Medical indemnity insurance
Sixth monitoring report
April 2009
Abbreviations

ABS    Australian Bureau of Statistics
ACCC   Australian Competition and Consumer Commission
AIL    Avant Insurance Limited
AMIL   Australasian Medical Insurance Limited
APRA   Australian Prudential Regulation Authority
ASIC   Australian Securities and Investment Commission
Avant  Avant Mutual Group Limited
AWE    average weekly earnings
ECS    exceptional claims scheme
GP     general practitioner
GST    goods and services tax
HCCS   high cost claims scheme
HIC    Health Insurance Commission
IAAust Institute of Actuaries Australia
Invivo Invivo Medical Pty Ltd
MCR    minimum capital requirement
MDAN   MDA National Pty Ltd
MDANI  MDA National Insurance Pty Ltd
MDASA  Medical Defence Association of South Australia Limited
MDAV   Medical Defence Association of Victoria Limited
MDAWA  Medical Defence Association of Western Australia
MDO    medical defence organisation
MIA    Medical Insurance Australia Pty Ltd
MIGA   Medical Insurance Group Australia
MIPS   Medical Indemnity Protection Society Limited
MIPSI  MIPS Insurance Pty Ltd
MPSTas Medical Protection Society of Tasmania
MISS   medical indemnity subsidy scheme
PIICA  Professional Indemnity Insurance Company Australia Pty Limited
PSS    premium support scheme
QBE    QBE Insurance (Australia) Limited
QDM    Queensland Doctors’ Mutual Pty Ltd
ROCS   run-off cover scheme
UMP    United Medical Protection Limited (as referred to in legislation)
United United Medical Protection Limited
Glossary of terms

attachment point The level of claims payments above which reinsurance recoveries can be claimed by the insurer.

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 This occurs when the insurer agrees to indemnify the policyholder for any valid claims arising from incidents that occur during the coverage period, with a claim able to be lodged at any time in the future.

claims-made cover This occurs when the insurer agrees to indemnify all claims arising from incidents notified during the policy period, as long as the incident occurred during the current period or any 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. Because of the more limited period the insurer is ‘on risk’, especially in early years. This type of cover is typically cheaper to underwrite than claims-incurred cover.

claims frequency The ultimate number of claims expected by year of notification expressed as a proportion of the total number of Medicare services provided in the corresponding year.

combined ratio The sum of the loss ratio and the expense ratio showing whether the sum of expenses (claims expenses and other expenses) is lower or higher than premium revenue for the year.

excess of loss reinsurance When the direct insurer carries all individual losses incurred in each individual claim up to a certain limit and the reinsurer pays the loss in excess of this amount (known as the attachment point) for each and every claim. There may also be an aggregate limit for all claims assumed by the reinsurer.

expense ratio 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 that may develop into a claim against the medical practitioner.

incurred but not reported claims Claims arising from incidents or losses that have occurred but are yet to be reported to the insurer.

indemnified members The number of members are ‘at risk’—that is, 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 the 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.
<table>
<thead>
<tr>
<th>Term</th>
<th>Description</th>
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<tr>
<td>minimum capital requirement</td>
<td>The amount of capital that the Australian Prudential Regulation Authority 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.</td>
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<tr>
<td>medical defence organisation</td>
<td>A not-for-profit mutual organisation created and owned by medical practitioners to provide various services, including indemnity, to members (indemnity was only able to be offered by medical defence organisations before 1 July 2003).</td>
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<td>medical indemnity provider</td>
<td>An organisation that provides liability insurance, either as an insurer or as an authorised representative of an insurer that indemnifies medical practitioners for financial loss arising from actions brought against them as a result of the performance of their professional duties.</td>
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<tr>
<td>notification year</td>
<td>The year in which the insurer is notified of a claim or an incident that may potentially give rise to a claim.</td>
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<tr>
<td>personal injury or death claim</td>
<td>A claim relating to an incident that results in injury to or the death of a third party individual.</td>
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<tr>
<td>premium revenue</td>
<td>The amount of gross written premium ‘earned’ during the period, earned being the proportion of risk covered.</td>
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<td>pure risk premium</td>
<td>The amount of premium needed just to meet the cost of expected medical indemnity claims and associated costs.</td>
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<td>reinsurance</td>
<td>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.</td>
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<tr>
<td>reinsurance ratio</td>
<td>The reinsurance expense as a proportion of premium revenue for that year.</td>
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<td>retroactive cover</td>
<td>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 that relate to incidents that occurred before joining that provider. Typically, this cover applies to claims-made cover.</td>
</tr>
<tr>
<td>return on net assets</td>
<td>The emerging surplus net of tax as a percentage of the total net assets held over the period.</td>
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<tr>
<td>run-off cover</td>
<td>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.</td>
</tr>
<tr>
<td>stop loss reinsurance</td>
<td>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 premiums or a fixed sum.</td>
</tr>
<tr>
<td>ultimate claims costs</td>
<td>All the claims costs that the insurer expects will eventually be paid for claims arising in a given notification year.</td>
</tr>
</tbody>
</table>
ultimate number of claims  The total number of notifications 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 that operated on a not-for-profit basis as ‘mutuals’ that were owned and operated by members. Indemnity was offered on a discretionary basis because 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, which resulted in a potential lack of indemnity cover for many doctors. At the same time, medical practitioners were experiencing significant increases in subscriptions charged across all medical indemnity providers.

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

ACCC’s monitoring role

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

This report is the sixth and final ACCC report requested by the Australian Government arising from this monitoring role.
The ACCC asked the five authorised medical indemnity insurers as at 30 June 2008 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 medical indemnity insurers as at 30 June 2008 were:

- Avant Insurance Limited (AIL)
- MDA National Insurance (MDANI)
- Medical Insurance Australia Pty Ltd (MIA)
- MIPS Insurance Pty Ltd (MIPSI)
- QBE Insurance (Australia) Limited (QBE).

This is the first report in which the ACCC has assessed the premiums of AIL. AIL began operation on 1 July 2007 after the merger of MDO parent entities Australasian Medical Insurance Limited (AMIL) and Professional Indemnity Insurance Company Australia Pty Ltd (PIICA).

Qualifications

The ACCC analysis is based on information supplied by each of the insurers. The ACCC has relied on information provided by insurers rather than performing an independent verification of their information or actuarial advice. As the MDO parent entities of insurers are no longer able to sell insurance, the ACCC has generally not examined their operations or membership pricing.

In preparing this report, it was necessary for the ACCC to maintain the confidentiality of individual insurers’ information. Therefore, some quantitative aspects of the ACCC analysis—particularly its assessment of individual insurers’ information—could not be disclosed in this report.

ACCC assessment methodology

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

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

The ACCC assessment of the commercial justification of premiums considers the ability of insurers to meet their commercial obligations to key stakeholders. It assesses how premium rates were affected by the Australian Prudential Regulation Authority’s minimum capital requirements that insurers must have achieved to reach a fully capitalised position by 30 June 2008. The ACCC also assesses broader commercial obligations, such as solvency targets and emerging surplus.
This report also provides information on the actuarial and commercial justification of premium relativities between jurisdictions. The ACCC’s assessment of these premium relativities examines the extent and the level of detail of the analysis to confirm or modify existing relativities, and the extent to which insurers took into account tort law reform in setting their jurisdictional relativities. The ACCC’s assessment of the commercial justification of premium relativities between jurisdictions compares the actuary’s recommended relativities against the actual relativities adopted. It also examines the quantification of cross-subsidies in the relativities.

QBE/Invivo

Following a request from the Australian Government in 2006, the ACCC began monitoring the activities of Invivo, then a new entrant in the medical indemnity insurance market. Invivo acts as a corporate authorised representative of QBE Insurance (Australia) Limited, which also owns half of Invivo. Invivo has exclusive arrangements with QBE to distribute and manage professional indemnity insurance covering medical practitioners. As an Australian Prudential Regulation Authority-regulated insurer, QBE is, however, ultimately responsible for providing insurance cover and services to its policyholders.

ACCC monitoring of the actuarial and commercial justification of premiums is undertaken by assessing decisions made by medical indemnity insurers (rather than their authorised representatives) on the setting of premiums. As indicated in the fifth medical indemnity insurance monitoring report, in monitoring Invivo the ACCC will have to consider decisions made by QBE when setting premiums for medical indemnity insurance. In this report ‘QBE premiums’ refers to premiums paid to Invivo for a QBE professional indemnity policy. Invivo, as the authorised representative of QBE, provided information to the ACCC on QBE premiums.

Assessment of the actuarial justification of medical indemnity premiums

The ACCC found that premiums were considered to be actuarially justified for all five insurers operating as at 30 June 2008.

The ACCC found that the aggregate premium pool of each insurer was actuarially justified. It was evident that insurers had made use of actuaries in premium liability assessments, pricing reports, funding plans and financial forecasts. In each case the ACCC considered that the construction of the recommended premium pool was soundly based and incorporated all major cost implications for the pricing of medical indemnity insurance. All insurers determined their aggregate premium pool having considered advice from their actuaries. However, different insurers involved actuaries at different points in the pricing process.

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2 Unlike other medical indemnity insurers, QBE does not have a common renewal date and premiums are based on its latest premium review. QBE’s premiums in this report are based on premiums set in 2007 for the 2008 calendar year.
The ACCC analysis of specialty premium rates found that most insurers conducted detailed analysis of risk relativities between specialties or relied on previous risk relativity analysis. As in previous monitoring reports, the ACCC found that insurers generally cited the unwinding of existing cross-subsidisation between specialties as an objective. The ACCC noted that this was a long-term process and that potentially not all cross-subsidies would be removed for a variety of reasons, including commercial factors as well as data limitations. However, the ACCC still found these rates and the relativities for income bands to be actuarially justified because the extent of cross-subsidisation was understood and, where possible, quantified.

The ACCC analysis of the impact of government reforms on premiums includes an examination of Australian Government medical indemnity reports (including the high cost claims scheme and the run-off cover scheme), and federal, state and territory tort law reforms. The ACCC found that all insurers appropriately considered HCCS and ROCS in their premium determinations and most insurers took full account of HCCS in their reinsurance programs. One insurer that did not reflect HCCS in its reinsurance program did so because of an unwillingness of reinsurers to fully reflect the full benefits of the scheme in their reinsurance pricing and structure. However, this insurer took HCCS recoveries into account when establishing their pure risk premium. All insurers took tort law reform into account when setting their aggregate premium pools for 2008–09.

**QBE/Invivo**

The ACCC also conducted separate analysis on QBE’s 2008 premiums and found them to be actuarially justified. In its analysis, the ACCC recognised that 2008 was only QBE’s third year of underwriting medical indemnity insurance, so it had limited claims experience available. The ACCC’s assessment included revisiting the original methodology used to set premiums, which compared scheduled premium rates with the actuary’s recommended premium rates. It also involved assessing the impact of specific government reforms on premiums and changes in rates based on emerging experience and other identified issues.

**Assessment of the commercial justification of medical indemnity premiums**

The ACCC found that the premiums set by medical indemnity insurers were commercially justified.

**MDO-owned insurers**

The net asset position of all insurers as at 30 June 2008 had improved upon their strong position as at 30 June 2007. However, the degree to which the net asset position had improved depended on the circumstances of individual insurers.

