



Australian Government

Australian Government Actuary

**Second report on the costs of the
Australian Government's
Run-Off Cover Scheme for
medical indemnity insurers**

2005-06 financial year

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1. INTRODUCTION

1.1. This report has been prepared to comply with certain requirements of the *Medical Indemnity Act 2002* (Medical Indemnity Act). Section 34ZW of the Medical Indemnity Act provides for a report on aspects of the Run-Off Cover Scheme to be tabled each year in Parliament. The report is required to contain a statement of the:

- number of persons eligible for membership of the Run-Off Cover Scheme (the Scheme);
- total run-off cover (ROC) indemnity payments paid by the Commonwealth during the financial year, including claims handling and administration expenses;
- total ROC support payments paid to the Commonwealth during the financial year; and
- projected liabilities of the Scheme in future financial years.

1.2. This is the second report that has been prepared under section 34ZW of the Medical Indemnity Act. It relates to financial year 2005-06. The first report was tabled in Parliament on 28 March 2006.

2. BACKGROUND

2.1 Medical indemnity insurance

2.1.1 Medical indemnity insurance is a form of professional indemnity insurance. It covers practitioners for their professional negligence.¹

2.1.2 Doctors who undertake private medical practice in Australia generally purchase medical indemnity insurance from private sector underwriters.² This report considers the six private sector underwriters operating in Australia during 2005-06. Figure 1 below illustrates the market shares of the six private underwriters calculated on the basis of premium data provided by them.

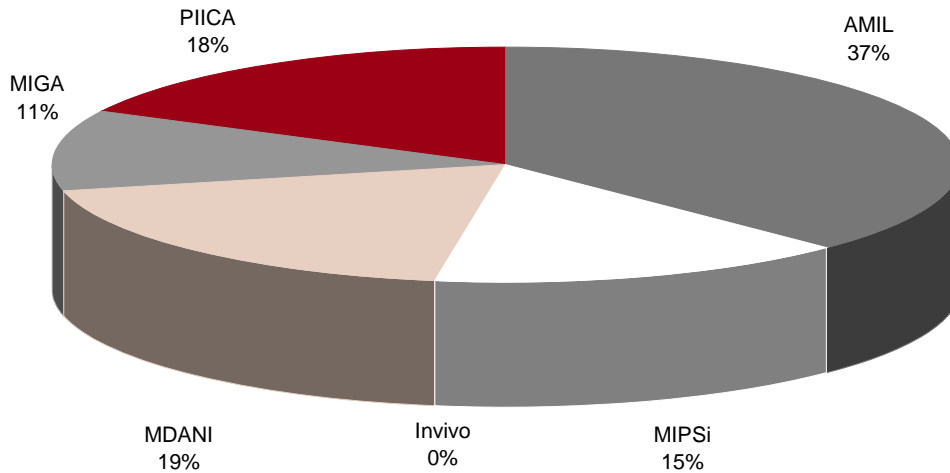
2.1.3 The six private underwriters are Australasian Medical Insurance Limited (AMIL), MIPS Insurance (MIPSi), MDA National Insurance (MDANI), Medical Insurance

1 Medical indemnity insurance can also cover other costs such as those associated with appearing at coronial inquiries.

2 On the other hand, many employed practitioners such as doctors practising solely in a public hospital will be indemnified by their employer against negligence.

Group Australia (MIGA), Professional Indemnity Insurance Company Australia (PIICA) and Invivo which has recently commenced writing business and according to the data has less than 1 per cent of the market.

Figure 1: Market share of medical indemnity insurers



2.1.4 Medical negligence claims are initiated by, or on behalf of, patients against doctors. Roughly 2,000 claims of negligence might be expected each year in relation to private medical practice in Australia. However, there can be substantial variation from one year to the next. It is difficult to project the number of medical indemnity claims with any precision. A significant number of claims will be successfully defended.

2.1.5 The cost of medical negligence claims is highly variable since the claims relate to bodily injury. The cost of a medical indemnity claim to the insurer is made up of damages which are payable to the plaintiff, any of the plaintiff's legal costs which the insurer is obliged to pay, and the insurer's own costs of defending and managing the claim. While most claims are finalised for less than \$100,000, a small number of claims are large. Perhaps 5 per cent of claims cost more than \$500,000. These large claims have a significant impact on the overall cost of medical indemnity insurance. At least 40 per cent of the cost of all medical indemnity claims relates to claims which are larger than \$500,000.

2.1.6 The medical indemnity claim process can be long. Years can elapse between the date of a negligent medical incident and the date that legal action against the practitioner is initiated. It is not unusual for claims to take a number of years to finalise after they have been initiated. It is common for the whole process to take more than five years for a single claim. The cost of a claim depends significantly on economic and judicial conditions prevailing at the time the claim is finalised (paid), rather than at the time of the medical incident or the time that the claim is made.

2.1.7 All of these factors make medical indemnity insurance difficult for an insurer to underwrite. It is hard to forecast claim numbers and claim sizes reliably. Moreover, much of the cost is likely to relate to a small minority of the claims, which adds further uncertainty. As a result, it is difficult to know how much premium to charge and how much money to hold in reserve to pay claims. For these reasons a robust private market in medical indemnity insurance requires professional and disciplined underwriting and management.

2.2 Brief history of private medical indemnity insurance in Australia — the lead-up to the Run-Off Cover Scheme

2.2.1 Historically, medical indemnity cover was provided to Australian doctors in private practice by medical defence organisations (MDOs). MDOs were not licensed insurers and were therefore not subject to prudential regulation.

