected to enable sufficient capital adequacy to be maintained in the short to medium term. However, continuing to rely on capital injections from the parent entity is not considered to be a viable strategy in the longer term. The ACCC encourages insurers to ensure their pricing in each underwriting year is sufficient to maintain capital at the desired level. If not, insurers should clearly quantify the shortfall and have clear established strategies for achieving that position.

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 five 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 insurers took into account tort law reform. The ACCC found that insurers were restricted in the extent to which the analysis could be undertaken because of a lack of reliable claims experience in some jurisdictions. In the absence of this data, the ACCC considered the approach used by insurers to be actuarially justified. The lack of reliable claims experience by jurisdiction also affected the ability of insurers to take into account tort law reform in premium relativities. However, all insurers generally took tort law reform into account in setting their aggregate premium pool.

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. The ACCC found that the relativities adopted by insurers generally reflected the actuarial advice received. The ACCC also found that no insurer explicitly cross subsidised between jurisdictions. However, due to the lack of reliable claims experience data, cross subsidies may exist. 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 announced that the Australian Competition and Consumer Commission (ACCC) would monitor medical indemnity premiums to assess whether they are actuarially and commercially justified.[4] This report is the last of three ACCC reports to the Australian Government arising from this role.

1.2 Ministerial request

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

The treasurer indicated that the ACCC's monitoring role was to start on 1 January 2003 for three years and was not a direction under the *Prices Surveillance Act 1983.*[5]

On 16 March 2005 the Minister for Revenue and Assistant Treasurer, the Hon. Mal Brough MP, requested that the ACCC 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, 2002, p. 4.

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

4 ibid.

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

1.3 Scope of report

The ACCC's monitoring role is limited to medical indemnity insurance written in Australia by insurers that indemnify medical practitioners (i.e. doctors) working in the private health sector. At the time of this report there were five such insurers:

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

Medical indemnity insurance is also offered by some commercial insurers to other medical professionals who practice in the private health sector, such as hospital and ancillary staff including nurses and other medical staff. Medical practitioners who practise in the Australian public health sector are generally indemnified against medical malpractice by the relevant state-based public sector insurer for the work they perform in the public health system.[6] They do not need to take out their own private medical indemnity insurance to cover this work.

1.4 Approach to monitoring

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

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

In assessing the **commercial** justification of premiums, the ACCC considers the ability of medical indemnity providers to meet their commercial obligations to key stakeholders. It assesses how premium rates were affected by APRA's minimum capital regulatory requirements that medical indemnity providers need to achieve to reach a fully capitalised position by 30 June 2008, as well as broader commercial obligations such as solvency targets and emerging surplus levels. The ACCC's assessment framework is discussed further in chapter 6.

This report also provides new information on the actuarial and commercial justification of premium relativities between jurisdictions. To assess these premium relativities the ACCC examines the extent and the level of detail of the analysis to confirm or modify existing relativities. It also looks at the extent to which insurers took into account 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.

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

The ACCC's analysis covers the five medical indemnity providers in Australia that offer insurance to private medical practitioners. In mid-2005 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.[7] 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 2005 to 30 June 2006, except for United/AMIL which has an underwriting period of 1 January 2005 to 31 December 2005. The ACCC has specifically not adjusted United/AMIL's calendar year results to 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's analysis is based on information supplied by each of the five insurers. The ACCC has relied on the information provided by insurers rather than performing an independent verification of their information or actuarial advice. In preparing this report, it was necessary for the ACCC to maintain the confidentiality of individual insurers' information. Therefore, some quantitative aspects of the ACCC's analysis, particularly on its assessment of individual insurers' information, could not be disclosed in this report.

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

1.6 Previous reports

This is the last of three annual monitoring reports 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. 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.

7 Some of the information required by the ACCC is also collected by APRA in its role of overseeing the prudential framework governing the medical indemnity industry from 1 July 2003.

The ACCC aligned its information requirements as much as possible to those of APRA in an effort to minimise duplication costs for insurers. However, the ACCC's role in medical indemnity insurance is one of price monitoring. Therefore, while the information required by both the ACCC and APRA was broadly consistent, in some cases the ACCC requested more detailed information.

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

The report found that all five medical indemnity providers were raising capital through premiums to 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.[8] 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.

The report concluded that the premiums charged by all five medical indemnity providers in 2004–05 were actuarially justified. It 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. It also found that each insurer adopted an aggregate premium pool at least equal to the actuary's recommended premium pool.

For the commercial justification of premiums the ACCC 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 as at 30 June 2004, ahead of earlier forecasts.

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 as at 1 July 2005.

Chapter 4 examines historical trends in costs, premiums and the financial performance of the industry between 1997–98 and 2004–05.

Chapter 5 presents the ACCC's findings on the actuarial justification of medical indemnity premiums charged for the 2005–06 underwriting period by the five current medical indemnity providers.

Chapter 6 presents the ACCC's findings on the commercial justification of medical indemnity premiums charged for the 2005–06 underwriting period by the five current medical indemnity providers.

Chapter 7 presents the ACCC's findings on the actuarial and commercial justifications of medical indemnity premiums charged in different jurisdictions for the 2005–06 underwriting period by the five current medical indemnity providers.

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

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

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

2. Overview of the medical indemnity industry

2.1 Introduction

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

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

2.2 What is medical indemnity insurance?

Insurance provides protection against the unfortunate consequence of future events by transferring the risk of possible loss from a person or organisation (the insured) to the insurer. To gain this benefit, the insured pays the insurer a sum of money known as a premium[9] for the cost of insurance.

2.2.1 Liability insurance

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

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

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

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

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.[10] 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.

2.2.2 Medical malpractice

Malpractice insurance is another name for professional indemnity insurance, but this title has generally been reserved for the medical professions.[11] Although medical indemnity insurance provides similar protection to that for other professionals, the nature of medical malpractice claims against medical practitioners will generally differ from claims against other professionals.

Accountants, lawyers, investment advisers and valuers, for example, are usually sued for 'economic loss', that is, loss of past and/or future income 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.

2.2.3 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.[12]

10 ibid, p. 26.

11 Insurance Council of Australia, *Submission to Ministerial Forum, Addressing the issues in professional indemnity insurance*, March 2002, p. 1.

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

2.2.4 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.[13] 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.[14] 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 that are notified to the indemnity provider after the practitioner ceases practicing medicine or moves to another indemnity provider.[15]

2.3 Characteristics of the industry—pre-1 July 2003

Before 1 July 2003 medical indemnity cover was traditionally offered by medical defence organisations (MDOs), which operated on a not-for-profit basis as 'mutuals' owned and operated by members. MDOs offered indemnity protection to medical practitioners as part of a range of services to their members.[16]

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 or not to provide indemnity to the medical practitioner. In practice, however, it was rare for an MDO not to provide indemnity except for cases 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 (MDASA)
- Medical Defence Association of Victoria (MDAV)
- MDA National (MDAN)[17]

13 ibid, p. 8.

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

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

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

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

- Medical Indemnity Protection Society (MIPS)
- Medical Protection Society of Tasmania (MPSTas)
- Queensland Doctors Mutual (QDM)[18]
- United

The above MDOs operated mainly along state lines[19] and were outside the prudential framework regulated by the Australian Prudential Regulation Authority (APRA). Although MDOs were not insurance companies authorised by APRA to conduct insurance business, they did have some associations with authorised insurers. Before 1 July 2003 all MDOs operating in Australia had access to subsidiary or 'captive' insurance companies, which were established primarily to provide reinsurance cover to the parent MDO.

2.4 Characteristics of the industry—post-1 July 2003

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

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

- AMIL—writing insurance for members of United
- HPIA—writing insurance for members of MIPS and MPSTas (and previously to QDM before it merged with MIPS)
- MDANI—writing insurance for members of MDAN
- MIA—writing insurance for members of MDASA
- PIICA—writing insurance for members of MDAV

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

18 QDM subsequently merged with MIPS on 22 July 2004.

19 The first monitoring report found that the MDO with the largest market share in each state was:

- New South Wales/Australian Capital Territory—United
- Victoria—MDAV
- Queensland—United
- South Australia—MDASA
- Western Australia—MDAN
- Tasmania—MPSTas
- Northern Territory—United

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

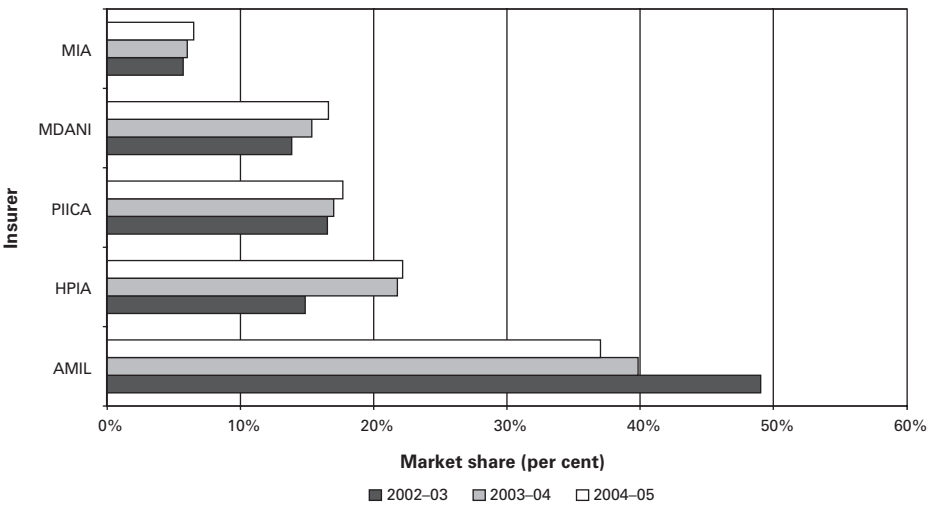
2.4.1 Market shares

The number of indemnity members that belong to each medical indemnity provider is one measure that can be used to determine the distribution of market shares within the industry. Only indemnified Australian medical practitioners are included in the analysis. Total 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 insurer. Although data on membership numbers provided by different insurers may not be comparable in some instances due to underlying data collection methodologies, it nevertheless provides a useful indication of the general market shares of all industry participants.

Chart 2.1 shows the percentage of the total number of indemnified[20] members in Australia with each medical indemnity provider based on the most recently available data provided by the medical indemnity insurers for 2002–03[21], 2003–04 and 2004–05.[22]

Chart 2.1 Medical indemnity provider indemnity members: 2002–03, 2003–04 and 2004–05[23]



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

The largest medical indemnity provider is AMIL, with approximately 37 per cent of all indemnified members in Australia in 2004–05. AMIL's market share fell by 9 per cent in 2003–04,[24] and again by 3 per cent in 2004–05. All other medical indemnity providers' share of indemnified members increased in both 2003–04 and 2004–05.

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

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

22 AMIL membership numbers relate to the previous calendar year, that is, membership for the 2004 calendar year has been recorded against the financial year ending 30 June 2005 and membership for the 2004 calendar year against the financial year ending 30 June 2005. The ACCC understands that AMIL membership levels are assessed in August of each calendar year and therefore this allocation is expected to have no material effect on market shares.

23 Results may not be directly comparable to that shown in the first and second ACCC monitoring reports due to revised data.

24 The decrease in market share for AMIL may be a result of it being in provisional liquidation from May 2002 and restricted to only being able to renew business.

2.4.2 Regulatory arrangements

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

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

For the existing medical indemnity insurers, APRA has established a scheme for transitional arrangements whereby providers have up to five years from 1 July 2003 to 30 June 2008 to comply with these minimum capital requirements (MCR).[28] From 1 July 2008 all medical indemnity providers must be fully capitalised.

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

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

ASIC also has a regulatory role in respect of medical indemnity insurance.[29] 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]

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

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

27 An insurer's minimum capital requirement (MCR) 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 APRA's website.

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

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

30 Retrospective 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 practice with protection against claims arising from previous incidents.

3. Government reforms of medical indemnity insurance

3.1 Introduction

In 2002 rising medical indemnity insurance premiums and the provisional liquidation of the largest provider, 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 current as at 1 July 2005.

3.2 Medical indemnity reform by the Australian Government

The government's medical indemnity reform package was developed throughout 2002 and announced in full on 23 October 2002. The government has subsequently outlined a series of modifications as well as introducing additional measures. This chapter examines only those reforms that were implemented and in force as at 1 July 2005. These reforms are particularly relevant because medical indemnity providers would often need to consider the effect of these reforms on their price setting arrangements for the 2005–06 underwriting year (this is discussed in more detail in chapter 5). For completeness, the development of the reform package from its inception to its current form is outlined in detail in appendix A.

The reforms include the:

- exceptional claims scheme (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.