The ACCC notes that one insurer has scheduled future capital injections to maintain its target net asset-to-minimum capital requirement ratio. Based on forecasts provided by the insurer, the ACCC found that this approach is currently commercially justified.
QBE/Invivo

The ACCC examined the commercial justification of QBE’s premiums by examining Invivo’s financial projections and how these are consolidated within QBE’s professional indemnity insurance business. The ACCC also examined QBE’s objectives and intentions for its medical indemnity insurance business.

Based on this analysis, the ACCC found that QBE premiums for the 2008 underwriting year were commercially justified.

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

The ACCC found that jurisdictional premium relativities were considered to be actuarially and commercially justified for the five insurers operating as at 30 June 2008.

For the actuarial justification of premium relativities, the ACCC considered the extent of the analysis used to determine the relativities, as well as the extent to which insurers took into account jurisdictional variations in tort law reform. The ACCC found those insurers’ analyses continues to be limited because of the absence of a sufficient volume of 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 sufficient claims experience by jurisdiction also affected the ability of insurers to take into account tort law reform in premium relativities.

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


The ACCC found that the premiums levied were generally actuarially justified. In one instance, the ACCC could not determine the actuarial justification of premiums for an insurer in the 2003–04 underwriting period. However, the premiums for this insurer were found to be justified in subsequent periods. In addition, issues identified by the ACCC in its reports regarding the determination of the premium pool for some insurers were generally addressed in subsequent underwriting periods.

The ACCC found that the premiums levied were commercially justified. The ACCC observed that the insurers’ capital levels had significantly improved since 2003–04, attributable to the transitional capital requirements set by the Australian Prudential Regulation Authority. At the end of the transitional period for the insurers (30 June 2008), all insurers had exceeded APRA’s target capital requirements.

Finally, the ACCC found that the jurisdictional relativities of premiums to be actuarially and commercially justified. The ACCC has found that the insurers, to the extent possible, have attempted to reduce cross-subsidies between jurisdictions.

Overall, the ACCC observed a significant change in the medical indemnity industry following the government reforms. The medical indemnity industry had made a transition from providing discretionary medical indemnity cover through MDOs to providing non-discretionary medical indemnity insurance contracts through insurance companies regulated by APRA. The insurers are currently in a much stronger capital position when compared to when they were established, moving away from an objective of raising capital to maintaining capital. The medical indemnity insurers also now actively use actuaries in the premium rating process. As outlined in this report, the ACCC has observed decreases in real premiums as well as improvements in claims experience over the period 2003–04 to 2007–08.

The ACCC considers that the continual and active involvement of actuaries in the premium-setting process would contribute to the actuarial and commercial justification of premiums over time.

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3 The ACCC’s first monitoring report was released by the Australian Government on 23 February 2004, the second on 16 March 2005, the third on 16 February 2006, the fourth on 12 April 2007 and the fifth on 2 May 2008.

4 QBE and the former AMIL determined premiums on a calendar year basis.
1 Introduction

In May 2002 the largest medical indemnity provider in Australia, United Medical Protection (United), was placed into provisional liquidation, which resulted 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 high-risk procedures like obstetrics. In response to this crisis, the Australian Government introduced a framework of reforms to ensure a viable and ongoing medical indemnity insurance market.

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

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

1.2 Ministerial request

On 19 November 2002 the then Treasurer, the Hon. Peter Costello MP, wrote to the ACCC about this new role and indicated that the ACCC’s monitoring role was to start on 1 January 2003 for three years and was not a direction under the Prices Surveillance Act 1983.5

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

1.3 Scope of report

The ACCC’s monitoring role is limited to medical indemnity insurance written in Australia by insurers that indemnify medical practitioners (i.e. doctors) working in the private health sector. As at 30 June 2008 there were five medical indemnity insurers:

- Avant Insurance Limited (AIL)
- MDA National Insurance Pty Ltd (MDANI)

5 The Prices Surveillance Act 1983 was repealed on 1 March 2004 when its main provisions were incorporated into Part VIIA of the Trade Practices Act 1974. Division 5 of Part VIIA of the TPA provides for the minister to direct the ACCC to monitor prices, costs and profits of a business or industry.
Medical indemnity insurance is also offered by some other commercial insurers to medical professionals practising 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 Unless medical practitioners are not covered for certain procedures, they generally do not need to take out their own private medical indemnity insurance to cover this work.

Avant Insurance

AIL began operation as a medical indemnity insurer on 1 July 2007 following the merger of the medical defence organisation (MDO) parent entities of Australasian Medical Insurance Limited (AMIL) and Professional Indemnity Insurance Company Australia Pty Ltd (PIICA).

In last year’s report, the ACCC assessed the actuarial and commercial justification, including within jurisdictions, of premiums set by both AMIL and PIICA before the merger. This is the first year that the ACCC has assessed the actuarial and commercial justification of the premiums of the merged entity, AIL.

QBE/Invivo

Invivo, established in late 2005, is a corporate authorised representative of QBE, which also owns half of Invivo. Invivo has exclusive arrangements with QBE to distribute and manage professional indemnity insurance covering medical practitioners. QBE as an Australian Prudential Regulation Authority-regulated insurer is, however, ultimately responsible for providing insurance cover and services to policyholders.

The ACCC’s monitoring of the actuarial and commercial justification of premiums is being undertaken by assessing decisions made by medical indemnity insurers (rather than their authorised representatives) on the setting of premiums. The monitoring of Invivo by the ACCC, therefore, necessitates consideration of the decisions made by QBE in setting premiums for medical indemnity insurance.

In this report ‘QBE premiums’7 refer to premiums paid to Invivo for a QBE professional indemnity policy. Invivo, as the authorised representative of QBE, provided information to the ACCC on QBE premiums.

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7 Unlike other medical indemnity insurers QBE does not have a common renewal date and premiums are based on its latest premium review. The premiums in this report are based on premiums set in 2007 for the 2008 calendar year.
1.4 Approach to monitoring

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

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

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

The ACCC’s analysis covered the five insurers in Australia that offered insurance to private medical practitioners as at 30 June 2008. In June 2008 the ACCC requested a range of quantitative and qualitative information from these insurers about their premium-setting arrangements, cost structures and the effect of various government reforms (including tort reforms) on their operations. Details of the ACCC’s information request can be found in appendix A.

This report examines premiums set by existing insurers as at 30 June 2008 for the underwriting period from 1 July 2008 to 30 June 2009, except for AIL and QBE, which had an underwriting period from 1 January 2008 to 31 December 2008. The ACCC has specifically not adjusted AIL’s calendar year results to the financial year except where otherwise noted. However, QBE’s results, where identified in this report, are provided on a financial year basis.

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

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8 Invivo, as the authorised representative of QBE, provided information to the ACCC on QBE premiums.
1.5 Qualifications

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

1.6 Previous reports

This is the sixth and final annual ACCC monitoring report requested by the Australian Government. The five previous reports generally found that the premiums charged by medical indemnity insurers were actuarially and commercially justified.

The third, fourth and fifth reports also made assessments regarding the actuarial and commercial justification of premiums within each jurisdiction. These three reports found that jurisdictional premium relativities were actuarially and commercially justified respectively for the 2005–06, 2006–07 and 2007–08 underwriting years.

1.7 Report outline

This report contains seven chapters and two appendixes.

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

Chapter 3 examines Australian Government reforms to medical indemnity insurance.

Chapter 4 examines historical trends in costs, premiums and the financial performance of the industry between 1997–98 and 2007–08.

Chapter 5 presents ACCC findings on the actuarial justification of medical indemnity premiums charged for the 2008–09 underwriting period by the five insurers operating as at 30 June 2008.

Chapter 6 presents ACCC findings on the commercial justification of medical indemnity premiums charged for the 2008–09 underwriting period by the five insurers operating as at 30 June 2008.

Chapter 7 presents ACCC findings on the actuarial and commercial justification of medical indemnity premiums charged in different jurisdictions for the 2008–09 underwriting period by the five insurers operating as at 30 June 2008.

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

Appendix B identifies some of the methodology differences between this report and Australian Prudential Regulation Authority’s national claims and policies database reports.
2 Overview of the medical indemnity industry

On 1 July 2003 Australian Government legislative reforms changed the nature of the medical indemnity insurance product offered to medical practitioners and the environment in which the industry operates in Australia. This chapter briefly examines the nature of the medical indemnity product and the pre-reform and post-reform characteristics of the medical indemnity industry. Specific information about the medical indemnity legislative reforms implemented by the Australian Government is in chapter 3.

2.1 What is medical indemnity insurance?

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

2.1.1 Liability insurance

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

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

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

Medical indemnity insurance is a type of professional indemnity insurance. Professional indemnity insurance indemnifies professional people for their legal liability to their clients and others relying on their advice and/or services.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.

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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.

10 ibid, p. 26.
2.1.2 Medical malpractice

Malpractice insurance is another name for professional indemnity insurance, but this term has generally been reserved for the medical professions.\(^{11}\) Although medical indemnity insurance provides protection similar to that for other professionals, the nature of medical malpractice claims against medical practitioners will generally differ from claims against other professionals.

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

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

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

2.1.3 Long-tail insurance

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

Depending on the statute of limitations, which varies between each state and territory, medical indemnity claims can be made years after an incident, even if the medical practitioner is no longer practising medicine. Although tort law reforms have reduced limitation periods, this long-tail characteristic continues to place considerable pressure on providers of such cover to be able to identify the likely cost of future claims and build this into their pricing (premium) structures.\(^{12}\)

2.1.4 Types of indemnity coverage

Traditionally medical indemnity cover was provided to medical practitioners on a claims-incurred (sometimes referred to as ‘incidents-occurring’) basis. Claims-incurred cover provides indemnity for valid claims arising from incidents that occur during the period of cover, with a claim able to be lodged at any time in the future.\(^{13}\) 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

\(^{11}\) Insurance Council of Australia, submission to ministerial forum, *Addressing the issues in professional indemnity insurance*, March 2002, p. 1.


\(^{13}\) ibid.
claim is lodged with the insurer after the practitioner ceases to practise (because of 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. Claims-made cover is standard within the broader general insurance industry for professional indemnity insurance contracts.

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

2.2 Characteristics of the industry—pre 1 July 2003

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

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

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

- Medical Defence Association of South Australia Limited (MDASA)
- Medical Defence Association of Victoria Limited (MDAV)
- MDA National Pty Ltd (MDAN)\(^{17}\)
- Medical Indemnity Protection Society Limited (MIPS)
- Medical Protection Society of Tasmania (MPSTas)
- Queensland Doctors Mutual Pty Ltd (QDM)\(^ {18}\)
- United Medical Protection Limited (United).

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

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 retroactive cover. Run-off cover provides the medical practitioner with indemnity coverage for claims notified to the insurer after the end of the recognised period for incidents occurring during that period. Retroactive cover allows the insured to notify the insurer of an incident that occurred before the current period of cover.

16 These services included legal advice for non-indemnity related situations, advice about medical practices 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).

18 QDM subsequently merged with MIPS on 22 July 2004.
The above MDOs operated mainly along state lines and were outside the prudential framework regulated by the Australian Prudential Regulation Authority. Although MDOs were not insurance companies authorised by APRA to conduct insurance business, they did have some associations with authorised insurers. Before 1 July 2003 all MDOs operating in Australia had access to subsidiary or ‘captive’ insurance companies, established primarily to provide reinsurance cover to the parent MDO.