2.2.2 Medical indemnity cover was originally provided to practitioners on a so-called 'claims-occurring' basis. Practitioners were protected against claims that might be made in relation to the medicine that they had practised while members of the MDO. Thus, practitioners who had claims made against them after retirement could seek assistance from their MDO provided that they had been members at the time of the medical incident. Medical indemnity is difficult to underwrite on a 'claims-occurring' basis, partly due to the often long delay between the date of medical incident and the time at which a claim is initiated.

2.2.3 During the 1990s most MDOs came under financial pressure as a result of increasing levels of claim payments and were forced to make calls on their members for additional funds.

2.2.4 At the same time, most MDOs progressively changed the basis of their cover from 'claims-occurring' to 'claims-made'. In simple terms, claims-made cover provided protection for the practitioner against claims that were made during the period of membership. Thus, in order to continue to be covered against claims that might emerge in relation to past medical practice, a doctor had to continue his MDO membership. Professional indemnity insurance is generally provided on a 'claims-made' basis.

2.2.5 In 2002, Australia's largest MDO, United Medical Protection, was placed in provisional liquidation. Following this, the Government took steps to stabilise the medical indemnity industry.

2.2.6 Since 1 July 2003, medical indemnity insurance has been required to be provided to Australian practitioners by insurers licensed under the *Insurance Act 1973* and prudentially supervised by APRA.

2.2.7 This has ensured a more disciplined approach to underwriting and has reduced the risk of failure of a medical indemnity provider.

2.2.8 Consistent with more disciplined underwriting, all medical indemnity insurance is now provided on a 'claims-made' basis. Consequently, doctors have to maintain insurance in order to remain covered against claims that might emerge, even if they are no longer practising. This form of insurance cover is known as run-off cover. Put simply, run-off cover provides insurance protection for doctors who have ceased medical practice. The potential delay between a medical incident and a claim highlights the need for doctors to maintain run-off cover after ceasing practice.

2.2.9 For some practitioners the annual cost of medical indemnity insurance runs into the tens of thousands of dollars. In order to address problems associated with the cost of run-off cover, including the potential threat to the provision of medical services, the Government established a scheme requiring medical indemnity insurers to provide free run-off cover to certain groups of doctors who have ceased private practice. The Scheme was intended to be largely cost neutral to taxpayers whilst not threatening the viability of the insurance companies. This scheme is known as the Run-Off Cover Scheme.

2.3 What is the Run-Off Cover Scheme?

2.3.1 The Run-Off Cover Scheme facilitates the provision of free medical indemnity insurance cover to particular groups of doctors who have ceased private medical practice.

2.3.2 The rules for the Scheme appear in the *Medical Indemnity (Prudential Supervision and Product Standards) Act 2003* (PSPS Act), the *Medical Indemnity (Run-off Cover Support Payment) Act 2004* (MI ROCSPA) and the Medical Indemnity Act. The principal elements of the Scheme are as follows:

- The PSPS Act imposes an obligation on insurers to provide free run-off cover to particular groups of doctors who have ceased private practice.
- The Medical Indemnity Act provides for the Commonwealth to make payments to the insurers to reimburse the costs of eligible run-off claims. These payments are known as ROC indemnity payments.
- The Medical Indemnity Act provides for the Commonwealth to make other payments to insurers to offset the relevant costs of administering the Scheme that are incurred by insurers.

- The Medical Indemnity Act also provides for the insurers to make payments to the Commonwealth to ensure that the Scheme is largely cost-neutral to taxpayers. These payments are funded by a tax on insurers' premium income. In practice, the cost is met by a loading on practitioners' medical indemnity insurance premiums. These payments are known as ROC support payments. The MI ROCSPA sets out the rules for calculating ROC support payments.

2.3.3 The Scheme provides for ROC support payments to be made by medical indemnity insurers to the Commonwealth and for ROC indemnity payments to be made by the Commonwealth to medical indemnity insurers (MIIs) and MDOs. Ancillary arrangements provide for payments to cover other costs such as administrative costs.

2.3.4 Amendments to the primary legislation were passed late in 2006 which simplified the administration of the Scheme. Protocols governing certain administration payments to insurers are now in place and payments to MIIs have commenced.

2.3.5 An important financial dynamic of the Scheme is the timing mismatch between the payment of ROC support payments by MIIs and the emergence, payment and reimbursement of medical indemnity claims of eligible doctors who are no longer in private practice. The first ROC support payments were received on 30 June 2005. The Scheme applies to eligible medical indemnity claims that are first notified to the MIIs or MDOs on or after 1 July 2004. As a result of inherent delays in the medical claims process, it is to be expected that the level of ROC support payments will be substantially greater than the level of ROC indemnity payments for a number of years. That is, in a cashflow sense, the Scheme is a very immature arrangement. It will probably take about 20 years to reach maturity when income from ROC support payments and expenditure on ROC indemnity payments are of a similar order of size. To preserve the financial integrity of the Scheme, a system of notional accounting is maintained and reported on in Section 4 of this report.

3. DATA

3.1 Data collection

3.1.1 For the purpose of preparing this report, certain data were collected from the MIIs and MDOs by Medicare Australia (formerly the Health Insurance Commission) during late 2006 and early 2007 including:

- details of practitioners who became eligible for membership of the Scheme during 2005-06;
- details of claims/incidents notified to MIIs and MDOs by 30 June 2006 which might be claims eligible for reimbursement under the Scheme;

- details of ROC support payments,³
- actuarial estimates of that part of the cost of claims which were notified to MIIIs and MDOs by 30 June 2006 which is expected to be reimbursed under the Scheme;
- actuarial estimates of that part of the future claims cost of medical incidents projected to be notified during the 2006-07 to 2009-10 financial years which is expected to be reimbursed under the Scheme; and
- actuarial estimates of that part of the future claims cost of medical incidents occurring during 2006-07 which is expected to be reimbursed under the Scheme.