3.2.1 Exceptional claims scheme (ECS)

The ECS[31] was introduced to address medical practitioners' concerns that their personal financial assets may be exposed to the risk of large awards and settlements above their insurance contract limit. This is known as the 'blue sky' issue.[32]

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

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

Under the ECS, the government assumes liability for 100 per cent of any damages payable against a medical practitioner that exceed the insurance contract limit, so long as the medical practitioner has cover to at least the threshold. The specified level of cover was $20 million for claims notified under medical indemnity insurance contracts from 1 July 2003.[33]

The threshold reflects the maximum level of cover offered by medical indemnity providers to medical practitioners. It will be reviewed to ensure that medical indemnity providers offer the highest level of insurance cover that can be backed by reinsurance and, conversely, if reinsurers reduce insurance contract limits the threshold will be reduced accordingly.[34]

Claims that arise from the treatment of public patients in public hospitals are exempt from this scheme. However, it does cover claims that arise from medical practitioners accompanying Australian sporting teams and cultural groups overseas.[35]

The ECS will operate for a minimum of three years and be reviewed to assess whether it remains necessary in light of state and territory tort reform and claims trends. The ECS operates on a claims-incurred basis and as such claims will continue to be met as long as the incident giving rise to the claim occurred while the scheme was in operation.

3.2.2 Run-off cover scheme (ROCS)

The ROCS[36] 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.[37]

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

The ROCS support payment is calculated as 8.5 per cent of the medical indemnity providers' premium income for a 12-month period (9.5625 per cent for United/AMIL).[38] These rates apply from 2004 to 2008.

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

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

35 This is contained in the Medical Indemnity Amendment Regulations 2004 (No. 2), which commenced on 5 December 2003.

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

37 Before 1 July 2003 medical practitioners generally obtained medical indemnity cover on a claims-incurred basis meaning that all claims for incidents while they were practising would be covered even after they retired. Those practitioners 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.

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

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

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

3.2.3 High cost claims scheme (HCCS)

The HCCS[39, 40] was introduced by the government to reduce the cost of large claims to insurers and thereby stabilise medical indemnity premiums.

Under this scheme, the government will reimburse medical indemnity providers 50 per cent of all claims above the $300 000 threshold up to a medical practitioner's limit of insurance. The HCCS does not extend to incidents that occur outside of Australia or to the treatment of public patients in public hospitals.[41]

3.2.4 Premium support scheme (PSS)

The PSS[42] was introduced to replace the medical indemnity subsidy scheme (MISS),[43] which provided premium subsidies specifically to neurosurgeons, obstetricians, procedural GPs and GP registrars undertaking procedural training.

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

39 The HCCS is contained in the *Medical Indemnity Act 2002*, which commenced on 1 January 2003, the Medical Indemnity Amendment Regulations 2003 (No. 2), Schedule 2 which commenced on 22 October 2003, and the Medical Indemnity Amendment Regulations 2004 (No. 1), Schedule 1 which commenced on 1 January 2004.

40 HCCS applies to a threshold of $2 million for all claims between 1 January 2003 to 21 October 2003, $500 000 for all claims between 22 October 2003 and 31 December 2003, and $300 000 for all claims from 1 January 2004 onwards.

41 It should be noted that 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*, such that the scheme would make a payment for high cost claims where a medical indemnity provider becomes aware of a claims **or becomes aware of an incident** against a medical practitioner. This brings the scheme into line with the claims-made insurance policies written by medical indemnity providers.

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

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

PSS applies to the following:

- medical practitioners whose gross indemnity costs exceed 7.5 per cent of estimated income from private billings—the subsidy is 80 per cent of the amount by which the member's gross indemnity cost exceeds the base amount
- medical practitioners who have applied for and been deemed eligible for the MISS—the subsidy is calculated as the greater of that under MISS or PSS
- special category members[44]—the subsidy is 80 per cent of the total cost to the member for the premium period of the member's gross indemnity costs.

3.2.5 The IBNR and UMP support schemes

Under the IBNR indemnity scheme[45] the Australian Government funds the 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.[46]

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 those medical practitioners who were members of United at 30 June 2000.[47]

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

45 The IBNR indemnity scheme is contained in the *Medical Indemnity Act 2002*, which commenced on 1 January 2003.

46 The UMP support scheme is contained in the *Medical Indemnity (UMP Support Payment) Act 2002* which commenced on 1 January 2003.

47 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. Its 2003–04 annual report reduced this valuation to $259.5 million due a combination of factors including favourable claims experience and transferring some liability to the HCCS and ROCS.

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 only make payments for the number of years they were members, and no medical practitioner would pay more than was originally required under the previous IBNR scheme.

There was an 18-month moratorium on IBNR levy payments above $1000 until 31 December 2004 which affected payment calculations for the first two years of the scheme.[48] 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
- two 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 into Competition Neutrality, the government reduced the UMP support payment further.

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.

It should also be noted that medical practitioners can apply for an exemption from the UMP support payment if they fall under one of the exemption categories, including:

- medical practitioners who earn less than $5000 per year
- medical practitioners who did not practice before 30 June 2000
- medical practitioners who are aged over 65 or turn 65 on or before 30 June of the contribution year
- medical practitioners who were impaired on or before 30 June of the contribution year, which has resulted in a continuing inability to work in a medical profession.[49]

3.2.6 Competitive neutrality review

On 4 November 2004 United announced that its licensed insurer, 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.[50]

48 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.

49 ibid.

50 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 to reduce its premiums.

On 7 December 2004 the Minister for Health and Ageing, the Hon. Tony Abbot MP, and the Minister for Revenue and Assistant Treasurer, the Hon. Mal Brough MP, 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.

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.

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 received royal assent on 19 October 2005 and are taken to have commenced on 1 July 2005.

The competitive advantage payment is defined as a percentage of the outstanding net IBNR exposure of the insurer's participating MDO at 30 June in the previous financial year multiplied by the MDO's unfunded IBNR factor. The percentage for a contribution year is to be prescribed in regulations made on or after the start of the contribution year and must not be greater than 15 per cent. Unless regulations are made there is no liability to make a payment, which consequently cannot be accrued on an insurer's balance sheet.

The first contribution year starts on 1 July 2005 and the last on 1 July 2014, although the final contribution year can be brought forward by regulations.

The UMP support payment scheme was also amended to reduce the extent and duration of payments required by medical practitioners. This was described in Section 3.2.5.

3.3 Tort law reform

Since early 2001 tort law reforms have been introduced progressively by Commonwealth, state and territory governments in response to concerns about the availability and affordability of public liability and professional indemnity insurance.[51] 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 the tort law reforms that have been introduced by Commonwealth, state and territory governments see the *ACCC's Public liability and professional indemnity insurance—fifth monitoring report—July 2005*, available at www.accc.gov.au.

51 The effect of tort law reform on costs and premiums of public liability and professional indemnity insurance is subject to a separate monitoring role by the ACCC. See ACCC report *Public liability and professional indemnity insurance—Monitoring report—July 2005*.

4. Trends in costs and premiums in medical indemnity insurance

4.1 Introduction

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

The ACCC has used this information to determine trends in the costs associated with providing medical indemnity insurance to 30 June 2005 and trends in premiums charged for indemnity protection.[52, 53]

The ACCC's previous monitoring reports also examined trends in financial performance of the industry based on data obtained from the annual reports of the MDOs.[54] In particular, the ACCC examined the gross and net loss, expense, reinsurance and combined ratios.[55]

However, the financial year accounting practices led to significant volatility in these results.[56] Changes to provisions held by some insurers in 2003–04 and 2004–05 influenced the industry results for these years meaning it was difficult to draw reliable conclusions from the analysis.

4.2 Cost components of medical indemnity insurance

The ACCC examined the cost components of the five insurers' total premium pools for the 2003–04, 2004–05 and 2005–06 underwriting years. Table 4.1 shows the percentage of the actuarially recommended aggregate premium pool for each cost category and is presented as an average estimate based on the responses across insurers.

52 With the exception of section 4.2, section 4.3 and chart 4.7, all analysis contained in this chapter includes United/AMIL results on a financial year basis.

53 In some instances the results for this report for historical years may differ from those in previous reports due to revised data.

54 The financial performance analysis contained in Chapter 6 is based on the actual results reported to APRA by the medical indemnity insurers.

55 These terms are defined in section 6.4.5.

56 The analysis of historical underwriting performance was prepared on a financial year basis and, as such, included not only the expenses incurred in the year, but also changes in provisions held for future expenses arising from the underwriting activities of previous years but expected to be paid in future years. Adjustments to claims provisions, reinsurance recovery provisions or other expense provisions can affect the actual results observed in a financial year. Because of this the ratios in any one year may not accurately reflect the results achieved by insurers from underwriting activities in that year.

Table 4.1 Components of actuarially recommended aggregate premium pool: 2003–04, 2004–05 and 2005–06 underwriting years

Components	Percentage of premium charged by insurers		
	2003–04	2004–05	2005–06
Expected surplus[57]	36	26	21
Net claims costs[58]	32	36	40
Reinsurance expenses	17	16	14
Underwriting and general expenses	15	22	25
Total premium pool	**100**	**100**	**100**

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

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

The table shows that for the 2005–06 underwriting year the net cost of claims was the largest component of the premium pool at 40 per cent. Expected surplus represented 21 per cent, underwriting and general expenses 25 per cent and reinsurance expenses 14 per cent.

The proportion of premium pool represented by the expected surplus has fallen significantly over the three-year period, while the proportion represented by the net claims costs has risen. Reinsurance expenses have fallen marginally while underwriting and general expense rose significantly in 2004–05 and again marginally in 2005–06.

57 The expected surplus was typically raised for the purpose of capital accumulation or maintenance. This is discussed in more detail in section 5.4.5.

58 The net cost of claims is the expected ultimate claims cost net of recoveries received or expected to be received, including those from the Australian Government under the HCCS, ROCS or UMP support scheme.

4.3 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:[59, 60]

- *Ultimate claims costs by notification year*—the ultimate costs of claims[61] expected to be met by medical indemnity providers by year of notification[62]
- *Claim frequency*—the ultimate number of claims expected by year of notification expressed as a proportion of the total number of indemnified members[63] in the corresponding underwriting year[64]
- *Average size of claims*—the ultimate expected[65] average size of claims arising from a given notification year that will eventually be settled.

59 Due to differing definitions of claims information adopted by individual insurers, the results contained in this section should be examined in terms of trends and not absolute numbers.

60 United records notifications by calendar year, not financial year. The ACCC considered it inappropriate to adjust these figures without knowledge of claim notification patterns. Data based on United's calendar years has therefore been allocated to the following financial year, i.e. the 2003 calendar year has been allocated to the 2003–04 financial year.

61 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—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 made/are expected to be made. It should also be noted that due to ultimate claims costs and numbers being based largely on expectations which can change from year to year, data contained within this section may not be directly comparable with that shown in the first or second monitoring reports.

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

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

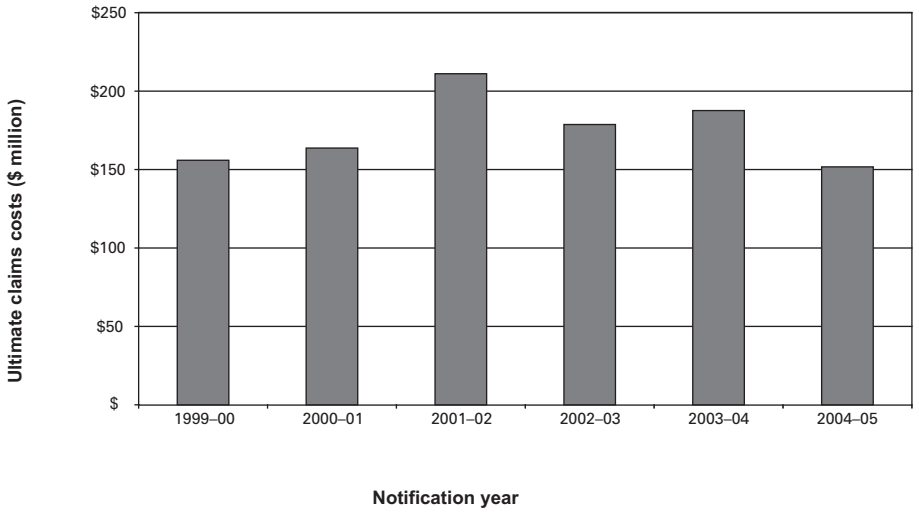
64 Notification year will generally correspond with underwriting year because membership is usually taken on a financial year basis.

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

4.3.1 Ultimate claims costs

Chart 4.1 shows the trend in ultimate claims costs[66] for claims notified between 1999–2000 and 2004–05.