2.3 Characteristics of the industry—post 1 July 2003

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

As at 30 June 2008, the five authorised providers of medical indemnity insurance in Australia were:

- Avant Insurance Limited (AIL)—writing insurance for members of Avant Mutual Group Limited (Avant), which consists of members of the former United and MDAV
- MIPS Insurance Limited (MIPSI)—writing insurance for members of MIPS and MPSTas (and previously to QDM before it merged with MIPS)
- MDANI—writing insurance for members of MDAN
- Medical Insurance Australia Pty Ltd (MIA)—writing insurance for members of MDASA
- Invivo Medical Pty Ltd/QBE Insurance (Australia) Limited (QBE).

Avant commenced operation on 1 July 2007 following the merger of United and MDAV, the parent MDOs of Australasian Medical Insurance Limited (AMIL) and Professional Indemnity Insurance Company Australia Pty Ltd (PIICA).

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

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19 The first monitoring report found the following MDOs had the largest market shares in each state and territory:

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

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

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

In preparing this analysis the ACCC relied on information provided by each medical indemnity provider. Although data on membership numbers provided by different medical indemnity providers may not be comparable in some instances because of underlying data collection methodologies, it nevertheless provides an indication of the general market shares of all industry participants.
Chart 2.1 shows the percentage of the total number of indemnified medical indemnity provider based on the most recently available data provided for the six financial years from 2002–03 to 2007–08.

After the merger of AMIL and PIICA, the largest medical indemnity provider is AIL, which had approximately 52 per cent of all indemnified members in Australia in 2007–08. PIICA's and AMIL's combined share of indemnified members declined during the period from 2002–03 to 2006–07, while MIPS's, MDANI's and MIA's share of indemnified members increased.

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

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

22 AIL membership numbers relate to the previous calendar year and financial year, depending on the member’s renewal date—that is, members who have either a 1 January 2007 or 1 July 2007 renewal date have been recorded as a member of the 2007–08 financial year.

23 The ACCC has specifically excluded QBE from its analysis of market share because its policyholder numbers were provided on the condition of confidentiality.

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

25 The AIL series is the sum of AMIL’s and PIICA’s indemnified members for the period from 2002–03 to 2006–07.

26 The ACCC calculates its market share using the membership figures provided by the insurers. As such, it may not be comparable to market share calculations from other publications.
2.3.2 Transitional regulatory arrangements

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

These requirements include, among other things:

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

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

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

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

2.3.3 Current regulatory arrangements

Since the end of the transitional arrangements effective 1 July 2008 all medical indemnity insurers have been subject to standard general insurance prudential standards. A new APRA guideline was introduced (effective from 1 July 2008) that suggests medical indemnity insurers should maintain a capital base at least 1.5 times the MCR. The target for other authorised insurers is 1.2 times the MCR.

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.

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

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

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

- the minimum cover limit that an insurer may offer or provide to a medical practitioner is $5 million
- a contract must provide an offer for retroactive and run-off cover for otherwise uncovered prior incidents.\(^3\)

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

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\(^3\) Retroactive cover provides medical practitioners joining a new medical indemnity provider with protection against incidents incurred before joining the provider but notified after. Run-off cover provides medical practitioners leaving practice with protection against claims arising from previous incidents.
3 Government reforms of medical indemnity insurance

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

3.1 Medical indemnity reform by the Australian Government

This chapter briefly examines the reforms programs operational as at 1 July 2008 that insurers need to take into account when considering their price setting arrangements for the 2008–09 underwriting year (discussed in more detail in chapter 5).

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

More detailed information on the development of the medical indemnity reform package from its inception to its current form is contained in the fourth ACCC medical indemnity premium monitoring report.31

3.1.1 Exceptional claims scheme

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

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

ECS has no sunset clause, although it can be ended by regulation. It is anticipated that the scheme will be reviewed from time to time in close consultation with the medical profession and insurers to determine whether it remains necessary in light of state and/or territory tort law reform and claims trends.\(^32\)

### 3.1.2 Run-off cover scheme

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

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

The scheme is funded on an ongoing basis through a charge on insurers called the run-off cover scheme support payment, which is levied as a percentage of insurers’ medical indemnity insurance income and is shown on doctors’ premium notices. ROCS therefore ensures that eligible doctors receive medical indemnity cover that is secure, does not require further payment and is based on the cover they had while they were working.\(^33\)

From 1 July 2008 this charge has been reduced from 8.5 per cent to 5.0 per cent.\(^34\)

### 3.1.3 High cost claims scheme

The HCCS was established to address upward pressure on medical indemnity premiums by reducing the cost of these large claims to insurers. It does so by reimbursing insurers 50 per cent of the cost of medical indemnity claims above a threshold amount up to the limit of the practitioner’s cover for claims notified on or after 1 January 2003.\(^35\)

### 3.1.4 Premium support scheme

The PSS is an Australian Government scheme that helps eligible doctors with the costs of their medical indemnity insurance. Eligible doctors see the benefit of the PSS through reductions in the level of premiums charged to them by their insurer.

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\(^{33}\) Ibid.


\(^{35}\) Medical Indemnity Policy Review Panel, op. cit.
The PSS was introduced to replace the medical indemnity subsidy scheme (MISS), which provided premium subsidies specifically to neurosurgeons, obstetricians, procedural general practitioners and general practitioner registrars undertaking procedural training.36,37

The PSS is designed to ensure that if a doctor’s gross medical indemnity costs exceed 7.5 per cent of their gross private medical income, they will only pay 20c to the dollar for the cost of the premium beyond that threshold limit.

The PSS applies to the following:

- medical practitioners whose gross indemnity costs exceed 7.5 per cent of estimated income from private billings—the subsidy is 80 per cent of the amount by which the member’s gross indemnity cost exceeds the base amount
- procedural general practitioners in a rural area38
- medical practitioners who have applied for and been deemed eligible for MISS—the subsidy is calculated as the greater of that under MISS or PSS
- special category members—the subsidy is 80 per cent of the total cost to the member for the premium period of the member’s gross indemnity costs.39

3.1.5 UMP support payment

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

To provide this assurance, the government agreed to fund most of these claims, with members of UMP funding around one-third of the arrangement over six years through the UMP SP (formerly the incurred but not reported levy).

The final year of the UMP SP program was 2007–08.40

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


38 Defined as rural, remote and metropolitan areas 3 to 7 by the Department of Health and Ageing. These areas are regions that are not capital cities or regions that contain more than 100 000 people.

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

40 Sourced from the Medicare Australia website (www.medicareaustralia.gov.au).
3.2 Tort law reform

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

The major reforms to tort law include the introduction of:

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

For more information on tort law reforms introduced by federal, state and territory governments, see *Available and affordable—improvements in liability insurance following tort law reform in Australia.*

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4 Trends in costs and premiums in medical indemnity insurance

The Australian Government asked the Australian Competition and Consumer Commission to monitor medical indemnity premiums to assess whether they are actuarially and commercially justified. To do this, the ACCC requested a range of information about costs and pricing from Medical Insurance Australia Pty Ltd (MIA), MDA National Insurance (MDANI), Avant Insurance Limited (AIL), MIPS Insurance Pty Ltd (MIPSI) and QBE Insurance (Australia) Limited (QBE)/Invivo as at 30 June 2008.

The ACCC used this information to determine trends in the costs associated with providing medical indemnity insurance to 30 June 2008 and trends in premiums charged for indemnity protection.42,43

The ACCC has not included data from QBE within the historical trend analysis of medical indemnity insurance in this chapter. QBE is a large insurer that underwrites significant volumes of professional indemnity insurance business other than medical indemnity44; therefore, it is difficult to disaggregate QBE’s medical indemnity insurance results from its other professional indemnity business. In addition, this is the third year that QBE has underwritten medical indemnity insurance, so it has relatively limited claims experience in medical indemnity insurance. Information on QBE’s costs and premiums are, however, analysed in chapters 5, 6 and 7.

4.1 Cost components of medical indemnity insurance

The ACCC examined the cost components of the medical defence organisation (MDO)-owned insurers’ total premium pools for the six underwriting years between 2003–04 and 2008–09. Table 4.1 shows the percentage of the actuarially recommended aggregate premium pool for each cost category, which is presented as an average estimate based on the responses across insurers.

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42 With the exception of section 4.1 and chart 4.7, all analysis contained in this chapter includes Avant results on a financial year basis.

43 In some instances the results for this report for historical years may differ from those in previous reports because revised data was provided by insurers.

44 The MDO-owned insurers only underwrite medical indemnity insurance, while QBE underwrites medical indemnity insurance as well as a range of commercial and personal lines of insurance.
Table 4.1 Components of actuarially recommended aggregate premium pool, 2003–04 to 2008–09

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<td>25</td>
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<td>Total premium pool(c)</td>
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Source: Derived from MDO-owned insurers by the ACCC.

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

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

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

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

Table 4.1 shows that for the 2008–09 underwriting year, the net cost of claims remains the largest component of the total premium pool at 45 per cent. The expected surplus represented 16 per cent; underwriting and general expenses, 26 per cent; and reinsurance expenses, 13 per cent.

The proportion of premium pool represented by the expected surplus has fallen over the period, while the proportion represented by the net claims costs has risen. This is because of a decrease in the absolute amount of surplus raised (as insurers approach their capital targets) combined with a proportionally smaller decrease in the absolute amount expected for net claims costs. Reinsurance expenses decreased from 17 per cent in 2003–04 to 13 per cent in 2008–09. Underwriting and general expenses rose from 15 per cent in 2003–04 to 25 per cent in 2005–06, and have since remained relatively constant.

4.2 Trends in medical indemnity claims

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

For the sixth monitoring report the ACCC specifically requested that insurers provide the total number of claims (including likely incidents as well as open and closed claims); the total amount of claims paid to date; and the actuarial outstanding claims liability (inflated but undiscounted) as at 30 June 2008. This ensured that insurers provided information to the ACCC on a consistent basis. Because of differing data sources, the results shown in section 4.2 may not be directly comparable with that shown in previous monitoring reports.
• ultimate claims costs by notification year—the ultimate costs of claims\textsuperscript{46} expected to be met by insurers by year of notification\textsuperscript{47}

• claim frequency—the ultimate number of claims expected by year of notification expressed as a proportion of the total number of Medicare services provided in the corresponding year

• average size of claims—the ultimate expected\textsuperscript{48} average size of claims arising from a given notification year that will eventually be settled.

### 4.2.1 Ultimate claims costs

Chart 4.1 shows the trend in ultimate claims costs\textsuperscript{49} for claims notified between 1997–98 and 2007–08.

![Chart 4.1 Ultimate claims costs by year of notification, 1997–98 to 2007–08](chart)

Source: Derived from MDO-owned insurers by the ACCC.

\textsuperscript{46} “Ultimate cost of claims” refers to all claim costs an insurer reasonably expects will eventually be paid for claims arising in that notification year. For example, an insurer may not finish paying claims arising in a notification year for several years, so until all notifications for that year have been finalised, the ultimate cost includes all payments made for claims to date as well as all those expected payments. Both past payments and expected payments are in nominal dollars for the years in which they were/are expected to be made. Since ultimate claims costs and numbers are largely based on expectations, which can change from year to year, data contained within this section may not be directly comparable with that shown in earlier reports.

\textsuperscript{47} The notification year is the year in which an insurer is either notified of an incident occurring or, where no prior notification has been made, when a claim is lodged with an insurer.

\textsuperscript{48} The ultimate cost of claims is based on an insurer’s past payments as well as a reasonable estimate of future expected payments on claims not yet finalised. As this estimate of future expected payments is uncertain, the average claim size for any given year will be an expected average size, until all claims have been settled for that notification year.