3.1.2 This report also utilises other data and information including that previously provided to Medicare Australia for the purpose of section 34ZW of the Medical Indemnity Act.

3.2 Data verification

3.2.1 The results in this report rely on information provided by MIIIs and MDOs. This information is regarded as the most suitable information available for the current purpose.

3.2.2 Steps were taken to ensure, as far as practicable, that the information provided was prepared on a basis suitable for the purpose. Despite this, it is not possible to guarantee that the information provided is free from material error. The information was not independently audited. As was the case last year, there were some notable disparities in the data provided, some of which could not be readily explained. Moreover, there were some inconsistencies between data provided for this review and that provided for the previous review. All of this means that figures and estimates provided in this report need to be treated with some caution.

3.2.3 Historically, MDOs have not maintained data in a form which is directly amenable to ROC analysis. For example, it has not been possible to establish a comprehensive list of doctors who were eligible for the Scheme on 1 July 2004. This is not a criticism of the MDOs. It simply reflects that their business and information systems were not developed with a scheme like the Run-Off Cover Scheme in mind. However, in order to monitor the operation of the Scheme effectively, accurate and timely data is clearly important.

3.2.4 At the time of preparing this report, insurers were still developing their computer systems to facilitate accurate and timely notification to Medicare Australia of

³ A database of ROC support payments is maintained by Medicare Australia.

details of practitioners who become eligible for the Scheme. Accordingly, the estimates of the number of eligible practitioners provided in this report need to be treated with caution.

3.2.5 Certain information was sought from industry actuaries. Guidance was provided as to the nature of the data, calculations and information required. Discussions with industry actuaries were held to supplement the data provided.

3.2.6 As was the case last year, there was a range of assumptions used by industry actuaries. Although some significant assumptions differ by only a few percentage points between actuaries, substantially different estimates of Scheme costs are produced. This reflects the highly uncertain nature of estimates of the costs of the Scheme.

3.2.7 It is to be expected that many of the data issues encountered will diminish in time. This is likely to take a few years. Until data issues subside, Scheme projections will be subject not only to the considerable inherent uncertainty which surrounds medical indemnity insurance business, but also to additional uncertainty associated with the amount and quality of the available data.

3.2.8 In general, the results in this report blend estimates provided by industry actuaries with other actuarial estimates based on data provided by the MIIs and assumptions and models developed within this office.

3.3 Eligible practitioners

3.3.1 Practitioners can become eligible for the Run-Off Cover Scheme by means of permanent retirement at age 65 years or older, cessation of practice for three years, death, permanent disability or maternity leave. In addition, practitioners who have worked under a subclass 422 (Medical Practitioner) or 457 (Business (Long Stay)) visa under the Migration Regulations 1994 become eligible for the Scheme when they have permanently ceased medical practice in Australia and ceased to reside in Australia.

3.3.2 Appendix 2 describes the test of eligibility for the Scheme and the process of issuing and notifying compulsory run-off cover to eligible practitioners. Eligible practitioners are entitled to receive notification of the terms and conditions of compulsory run-off cover from their MII. MIIs are also required to notify Medicare Australia of the details of the compulsory run-off cover provided, including the name of the practitioner and the date from which the cover took effect.

3.3.3 At the time of preparing this report, insurers were still developing their computer systems to facilitate accurate and timely notification to Medicare Australia of details of practitioners who become eligible for the Scheme. There are inherent lags in the system which mean that, at any time, it will be possible only to estimate the number of practitioners who are eligible for the Scheme. For example, there will often be a

delay between the time that a practitioner becomes eligible for the Scheme and the time when the insurer becomes aware of this. It is also possible that there will be circumstances where an insurer is unsure of the eligibility status of a practitioner; for example, where a practitioner has not renewed their insurance for, say, three years. For all of these reasons, the estimates of the number of eligible practitioners provided in this report need to be treated with caution.

3.3.4 The estimated number of practitioners eligible for the Scheme in this report is based on data produced manually by the medical indemnity industry relating to:

- practitioners eligible at the commencement of the Scheme on 1 July 2004; and
- practitioners identified as having become eligible between 1 July 2004 and 30 June 2006.

3.3.5 Individual records of all practitioners identified as having become eligible for the Scheme between 1 July 2004 and 30 June 2006 were provided by all MIIIs. In general, the numbers provided by the MIIIs for practitioners eligible at 1 July 2004 are estimates.

3.3.6 Table 1 below divides eligible Run-Off Cover Scheme members into those eligible at the commencement of the Scheme on 1 July 2004, and those identified as having become eligible for membership since. The numbers specified are the sum of the numbers of eligible practitioners for each of the MIIIs.