Chart 4.1 Ultimate claims costs by year of notification: 1999–2000 to 2004–05



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

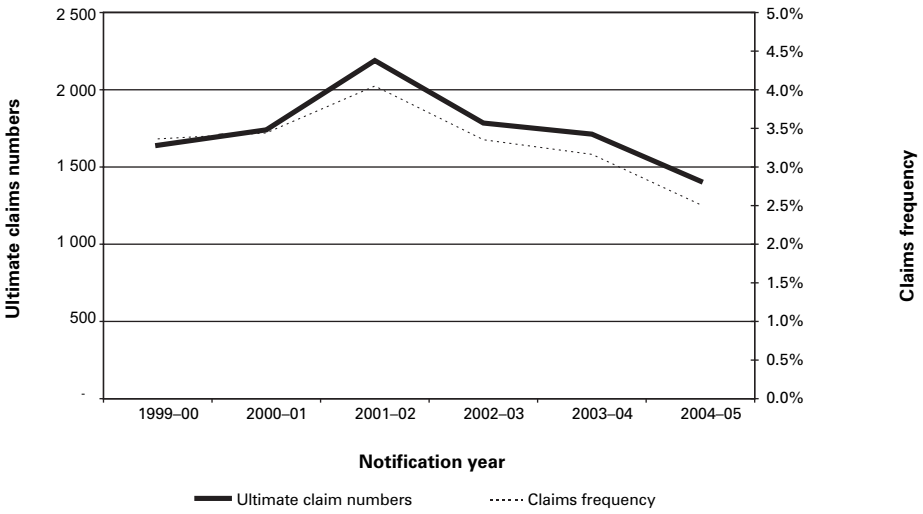
The ultimate cost of claims expected by year of notification increased between 1999–2000 and 2001–02 from $156 million to $211 million. In 2002–03 the ultimate cost of claims fell before increasing marginally to $188 million in 2003–04. In 2004–05 the ultimate cost of claims fell to $152 million, 28 per cent below the peak in 2001–02.

66 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.

4.3.2 Claims frequency

Chart 4.2 shows the ultimate number of claims expected to be met by insurers for each notification year between 1999–2000 and 2004–05, and the corresponding claims frequency.

Chart 4.2 Ultimate claim numbers and claims frequency by year of notification: 1999–2000 to 2004–05



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

The ultimate number of claims increased by 33 per cent between 1999–2000 and 2001–02 (from 1640 to 2189) before falling by 36 per cent over the following three years to 1408 in 2004–05. The observed trend is similar to that for the ultimate cost of claims as shown in chart 4.1.

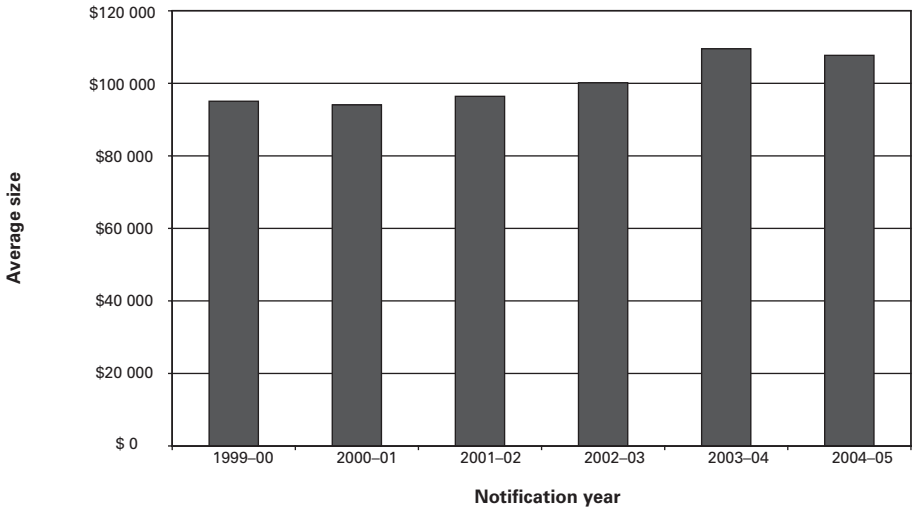
Claims frequency has followed a similar trend to the ultimate number of claims. The claims frequency increased from 3.4 per cent in 1999–2000 to 4.0 per cent in 2001–02 before decreasing over the following three years to 2.5 per cent in 2004–05.

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

4.3.3 Ultimate average size of claims

Chart 4.3 shows the trend in the ultimate average size of claims expected by notification year between 1999–2000 and 2004–05.[67]

Chart 4.3 Ultimate average size of claims by year of notification: 1999–2000 to 2004–05



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

This chart shows that the average size of claims fell marginally between 1999–2000 and 2000–01 from $95 061 to $94 057. It then increased each year to $109 539 in 2003–04. In 2004–05 the average size of claims fell marginally to $107 718.

4.4 Trends in other expenses

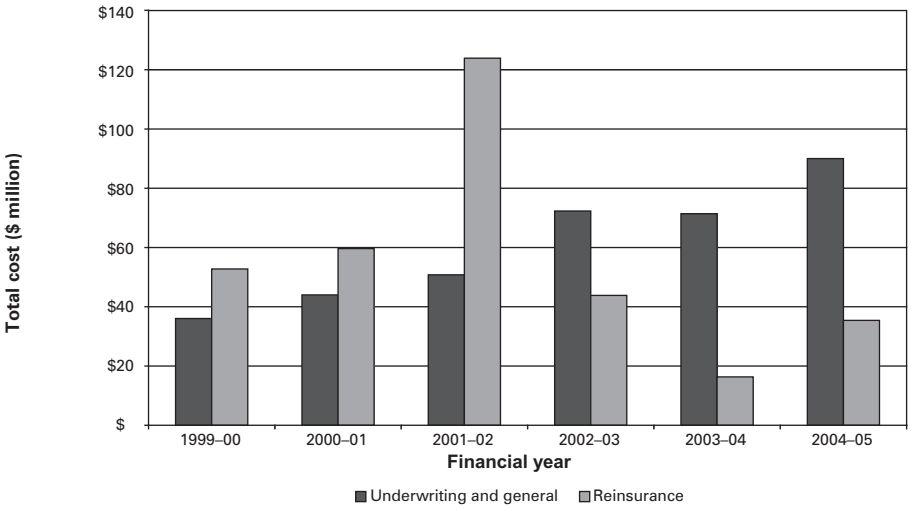
The ACCC examined trends in two other major categories of expenses—underwriting and general expenses, and reinsurance expenses. Underwriting and general expenses relate to all expenses incurred by insurers, other than reinsurance expenses and claims costs and related expenses. Reinsurance expenses refer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

Chart 4.4 shows reinsurance expense and underwriting and general expenses for the years 1999–2000 to 2004–05.[68]

67 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 are still largely uncertain. This is because expected future payments is 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.

68 It should be noted that the analysis in chart 4.4 will not be directly comparable with that shown in previous monitoring reports due to changes in the way the ACCC allocated some annual report data to specific categories.

Chart 4.4 Reinsurance expense and underwriting and general expenses: 1999–2000 to 2004–05



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

Underwriting and general expenses increased in almost all years, from $36 million in 1999–2000 to $90 million in 2004–05.

Reinsurance expenses increased from $53 million in 1999–2000 to $60 million in 2000–01, before increasing markedly to $124 million in 2001–02. Reinsurance expenses then fell significantly to $44 million in 2002–03.

In 2003–04 reinsurance expenses were substantially lower than previous years, at $16 million. This result was influenced by one insurer that altered its reinsurance arrangements in 2003–04, which had the effect of creating a positive reinsurance expense.[69] In 2004–05 reinsurance expenses were higher than 2003–04, but lower than all previous years at $35 million. This result was again influenced by the same insurer altering its reinsurance arrangements.

69 In the ACCC's second monitoring report this effect was removed from the industry results leading to reinsurance expenses of $46 million in 2003–04.

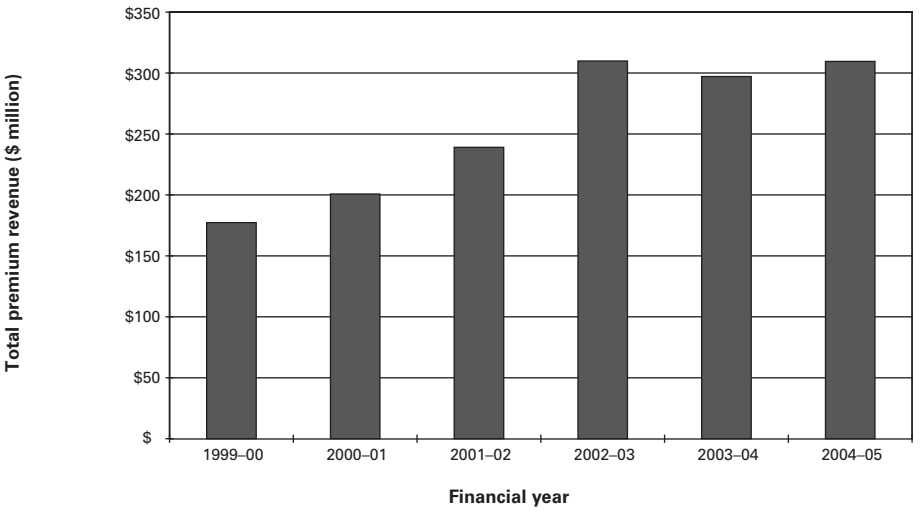
4.5 Trends in premiums

The ACCC examined medical indemnity premiums by examining trends in total premium revenue and the average premium. The average premium is the total premium revenue earned per financial year divided by the total number of indemnified policy holders for that year, in real terms.[70]

4.5.1 Total premium revenue

Chart 4.5 shows the trend in the total gross premium revenue[71] by underwriting year for the period 1999–2000 to 2004–05.

Chart 4.5 Total gross premium revenue by underwriting year: 1999–2000 to 2004–05



Source: Derived by ACCC from data for five medical indemnity providers.
Notes: Excludes call revenue.[72]
Excludes all statutory third party collections including GST, stamp duty and ROCS.

The total gross premium revenue rose significantly from $177 million in 1999–2000 to $310 million in 2002–03. The total gross premium revenue then remained relatively stable in 2003–04 and 2004–05 at $297 million and $310 million respectively.

70 Adjusted to 30 June 2005 values using the average weekly earning index (AWE) published by the Australian Bureau of Statistics (ABS) (catalogue number 6302.0).

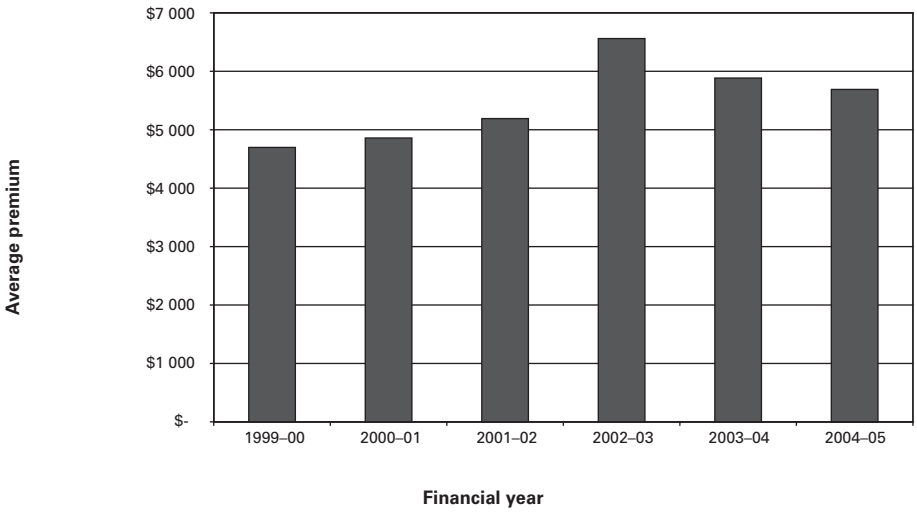
71 Premium revenue is earned premium, that is, the total amount of gross written premium that is earned during the period, 'earned' being that proportion of risk covered by the policy that has expired at the end of the reporting period.

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

4.5.2 Average premium

Chart 4.6 shows the trend in the average premium paid by members of medical indemnity providers. This average gives an indication of the trend in real premiums payable by all indemnified medical practitioners between 1999–2000 and 2004–05. [73]

Chart 4.6 Average premium—real terms: 1999–2000 to 2004–05



Source: Derived by ACCC from data for five medical indemnity providers.
Notes: Data is shown in real terms adjusted to 30 June 2005 values using the average weekly earnings (AWE) index published by the ABS
Rates exclude third party statutory collections such as GST, stamp duty and ROCS.

The average premium increased by approximately 3 per cent in 2000–01, 7 per cent in 2001–02 and 26 per cent in 2002–03 to $6560. The real average premium fell by 10 per cent in 2003–04[74] and again in 2004–05 by 3 per cent to $5690.