\textsuperscript{49} 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.

It should be noted that the recent notification years largely reflect actuarial estimates. The ultimate claims cost changes over time as these estimates are replaced by actual experience.

### 4.2.2 Claims frequency

Chart 4.2 shows the ultimate number of claims expected to be met by insurers for each notification year between 1997–98 and 2007–08, and the corresponding claims frequency for the number of claims per million Medicare services provided.

**Chart 4.2 Ultimate claim numbers and claims frequency by year of notification, 1997–98 to 2007–08**

Source: Derived from MDO-owned insurers by the ACCC.

The ultimate number of claims increased by 67 per cent between 1997–98 and 2001–02 (from 1441 to 2403). The ultimate number of claims fell in 2002–03 to 2047, but generally remained around the level experienced in 2001–02 over the next six years. The most recent actuarial estimate of the ultimate number of claims expected for the 2007–08 notification year is 2489.
The ultimate number of claims per million Medicare services increased from seven to 11 between 1997–98 and 2000–01. The claims frequency fell to nine per million Medicare services in 2002–03 and then fluctuated around this level for the next three years before falling in 2007–08 to nine claims per million Medicare services. The fall from 2006–07 to 2007–08 represents a 10 per cent drop in ultimate number of claims per million Medicare services.

Claims frequency has followed a largely similar trend to the ultimate number of claims. However, between 2004–05 and 2006–07 the ultimate number of claims increased from 2360 to 2561 while the number of claims per million Medicare services remained at approximately 10.

Chart 4.3 shows the trend in the ultimate average size of claims expected by notification year between 1997–98 and 2007–08.

Chart 4.3 Ultimate average sizes of claims by year of notification, 1997–98 to 2007–08

![Chart showing the trend in the ultimate average size of claims by year of notification](chart.png)

Source: Derived from MDO-owned insurers by the ACCC.

The ultimate average size of claims increased from $68 801 in 1997–98 to $82 293 in 1999–00. The spike in 2002–03 aside, the ultimate average size of claims declined to $67 740 in 2004–05. In 2007–08 the ultimate average size of claims increased to $81 690, representing an increase of 13 per cent over 2006–07 levels. The spike in 2002–03 is attributable to the reported 15 per cent fall in claim numbers in that year (refer to chart 4.2). The apparent increase in average size of claims in 2007–08 reflects a reduction in the estimated claims costs by actuaries for 2004–05 to 2006–07—and hence in average claims size—rather than an increase in expected costs in 2007–08.
4.3 Trends in other expenses

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

Chart 4.4 shows reinsurance expenses and underwriting and general expenses from 1999–2000 to 2007–08.

**Chart 4.4 Reinsurance expenses and underwriting and general expenses, 1999–2000 to 2007–08**

Source: Derived from MDO-owned insurers by the ACCC.

Note: Previously one insurer’s reinsurance cost as sourced from its annual report was adjusted based on information it directly provided.51

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50 Reinsurance and underwriting expenses for the period 1999–2000 to 2007–08 is MDO-consolidated data. In previous reports, the underwriting and general expenses of one MDO was adjusted to remove APRA-approved transfers; however, this adjustment is not required for MDO-consolidated data. This adjustment has also been removed from historical data in chart 4.4.

51 This insurer had previously held a reinsurance contract that included ongoing adjustment premiums for which the insurer held reserves. As experience developed, the insurer was able to release these reinsurance premium reserves and these releases were allocated to the reinsurance expense on the profit and loss statement. As a result of these reserve releases, this insurer experienced a positive reinsurance expense in the three years to 2005–06, which distorted the actual reinsurance costs experienced by the industry. The ACCC sought information on the actual reinsurance cost for each year between 2003–04 and 2005–06, excluding the impact of any release of reserves.
Underwriting and general expenses increased from $36 million in 1999–00 to $120 million in 2006–07. In 2007–08 underwriting and general expenses declined to $107 million. The industry results observed in 2006–07 do not reflect individual experience; they mainly reflect abnormal increases in expenses.

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 and remained approximately at this level from 2003–04 and 2005–06. Reinsurance expenses continued to fall to $41 million in 2006–07 and $37 million in 2007–08 as some insurers retained more risk.

4.4 Trends in premiums

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

4.4.1 Total premium revenue

Chart 4.5 shows the trend in the total gross premium revenue by underwriting year for 1999–2000 to 2007–08.

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52 The spike in reinsurance expenses in 2001–02 was largely driven by the reinsurance arrangements of one insurer.
53 Total premium revenue as sourced from insurer’s annual reports includes revenue earned from medical indemnity insurance policies provided to medical practitioners and, for some insurers, premium revenue from medical indemnity insurance policies provided to other health professionals (such as optometrists and dentists).
54 Adjusted to 30 June 2008 values using the average weekly earnings index published by the Australian Bureau of Statistics (ABS) (catalogue number 6302.0).
55 Premium revenue is earned premium—that is, the total amount of gross written premium earned during the period (‘earned’ being that proportion of risk covered by the policy that expired at the end of the reporting period).
Chart 4.5 Total gross premium revenue by underwriting year, 1999–2000 to 2007–08


4.4.2 Average premium

Industry average premium

Chart 4.6 shows the trend in real average premium revenue (noting that it excludes stamp duty and the run-off cover scheme) generated by medical indemnity providers from indemnified members. This average gives an indication of the trend in real average premiums paid by medical indemnity insurance policyholders between 1999–2000 and 2007–08.

Source: Derived from MDO-owned insurers by the ACCC.

Note: Excludes call revenue.56

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56 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.
Medical indemnity insurance report—Sixth monitoring report

Chart 4.6 Average premium—real terms, 1999–2000 to 2007–08

Source: Derived from MDO-owned insurers by the ACCC.
Notes: Data is shown in real terms adjusted to 30 June 2008 values using the average weekly earnings (AWE) index published by the ABS.
Rates exclude third party statutory collections such as stamp duty and ROCS.

The real average premium increased steadily from $5263 in 1999–00 to $5816 in 2001–02, before rising sharply in 2002–03 to $7500. The real average premium then fell gradually in each of the next five years to 2007–08. In 2007–08 the average premium fell to $5392. This gradual decline in real average premiums is attributable to a number of factors, including premium reductions and changes to membership composition over time.

Medical specialty average premium

Medical practitioners who practise relatively more complex medical procedures are likely to face a higher risk of medical negligence claims against them than those 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.

Results may not be directly comparable to those shown in previous reports because of revised membership data and the exclusion of some non-medical practitioners and non-indemnified members from historical data.
To understand the relativities that apply between certain specialties, the ACCC obtained information from insurers on the gross written premiums and membership for individual specialties for the underwriting years between 2003–04 and 2008–09. This information allowed the ACCC to examine the average written premium for selected specialties across the six underwriting years to determine the relativities between specialties as well as any changes in those relativities.

Chart 4.7 Average premium by specialty—real terms, 2003–04 to 2008–09

Source: Derived from MDO-owned insurers by the ACCC.

Notes: Data is shown in real terms adjusted to 30 June 2008 values using the AWE index published by the ABS. Rates exclude third party statutory collections such as stamp duty, GST and ROCS.

The ACCC asked insurers to provide gross written premium and membership numbers as at a specific date in the 2008–09 underwriting year to allow insurers to provide the data before the end of the underwriting year. However, because the majority of insurance is underwritten at the beginning of the underwriting year, the data should provide a reasonable estimate of the full year’s results.
Chart 4.7 shows that average premiums in real terms for the selected specialties varied between $2667 for a non-procedural general practitioner (GP) to $48 910 for an obstetrician in 2008–09. The average written premiums in 2008–09 compared to 2007–08 were generally lower across the specialties. In real terms the average written premium decreases ranged from 3 per cent for anaesthetists to 16 per cent for plastic surgeons. Average written premiums for the GP procedural with obstetrics, GP procedural and general physician specialties increased by 3 per cent, 3 per cent and 1 per cent respectively.

Chart 4.7 also shows the change in the average written premium for the selected specialties between 2003–04 and 2008–09. In real terms the average written premium of all the selected specialties decreased over the period; over the six-year period these decreases ranged from 9 per cent for obstetricians to 39 per cent for anaesthetists.

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, different income levels and different jurisdictions. All these factors may influence the average written premium for reasons other than specialty relativities.

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

60 Different data sources mean that the results in chart 4.7 may not be directly comparable with those in chart 4.6.

61 Under a claims-made policy the insurer agrees to indemnify all claims arising from incidents notified during the policy period, as long as the incident occurred during the current period or any previous periods in which the policyholder has held continuous claims-made cover with the insurer up to, and including, the current period. As a result of 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.

62 For example, some high-risk categories are more prevalent in jurisdictions where different legislative requirements and historical claims experience results in a higher premium.
5 Actuarial justification of medical indemnity premiums

This chapter presents the findings of the Australian Competition and Consumer Commission on the actuarial justification of medical indemnity premiums charged for the 2008–09 underwriting period by the five authorised providers of medical indemnity insurance to private medical practitioners as at 30 June 2008. 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 2008–09 are discussed in chapter 7.

5.1 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. As the parent entities of the four medical defence organisation-owned insurers are no longer able to underwrite risks, the ACCC has generally not examined their operations or membership pricing. The ACCC’s analysis examined only the premiums charged by each insurer for primary medical indemnity insurance and specifically excluded any examination of ancillary policies, allied health care professionals or the subscription charged by the MDO.

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

5.2 Assessment methodology

5.2.1 Four MDO-owned insurers

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

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63 The 2008 calendar year in the case of 1 January renewal Avant Insurance Limited (AIL) members and Invivo/ QBE Insurance (Australia) Limited (QBE) policyholders.
Specifically, the ACCC examined the following:

• Ratings process—the method used by the medical indemnity insurer’s actuary to determine premium rates. The factors considered by the ACCC include:
  • the extent to which premium rates are based on sound actuarial principles and professional standards
  • the method employed by the actuary to construct the aggregate premium pool, associated premium relativities, the assumptions adopted and the rigour associated with setting those assumptions
  • the extent to which the insurer’s board adopted the actuary’s recommended premium rates
  • the degree to which the recommended actuarial premium pool details in the pricing report are consistent with, and supported by, other reports, such as the financial condition report and the outstanding liability assessment.

• Pure risk premium—the level of premium needed just to meet the cost of expected medical indemnity claims and associated costs. This can be difficult to determine accurately because the ultimate costs associated with these claims are unlikely to be known for some years after the premium has been set (see section 5.3.2). 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
  • projected rate of claims cost increases
  • legal costs
  • discount rate
  • projected growth rate of membership numbers
  • specialty mix and claims-made profile
  • jurisdiction of claims.

• Expenses—the expense incurred by the insurer as a result of acquiring, writing and servicing the insurance business. Factors considered include assessing the appropriateness of the expected level of costs.

• Reinsurance expenses—the amount of premium ceded to reinsurers for reinsurance. Factors considered include:
  • whether the reinsurance premium is used effectively to minimise the risk exposure of the portfolio
  • the extent to which the cost of reinsurance is included in premium rates recommended by the actuary.
Surplus—the surplus of funds expected to emerge after the cost of claims, expenses and reinsurance costs are deducted from premium revenue. For insurers, these funds are typically used to meet and maintain target capital levels and provide a contingency margin on expected claims costs. Factors considered by the ACCC include:

- assessing the capital structure of the insurer and the cost-effectiveness of how the capital is raised
- examining the purpose for building a surplus into premiums and the appropriateness of the amount needed for each purpose
- quantifying the effect on premiums of any allowance for the surplus.