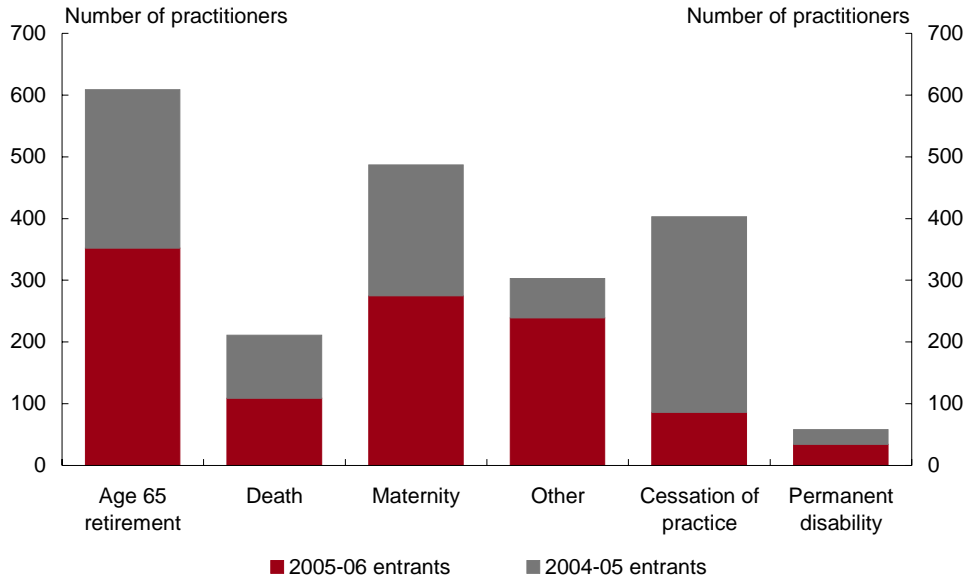
Table 1: Run-Off Cover Scheme eligible practitioners

Practitioners eligible for the Scheme as at 1 July 2004	2,112
Practitioners who became eligible for the Scheme during the 2004-05 financial year	976
Practitioners who became eligible for the Scheme during the 2005-06 financial year	1,095
Total number of practitioners who had become eligible for the Scheme by 30 June 2006	4,183

3.3.7 Based on data provided by the medical indemnity industry, over 4,000 practitioners had become eligible for cover under the Scheme by 30 June 2006 (we have not attempted to estimate the number who have ceased to be eligible). Over 2,000 of these were estimated to have been eligible for the Scheme at its commencement. This latter estimate is subject to considerable uncertainty, and may not represent the entire group of eligible practitioners at that date. According to the data provided by the industry, 976 practitioners have been identified as having become eligible for cover under the Scheme during 2004-05, and 1,095 during 2005-06.

3.3.8 Figure 2 below illustrates the break-up of the 2004-05 and 2005-06 new entrants by reason of eligibility.

Figure 2: Run-Off Cover Scheme new entrants by reason of eligibility



3.3.9 According to the data provided, 32 per cent of new entrants during 2005-06 were age retirements, 25 per cent were practitioners on maternity leave, 13 per cent were practitioners who died or became permanently disabled and 8 per cent were practitioners who became eligible for the Scheme three years after ceasing private practice. The remaining 22 per cent were overseas trained doctors who had permanently ceased practice under a 422 or 457 visa, labelled as 'other' in Figure 2 above.

3.3.10 As was the case last year, the number of age retirement new entrants reported by MIs is lower than we would have expected. This may be due to some under-reporting. Alternatively, the concept of retirement might be less clear-cut for a private medical practitioner than for a member of the general workforce. For example, medical practitioners may move in and out of private practice as they approach 'permanent' retirement. This issue will need to be monitored in future years, and also in the administration of the Scheme. It should be noted that, for this investigation, we have not adjusted our assumed rates of retirement despite the apparently low retirement experience. As noted above, insurer systems for accurate and timely notification to Medicare Australia of Run-Off Cover Scheme eligibility are still being developed. Accordingly, we have decided to wait to see the results of more systematic notification processes before making adjustments. It is worth noting that estimates of the costs of the Scheme are very sensitive to the assumed retirement pattern.

3.3.11 The number of maternity leave new entrants is also lower than we would have expected. This may be due to under-reporting or may reflect relatively low fertility rates among practitioners or that relatively few practitioners tend to take maternity leave. Cost estimates are relatively insensitive to the maternity leave assumption.

3.3.12 The number of new entrants during 2005-06 who were practitioners who became eligible for the Scheme three years after ceasing private practice (resignation) is also lower than we would have expected. This number should be treated with caution for a number of reasons. Firstly, it is very possible that an insurer might not know whether a doctor has been out of private medical practice for three years. Secondly, the rate of reported resignations varied significantly amongst the insurers, and between 2004-05 and 2005-06.

3.3.13 These calculations exclude certain eligibility records related to practitioners whose eligibility status is unknown. However, a number of these records may represent practitioners who are eligible for the Scheme.

3.4 Claims eligible for ROC indemnity payments

3.4.1 MII and MDOs are entitled to reimbursement from the Australian Government for the costs of claims which:

- are first notified to the MII or MDO on or after 1 July 2004;
- relate to a practitioner who is eligible under the Scheme at the date of notification (see Section 3.3); and
- meet the other requirements for 'payable claims' (see Appendix 3).

3.4.2 MII provided details of individual medical incidents which they have identified as potentially being eligible for the Scheme. The data provided was not wholly consistent with that provided for last year's report. Moreover, there were some apparent internal inconsistencies within the data. It is quite possible that other medical incidents have been notified to MII since 1 July 2004 which were not included in the data but which will be eligible for the Scheme. It is also possible that some of the incidents notified will not be eligible for the Scheme. Accordingly, these numbers should be treated with caution.