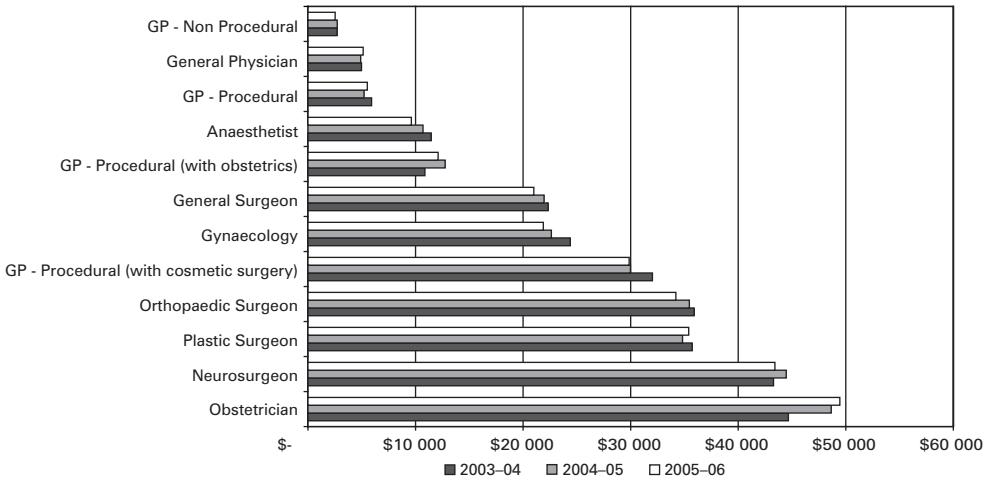
Medical practitioners who practise relatively more complex medical procedures are likely to face a higher risk of medical negligence claims being made against them than ones who perform less complex procedures. The complexity of medical procedures is also a key determinant of the size of medical negligence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

73 Results shown in chart 4.6 may not be directly comparable to that shown in the first and second ACCC monitoring reports due to revised data.

74 The fall in the average premium in 2003–04 may reflect the move by some insurers from claims incurred policies (which are typically more expensive) to first year claims made policies (which are typically cheaper than mature claims made policies and claims incurred policies).

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 2003–04, 2004–05 and 2005–06[75]. This information allowed the ACCC to examine the average written premium for selected specialties across the three underwriting years to determine the relativities between specialties as well as any changes in those relativities.

Chart 4.7 Average written premium—by specialty: 2003–04, 2004–05 and 2005–06



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

Chart 4.7 shows that the average written premium[76] for the selected specialties varied between $2529 for a non-procedural GP in 2005–06 to $49 451 for an obstetrician in 2005–06.[77]

Chart 4.7 also shows the change in the average written premium for the selected specialties between 2003–04 and 2005–06. The gross written premium for most selected specialties fell over the period. The only significant exceptions were those for procedural GPs with obstetrics for which the average written premium rose from $10 877 in 2003–04 to $12 101 in 2005–06 (an increase of 11 per cent), and for obstetricians for which the average written premiums rose from $44 665 in 2003–04 to $49 451 in 2005–06 (an increase of 11 per cent).

75 The ACCC asked insurers to provide gross written premium and membership numbers at a specific date in the 2005–06 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 years results.

76 The average written premium by specialty is presented on a nominal basis meaning the results are presented in current values at the end of each year and are not adjusted into real terms (that is, they do not reflect the effect of inflation). However, due to the short period examined in the analysis this is not expected to make a material difference to the results.

77 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 provider and jurisdictions. This analysis examines the total gross written premium for all insurers for selected specialties divided by the total membership for all insurers for those specialties.

The average written premium for the remaining selected specialties generally remained stable or fell over the period, ranging from no significant change for general physicians and neurosurgeons to a decrease of 16 per cent for anaesthetists.

It should be noted that 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[78], different income levels and different jurisdictions[79]. All of these factors may influence the average written premium for reasons other than specialty relativities.

78 Under a claims made policy the insurer agrees to indemnify all claims arising from incidents notified during the policy period, so long as the incident occurred during the current period, or any prior 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.

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

5. Actuarial justification of medical indemnity premiums

5.1 Introduction

This chapter presents the ACCC's findings regarding the actuarial justification of medical indemnity premiums charged for the 2005–06 underwriting period[80] by the five current medical indemnity providers to private medical practitioners.

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

The ACCC's findings regarding the actuarial justification of medical indemnity premiums charged within each jurisdiction for 2005–06 are discussed in chapter 7.

5.2 Qualifications

The ACCC's analysis is based on information supplied by each of the five insurers and their affiliated MDOs. The ACCC relied on the information provided by insurers rather than performing an independent verification. This analysis only examined the premiums charged by each insurer for primary medical indemnity insurance and specifically excluded any examination of ancillary policies or the subscription charged by the MDO.

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

5.3 Assessment methodology

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

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

80 2005 calendar year in the case of AMIL.

- the extent to which the insurer's board adopted the actuary's recommended premium rates
- the degree to which the recommended actuarial premium pool detailed in the pricing report is consistent with, and supported by, other reports, such as the financial condition report and the outstanding liability assessment.

- Pure risk premium—the level of premium 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 not likely to be known for some years after the premium has been set (see section 2.2.2). The estimate of pure risk premium excludes the premium amount necessary to cover the insurer's expenses, reinsurance expenses and any surplus required. Factors considered include:
  - issues related to the cost structure of claims, such as the adopted claims frequency assumption, allowances for large claims, the projected rate of claims cost increases, legal costs, discount rate, the projected growth rate of membership numbers, and the specialty mix and claims-made profile.
- Expenses—the expenses incurred by the insurer as a result of acquiring, writing and servicing the insurance business. Factors considered include:
  - assessing the appropriateness of the expected level of costs and the basis of cost allocation across membership categories.
- Reinsurance expenses—the amount of premium ceded to reinsurers for reinsurance. Factors considered include:
  - whether or not the reinsurance premium is used effectively to minimise the risk exposure of the portfolio
  - the extent to which the cost of reinsurance is included in premium rates recommended by the actuary
  - an assessment of expected recoveries compared with premiums.
- Surplus[81]—the surplus of funds that is 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 capital at least at the MCR and provide a contingency margin on expected claims costs. Factors considered by the ACCC include:
  - assessing the capital structure of the insurer and the cost effectiveness of how the capital is raised
  - examining the purpose for building a surplus into premiums and the appropriateness of the 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

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

- comparing the actuary's recommended premium relativities against the actual premium rates charged by the insurer, with insurers being asked to explain material differences.

In this report **jurisdictional relativities** have been considered separately. This analysis is contained 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:
  - high cost claims scheme (HCCS)—medical indemnity providers were asked to detail the degree of influence this scheme has had on the calculation of the required premium pool and/or recommended premium rates, estimated claims cost reductions, as well as any allowances made for changes in the level and cost of reinsurance and the insurer's capital requirements
  - run-off cover scheme (ROCS)—medical indemnity providers were asked to detail the degree of influence this scheme has had on the calculation of the required premium pool and/or recommended premium rates, estimated claims cost reductions, as well as any allowances made for changes in the level and cost of reinsurance and the insurer's capital requirements. Insurers were also asked to outline the principal for allocating the cost of ROCS to each membership category
  - tort law reform—medical indemnity providers were asked to detail the effect of tort reforms on the premium setting arrangements. This included specific commentary by jurisdiction of the effect on costs, premiums, assumptions and the methodology employed. When no consideration of the effect of tort reforms on costs and premiums was given, this was to be noted.

5.4 Analysis

5.4.1 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 medical indemnity providers. Insurers estimated the aggregate premium pool required by establishing the estimated cost of claims, reinsurance costs, administration expenses plus an additional margin for capital growth or maintenance.

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

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

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

In the ACCC's second monitoring report it was noted that in some cases actuaries were only used to establish the pure risk premium component and relied on the insurer to determine the amount needed for the other components of the aggregate premium pool. The ACCC's analysis of 2005–06 premiums found that this is still the case for some insurers, especially for the surplus component of premiums. Again, the ACCC recognises that there are limitations on the extent to which actuaries can assess the appropriateness of components of premiums based on insurers' projections. However, it may be prudent for actuaries to consider how these recommendations compare with their understanding of the insurers' operations in their pricing reports.

The ACCC noted in its second monitoring report that the Institute of Actuaries of Australia (IAAust) was formulating a Guidance Note on Actuarial Premium Reports for medical indemnity insurance. The ACCC encourages the IAAust to finalise this guidance note as it believes it will help actuaries determine what issues should be covered off in their pricing reports to insurers and the depth to which each issue should be dealt with and reported on.

The ACCC also understands that the IAAust is currently finalising a Professional Standard on Financial Condition Reports for general insurers, which will encompass medical indemnity insurers. This standard is expected to require the actuary to consider the profitability of an insurer and the adequacy of premiums. This mandatory standard is expected to be issued in time for the 2006–07 underwriting year.

5.4.2 Pure risk premium

The ACCC considered the pure risk premium component of the aggregate premium pool for the 2005–06 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[82] represented 40 per cent of the aggregate premium pool for the 2005–06 underwriting year.

The ACCC found that insurers adopted a similar methodology in setting the 2005–06 aggregate premium pool as that used in the 2004–05 underwriting year.

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 some actuaries 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 actuarial assessment of insurers' outstanding claims liabilities.

82 The net claims cost is the expected ultimate claims cost net of recoveries received or expected to be received including those from the Australian Government under the HCCS, ROCS or UMP support scheme in respect of incidents notified in the period of cover.

5.4.3 Expenses

The ACCC considered the amount of expenses that were incorporated into the aggregate premium pool for the 2005–06 underwriting year. Table 4.1 shows that expenses represented 25 per cent of the aggregate premium pool for the 2005–06 underwriting year.

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

In its second monitoring report the ACCC noted that in some cases the actuary relied solely on information provided by the insurer in their determination of the expenses component of the aggregate premium pool. The ACCC suggested that it may be prudent for actuaries to consider how these recommendations compare with past experience and their understanding of the insurer's operations.

All insurers made significant advances towards meeting the goals suggested in the ACCC's second monitoring report.

5.4.4 Reinsurance expenses

The ACCC considered the reinsurance expenses incurred by insurers to assess whether or not the reinsurance program was used effectively to minimise the insurer's risk exposure, and the extent to which the cost of reinsurance was included in premium rates recommended by the actuary. Table 4.1 shows that the reinsurance expenses represented 14 per cent of the aggregate premium pool.

All medical indemnity insurers used reinsurance programs for the 2005–06 period to manage the risks inherent in their portfolio. They all used a combination of 'excess of loss' and 'stop loss' reinsurance to manage their risk exposure.[83] 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.[84]

The ACCC examined the expected net cost of reinsurance and found that generally all insurers expected reinsurance recoveries to be considerably less than the value of the premiums ceded to the reinsurer, similar to the 2003–04 and 2004–05 underwriting years.[85]

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.

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83 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 an 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.

84 In some cases the reinsurance program covered IBNR claims in respect of cover provided by the parent MDO. A portion of the reinsurance premium was then charged to the MDO.

85 The ACCC was unable to accurately compare reinsurance costs between the 2003–04, 2004–05 and 2005–06 underwriting periods due to the circumstances surrounding reinsurance arrangements changing 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.

5.4.5 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 APRA's target level[86, 87]
- build the additional capital needed as a result of risks underwritten in 2005–06 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 provision 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 three underwriting years, from 36 per cent 2003–04 to 26 per cent in 2004–05 and 21 per cent in 2005–06.

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 MCR and, as insurers capital levels approach this target, a significant surplus loading is no longer needed.

For the 2005–06 underwriting period the ACCC found that three 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.[88] The remaining two medical indemnity providers continued to build capital loadings into their aggregate premium pools mainly to meet APRA's capital target.[89]

The medical indemnity providers with capital that had reached or exceeded APRA's target capital still included a loading in their premiums for additional capital. This capital was built into premiums for one of two reasons—to maintain their capital at a sufficient level so as to continue to meet or exceed APRA's target capital after taking into account the additional risks underwritten in 2005–06, or to maintain a contingency margin.[90]

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

86 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.

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

88 The ACCC's second monitoring report found that for the 2004–05 underwriting year only two insurers indicated that they had satisfied their internal solvency targets.

89 The ACCC 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 on the level of stamp duty) of capital.

90 One insurer that had reached its targeted capital level indicated that a portion of the surplus raised through its premiums was a contingency margin to buffer fluctuations in investment returns.

The ACCC noted in its second monitoring report that in some cases the actuary relied on information provided by the insurer in their determination of the surplus component of the premium pool. The ACCC found that actuaries continued to rely on the insurer to determine the surplus component of the 2005–06 aggregate premium pool. In some cases the insurer did not nominate a desired level of surplus, but instead surplus was the balancing item once the actual premium pool was set.

The ACCC encourages the actuary to consider the level of surplus contained within the aggregate premium pool in the context of their understanding of the insurers operations and capital position. An IAAust Guidance Note on premium determination would help to address this issue.

5.4.6 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. Some insurers conducted new analysis on relativities between specialties for the 2005–06 underwriting year, while others updated previous analysis to incorporate recent developments (including new specialties).

The ACCC found that cross subsidisation between risk specialties was common across most medical indemnity providers. While insurers were moving to unwind these cross subsidies, many noted the practical hurdles that limit the extent and speed to which this can be achieved. All insurers identified and quantified cross subsidies between risk specialties.[91]

The ACCC also examined the premium relativities applied across broad income bands. Similar to the analysis done for specialties, some insurers conducted new analysis while others updated previous analysis.

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.

5.4.7 Government reforms

The ACCC examined the effect of the Australian Government's medical indemnity reforms (in particular, the 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 ACCC found that the extent to which these measures had been considered by insurers in determining premiums varied across the industry.