Recommended rates/relativities—the premium rate and/or price relativities for each classification used, including specialty and income band relativities. Factors considered include:

- the method of derivation of relativities across classifications, including the extent of the analysis to confirm or modify risk classifications
- quantifying cross-subsidies and incorporation of board policy in the recommended rates
- comparing the actuary's recommended premium relativities against the actual premium rates charged by the insurer, with insurers being asked to explain material differences.

The analysis of jurisdictional relativities is considered separately in chapter 7.

Government reforms—the impact of measures arising from the Australian Government’s medical indemnity package and relevant tort law reforms introduced by the federal government and state and territory governments on costs and premiums. The ACCC requested specific commentary on the following government initiatives:

- High cost claims scheme (HCCS)—insurers were asked to detail the degree of influence this scheme has had on the calculation of the required premium pool and/or recommended premium rates and 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)—insurers were asked to detail the degree of influence this scheme has had on the calculation of the required premium pool and/or recommended premium rates and estimated claims cost reductions, as well as any allowances made for changes in the level and cost of reinsurance and the insurer’s capital requirements.
- Tort law reform—insurers were asked to detail the effect of tort reforms on the premium-setting arrangements. This included specific commentary by jurisdiction of the effect on costs, premiums, assumptions and the methodology employed. When no consideration of the effect of tort law reforms on costs and premiums was given, this was to be noted.

5.2.2 QBE Insurance (Australia) Limited

QBE's pricing methodology differs from MDO-owned insurers that price top-down using an aggregate premium pool combined with risk relativities based on an insured profile to determine individual premium. QBE determines individual premiums for each specialty and jurisdiction on a bottom-up basis. QBE's pricing methodology is described in further detail in section 5.4.1.
Because of this, the ACCC’s assessment methodology for QBE differed from that outlined above for the four MDO-owned insurers. The ACCC’s assessment of the actuarial justification of QBE’s premiums examined the following:

- **Ratings process**—the method used by QBE’s actuary to determine premium rates. Factors considered by the ACCC include the:
  - extent to which premium rates are based on sound actuarial principles and professional standards
  - method employed by the actuary to construct the individual premiums for each specialty, the assumptions adopted and the rigour associated with those assumptions
  - actuary’s inclusion of reasonable allowance for expense, reinsurance and surplus loadings in individual premiums
  - extent to which the insurer adopted the actuary’s recommended premium rates.

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

Because of the differences in QBE’s pricing methodology, the actuarial justification of QBE’s premiums is discussed separately in section 5.4.

### 5.3 Analysis—MDO-owned insurers

#### 5.3.1 Ratings process

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

The methodology adopted by all insurers to establish their actual premium pools was supported by actuarial advice.
All insurers determined their aggregate premium pool having considered advice from their actuaries. However, different insurers involved actuaries at different points in the pricing process.

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

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

5.3.2 Pure risk premium

The ACCC considered the pure risk premium component of the aggregate premium pool for the 2008–09 underwriting year. Pure risk premium is the basic building block for determining the aggregate premium pool and represents the direct cost of settling claims. As shown in table 4.1, the net claims cost represented 45 per cent of the aggregate premium pool for the 2008–09 underwriting year.

The ACCC found that insurers now employ similar methodologies. Insurers estimate the total losses arising from claims notified in the year following the latest liability assessments. In some cases explicit assumptions are made for claims frequencies and average claims costs. The projected payments are then discounted based on an assumed pattern of payments to allow for expected investment income. Insurers assume that the cost of claims will increase at a rate equal to or greater than normal wage inflation.

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

5.3.3 Expenses

The ACCC considered the amount of expenses incorporated into the aggregate premium pool for the 2008–09 underwriting year. Table 4.1 shows that the expenses represented 26 per cent of the aggregate premium pool for the 2008–09 underwriting year.

All aggregate premium pool estimates included an allowance for expenses. The proportion of expenses to the aggregate premium pool varied between insurers; however, the ACCC has assessed that they are actuarially justified.

One insurer experienced a large decrease in expenses following the correction of the previous year’s calculation of expenses.

Different insurers use different service models. Some insurers provide all services to policyholders while others outsource this to the parent MDO, which means the allocation of expenses can vary between different insurers. Both approaches are considered reasonable and in all instances the servicing costs were recognised and appropriate allowances for insurance company expenses were incorporated in the aggregate premium pool.

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64 The 2008 calendar year in the case of 1 January renewal AIL members.
65 The net claims costs is the expected ultimate claims cost net of recoveries received or expected to be received, including those from the Australian Government, under the HCCS, ROCS and the UMP support scheme.
5.3.4 Reinsurance expenses

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

All medical indemnity insurers used reinsurance programs for the 2008–09 underwriting period to manage the risks inherent in their portfolio. Most insurers used a combination of excess of loss and stop-loss reinsurance to manage their risk exposure.66 The attachment points for excess of loss reinsurance and the aggregate retention for stop-loss reinsurance adopted by insurers varied across the industry according to individual circumstances. All insurers factored the total cost of reinsurance into the premiums charged to medical practitioners.67

The ACCC acknowledges that the trade-off between the net cost of reinsurance and the level of risk the insurer is willing to undertake is ultimately a business decision for the insurer. The ACCC notes that, similar to last year’s report, one insurer’s reinsurance arrangements for the 2008–09 underwriting year reflected its assessment that one component of its potential reinsurance program would have been ineffective in reducing risk given the premium being asked by the reinsurer. The effect of this change was that the insurer has increased its potential loss in the event of adverse claims experience; however, this increase in volatility is managed by holding a greater amount of capital.

5.3.5 Surplus

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

- build the capital needed to achieve the target level set by the Australian Prudential Regulation Authority (APRA)68,69
- build the additional capital needed as a result of risks underwritten in 2008–09 to maintain total capital at, or above, the level required by APRA
- maintain a contingency (or prudential) margin over and above the actuary’s central estimate of the outstanding claims liability to increase the probability that the pure risk premium is adequate to meet the cost of claims
- provide a surplus (profit) to the insurer.

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

67 In some cases the reinsurance program covered risk incurred as a result of incurred but not reported claims resulting from cover provided by the parent MDO. A portion of the reinsurance premium was then charged to the MDO.

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

69 The ACCC understands that APRA has targeted 150 per cent minimum capital requirement as the expected level of capital to be held by medical indemnity insurers.
Table 4.1 shows that the amount of surplus in the aggregate premium pool has decreased over the past four underwriting years, from 35 per cent in 2003–04 to 16 per cent in 2008–09. However, it should be noted that the actual surplus levels varied between insurers.

The decrease in the proportion of the aggregate premium pool represented by surplus reflects the fact that insurers initially used the surplus to build capital to APRA's target level of 150 per cent of minimum capital requirement (MCR) and, as insurers’ capital levels passed this, their own internal targets. As a result, a significant surplus is no longer needed.

For the 2008–09 underwriting period the ACCC found that all insurers had generated sufficient capital to satisfy APRA's target level of 150 per cent of the MCR and no longer needed to include the significant surplus loading built into previous years’ premiums.

Most insurers no longer include an explicit loading in their premiums for additional capital; however, one insurer took a different approach to determine the surplus in its premium pool. Importantly, the level of surplus was quantified by each insurer as the difference between expected collections and the explicit premium pool components identified above.

As discussed in the last year's report, one insurer continued to expect its aggregate premium pool to increase its capital levels beyond its internal target levels. Smoothing premium increases over several years has meant that in the short term this insurer will continue to generate capital at a greater rate than required. Other mechanisms such as premium rebates were also employed for returning surplus capital to policyholders.

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

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

5.3.6 Recommended relativities and cross-subsidisation

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

The ACCC found that most insurers have examined premium relativities across specialties. Insurers typically examined historical frequency and average size by specialty. The ACCC found that cross-subsidisation between specialties was common across insurers and that in some cases significant variance between the technical and actual relativities remained. While insurers stated that their objective is to unwind these cross-subsidies, many indicated that this was a long-term process and potentially not all cross-subsidies would be removed for a variety of reasons.

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70 The ACCC understands that while APRA has targeted 150 per cent MCR as the expected level of capital to be held by the four MDO-owned insurers, all insurers have set internal targets higher than this amount.
including commercial factors as well as data limitations. All insurers identified and quantified cross-
subsidies between risk specialties.\(^71\)

The ACCC also examined the premium relativities applied across broad income bands. Similar to
the analysis done for specialties, insurers generally examined these rates by comparing the risk
relativities between income bands. Cross-subsidies exist between income bands and again some
insurers indicated a desire to unwind these.

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

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

### 5.3.7 Government reforms

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

#### High cost claims scheme

The HCCS was introduced to address the issue of high-cost claims for medical incidents. It was
designed to reduce the potential cost of large claims to insurers and is expected to affect premiums
in two ways: first, to reduce the pure risk premium component of premiums because the Australian
Government will pay 50 per cent of high-cost claims above a threshold amount\(^72\); and, second, to
reduce the amount of reinsurance needed to cover the total cost of high-cost claims. These effects
will, to some degree, be interdependent, depending on the attachment points of each insurer’s
reinsurance program.

All insurers took into account the full amount of expected HCCS recoveries in determining the pure
risk premium for the 2008–09 underwriting year. Most insurers indicated that they had factored the
full effect of the HCCS into their 2008–09 reinsurance programs. As noted in previous reports, the
rationale of the one insurer for not factoring the HCCS into the reinsurance program is as a result of
the unwillingness of the reinsurance company to factor HCCS in.

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\(^{71}\) Cross-subsidisation between current and retired insureds has now been formalised by the introduction of ROCS, which
provides automatic free insurance cover to doctors for death, disability, maternity and retirement (doctors aged 65 or over or
who have left the workforce for three or more years). The scheme is funded by a percentage charged on the total premium
pool of medical indemnity providers, which in turn is passed on to the premiums charged to current financial medical
practitioners.

\(^{72}\) The threshold is currently $300,000. See the Department of Health and Ageing, viewed at www.health.gov.au/internet/main/
publishing.nsf/Content/health-medicalindemnity-faq-hccs.htm.
The ACCC view continues to be that because the rationale for not taking the HCCS fully into account in the reinsurance program appears to be unwillingness by some reinsurers to fully reflect the benefits of the Australian Government’s scheme, the aggregate premium pool of these insurers is actuarially justified. Importantly, these insurers fully took HCCS recoveries into account in establishing their pure risk premium.

Run-off cover scheme

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

All insurers commented on the effect of ROCS on 2008–09 premiums. All insurers indicated that they expected to make recoveries from ROCS on claims costs resulting from notifications received in the 2007–08 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.

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

Based on this, the ACCC found that the insurers’ consideration of ROCS in determining their premiums for the 2008–09 underwriting year was actuarially justified.

Tort law reform

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

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

The impact of tort law report on the average cost of claims was less clear because the reduction in claim numbers occurred in both low-cost and high-cost claims.

5.3.8 Conclusion

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

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

The ACCC found that the aggregate premium pool of each insurer was actuarially justified. It was evident that insurers had generally made use of actuaries in premium liability assessments, pricing reports, funding plans and financial forecasts. In each case it was considered that the construction of the recommended premium pool was soundly based and incorporated all major cost implications for the pricing of medical indemnity insurance. All insurers determined their aggregate premium pool having considered advice from their actuaries. However, different insurers involved actuaries at different points in the pricing process.