3.4.3 As at 30 June 2006, 114 medical incidents had been notified to MII and MDOs relating to eligible medical practitioners since the commencement of the Scheme. Some of these incidents are formal medical indemnity claims and others might convert into formal medical indemnity claims which may then become payable under the Scheme. 39 incidents relate to the 2004-05 new entrants to the Scheme and

24 incidents relate to the 2005-06 new entrants. The other 51 incidents relate to those practitioners who were eligible at the commencement of the Scheme on 1 July 2004.⁴

3.4.4 The number of medical incidents notified to MIs and MDOs which could potentially give rise to a future ROC indemnity payment is lower than perhaps might have been expected. There are a number of possible reasons for this:

- The medical indemnity insurance industry experienced high levels of claim activity prior to the commencement of the Run-Off Cover Scheme. High levels of claim activity prior to the commencement of the Scheme may have included claims that were 'brought forward' (that is, made earlier than they otherwise would have been), resulting in a lower than normal level of general claim activity during 2004-05 and 2005-06.
- It is possible that not all Scheme eligible claims have been identified. MIs are likely to pursue Scheme recoveries diligently at a late stage in the claim process. Thus at this early stage (first twenty four months) some claims which will actually turn out to be eligible ROC claims may not yet have been identified as such. Similarly, MIs might have adopted a cautious approach to identifying as eligible claims which were not clearly eligible at the time that the data was provided.
- It is possible that doctors approaching retirement might cut down on their practice hours and possibly engage in less 'risky' practice (for example, less surgery). This would be expected to lead to a lower level of claim activity among retired Scheme members.
- The assumed claim reporting pattern might be too heavily weighted to the 'tail'. That is, claims might generally be reported earlier than assumed.
- The assumed decrement rates (rates of retirement, maternity leave, disability etc) might be too high.
- Only a small number of claims is expected in any one year. Random variation in the actual number of claims from year to year could be substantial.

3.5 ROC indemnity payments

3.5.1 ROC indemnity payments are the payments made by the Australian Government to MDOs and MIs as reimbursement of the costs of eligible claims.

4 Differs from the corresponding number reported last year of 59.

3.5.2 No ROC indemnity payments had been made by 30 June 2006. This is not altogether surprising because of the length of time involved in the claim process. ROC indemnity payments will generally be made close to or after the time when an MDO/MII has finalised a claim.

3.5.3 The Scheme also provides for payments in respect of administration and internal claims handling costs under the ROC Claims and Administration Protocol (section 34ZN of the Medical Indemnity Act).

3.5.4 During 2005-06, Medicare Australia made payments totaling \$4.654 million to MIIs in respect of administration costs, covering both initial implementation and subsequent administration.

3.5.5 The Commonwealth's own administration costs are Budget-funded and so are not considered in this report.

3.6 ROC support payments

3.6.1 ROC support payments are paid to Medicare Australia in the form of an annual lump sum imposed as a tax on each MII from 1 July 2004 under the MI ROCSPA.

3.6.2 The amount of ROC support payments is calculated using a method set out in the MI ROCSPA. Appendix 1 describes the calculation in detail. Very briefly, it is based on:

$$\text{Applicable rate} \times (\text{premium income less taxes and charges}) \div (1 + \text{applicable rate}).$$

3.6.3 For most MIIs the applicable rate is currently 8.5 per cent. In order to provide equivalence on a present value basis, a slightly higher percentage applies to one insurer, AMIL, whose policy year is a calendar year and which remits its ROC support payment six months after the other MIIs.

3.6.4 Table 2 below summarises the ROC support payments received during the 2005-06 financial year.

Table 2: ROC support payments

		ROC support payments (\$'m)
Paid 31 December 2005	AMIL	9.634
Paid 30 June 2006	MIPSi	3.733
	Invivo	0.035
	MDANI	4.328
	MIGA	2.791
	PIICA	4.315
	Total	

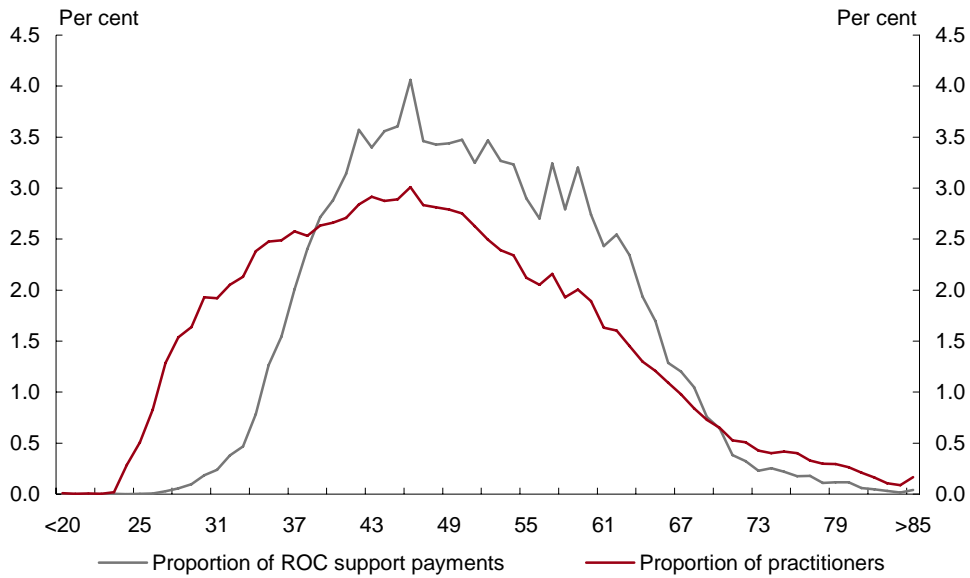
(a) Numbers do not add exactly due to rounding.