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

The high cost claim scheme (HCCS)

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 would be expected to reduce the pure risk premium component of premiums, as the Australian Government would 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 examined the effect of the HCCS on their pure risk premium. In the ACCC's second monitoring report it was found that one insurer only took 50 per cent of expected HCCS recoveries into account when determining the 2004–05 pure risk premium. This insurer indicated that this was largely due to perceived problems with the scheme's operation, which the ACCC has noted have been addressed by the Australian Government.[92] In determining the pure risk premium for the 2005–06 underwriting year all insurers took into account the full amount of expected HCCS recoveries.

Three insurers indicated that they had factored the full effect of the HCCS into their 2005–06 reinsurance program. The remaining two insurers did not. The rationale for not factoring the HCCS into the reinsurance program differed between the two insurers.

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

The second insurer stated that it continued to have concerns with the HCCS and potential gaps in the cover it offers. Therefore, it placed its reinsurance program by reinsuring the full amount of all high cost claims, but then allowing for a mechanism through which 50 per cent of HCCS recoveries inured directly to its reinsurers. By doing this, the insurer obtained a discount on the reinsurance premium agreed upon with some of its reinsurers. However, because not all of its reinsurers were able to reach agreement on appropriate terms with regard to the HCCS the remaining 50 per cent of HCCS recoveries accrue directly to the insurer.

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 their 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.

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

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

Taking this into account, the ACCC still considers that the aggregate premium pool of those insurers that did not take the HCCS into account in their reinsurance arrangements are still actuarially justified because the pure risk premium of these insurers takes into account HCCS recoveries. It appears that the rationale for the HCCS not being taken into account in the reinsurance program lies with some reinsurers that appear unwilling to fully reflect the benefits of the Australian Government's scheme.

The ACCC encourages all insurers to ensure the HCCS is fully taken into account in their reinsurance arrangements for 2006–07 premiums.

Run-off cover scheme (ROCS)

The ROCS was introduced to provide secure cover for medical practitioners who retire, die, become permanently disabled, or permanently leave the workforce for three years or more. The scheme 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 the ROCS on 2005–06 premiums. Four insurers indicated that they expected to make recoveries from the ROCS on claims costs resulting from notifications received in the 2005–06 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 the 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 the ROCS in determining their premiums for 2005–06 was actuarially justified.

Tort law reform

Since early 2001 tort law reforms have been introduced progressively by Commonwealth, state and territory governments in response to perceived problems in the availability and affordability of public liability and professional indemnity insurance.[93] 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.

Of the five insurers, three took tort law reform into account in setting their premiums for 2005–06. However, the level of savings afforded by tort law reform differed between insurers. Two of these insurers estimated some minor savings which were built into premiums, while the remaining insurer conducted detailed analysis on the expected effect of individual legislative changes on claims costs and how these would affect the pure risk premium.

93 The effect of tort law reform on costs and premiums in public liability and professional indemnity insurance is subject to a separate monitoring role by the ACCC. See ACCC report *Public liability and professional indemnity insurance—Monitoring report—July 2005*.

The remaining two insurers did not take into account tort reforms in determining premiums. One insurer cited the fact that the claims experience was still immature and thus opted to take a cautious approach. The other insurer estimated that reforms would affect its claims costs, but the benefits were likely to be seen by its reinsurers due to the nature of its reinsurance program.

While the ACCC considers the premiums of those insurers that took a more cautious view of tort law reform as actuarially justified, it would encourage all insurers to conduct a detailed examination of the effect of tort law reform on claims experience prior to the 2006–07 underwriting year.

5.5 Conclusion

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

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 made extensive use of actuaries in preparing liability assessments, pricing reports, funding plans and financial forecasts. In each case the construction of the recommended premium pool was considered to be soundly based and incorporated all major cost implications for the pricing of medical indemnity insurance. Each insurer adopted an aggregate premium pool after considering advice from the actuary.

One issue that arose in relation to the aggregate premium pool was the actuaries' consideration of the surplus component. The ACCC found that actuaries continued to rely on the insurer to determine this component, and in some cases the insurer did not nominate a desired level of surplus, but instead surplus was the balancing item once the actual premium pool was set. The ACCC notes that the IAAust was developing medical indemnity premium guidelines. Such a guideline would assist actuaries address this issue in future pricing reports.

The ACCC's analysis of specialty premium rates found that most insurers conducted detailed analysis on premium relativities between specialties. Insurers generally indicated a desire to unwind existing cross subsidisation between specialties but noted that many practical hurdles limited the extent and speed to which this could be achieved. However, the ACCC still found these rates, and the relativities for income bands, were considered 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 included an examination of Australian Government medical indemnity reforms (including the HCCS and the ROCS), and Commonwealth, state and territory tort law reforms. The ACCC found that all insurers factored the HCCS and ROCS into determining their pure risk premium, while most insurers took full account of the HCCS in their reinsurance program. Some insurers indicated that reinsurers were unwilling to fully reflect the benefits of the HCCS in determining the reinsurance program. Nevertheless, the ACCC encourages all insurers to ensure the HCCS is fully taken into account in their reinsurance arrangements for 2006–07 premiums. The majority of insurers took tort law reform into account in setting their aggregate premium pools for 2005–06. However, the level of estimated savings differed significantly between these insurers.

6. Commercial justification of medical indemnity premiums

6.1 Introduction

This chapter presents the ACCC's findings regarding the commercial justification of medical indemnity premiums charged for the 2005–06 underwriting period[94] by the five current medical indemnity providers to private medical practitioners.

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

The ACCC's findings regarding the commercial justification of medical indemnity premiums charged within each jurisdiction for 2005–06 are discussed in chapter 7.

6.2 Qualifications

The ACCC's analysis is based on information supplied by each of the five insurers and their affiliated MDOs. The ACCC relied on the information provided by insurers rather than performing an independent verification. This analysis only examined the premiums charged by each insurer for primary medical indemnity insurance and specifically excluded any examination of ancillary policies or the subscription charged by the MDO.[95]

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

6.3 Assessment methodology

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

Fiscally responsible insurers examine the financial impact of pricing decisions on their operations by preparing business plans that describe how they intend to manage their business. They also prepare detailed corporate plans on the financial effect (including on the statement of financial performance and statement of financial position) of the business plan on their overall corporate strategies. This type of analysis is necessary to ensure that insurers are capital compliant with APRA's targeted capital 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.

94 2005 calendar year in the case of AMIL.

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

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

- financial projections contained in their initial funding plans as provided to APRA to make use of the transition period for building the capital to the APRA targeted capital (referred to as 2002–03 projections)[96]
- revised financial projections prepared in 2003–04 (referred to as 2003–04 projections)[97]
- revised financial projections prepared in 2004–05, which take into account more recent data and developments (referred to as 2004–05 projections)[98]
- actual financial position as at 30 June 2004 based on **annual** reporting data provided[99] to APRA and the actual financial position as at 30 June 2005 based on **quarterly** reporting data provided to APRA (referred to as actual results)[100].

Comparing these sets of data allows the ACCC to examine how insurers' financial position forecasts have changed over the three years and whether forecasts for 2004–05 were achieved based on actual data for 2004–05.

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

- solvency[101]—the current and forecast net asset position of insurers to assess levels of solvency
- emerging surplus—the emerging and forecast levels of surplus loading in premiums and whether this was sufficient to achieve the medical indemnity providers' targeted solvency and capital requirements
- MCR coverage and capital targets—current and forecast levels of MCR coverage to examine whether capital targets would be met
- return on net assets—current and forecast return on net assets
- underwriting performance—the emerging and forecast underwriting performance in terms of the loss ratio, expense ratio, reinsurance ratio and combined ratio. These ratios are defined in section 6.4.5.

96 APRA required all medical indemnity providers that intended to use the transitional period to build the required minimum capital to provide it with a funding plan indicating how this capital was going to be raised over the transition period. This funding plan was typically provided to APRA in mid-2003. It should be noted that due to differences in the time period specified by insurers when submitting these funding plans the financial projections period analysed by the ACCC has been limited to 2003–04 to 2006–07.

97 These revised projections were updated at different times depending on the insurer. The ACCC endeavoured to use the most recent projections up to 30 June 2004.

98 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 2005. The ACCC's analysis of the 2004–05 financial projections excludes 2003–04, as this is shown as actual results.

99 In the second monitoring report the ACCC relied on quarterly reporting data for the 2003–04 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 report. This may mean that the results between the second monitoring report and this report may not be directly comparable due to changes made to the final audited annual returns.

100 APRA's reporting requirements require quarterly reporting forms to be provided within four weeks of the end of the reporting period, whereas annual reporting forms are required to be provided within three to four months. Due to these timing constraints the ACCC relied on the reporting forms provided for the June quarter 2005 for the 2005 actual results. This data may be different to that provided in the annual reporting forms.

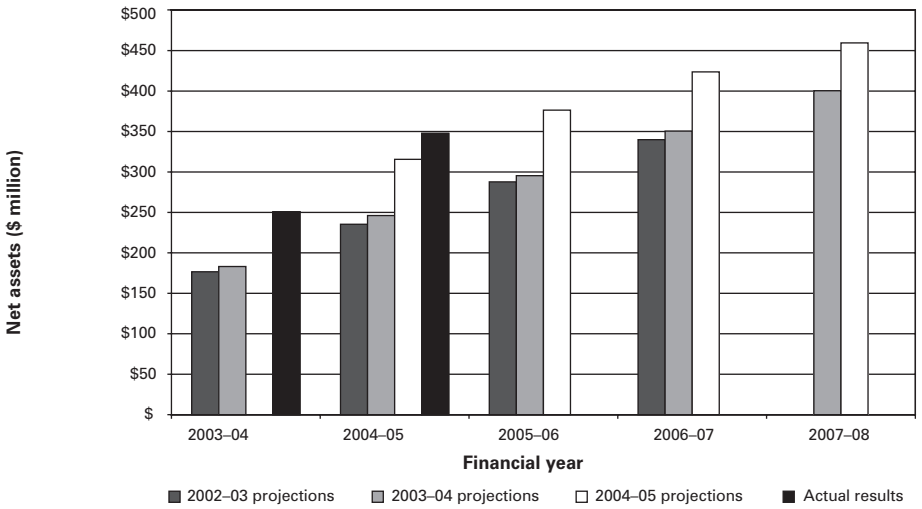
101 Solvency is a measure of whether an insurance company has sufficient assets (capital, surplus, reserves etc) to meet all liabilities (the cost of claims and all other expenses).

6.4 Analysis

6.4.1 Solvency targets

The ACCC assessed medical indemnity providers' actual solvency levels for 2003–04 and 2004–05 and compared these against the 2002–03, 2003–04 and 2004–05 projections of solvency. This is shown in chart 6.1.

Chart 6.1 Net assets: 2003–04 and 2004–05 actual position and 2002–03, 2003–04 and 2004–05 projections



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

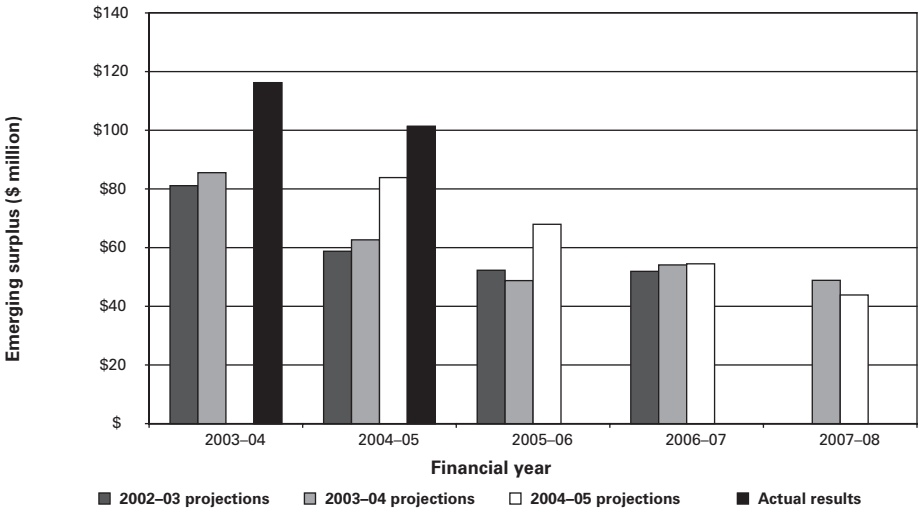
Chart 6.1 shows that the 2002–03 projections originally forecast the net assets of the medical indemnity industry to increase from $177 million to $340 million between 2003–04 and 2006–07. These forecast positions improved when subsequently revised in 2003–04 to $183 million and $351 million (rising to $400 million in 2007–08). The 2004–05 projections again increased the forecast net asset position, which is expected to grow to $460 million in 2007–08.

As at 30 June 2005 the industry was in a strong solvency position with total assets exceeding total liabilities by $348 million. This was a significant improvement on the actual result observed at 30 June 2004 of $251 million. Further, the solvency position at 30 June 2005 was greater than anticipated in the 2002–03, 2003–04 and 2004–05 projections.