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

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

Although one insurer did not reflect HCCS in its reinsurance program because of the unwillingness of its reinsurers to fully reflect the full benefits of the scheme, the insurer fully took HCCS recoveries into account when establishing their pure risk premium. All insurers, either implicitly or explicitly, also took tort law reform into account in setting their aggregate premium pools for 2008–09.

5.4 Analysis—QBE

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

This difference in approach meant that the ACCC’s analysis of QBE is separate to the four MDO-owned insurers.
5.4.1 Ratings process

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

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

As a relatively new medical indemnity underwriter, QBE’s limited claims experience does not provide a sufficient volume of claims for deriving or adjusting premium rates. However, it is being monitored by an actuary as an input into the pricing process. Premium levels and adjustments to 2007 rates for the 2008 calendar year were based on analysis of available market information and identified issues considered by QBE actuaries to be likely to affect premiums. Differential premiums were applied in each jurisdiction, also based on analysis of available industry data.

5.4.2 Government reforms

High cost claims scheme

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

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

Run-off cover scheme

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

QBE did not explicitly take any ROCS recoveries into account when estimating its claims costs because its pricing methodology prices risks individually.
Tort law reform
As tort law reform predominantly deals with constraining the number and size of personal injury cases, it is expected to affect the cost of providing medical indemnity insurance because most medical indemnity claims relate to personal injury. QBE took into account tort law reform during the process of establishing its final average claims costs by specialty.

5.4.3 Conclusion
The ACCC found that QBE’s 2008 premiums were actuarially justified. The analysis recognised that this is only QBE’s third year of underwriting medical indemnity insurance and therefore it has limited available claims experience. The ACCC’s assessment included revisiting the original methodology used to set premiums, which compared scheduled premium rates with the actuary’s recommended premium rates. It also involved assessing the impact of specific government reforms on premiums and changes in rates based on emerging experience and other identified issues.

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

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

The ACCC’s analysis of specialty premium rates found that all MDO-owned insurers either conducted detailed analysis on the risk relativities between specialties or relied on recent analysis. As in previous monitoring reports, the ACCC found that insurers generally cited the unwinding of existing cross-subsidies between specialties as an objective, but noted that this was a long-term process and potentially not all cross-subsidies would be removed for a variety of reasons, including commercial factors as well as data limitations.

For most insurers, no major realignment of rates was conducted for 2008–09. However, the ACCC still found these rates and the relativities for income bands to be actuarially justified because the extent of cross-subsidisation was understood and, where possible, quantified.

The ACCC found that all insurers appropriately considered the HCCS and ROCS into their premium determination and most insurers took full account of the HCCS in their reinsurance programs. The insurer that did not reflect the HCCS in its reinsurance program did so because of an unwillingness of reinsurers to reflect the full benefits of the scheme in their reinsurance pricing and structure. Importantly, these insurers took the HCCS recoveries into full account when establishing their pure risk premium. All insurers took tort law reform into account when setting their aggregate premium pools for 2008–09.

The ACCC also conducted separate analysis of QBE’s premiums and found them to be actuarially justified.
6 Commercial justification of medical indemnity premiums

This chapter presents Australian Competition and Consumer Commission (ACCC) findings on the commercial justification of medical indemnity premiums charged for the 2008–09 underwriting period by insurers to private medical practitioners.74

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

The ACCC findings regarding the commercial justification of medical indemnity premiums charged within each jurisdiction for 2008–09 are discussed in chapter 7.

6.1 Qualifications

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

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

6.2 Assessment methodology

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

Fiscally responsible insurers examine the financial impact of pricing decisions on their operations by preparing business plans that describe how they intend to manage their business. They also prepare detailed corporate plans on the financial effect (including on the income statement and balance sheet) of the business plan on their overall corporate strategies. This type of analysis

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74 On 1 July 2007 Avant Insurance Limited began operating as a medical indemnity insurer as the result of the merger of the parent-MDO entities Australasian Medical Insurance Limited and Professional Indemnity Insurance Company Australia Pty Limited. In previous reports, the commercial justification of AMIL and PIICA was assessed separately. This report is the first to assess the commercial justification of AIL.
is necessary to ensure that insurers remain capital-compliant with the targeted capital level following the end of the transition period.\textsuperscript{75}

The sixth medical indemnity premium monitoring report coincides with the end of Australian Prudential Regulation Authority’s transitional arrangements. Medical indemnity providers are now required to meet APRA’s minimum capital requirements.

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

- The financial projections contained in their initial funding plans as provided to APRA to make use of the transition period for building the capital to APRA-targeted capital (referred to as ‘2002–03 projections’).
- The actual financial position as at 30 June 2004, 30 June 2005, 30 June 2006, 30 June 2007 and 30 June 2008 based on data provided by APRA (referred to as ‘actual results’).\textsuperscript{77}

Comparing these sets of data allows the ACCC to examine how insurers’ financial position forecasts have changed over the six years and whether forecasts for 2008–09 were based on insurers’ recent experiences.\textsuperscript{78}

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

- solvency\textsuperscript{79}—the current and forecast net asset position of insurers to assess levels of solvency
- emerging surplus—the emerging and forecast levels of surplus loading in premium and whether this was sufficient to achieve the insurers’ targeted solvency and capital requirements
- minimum capital requirement coverage and capital targets—current and forecast levels of MCR coverage to examine whether capital targets would be met
- return on net assets—current and forecast return on net assets
- underwriting performance—the emerging and forecast underwriting performance in terms of the loss, expense, reinsurance and combined ratios (defined in section 6.3.5).

\textsuperscript{75} The Australian Prudential Regulation Authority established a scheme for transitional arrangements whereby providers had up to five years from 1 July 2003 to 30 June 2008 to comply with these minimum capital requirements. APRA required all medical indemnity providers intending to use the transitional period to build the required minimum capital to provide it with a funding plan indicating how this capital was going to be raised over the transitional period.

\textsuperscript{76} These revised projections were updated at different times depending on the insurer. The ACCC endeavoured to use the most recent projections up to 30 June of each year.

\textsuperscript{77} The 30 June 2008 values are derived from quarterly data provided by APRA. The 30 June 2004, 30 June 2005, 30 June 2006 and 30 June 2007 values are derived from annual data provided by APRA.

\textsuperscript{78} Some historical figures have been restated to better reflect the experience of the insurance companies.

\textsuperscript{79} Solvency is a measure of whether an insurance company has sufficient assets (capital, surplus, reserves and so on) to meet its liabilities (the cost of claims and all other expenses) as they fall due.
The ACCC’s ability to report on the commercial justification of QBE’s premiums for the 2008–09 underwriting year was limited because of data constraints surrounding the company. This is because QBE:

- has limited historical information specific to medical indemnity insurance
- is a large insurer that underwrites significant volumes of professional indemnity insurance business other than medical indemnity insurance and, therefore, it is difficult to disaggregate QBE’s medical indemnity insurance results from its other professional indemnity business.

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

### 6.3 Analysis—MDO-owned insurers

#### 6.3.1 Solvency targets

The ACCC assessed insurers’ actual solvency level as at 30 June 2004 to 30 June 2008 and compared these against the projections of solvency based on the six projection years between 2002–03 and 2007–08. This is shown in chart 6.1.

**Chart 6.1 Net assets: actual results, 30 June 2004 to 30 June 2008; and projections, 2002–03 to 2007–08**

![Net assets chart](chart.png)

Source: Derived from MDO-owned insurers by the ACCC.

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80. The MDO-owned insurers only underwrite medical indemnity insurance, whereas QBE underwrites medical indemnity insurance as well as a range of commercial and personal lines of insurance.
Chart 6.1 shows that the 2003–04 projections originally forecast that the net assets of the medical indemnity industry would increase from $186 million to $390 million between 30 June 2004 and 30 June 2008. These forecast positions improved in later projections. The 2007–08 projections forecast the net asset position to grow from $577 million at 30 June 2008 to $707 million at 30 June 2012.

As at 30 June 2008 the industry is in a strong solvency position, with total assets exceeding total liabilities by $619 million. This represents an improvement on the actual result observed at 30 June 2007 of $529 million.

While the actual net asset position of all insurers steadily improved from $251 million in 2003–04 to $619 million in 2007–08, the degree to which net assets improved for individual insurers depended on their circumstances.

### 6.3.2 Emerging surplus

The ACCC assessed the actual emerging surplus as at 30 June 2008 and compared this to the emerging surplus forecast in the projection years between 2002–03 and 2007–08. This is shown in chart 6.2.

![Emerging surplus chart](chart6.2.png)

**Chart 6.2 Emerging surplus: actual position, 2003–04 to 2007–08; and projections, 2002–03 to 2007–08**

Source: Derived from MDO-owned insurers by the ACCC.
The chart shows that the 2003–04 projections forecast that the level of emerging surplus would decrease from $86 million in 2003–04 to $49 million in 2007–08. A declining emerging surplus is also reflected in all six projection sets for 2007–08. The 2007–08 projections show that the industry is expecting emerging surplus to reduce in 2008–09 to $8 million, but to increase to approximately $39 million in 2009–10, 2010–11 and 2011–12. Surpluses are now considered to be at a level generally designed to maintain target capital goals.

The medical indemnity industry recorded a surplus of $25 million in 2007–08. The decline in emerging surplus compared with forecast emerging surplus is because of higher than anticipated expenses for some insurers as well as poor investment earnings.

6.3.3 MCR cover and capital targets

The ACCC assessed the actual financial position of MDO-owned medical indemnity insurers as at 30 June 2008 and compared this with the financial position forecast in the projection years between 2002–03 and 2007–08. The ACCC examined the net asset\(^{\text{81}}\) to MCR ratio as an indicator of financial strength, as shown in chart 6.3.

Chart 6.3 Net assets to MCR ratio: actual position, 2003–04 to 2007–08; and projections, 2002–03 to 2007–08

Source: Derived from MDO-owned insurers by the ACCC.

81 For the analysis in section 6.3.3, the net asset position is, where possible, based on the APRA-determined capital base of the insurers. The APRA determined capital base is used by APRA to gauge compliance with the MCR.
This chart shows that the 2003–04 projections forecast that the medical indemnity insurance industry would have a net asset position of 119 per cent of MCR at 30 June 2004, rising to 151 per cent by 30 June 2008. Subsequent projections of the 30 June 2008 net assets-to-MCR ratio show increases in levels for each updated projection. The 2007–08 projections forecast the MCR coverage to be 260 per cent at 30 June 2008 and then to gradually decrease to 229 per cent by 30 June 2012.

The actual net asset to MCR ratio of the medical indemnity industry at 30 June 2008 of 296 per cent was higher than all prior projections.

As at 30 June 2008 all insurers have exceeded the original target and, from 1 July 2008, the advisory target of 150 per cent MCR coverage required by APRA.82

The ACCC notes that, for the 2007–08 underwriting year, one insurer scheduled to inject capital to maintain its net assets to MCR ratio.

Capital injections from the parent entity can be an effective way to raise capital compared with retained surplus from insurance premiums83; further, it may also represent a more efficient way to use otherwise unused capital in not-for-profit organisations, such as MDOs.84

Forecasts show that capital injections funded through a combination of subscriptions and unused capital from the MDO allow the insurer to meet its internal target capital levels in the planning period. The ACCC found that this approach is commercially justified.