3.6.5 In order to provide full transparency for practitioners, MIs are required to attribute ROC support payments to individual policyholders. Each premium notice specifies the amount that has been included in the policyholder's invoice to meet the MI's ROC support payment obligations. All amounts are reported to Medicare Australia, which maintains a record of each practitioner's total run-off cover credit. Interest is applied to this balance annually at the short-term bond rate in accordance with section 34ZS of the Medical Indemnity Act.

3.6.6 Part 2, Division 2B, Subdivision E of the Medical Indemnity Act provides for certain payments, should the Scheme ever be wound up without alternative arrangements being put in place. Thus, doctors who were still practising at the time of the wind-up of the Scheme would be entitled to have an amount not exceeding their total run-off cover credit paid to their nominated medical indemnity provider. Practitioners who were eligible for the Scheme at the time of its wind-up would not be entitled to any refund but would continue to be covered for any future claims that might emerge.

3.6.7 Figure 3 below summarises the contribution to ROC support payments by age of practitioner. The shape of the graph is similar to that produced in last year's report. The proportion of ROC support payments is greater than the proportion of practitioners for doctors in their 40s up to their mid to late 60s. This reflects the low level of premiums for interns, trainees and hospital indemnified doctors aged in their 20s and 30s. The proportion of ROC support payments tends to diminish at higher ages. This provides some support for the suggestion that doctors tend to wind down their practice hours and possibly perform fewer risky medical procedures (for example, surgery) as they approach retirement, resulting in lower premiums.

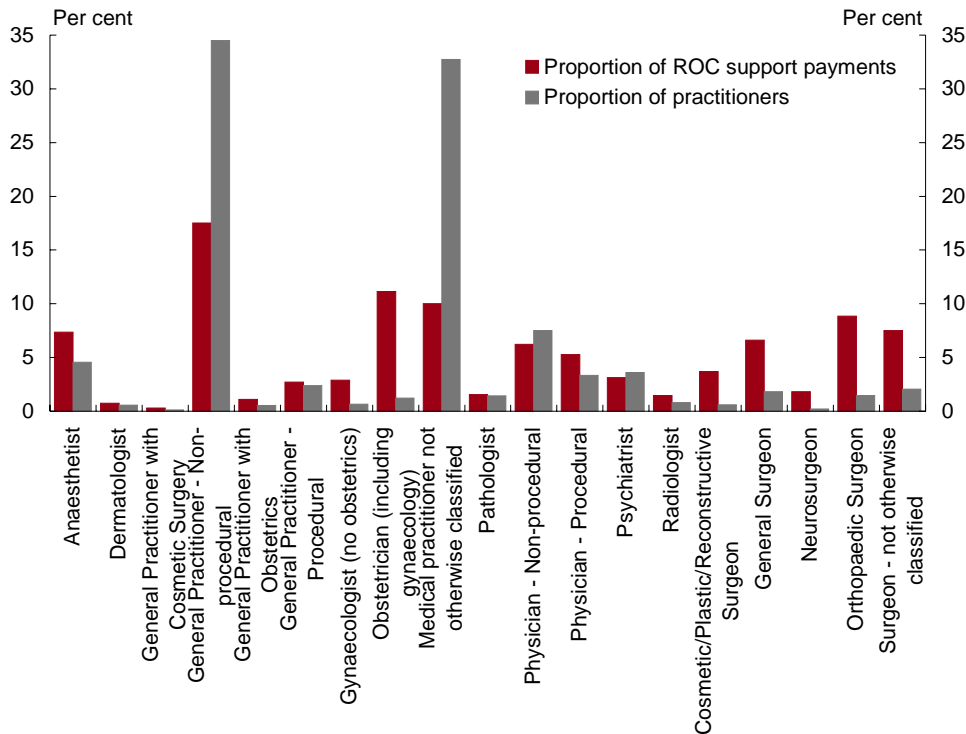
Figure 3: Contribution to ROC support payments by age



3.6.8 Figure 4 below summarises the contribution to ROC support payments by area of specialisation.

3.6.9 Medical indemnity insurance premiums tend to be risk-based. Thus, practitioners operating in risky areas of specialisation are likely to incur the highest premiums and, accordingly, the highest ROC support payment liabilities. The largest ROC support payments are for obstetricians, gynaecologists, neurosurgeons, cosmetic/plastic/reconstructive surgeons, orthopaedic surgeons and general surgeons. Medical practitioners not otherwise classified (including interns, trainees and hospital indemnified doctors) have the smallest ROC support payments.

Figure 4: Contribution to ROC support payments by specialisation



4. FINANCIAL MANAGEMENT OF THE RUN-OFF COVER SCHEME

4.1 Future liabilities of the Run-Off Cover Scheme

4.1.1 The estimation of the Commonwealth's liabilities under the Run-Off Cover Scheme in future years is an inherently imprecise process. The operation of the Scheme is likely to be characterised by a small number of claims of highly variable size. It is not possible to predict the costs of the Scheme with a high level of confidence. For example, the presence of a single very large claim in any given year could have a substantial effect on the total amount of ROC indemnity payments for that year.

4.1.2 The liabilities of the Scheme could be measured in a number of ways. It is normal for insurance-type liabilities to be measured on either a 'notified' or an 'occurrence' basis. On a notified basis, new liabilities would accrue to the Scheme as new claims were notified. On an occurrence basis, new liabilities would accrue to the Scheme at the time of the occurrence of the medical incidents which were expected to give rise to medical indemnity claims which would attract a ROC indemnity payment.