6.4.2 Emerging surplus

The ACCC assessed the actual emerging surplus of the medical indemnity industry as at 30 June 2005 and compared this against the emerging surplus forecast in the 2002–03, 2003–04 and 2004–05 financial projections. This is shown in chart 6.2.

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



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

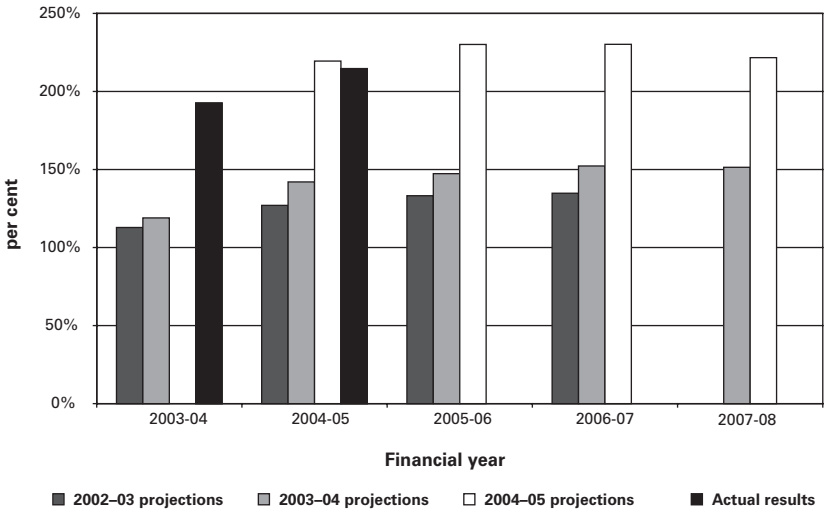
Chart 6.2 shows that based on the 2002–03 projections the level of emerging surplus was forecast to decrease from $81 million in 2003–04 to $52 million in 2006–07. The 2003–04 projections raised these forecasts marginally. The emerging surplus predicted in the 2004–05 projections was higher for 2004–05 and 2005–06 but remained in line with earlier projections for 2006–07 and 2007–08. 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 $101 million in 2004–05, significantly higher than that forecast in all three projections. This primarily resulted from higher income (both premium and investment) combined with a lower claims expense than was expected in 2004–05. While the emerging surplus for 2004–05 was higher than projected, the decrease from $116 million in 2003–04 is consistent with the projected downward trend.

6.4.3 MCR Coverage and Capital Targets

The ACCC assessed the actual financial position of the medical indemnity industry as at 30 June 2005 and compared this against the financial position forecast in the 2002–03, 2003–04 and 2004–05 financial projections. The ACCC examined the net asset[102] to MCR ratio as an indicator of financial position, as shown in chart 6.3.

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



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

Chart 6.3 shows that the 2002–03 projections forecast the medical indemnity industry to have a net asset position equal to 113 per cent of MCR in 2003–04, rising to 135 per cent by 2006–07. The 2003–04 projections forecast net assets to equal 119 per cent of MCR in 2003–04 rising to 152 per cent in 2006–07 (and remaining at this level in 2007–08). The 2004–05 projections forecast the MCR coverage increase to 219 per cent in 2004–05 and remain around this level until 2007–08.

The 2004–05 projections had all insurers maintaining their MCR coverage at or near the 2004–05 projected level through to 2007–08, suggesting that most insurers expected to only raise capital for the purposes of maintaining MCR coverage or as a contingency margin.

The actual net asset to MCR ratio of the medical indemnity industry at 30 June 2005 of 215 per cent was significantly higher than the 2002–03 and 2003–04 projections but marginally below the 2004–05 projections.

At 30 June 2005 three insurers exceeded or were only marginally below their 2004–05 projections. The remaining two insurers were below their 2003–04 and 2004–05 projections, but exceeded their 2002–03 projections. One insurer exceeded the 150 per cent MCR required by APRA. The other was below its projections, but the ACCC understands it was expected to recover from that position by the September 2005 quarter.

102 For the analysis in section 6.4.3 the net asset position is, where possible, based on the APRA determined capital base of the insurers. This APRA determined capital base is used by APRA to gauge compliance with the MCR.

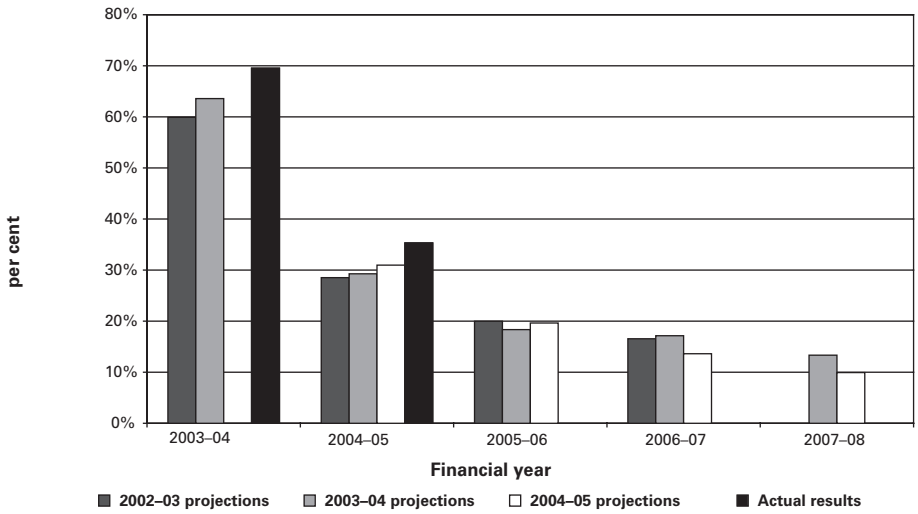
The ACCC notes that as a result of a pricing decision made by one insurer in the 2005–06 underwriting year, its MCR coverage was expected to fall below the levels projected in the 2004–05 projections. In order to maintain its desired net asset to MCR ratio, two separate capital injections from the parent entity are scheduled in future years. While the capital injections are expected to enable the net asset to MCR ratio to be maintained in the short to medium term for this insurer, future reliance on capital injections from the parent entity is not considered to be a viable strategy in the longer term.

The ACCC encourages all insurers to ensure their pricing in each underwriting year is sufficient to maintain capital at the desired level. If not, insurers should clearly quantify the shortfall and have clear established strategies for achieving that position.

6.4.4 Return on net assets

The ACCC assessed the returns of medical indemnity providers relative to their net asset position and compared these against the 2002–03, 2003–04 and 2004–05 forecasts. This is shown in chart 6.4.

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



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

The chart shows that in 2002–03 the projected return on net assets was forecast to decrease from approximately 60 per cent in 2003–04 to 17 per cent in 2006–07. This forecast remained largely the same in both the 2003–04 and 2004–05 projections.

The return on net assets is projected to decrease because initially insurers raised significant surpluses to fund the capital requirements when their asset base was low, but once those capital targets are achieved the required surplus reduces.[103]

The actual return on net assets of 70 per cent for 2003–04 and 35 per cent for 2004–05 were both higher than all projections. The downwards trend in the actual results, however, was consistent with the projections.

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

6.4.5 Underwriting performance

The ACCC examined the underwriting performance in terms of the:

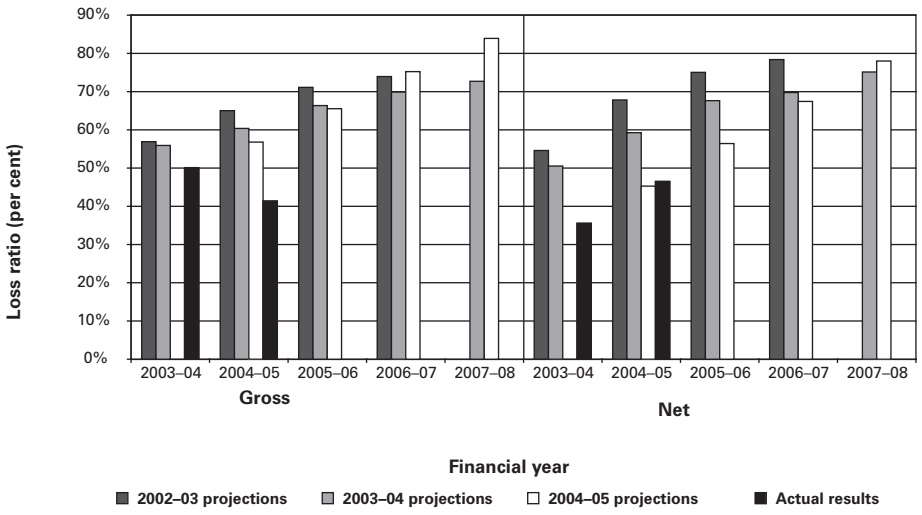
- *Loss ratio*—the total claims expense attributable to each financial year on claims arising from that or previous years as a proportion of premium revenue.
- *Expense ratio*—the sum of all underwriting and general expenses (excluding reinsurance expenses) as a proportion of premium revenue.
- *Reinsurance ratio*—the reinsurance expense as a proportion of gross premium revenue.
- *Combined ratio*—the sum of the loss ratio and the expense ratio. A combined ratio less than 100 per cent indicates that a company makes an underwriting surplus (i.e. premiums more than cover the cost of claims and operating expenses). A ratio greater than 100 per cent indicates that the company has an underwriting loss.[104]

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

Loss ratio

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

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



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

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, with the 2003–04 projections showing a similar trend, albeit at a marginally lower level. The 2004–05 projections forecast the loss

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

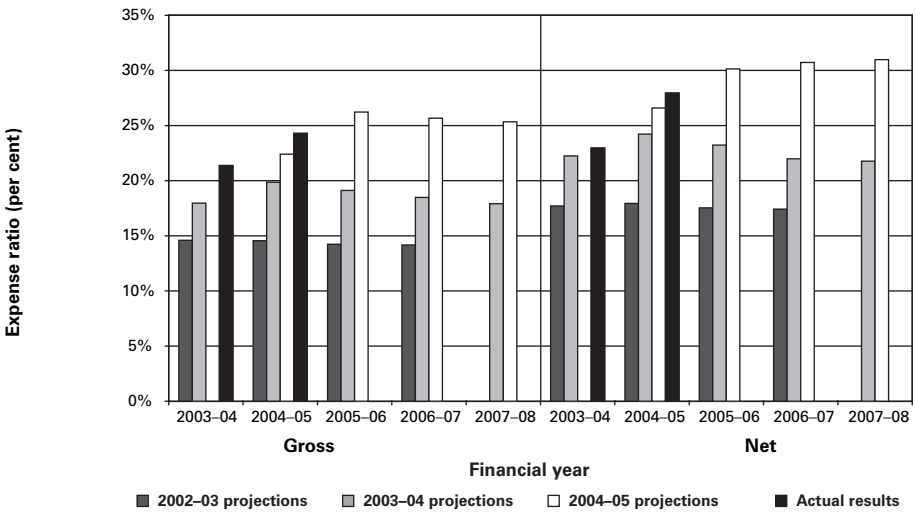
ratio being lower than the two earlier projections in 2004–05, but slowly increasing over the period until it is higher in 2007–08 than the 2003–04 projections. The trend for the forecast net loss ratios was similar to that observed for the gross loss ratios.

The actual result for the gross loss ratio in 2004–05 of 41 per cent is a significant improvement on all projections, while the net loss ratio of 46 per cent is an improvement on 2002–03 and 2003–04 projections and meets the target set in 2004–05 projections.

Expense ratio

Chart 6.6 shows the gross and net expense ratios for the industry based on the 2002–03, 2003–04 and 2004–05 financial projections of insurers. It also shows the actual expense ratios for 2003–04 and 2004–05.

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



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

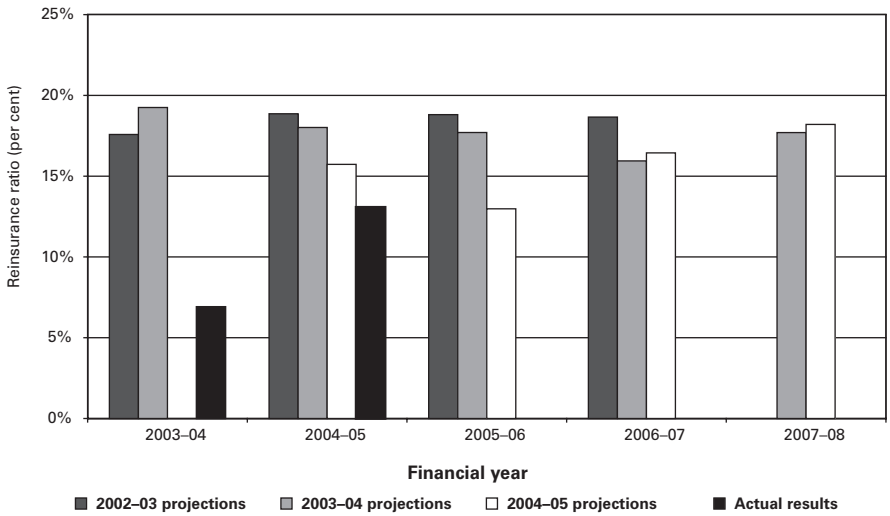
The chart shows that based on 2002–03 projections the gross expense ratio was forecast to be between 14 and 15 per cent between 2003–04 and 2006–07, while the net expense ratio was forecast to be between 17 and 18 per cent. The 2003–04 projections revised these forecasts to between 18 and 20 per cent gross, and 22 to 24 per cent net. The 2004–05 projections revised these forecasts again to between 22 and 26 per cent gross, and 27 and 31 per cent net.