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82 APRA’s transitional arrangements enable medical indemnity providers to build capital up to APRA’s targeted capital level by 30 June 2008. Effective 1 July 2008, APRA advised in practice note GPG 100 that medical indemnity insures are expected to maintain a capital ‘buffer’ of at least 150 per cent.

83 Raising capital through insurance premiums incurs a 10 per cent GST, stamp duty (which varies depending on the jurisdiction) and 5 per cent run-off cover scheme (ROCS) levy (before 1 July 2008 it was 8.5 per cent). Income tax is also charged on profit at 30 per cent.

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

84 MDOs are not subject to the same prudential requirements as the licensed insurer and as such have a lesser statutory obligation to hold free capital.
6.3.4 Return on net assets

The ACCC assessed the returns of MDO-owned medical indemnity insurers relative to their net asset position and compared these with the projection years between 2002–03 and 2007–08. This is shown in chart 6.4.

Chart 6.4 Return on net assets: actual position, 2003–04 to 2007–08; and projections, 2002–03 to 2007–08

Source: Derived from MDO-owned insurers by the ACCC.

Chart 6.4 shows that the 2003–04 projections forecast the return on net assets to decrease from 64 per cent in 2003–04 to 13 per cent in 2007–08. A decline in the return on net assets was reflected in all projections, aside from 2007–08. The 2007–08 projections show that return on net assets is expected to increase from 1 per cent in 2008–09 to 6 per cent in 2011–12.

The return on net assets was projected to decrease because insurers initially raised significant surpluses to fund capital requirements when their asset bases were low. However, once those capital targets are achieved, the required surplus is reduced. The 2007–08 projections of return on net assets reflect the industry maturing and meeting its required capital targets.

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85 This is further influenced by the fact that the net asset position of insurers increases as they approach their capital targets.
The downward trend in the actual results is consistent with the projections. The actual return on net assets of 4 per cent in 2007–08 is lower than projected because of poorer than expected investment returns and higher than projected expenses for some insurers.

### 6.3.5 Underwriting performance

The ACCC examined the underwriting performance in the following terms.

- **Loss ratio**—the total claims expense attributable to each financial year on claims arising from that or previous years as a proportion of gross premium revenue.\(^{86}\)
- **Expense ratio**—the sum of all underwriting and general expenses (excluding reinsurance expenses) as a proportion of gross premium revenue.
- **Reinsurance ratio**—the reinsurance expense as a proportion of gross premium revenue.
- **Combined ratio**—the sum of the loss and the expense ratio. A combined ratio of 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.\(^{87}\)

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

**Loss ratio**

Charts 6.5a and 6.5b show the gross and net loss ratios for MDO-owned insurers based on the financial projections of insurers between 2002–03 and 2007–08. They also show the actual loss ratios for 2003–04 to 2007–08.

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

87 Analysis of underwriting performance may not necessarily indicate an insurer’s overall profitability because of the exclusion of investment income.

Source: Derived from MDO-owned insurers by the ACCC.
Charts 6.5a and 6.5b show that the 2003–04 projections forecast that the gross loss ratio would rise from 56 per cent in 2003–04 to 73 per cent in 2007–08, and the net loss ratio would rise from 51 per cent in 2003–04 to 75 per cent in 2007–08. Subsequent projections also forecast increasing gross and net loss ratios. The 2007–08 projections forecast that the gross loss ratio will increase from 89 per cent in 2008–09 to 97 per cent in 2011–12, and forecast that the net loss ratio will increase from 69 per cent in 2008–09 to 80 per cent in 2011–12.

The actual gross loss ratio in 2007–08 of 51 per cent and actual net loss ratio of 48 per cent in 2007–08 were lower than projected. This was also the case in 2003–04, 2004–05, 2005–06 and 2006–07. Actual loss ratios have been lower than projections because actual premium income is generally higher than projections and actual claims costs are generally lower than projections.

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

Charts 6.6a and 6.6b show the gross and net expense ratios for MDO-owned insurers based on the 2002–03 to 2007–08 financial projections of insurers. They also show the actual expense ratios from 2003–04 to 2007–08.88

Chart 6.6a  Gross expense ratio: actual position, 2003–04 to 2007–08; and projections, 2002–03 to 2007–08

Source: Derived from MDO-owned insurers by the ACCC.

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88 The ACCC has adjusted one insurer’s actual expense ratios to remove some APRA-approved transfers.
Charts 6.6a and 6.6b show that the 2003–04 projections forecast the gross expense ratio would be between 18 and 20 per cent and the net expense ratio would be between 22 and 24 per cent between 2003–04 and 2007–08. The 2004–05 and 2005–06 and 2006–07 projections forecast an increase in the level of gross and net expense ratio compared to the 2003-04 projections. The 2007–08 projections show that the gross expense ratio is expected to decrease from 31 per cent in 2008–09 to 29 per cent in 2011–12, and the net expense ratio is expected to decrease from 37 per cent in 2008–09 to 34 per cent in 2011–12.

The actual gross expense ratio of 30 per cent and the net expense ratio of 35 per cent in 2007–08 were slightly lower than projected.

Initial expense projections understated actual expenses. Recent forecasts now more accurately reflect actual expenses and show an upward trend continuing in the short term.

The high expense ratio experienced in 2006–07 does not reflect the individual experience of all insurers and mainly reflected abnormal expenses incurred by some insurers.
Reinsurance ratio

Chart 6.7 shows the reinsurance ratio for MDO-owned insurers based on the 2002–03 to 2007–08 financial projections of insurers. It also shows the actual reinsurance ratio for 2003–04 to 2007–08.

**Chart 6.7  Reinsurance ratios: actual position, 2003–04 to 2007–08; and projections, 2002–03 to 2007–08**

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Source: Derived from MDO-owned insurers by the ACCC.

The chart shows that the 2003–04 projections forecast reinsurance ratios would be between 16 and 19 per cent between 2003–04 and 2007–08. Subsequent forecasts for 2007–08 predicted that the reinsurance ratio would remain between 15 and 18 per cent. The actual reinsurance ratio for the industry of 13 per cent in 2007–08 is lower than projected, which mainly reflects the lower-than-forecast reinsurance expenses experienced by some insurers.

The 2007–08 projections show that the reinsurance ratio is forecasted to remain relatively steady. It is expected that the reinsurance ratio will increase from 15 per cent in 2008–09 to 16 per cent in 2011–12.
Combined ratio

Charts 6.8a and 6.8b show the gross and net combined ratios for MDO-owned insurers based on projections from 2002–03 to 2007–08 provided by insurers. It also shows the actual combined ratios for 2003–04 to 2007–08.

**Chart 6.8a  Gross combined ratio: actual position, 2003–04 to 2007–08; and projections, 2002–03 to 2007–08**

![Graph showing combined ratio](Image)

Source: Derived from MDO-owned insurers by the ACCC.
The chart shows that the 2003–04 projections forecast that the gross combined ratio would increase from 74 per cent in 2003–04 to 91 per cent in 2007–08, and that the net combined ratio would increase from 73 to 97 per cent for the same period. The upward trend is also reflected in subsequent projections. The 2007–08 projections forecast the gross combined ratio will increase from 121 per cent in 2008–09 to 125 per cent in 2011–12, and that the net combined ratio will increase from 106 per cent to 115 per cent for the same period.

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

The projected gross and net combined ratios from 2008–09 to 2011–12 are generally over 100 per cent. While a combined ratio greater than 100 per cent indicates that an insurer is making a loss on its underwriting activities, it should be noted that a combined ratio exceeding 100 per cent may still be profitable for an insurance business once investment income is taken into account.

The actual gross combined ratio was 82 per cent and net combined ratio was 83 per cent in 2007–08. These are both lower than projected.
6.3.6 QBE

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

The ACCC examined the commercial justification of QBE’s premiums by examining Invivo’s financial projections and how these are consolidated within QBE’s professional indemnity insurance business. The ACCC has also examined QBE’s objectives and intentions for its medical indemnity insurance business.

Based on this analysis, the ACCC found that QBE’s premiums for the 2008 underwriting year were commercially justified.

6.4 Conclusion

The ACCC found that the premiums set by MDO-owned insurers are commercially justified.

The net asset position of all insurers as at 30 June 2008 was an improvement on the strong position observed as at 30 June 2007. This is evidenced by the actual net asset position for the MDO-owned insurers being higher than forecasted as at 30 June 2008.

Since the ACCC’s first medical indemnity premium monitoring report, MDO insurers have steadily increased their net assets to reach their capital target levels. This was achieved through the surplus that MDO insurers generated through their insurance business and, in some instances, capital injections. As they increase their net assets, MDO insurers have reduced the surplus generated from premiums. The lower levels of surpluses are reflected in reductions in the return on assets as they have matured. As at 30 June 2008, all MDO insurers have met the 150 per cent MCR coverage as required by APRA.

The ACCC notes that one insurer has scheduled future capital injections to maintain its target net asset-to-MCR ratio. Based on forecasts provided by the insurer, the ACCC found that this approach is currently commercially justified.

The ACCC also separately analysed QBE’s 2008 premiums and found them commercially justified.
7  Actuarial and commercial justification of medical indemnity premiums within each jurisdiction

This chapter presents findings by the Australian Competition and Consumer Commission (ACCC) on the actuarial and commercial justification of medical indemnity premiums charged for the 2008–09 underwriting period\(^9\) within each jurisdiction by the five authorised providers of medical indemnity insurance to private medical practitioners as at 30 June 2008.

7.1 Qualifications

In preparing this analysis it was necessary for the ACCC to maintain confidentiality of information provided by individual insurers. As noted in section 2.3, medical indemnity providers have largely continued the tradition of providing insurance primarily in their home states.\(^{90}\) Because of this, some quantitative aspects of the ACCC analysis of the jurisdictional premiums could not be disclosed in this report.

7.2 Background

7.2.1 Findings of previous ACCC monitoring reports

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

The ACCC’s third, fourth, fifth and sixth monitoring reports separately examined the actuarial and commercial justification of jurisdictional relativities for the 2005–06, 2006–07, 2007–08 and 2008–09 underwriting periods. These reports all found that jurisdictional premium relativities were considered actuarially and commercially justified for all monitored insurers.

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

\(^{9}\) The 2008 calendar year in the case of 1 January renewal Avant Insurance Limited (AIL) members and Invivo/QBE Insurance (Australia) Limited (QBE) policyholders.

\(^{90}\) As noted in section 2.3, some insurers now have a large portion of their membership outside their home state. However, the home state still generally represented the largest proportion of their membership base.
7.2.2 Pricing medical indemnity insurance by jurisdiction

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

The pricing process typically adopted by the four medical defence organisation (MDO)-owned insurers involves each insurer determining the aggregate premium pool. The aggregate premium pool typically includes:

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

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

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

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

QBE Insurance (Australia) Limited’s pricing methodology\(^{91}\) differs from that outlined above for the four MDO-owned insurers because it determines jurisdictional relativities based on available industry data. As such, the ACCC has considered QBE’s jurisdictional premium relativities relative to industry jurisdictional premium relativities, as opposed to preparing a separate analysis as discussed in chapters 5 and 6.

### 7.2.3 Premium relativities

To obtain an understanding of the actual relativities applied between jurisdictions the ACCC obtained information from the four MDO-owned insurers\(^{92}\) on the gross written premium and membership numbers by individual jurisdiction for the underwriting years 2003–04 to 2008–09.\(^{93}\) This information allowed the ACCC to examine the average written premium in each jurisdiction across the six underwriting years to determine the relativities between jurisdictions as well as any changes in those relativities.