4.1.3 Under the occurrence model, liabilities are recognised more quickly than under the notified model. The occurrence model is more consistent with the notion that the Scheme is ongoing. Accordingly, the occurrence model has been adopted for this report. The liabilities of the Scheme are therefore taken as the present value of future ROC indemnity payments (plus associated insurer claims handling expenses) which relate to medical incidents which occurred before the effective date of valuation.

Comment on experience during 2005-06

4.1.4 In any actuarial investigation it is appropriate to compare the emerging experience with that previously projected. This analysis informs the assumption setting process for the current investigation.

4.1.5 Based on input from industry actuaries, the previous report estimated the incurred-but-not-reported (IBNR) Run-Off Cover Scheme liability at 30 June 2005 as \$28.9 million. Implied within that estimate was an expectation that approximately \$5 million in new notifications would emerge during 2005-06. In fact, the most recent actuarial estimates suggest a total of less than \$2 million in new notifications for 2005-06. There are a number of possible ways of responding to this emerging experience in the current investigation.

4.1.6 It is theoretically possible that the difference between expected notifications and actual experience relates only to lags in the system. This would be consistent with factors such as delays in identification of ROC claims and the legal profession taking some time to adjust to new tort arrangements. The response in this case would be to make no adjustment to the initial estimate.

4.1.7 On the other hand it could be argued that comparison between the actual notifications and the expected notifications is the only available tangible indicator of the reliability of the original estimate of \$28.9 million and that therefore the implied estimates of future notifications should be revised down accordingly, leading to an adjusted estimate of around \$8 million.

4.1.8 However, the implied estimate of \$5 million for the 2005-06 notification year is highly uncertain. For example, actual experience is likely to be significantly driven by the presence or absence of even a single large claim. This means that the fact that actual experience has diverged substantially from what was expected does not of itself imply that the original estimate was unreasonable. Further, it suggests caution in adjusting estimates for the remaining notification years. An approach which allows differences to be recognised as the experience emerges has been adopted in this report, rather than one which replaces one set of subjective estimates with another. The original estimate has been adjusted only in respect of the experience during the 2005-06 notification year.

4.1.9 In relation to Scheme-eligible claims which had been notified at the time of the previous investigation (30 June 2005), actuarial estimates of the corresponding ROC indemnity payments had a present value then of \$1.5 million. Since then, claim

payments of \$0.7 million have been made by MIIs/MDOs. All else being equal, this would suggest a residual figure at 30 June 2006 of less than \$1 million. In fact, up to date actuarial estimates put the number at around \$1.2 million. However the numbers are so small that it would be inappropriate to draw conclusions based on them.

4.1.10 In summary, we have made adjustments to the 2005 estimates provided by the industry actuaries only in respect of the implied 2005-06 notification year estimate and in respect of the development of claims that had been notified as at 30 June 2005. In both cases we have used the most recent information provided by industry actuaries directly.

4.1.11 In relation to the Scheme accrual for 2005-06,⁵ we have made three adjustments to the estimate provided in the previous report. The first was in respect of a technical error which has been discovered in the valuation program. The second results from a changed interest rate assumption. The third relates to a slightly modified assumed payment pattern. The combined effect of these adjustments was around 1 per cent of the estimate. There is insufficient information available in relation to the emerging experience at this time to make any other credible adjustments.

4.1.12 More generally, as a result of this, the main demographic and experience assumptions remain largely as they were for the previous investigation. Apart from modifying the valuation programs to correct the technical error referred to above, no changes have been made. The current projections are based, however, on the latest available data regarding the insured medical workforce.

4.1.13 Appendix 4 sets out the main assumptions and describes the methodology that was used to estimate the liabilities. Appendix 5 looks at the effect of the High Cost Claims Scheme.

Projected ROC indemnity payments

4.1.14 This section sets out projections of ROC indemnity payments for the next 10 financial years. For the reasons described above, the projections should be regarded as indicative only. The data issues referred to earlier in this report also contribute to the uncertainty. The underlying assumptions and methodology are described in Appendix 4, with the calculations summarised in Table 14. Table 3 below sets out the projections, which are illustrated in Figure 5. The Scheme is not expected to become mature in a cashflow sense for many years. The payments projected below are in nominal dollars and have not been discounted to current dollar values.

4.1.15 The projected payment for 2006-07 assumes that all ROC indemnity payments which are 'due' at 30 June 2006 (that is which relate to claim payments already made by MIIs/MDOs) will be made during 2006-07. More generally, other ROC indemnity

5 Under the occurrence model, the Scheme accrual for 2005-06 refers to the present value of future ROC indemnity payments that are attributable to medical incidents which occur during 2005-06.