The actual results for 2003–04 and 2004–05 of 21 and 24 per cent gross expense ratio respectively and 23 and 28 per cent net expense ratio respectively was marginally higher than projected. This trend was generally observed across all insurers.

Reinsurance ratio

Chart 6.7 shows the reinsurance ratio for the industry based on the 2002–03, 2003–04 and 2004–05 financial projections of insurers. It also shows the actual reinsurance ratio for 2003–04 and 2004–05.

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



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

The chart shows that based on 2002–03 projections the reinsurance ratio was forecast to be between 18 and 19 per cent between 2003–04 and 2006–07, with the 2003–04 projections similar. The 2004–05 projections were also at a similar level, with the exception of 2005–06 when the reinsurance ratio is expected to fall to 13 per cent.

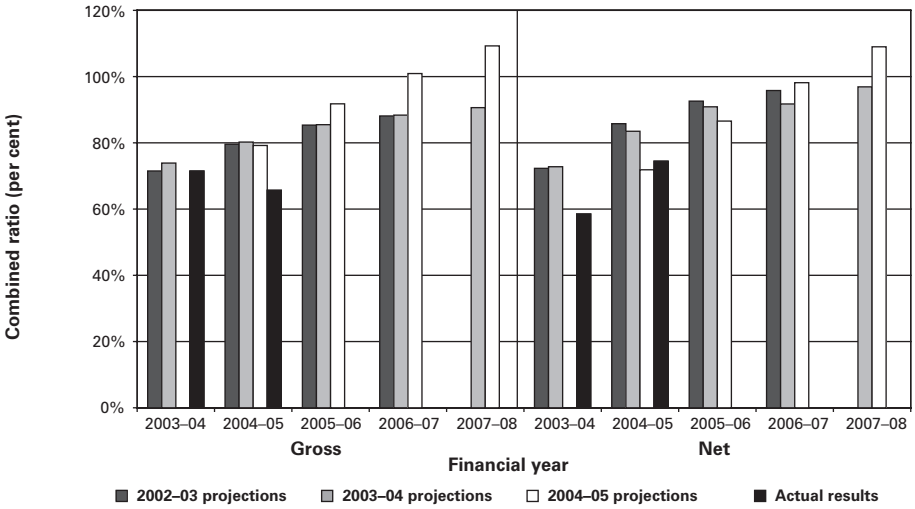
The actual reinsurance ratio for the industry of 13 per cent for 2004–05 was lower than projected.[105]

Combined ratio

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

105 The ACCC's second monitoring report noted the actual result observed in 2003–04 did not reflect the individual experience of all insurers. Some insurers' reinsurance ratios based on actual results for 2003–04 were higher than that forecast based on 2002–03 and 2003–04 projections. Other insurers achieved a reinsurance ratio equal to or close to their projections. One insurer achieved a better than forecast reinsurance ratio, although, this was due to changes in its reinsurance circumstances as opposed to achieving better reinsurance expense.

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



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

The chart shows that the 2002–03 projections forecast the gross and net 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. The 2003–04 projections did not differ substantially from the 2002–03 projections. However, the 2004–05 projections were different to the earlier projections:

- the forecast gross combined ratio was higher than previous projections from 2005–06 to 2007–08
- the net combined ratio was lower than earlier projections in 2004–05 and 2005–06, and higher than earlier projections in 2006–07 and 2007–08.

As noted in section 6.4.2 insurers are raising significant surpluses to fund capital requirements. However, this is projected to decrease as insurers capital bases increase. Combined ratios are therefore projected to increase, because insurers expect to generate lower levels of surplus as capital targets are reached.

The 2007–08 projected gross and net combined ratios observed in the 2004–05 projections are both 109 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 it is not uncommon for combined ratios to exceed 100 per cent because these activities may still be profitable once investment income is taken into account.

The actual results observed for 2003–04 show that the gross combined ratio of 71 per cent was in line with the 2002–03 and 2003–04 forecasts, while the net combined ratio of 59 per cent was significantly below the forecast values. The actual results for 2004–05 show the converse, with the gross combined ratio significantly lower than expected, while the net combined ratio was in line with projections.

The industry result is not representative of the experience of all insurers. While some insurers' actual results for 2004–05 were more favourable than forecast, others were worse. The source of this deterioration in actual outcomes relative to projections differed between insurers—as noted above, all insurers experienced a deterioration in their expenses relative to premiums, while others also had a deterioration in their claims experience.

6.5 Conclusion

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

The net asset position of all insurers as at 30 June 2005 was an improvement on the strong position observed as at 30 June 2004. The degree to which the net asset position had improved depended on the circumstances of individual insurers. Two insurers were in a position as at 30 June 2004 such that they no longer intended to build capital into premiums for the 2004–05 underwriting year, and this led to the emerging surplus for those insurers falling for 2004–05. The stronger results as at 30 June 2005 meant that an additional insurer no longer needed to build capital through premiums in the 2005–06 underwriting year.

It is noted, however, that as a result of a pricing decision in the 2005–06 underwriting year one of the remaining two insurers has scheduled two separate capital injections from the parent entity in future years. These capital injections are projected to enable sufficient capital adequacy to be maintained in the short to medium term. However, continuing to rely on capital injections from the parent entity is not considered to be a viable strategy in the longer term. The ACCC encourages insurers to ensure their pricing in each underwriting year is sufficient to maintain capital at the desired level. If not, insurers should clearly quantify the shortfall and have clear established strategies for achieving that position.

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

7.1 Introduction

This chapter presents the ACCC's findings regarding the actuarial and commercial justification of medical indemnity premiums charged for the 2005–06 underwriting period[106] **within each jurisdiction** by the five current medical indemnity providers to private medical practitioners.

7.2 Qualifications

In preparing this analysis it was necessary for the ACCC to maintain confidentiality of information provided by individual insurers. As noted in section 2.4 medical indemnity providers have largely continued the tradition of providing insurance primarily in their home states.[107] Because of this, some quantitative aspects of the ACCC's analysis of jurisdictional premiums could not be disclosed in this report.

7.3 Background

7.3.1 Ministerial request

On 16 March 2005 the Minister for Revenue and Assistant Treasurer, the Hon. Mal Brough MP, 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.

In the first and second monitoring reports the ACCC's assessment of the actuarial justification of premium 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 has examined the actuarial and commercial justification of premium relativities separately from the actuarial and commercial justification of the aggregate premium pool.

7.3.2 Pricing medical indemnity insurance by jurisdiction

To understand how jurisdictional relativities apply and are derived it is important to understand the overall process typically adopted by medical indemnity providers to determine individual premiums.

106 2005 calendar year in the case of AMIL.

107 As noted in section 2.4 some insurers now have more than half of their membership outside of their home state. However, the home state still represented the largest proportion of their membership base.

The first part of the pricing process involves an insurer determining the aggregate premium pool. The aggregate premium pool typically includes:

- the expected net cost of claims that are 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 rating 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 more than 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 practise 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.

It should be noted that in some instances it can be difficult to accurately determine ratings factors for medical specialty, income bands or jurisdiction relativities when insurers have a small membership in some categories, as this leads to a lack of statistically robust claims experience upon which to base relativities.

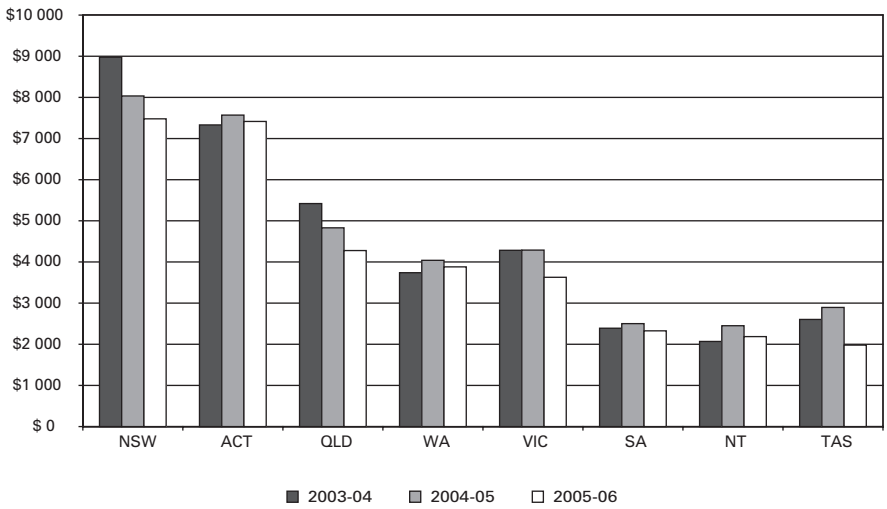
It is this last risk relativity, jurisdiction of practise, that the Australian Government has asked the ACCC to examine in more detail.

7.3.3 Premium relativities

To obtain an understanding of the actual relativities applied between jurisdictions the ACCC obtained information from all insurers on the gross written premium and membership numbers by individual jurisdiction for the underwriting years 2003–04, 2004–05 and 2005–06[108]. This information allowed the ACCC to examine the average written premium in each jurisdiction across the three 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 all insurers across the three years.[109, 110]

Chart 7.1 Average written premium—by jurisdiction: 2003–04, 2004–05 and 2005–06



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

Chart 7.1 shows that the average written premium is highest in NSW and the ACT and lowest in SA, NT and Tasmania. The chart also shows that all jurisdictions experienced a reduction in the average written premium in 2005–06.

108 The ACCC asked insurers to provide the gross written premium and membership numbers at a specific date in the 2005–06 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.

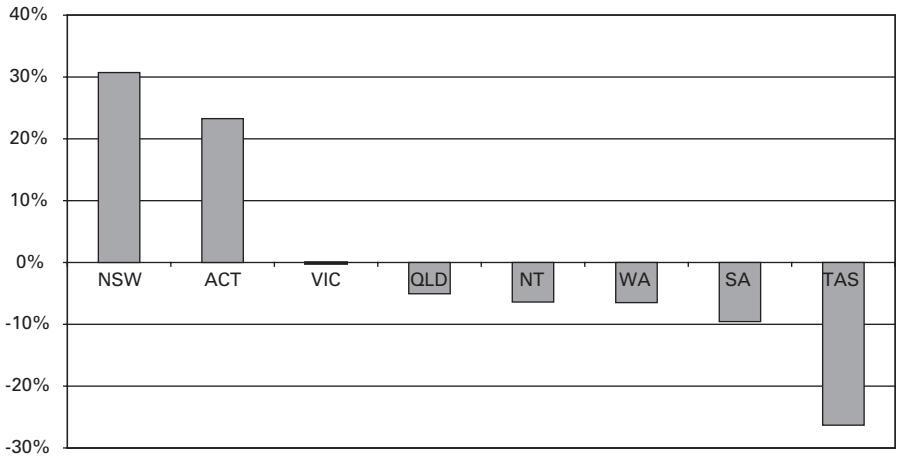
109 The ACCC prepared the average written premium analysis by jurisdiction by examining the average written premium of each provider and then averaging the result across the five insurers. As noted in section 2.4 medical indemnity providers have largely continued the tradition of providing insurance 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.

110 The average written premium by jurisdiction is presented on a nominal basis meaning the results are presented in current values at the end of each year and are not adjusted into real terms (that is they do not reflect the effect of inflation). However, due to the short period examined in the analysis this is not expected to make a material difference to the results.

It should be noted that 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[111] resulting in these jurisdictions having a lower comparable average written premium.

The ACCC therefore also examined the observed jurisdictional premium relativities used by insurers for the 2005–06 underwriting year by examining the premium rates across jurisdictions. Specifically, the ACCC compared all equivalent mature claims-made premium categories (including specialties and income bands) between the 'home' state of each insurer and other jurisdictions. As noted previously, insurers apply the jurisdictional relativities to premiums by applying a loading or a 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 jurisdictions' premium relativity to the average premium relativity by jurisdiction across all insurers. Chart 7.2 shows the average industry observed jurisdictional relativities for the 2005–06 underwriting year.[112]

Chart 7.2 Average observed jurisdictional relativity: 2005–06



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

As can be seen from chart 7.2, NSW and ACT has the highest jurisdictional relativity (at 31 and 23 per cent respectively), while Tasmania has the lowest (at minus 26 per cent). The relativities for the remaining jurisdictions ranged between 0 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.[113] As claims costs is one of the largest components of premiums, this will be a significant driver of premium differences between jurisdictions.

111 Under a claims-made policy the insurer agrees to indemnify all claims arising from incidents notified during the policy period, so long as the incident occurred during the current period, or any prior 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.

112 The ACCC compared the observed premium relativity to the technically advised premium relativity where possible and found the results were generally consistent.