Chart 7.1 shows the average written premium of the four MDO-owned insurers by jurisdiction in real terms across the six years.\(^{94,95}\)

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\(^{91}\) QBE’s pricing methodology is described in detail in section 5.4.1.

\(^{92}\) The ACCC was also provided with information on QBE’s gross written premium and policyholder numbers; however, as this data was only available for three underwriting years, it has not been incorporated in the ACCC’s historical analysis of jurisdictional premiums.

\(^{93}\) The ACCC asked insurers to provide the gross written premium and membership numbers at a specific date in the 2008–09 underwriting year to allow insurers to provide data before the end of the underwriting year. However, because the majority of insurance is written at the beginning of the underwriting year, the data should provide a reasonable estimate of the full year’s results.

\(^{94}\) The ACCC prepared the average written premium analysis by jurisdiction by examining the average written premium of each of the four MDO-owned medical indemnity providers and then averaging the result across all four. As noted in section 2.3, some 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 results being driven by individual insurers within their home states. The ACCC deemed the methodology adopted necessary to maintain confidentiality of data.

\(^{95}\) The average written premium by jurisdiction is presented on a real basis to reflect the impact of inflation with nominal premiums adjusted to 30 June 2008 values using the average weekly earnings index published by the Australian Bureau of Statistics (catalogue number 6302.0).
Chart 7.1  Average written premium in real terms by jurisdiction, 2003–04 to 2008–09

Chart 7.1 shows that the real average written premium in 2008–09 is highest in New South Wales and the Australian Capital Territory and lowest in South Australia and the Northern Territory. The chart also shows that in 2008–09 the real average written premium decreased in a majority of jurisdictions, ranging from less than 1 per cent in the Queensland to 10 per cent in Western Australia. The chart also shows that in 2008–09 the real average written premium increased in Tasmania and South Australia, by 6 per cent and 4 per cent respectively.

Overall, according to chart 7.1, average premiums have decreased in 2008–09. 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, resulting in these jurisdictions having a lower comparable average written premium.

96 The jurisdictional average written premium is calculated as the total gross written premium for a particular year for a particular jurisdiction, divided by the total membership for that jurisdiction. The national average written premium is calculated in the same manner.

97 Under a claims-made policy the insurer agrees to indemnify all claims arising from incidents notified during the policy period, as long as the incident occurred during the current period or any prior periods in which the policyholder has held continuous claims-made cover with the insurer up to, and including, the current period. Because of 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.
The ACCC also examined the observed jurisdictional premium relativities used by the five authorised insurers (including QBE) for the 2008–09 underwriting year by examining the premium rates actually set across jurisdictions. Specifically, the ACCC compared all equivalent mature claims-made premium categories (including specialties and income bands) between the home state of each insurer and other jurisdictions.

As noted previously, insurers apply the jurisdictional relativities to premiums by applying a loading or discount to premiums in their home jurisdiction. As each insurer generally had a different home jurisdiction to which other jurisdictions were compared, the ACCC compared each jurisdiction’s premium relativity to the average premium relativities by jurisdiction across all insurers. Chart 7.2 shows the average industry observed jurisdiction relativities for all insurers (including QBE) for the 2008–09 underwriting year.

**Chart 7.2 Average observed jurisdictional relativity, 2008–09**

![Chart showing jurisdictional relativities](chart)

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

Chart 7.2 shows that New South Wales and the Australian Capital Territory had the highest jurisdictional premiums relative to the national average (at 24 and 20 per cent respectively), while Tasmania has the lowest (at −16 per cent). The premiums relative to the national average for the remaining jurisdictions ranged from between −4 per cent to −7 per cent.

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98 The relative percentages refer to the premiums of a specific state relative to the national premium average.
Jurisdictional premium relativities exist because, for a variety of procedural and social reasons, the level of common law awards and settlements varies between states. As claims costs is one of the largest components of premiums, this will be a significant driver of premium differences between jurisdictions.

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

7.3 Actuarial and commercial justification of premium relativities by jurisdiction

The ACCC examined the actuarial and commercial justification of the jurisdictional relativities applied for the 2008–09 underwriting year by the five current insurers.

The ACCC found that most insurers who underwrote medical indemnity insurance in 2008–09 analysed whether changes should be made to jurisdictional relativities. However, most insurers indicated that their analysis was limited by a lack of sufficient claims experience in some jurisdictions. Partly reflecting this data issue, only two insurers that provided medical indemnity insurance in 2007–08 decided to change their existing jurisdictional relativities in the 2008–09 underwriting year. One insurer had set interim jurisdictional premiums and another separately analysed premiums for a specific jurisdiction.

7.3.1 Actuarial justification of jurisdictional relativities

Methodology

The ACCC examined the actuarial justification of premium relativities for the 2008–09 underwriting year. Specifically the ACCC examined the:

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

Extent of analysis in determining jurisdictional relativities

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

The extent to which this analysis was conducted varied across insurers. The majority of insurers conducted a detailed analysis by comparing loss ratios for different jurisdictions to derive the jurisdictional relativities for the 2008–09 underwriting year. Other insurers generally based their analysis on reviews of detailed jurisdictional analysis prepared in previous years.
As noted in earlier ACCC monitoring reports, insurers, especially smaller insurers, generally experienced some difficulties in accurately determining jurisdiction-based premium relativities because of a lack of sufficient jurisdiction-based claims experience. Therefore, most insurers made relatively simple estimates and included a flat loading or discount on premiums for medical practitioners outside their home jurisdictions. All insurers experienced difficulties associated with a lack of sufficient jurisdiction-based claims experience for some states and territories.

Relativities were adjusted by some insurers in some jurisdictions. These adjustments were based on analysis of emerging claims experience.

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

Interim arrangements were introduced according to information provided by one insurer. The approach adopted was considered reasonable with the expectation that detailed actuarial assessments will continue.

**Tort law reform**

Most insurers commented on the impact of tort law reform, which has generally led to decreases in the cost of claims. Allowance for tort law reforms is achieved through the analysis of post-tort law reform claims experience.

**7.3.2 Commercial justification of jurisdictional relativities**

**Methodology**

The ACCC examined the commercial justification of premium relativities for the 2008–09 underwriting year. Specifically the ACCC examined:

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

**Adoption of actuarial recommendations**

Insurers generally used the approved actuary when determining jurisdictional relativities. However, the timing of the actuary’s involvement differed across insurers, with some insurers relying on advice from their actuary to determine and recommend relativities.

Interim arrangements were a consideration for one insurer. These arrangements acted to limit the size of any increase or decrease experienced by members moving to new premiums.

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101 The 2008 calendar year in the case of 1 January renewal AIL members and Invivo/QBE policyholders.
The ACCC found that final relativities, as selected or approved by the actuary, were generally adopted by all insurers in their final rates. The ACCC also found the interim premium relativities set by one insurer were appropriate.

**Quantification of cross-subsidies and incorporation of board policy**

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

### 7.4 Conclusion

The ACCC found that jurisdictional premium relativities were considered actuarially and commercially justified for the five insurers operating as at 30 June 2008.

For the actuarial justification of premium relativities, the ACCC considered the extent of the analysis used to determine the relativities, as well as the extent to which insurers took into account jurisdictional variations in tort law reform. The ACCC found that insurers’ analyses were limited to an extent because of a lack of sufficient claims experience in some jurisdictions. The ACCC has also found that insurers have implicitly accounted for tort law reform through post-tort law reform claims analysis. In the absence of a sufficient volume of claims data, the ACCC considered the approach used by insurers to be actuarially justified.

For the commercial justification of premium relativities, the ACCC considered the extent to which relativities recommended by actuaries were adopted in final premium rates as well as the level of cross-subsidisation in the premium relativities. The ACCC found that in some instances recommendations were not adopted in final premium rates because of a lack of sufficient claims experience in some jurisdictions. The ACCC also found that interim arrangements were a consideration for one insurer. While no insurers reported explicit cross-subsidies between jurisdictions, some cross-subsidies may exist because of the lack of a sufficient volume of claims experience. The ACCC considers that the relativities adopted are commercially justified.
Appendix A  ACCC information request

To fulfil its monitoring requirements, it was necessary for the Australian Competition and Consumer Commission to approach medical indemnity providers directly to request relevant information. In consultation with actuaries, the ACCC developed a uniform information request for the four medical defence organisation (MDO)-owned insurers to complete.102 This appendix briefly describes the nature of the reports and information the ACCC requested from insurers.

A.1 Actuarial pricing report

Insurers generally commissioned actuarial pricing reports for premiums to apply for the 2008–09 underwriting year. These reports provide advice to the insurer on the aggregate premium pool and, in some cases, specialty rates. The ACCC requested a copy of this report.

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

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

- 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.

A.2 Actual premium rate report

The ACCC requested a report detailing the actual premiums charged for all forms of indemnity for the 2008–09 underwriting year. If actual premium rates differed from those set out in the actuarial pricing report, the insurer was asked to detail the reasons for these differences. This discussion was to include all relevant commercial and regulatory factors affecting the pricing decisions made by the indemnity provider.

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

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

102 The ACCC modified its information request for Invivo, which, as the authorised representative of QBE Insurance (Australia) Limited, provided information to the ACCC on QBE premiums.
A.3 Membership, premium and claims data

The ACCC also requested the following data from insurers:

Membership data
- Membership numbers by membership category, jurisdiction and income band for the 2007–08\(^{103}\) and 2008–09 underwriting years.

Premium data
- Recommended individual actuarial subscription rates by membership category, jurisdiction and income band for the 2008–09 underwriting year.
- Actual subscription rates by membership category, jurisdiction and income band for the 2008–09 underwriting year.
- Total gross written premium by membership category and jurisdiction for the 2007–08\(^{104}\) and 2008–09 underwriting years.

Claim data
- The total number of claims (including incidents likely as well as open and closed claims), the total amount of claims paid to date and the actuarial outstanding claims liability (inflated but undiscounted) as at 30 June 2008.

A.4 Other information

The ACCC also requested the following information to assist in its monitoring role:
- the most recent financial condition report, which is submitted to the Australian Prudential Regulation Authority on an annual basis and provides a comprehensive overview of the insurer’s financial soundness
- copies of financial projections prepared by the authorised insurer in 2007–08 as well as any updates to these projections
- recent annual reports for both the insurer and the MDO group of companies
- a brief outline of any changes to the insurance policies previously offered to medical practitioners for the 2008–09 indemnity period.

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103 While information on membership numbers was also provided by insurers for the 2007–08 underwriting year in the context of the previous monitoring request, generally this information was provided at a specific time and may not reflect the actual result for the full year. As such the ACCC sought revised data where this was available.

104 While information on premium rates was also provided by insurers for the 2007–08 underwriting year in the context of the previous monitoring request, generally this information was provided at a specific time and may not reflect the actual result for the full year. As such the ACCC sought revised data where this was available.
Appendix B  Differences with APRA reports

The Australian Prudential Regulation Authority produces reports from its national claims and policies database that cover professional indemnity and public and product liability insurance. The NCPD reports provide an overview of professional indemnity and public and product liability insurance based on information provided by Australian APRA-regulated general insurers.

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

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

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

Infocentre: 1300 302 502
Website: www.accc.gov.au

Callers who are deaf or have a hearing or speech impairment can contact the ACCC through the National Relay Service: www.relayservice.com.au.

Voice-only (speak and listen) users—phone 1300 555 727 and ask for 1300 302 502.

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