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

Despite the different methodologies adopted for the two analyses the results are similar—NSW and ACT have high relativities while Tasmania has a low relativity. 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.

7.4 Actuarial and commercial justification of premium relativities by jurisdiction

The ACCC examined the actuarial and commercial justification of the jurisdictional relativities applied for the 2005–06 underwriting year by the five medical indemnity providers.

The ACCC's analysis found that, of the five insurers, three had changed their jurisdictional relativities in the 2005–06 underwriting year. The remaining two kept the jurisdictional relativities at the same level as for the 2004–05 underwriting year.[114] Regardless of the fact that two insurers did not alter their premium relativities, the ACCC examined the relativities of all insurers because its analysis looked at the determination of the absolute levels as opposed to the reasons for changes between underwriting years.

7.4.1 Actuarial justification of jurisdictional relativities

Methodology

The ACCC examined the actuarial justification of premium relativities for the 2005–06[115] underwriting year. Specifically the ACCC examined:

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

Extent of analysis in determining jurisdictional relativities

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

The extent to which this analysis was conducted varied across insurers. Some insurers based their analysis on a brief review of detailed jurisdictional analysis prepared in previous years. Other insurers conducted a more detailed analysis by comparing loss ratios for different jurisdictions to derive the jurisdictional relativities for the 2005–06 underwriting year.

As noted in the ACCC's first and second monitoring reports, insurers, especially smaller insurers, were unable to accurately determine jurisdictional-based premium relativities due to a lack of reliable jurisdictional-based claims experience. Most insurers therefore made relatively simplistic estimates and included a flat loading or discount on premiums for medical practitioners outside of the insurer's home jurisdiction. All insurers experienced difficulties associated with a lack of reliable jurisdictional-based claims experience for some states and territories.

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

114 In both cases the actuary determined that the jurisdictional relativities adopted in the previous underwriting period were not inappropriate.

115 2005 in the case of AMIL.

Tort law reform

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

7.4.2 Commercial justification of jurisdictional relativities

Methodology

The ACCC examined the commercial justification of premium relativities for the 2005–06[116] underwriting year. Specifically the ACCC examined:

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

Adoption of actuarial recommendations

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

The final relativities, as selected or approved by the actuary, were generally adopted by the insurers in their final rates.

Quantification of cross subsidies and incorporation of board policy

No insurer specifically quantified cross subsidisation 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 insurers gain greater experience in new jurisdictions and more technical relativities can be derived, these potential cross subsidies can be addressed.

No insurers specifically identified any board policy as justification for the selected jurisdictional relativities.

116 2005 in the case of AMIL.

7.5 Conclusion

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

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

For the commercial justification of premium relativities, the ACCC considered the extent to which recommended relativities were adopted in final premium rates as well as the level of cross subsidisation in the premium relativities. The ACCC found that the relativities adopted by insurers generally reflected the actuarial advice received. The ACCC also found that no insurer explicitly cross subsidised between jurisdictions. However, due to the lack of reliable claims experience data, cross subsidies may exist. The relativities adopted were considered to be commercially justified.

Appendixes

A. Medical indemnity reforms as at 30 June 2005

A.1 Background

In May 2002 the largest medical indemnity provider in Australia, 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.[117] In response to this crisis, the government introduced a framework of reforms to ensure a viable and ongoing medical indemnity insurance market.[118]

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/AMIL, the government announced the UMP guarantee on 1 May 2002.[119]

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 announced an enhancement to the UMP guarantee as well as the introduction of a new scheme to fund currently unfunded IBNRs.[120]

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

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

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

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

A.3.1 UMP guarantee

The government extended the UMP guarantee by six months to cover claims notified between 29 April 2002 and 31 December 2002 under an existing or renewed claims-made policy. The government's guarantee enabled the provisional liquidator of 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 IBNR scheme

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

The IBNR scheme would apply to liabilities that were currently unfunded and could not be adequately provided for by the medical indemnity providers. The scheme would be financed through a levy on medical practitioners 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 announced the new medical indemnity insurance reform package on 23 October 2002. This package included: [121]

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

121 The legislative framework for this package included the:

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

These Acts commenced on 1 January 2003.

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

A.4.1 UMP guarantee

The government extended the term of the UMP guarantee by a further year until 31 December 2003. This gave the provisional liquidator time to fully explore options for restructuring the business, and for other measures to take effect.[122] The extension of the guarantee meant that amounts payable by United/AMIL between 29 April 2002 to 31 December 2003 for claims notified or finalised before 29 April 2002 were covered. The UMP guarantee would also cover amounts payable for claims notified in the period 29 April 2002 to 31 December 2003, whenever the claim is finalised (including after 31 December 2003).

A.4.2 IBNR scheme

The government announced further details of the IBNR scheme.[123] The IBNR scheme was designed to fund medical indemnity providers' IBNR liabilities that were unfunded as at 30 June 2002, with funding to begin in early 2003.

The scheme was to be funded by a levy on medical practitioners 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. [124]

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

A.4.4 High cost claims scheme (HCCS)

The government announced the introduction of the HCCS so as to lower premiums by reducing the potential cost of large claims to insurers. [126]

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

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

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

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

125 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.

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

A.4.5 Medical indemnity regulatory framework

From 1 July 2003,[127] medical indemnity providers were to be placed within a regulatory framework to encourage a more commercially sustainable focus in providing insurance by service providers.[128]

First, medical indemnity providers were required to become 'authorised' insurers and thus be subject to a range of prudential safeguards enforced by APRA that aim to mitigate insolvency risks. For example, medical indemnity providers must maintain capital at a level specified by APRA as part of its minimum capital requirements (MCR). For those insurers that did not have this level of funding at the outset (1 July 2003 or 1 January 2003 in the case of AMIL), transitional provisions were put into place until 30 June 2008. Medical indemnity insurance was also required to be offered to practitioners in a contract of insurance, rather than as 'discretionary assistance', 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.[129]

Finally, authorised providers of medical indemnity cover were required to submit data to the Australian Government, including to the Health Insurance Commission (HIC)[130] 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.[131]

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.[132]

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

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

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

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

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

132 The Hon. John Howard MP, 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.[133]

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.[134] 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 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.[135]

A.6.1 Exceptional claims scheme (ECS)

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.

In response, the government announced its plans to implement the 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.[136]

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

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

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

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

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

A.7 Government measures announced on 3 October 2003

A.7.1 IBNR scheme

In response to medical practitioners' concerns over the effect of the IBNR levy, the government met with industry representatives on 3 October 2003.[137] The government subsequently agreed to an 18-month moratorium on IBNR levy payments above $1000 per year, until 31 December 2004.[138]

A.8 Government measures announced on 10 October 2003

On 10 October 2003, after further discussions with the Australian Medical Association (AMA), the Minister for Health and Ageing, the Hon. Tony Abbott MP, announced enhancements to the medical indemnity insurance reform package.[139] These enhancements included changes to the HCCS and IBNR scheme. Further details of the ECS (the blue sky scheme) were also announced.

A.8.1 High cost claims scheme (HCCS)

The government agreed to reimburse medical indemnity providers, on a per claim basis, 50 per cent of claims above a $500 000 threshold up to a medical practitioner's limit of insurance.[140] 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.[141]

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

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

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

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

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

A.8.3 Exceptional claims scheme (ECS)

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.[142] 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.[143]

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 practice to its full potential
- safeguard the interests of the consumers and the community.[144]

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.

The government appointed a panel that consisted of six non-government members including a lawyer experienced in insurance issues, a financial expert and four doctors. The Hon. Tony Abbott MP, Minister for Health and Ageing, chaired the panel which was assisted by a secretariat drawn from the government taskforce on Medical Indemnity Insurance.[145]

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

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

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

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

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

A.10.1 High cost claims scheme (HCCS)

On the panel's recommendation, the government extended the HCCS to cover 50 per cent of all claims above a $300 000 threshold up to a medical practitioner's limit of insurance. These regulations applied to claims notified on or after 1 January 2004.[147]

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[148]
- 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.[149]

On 15 June 2004 the Hon. Tony Abbott MP, Minister for Health and Ageing formulated the *Premium Support Scheme* 2004[150] (PSS) 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[151] (the subsidy is the higher of the subsidies under either the MISS or PSS).

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

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

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

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

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

151 A special category member is a member who either:

- no longer practices as a doctor
- no longer derives a private medical income from practicing as a doctor
- practices as a doctor only in the public sector and has a contract of insurance providing indemnity cover that does not offer indemnity for damages awarded against a doctor (except arising from good Samaritan acts or gratuitous advice for which no income is received).

In addition to this, a special category member is one who has a liability in a premium period for run-off cover or retroactive cover and does not at any time have a contract of insurance providing medical indemnity cover with any other medical indemnity provider.

A.10.3 UMP support payment (formerly the IBNR scheme)[152]

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

The new arrangements for the UMP support payment[154] 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, if a medical practitioner's annual contribution for 2003–04 would have been over $1000, the medical practitioner is only required to pay $1000 so that the maximum annual contribution for 2003–04 would be capped at $1000.

Finally, medical practitioners can pay their UMP support payment 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 the 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.[155]

152 United was the only medical indemnity provider to participate fully in the scheme.

153 Medical Indemnity Policy Review Panel, *Affordable, secure and fair—report to the Prime Minister,* 10 December 2003.

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

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

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
- 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.[156]

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.[157] 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.[158]

A.11.2 High cost claims scheme (HCCS)

The government also announced changes to the HCCS. In particular, an amendment was made to the circumstances in which a high cost claim would be payable under the scheme. Originally, a medical indemnity provider must have become aware of the claim against the practitioner for it to qualify as a high cost claim.[159] Since the amendment,[160] 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 (ECS)

The government also legislated to improve access to the ECS,[161] which was broadened to provide cover for Australian medical practitioners accompanying Australian sport teams and cultural groups travelling overseas.

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

157 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.

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

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

160 These amendments received royal assent on 23 June 2004.

161 The changes to the ECS are contained in the Medical Indemnity Amendment Regulations 2004 (no. 2) which commenced 5 December 2003.

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.[162]

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 Minister for Health and Ageing, the Hon. Tony Abbot MP, and the Minister for Revenue and Assistant Treasurer, the Hon. Mal Brough MP, announced that the government would commission an independent review of competitive neutrality in the medical indemnity insurance market.

The terms of reference of the review 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.

162 United Medical Protection, 'Premiums to drop as AMIL exceeds APRA's minimum capital requirements', Press Release, 4 November 2004.

The competitive advantage payment is defined as a percentage of the outstanding net IBNR exposure of the insurer's participating MDO at 30 June in the previous financial year multiplied by the MDO's unfunded IBNR factor. The percentage for a contribution year is to be prescribed in regulations made on or after the start of the contribution year and must not be greater than 15 per cent. Unless regulations are made there is no liability to make a payment, which consequently cannot be accrued on an insurer's balance sheet.

The first contribution year starts on 1 July 2005 and the last on 1 July 2014, although, the final contribution year can be brought forward by regulations.

The UMP support payment scheme is 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 number of contribution years will 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
- 2 per cent of their gross medical income in excess of $50 000.

A.12 Government measures announced on 17 February 2005

The Australian Government introduced the *Medical Indemnity Legislation Amendment Act 2005* into Parliament on 17 February 2005 to give effect to improvements identified following on from consultations with the medical indemnity industry, the medical profession and the HIC.[163]

The Act implements changes to 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*.

The Act implements changes to improve the operation of the medical indemnity legislation package to address minor problems that have emerged as the various schemes have been implemented.

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

B. ACCC information request

For the ACCC to fulfil its monitoring requirements, it was necessary to directly approach medical indemnity providers to request relevant information. In consultation with *am actuaries,* the ACCC developed a uniform information request for insurers to complete. This request was similar to that used for the preparation of the first and second medical indemnity insurance monitoring reports.

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

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 2005–06 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,[164] the ACCC outlined its desired scope and detail to be covered in these reports. Specifically, the ACCC requested that the report include additional commentary on 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:

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

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

164 The ACCC notes that IAAust is currently preparing medical indemnity premium guidelines, such a guideline would assist actuaries in preparing future reports.

B.2 Actual premium rate report

The ACCC requested a report detailing the actual premiums charged for all forms of indemnity for the 2005–06 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. 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.

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

B.3 Actuarial liability valuation report

The ACCC requested the latest available liability valuation report produced by the indemnity provider's actuary. The latest report was from 30 June 2004. This report was expected to contain commentary on all material issues influencing the assessment of the outstanding claims and the premium liabilities.

The ACCC sought information on the impact of government reforms on the authorised insurer's liability valuation results. The ACCC specifically asked insurers to address the following reforms:

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

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 2004–05 as well as any updates to these projections
- the most recent annual report for both the insurer and the MDO group of companies
- a copy of the insurance policies offered to medical practitioners and details of any changes made since the 2003 indemnity period
- copies of general insurance reporting forms submitted to APRA on a quarterly and annual basis outlining financial information including the minimum capital requirement, the assessed capital base, the statement of financial position and performance and information reconciling the annual statements between APRA reporting and AASB reporting.