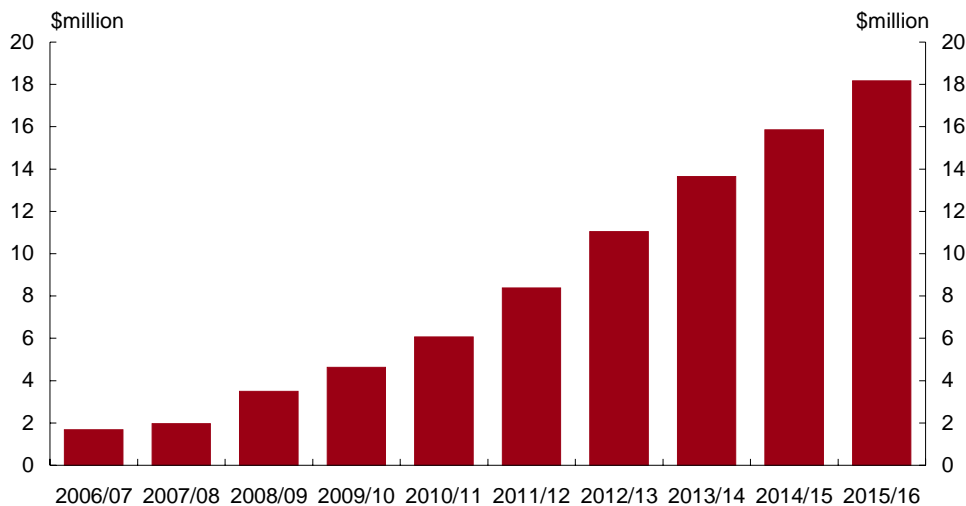
payments are assumed to be made at the same time as the corresponding claim payment. The estimate for 2006-07 is reasonably close to the estimate presented in our 2004-05 report, before the inclusion of the indirect costs associated with handling claims, referred to as indirect claims handling expenses (CHE)⁶ (see 4.2.8 below), which is new in this current report. This is because changes made in response to the emerging experience were largely offsetting.

Table 3: Projected ROC indemnity payments plus CHE

Year ending 30 June	Projected ROC indemnity payments plus CHE \$'000 ^(a)
2007	1,681
2008	1,962
2009	3,502
2010	4,632
2011	6,068
2012	8,378
2013	11,041
2014	13,644
2015	15,852
2016	18,169

(a) These projected payments do not include administration amounts payable under the ROC Claims and Administration Protocol.

Figure 5: Projected ROC indemnity payments plus CHE



⁶ CHE are separate from administration costs. Administration costs refer to the costs of administering the Scheme and have not been included in the projected Scheme payments.

4.2 Notional Account

4.2.1 The Scheme must be managed over a long time frame. As discussed previously, ROC indemnity payments are likely to be 'lumpy' in nature and immature in size for some years. ROC support payments will be received well in advance of ROC indemnity payments. As a result of the payment timing mismatch and the expected volatility in the ROC indemnity payment pattern, it is appropriate to have a system which enables proper tracking of the financial flows over time. Accordingly, a Run-Off Cover Scheme notional account (the Notional Account) is maintained.

4.2.2 It is important to appreciate that the Notional Account is not an official Government account. Rather, it is a device established for the sole purpose of facilitating equity between practitioners and other taxpayers.

4.2.3 The Notional Account is credited with:

- ROC support payments; and
- notional interest.

4.2.4 Notional interest is credited to the Notional Account to ensure that practitioners derive the proper benefit of the time value of money since ROC support payments are received by Medicare Australia well in advance of any ROC indemnity payments being made by Medicare Australia. Notional interest is applied at the short-term bond rate for consistency with section 34ZS of the Medical Indemnity Act which requires interest at the short-term bond rate to be applied to the total run-off cover credit balances of individual practitioners.

4.2.5 On establishment of the Scheme, the Government announced that it would fund the opening liability that was attributable to practitioners who were already eligible for cover under the Scheme at the time of its commencement. Accordingly, this obligation represents an asset of the Notional Account.

4.2.6 The Notional Account is charged with:

- ROC indemnity payments; and
- payments made under the ROC Claims and Administration Protocol.

4.2.7 The Run-Off Cover Scheme 'operates after' the High Cost Claims Scheme (HCCS). The HCCS meets 50 per cent of the excess above \$300,000 of the cost of individual large claims. For example, for a claim which costs \$1 million, the HCCS will pick up:

$$50 \text{ per cent} \times (\$1,000,000 - \$300,000) = \$350,000$$

4.2.8 The Run-Off Cover Scheme will also pay an amount to a MII or MDO to cover the indirect costs associated with handling claims, referred to as indirect claims handling expenses (CHE). The Scheme pays 5 per cent of the cost of each claim to cover CHE. Table 4 below describes how an eligible \$1 million claim would be funded. The total amount paid of \$1,050,000 includes claim costs of \$1 million and CHE of \$50,000.

Table 4: Funding sources for a \$1 million claim which is eligible for the Run-Off Cover Scheme

Funding source	Amount
HCCS	\$350,000
<i>ROC indemnity payment (direct claim costs)</i>	<i>\$650,000</i>
<i>Run-Off Cover Scheme CHE (5 per cent x \$1 million)</i>	<i>\$50,000</i>
Run-Off Cover Scheme (Total)	\$700,000

4.2.9 Appendix 3 provides more detail on claim amounts eligible under the Run-Off Cover Scheme.

4.2.10 As noted earlier, the Medical Indemnity Act provides for payment of a practitioner's total run-off cover credit, should the Scheme ever be wound up without alternative arrangements being put in place. Thus, in this event, a large part of the accumulated ROC support payment balance would become a liability of the Scheme. At the same time, since the Scheme liabilities are being measured on an occurrence basis, some of the liabilities of the Scheme would be released, partially offsetting this impact. However, for the purpose of this report, the Scheme has been assumed to be ongoing and the whole amount of the accumulated ROC support payments has been taken to be available to meet relevant ROC indemnity payments.

4.2.11 The liability estimates given in this report are central estimates. In broad terms, this means that they are intended to be equally likely to be too high or too low. In particular, it is not intended that the liability estimates contain any margin for risk or prudence. Funding considerations for the Scheme are not the same as for private sector insurance arrangements. The objective here is to manage the funding over the long term. Since substantial volatility in the liability estimates is likely from time to time, periods of surplus and periods of deficit in the Notional Account might be expected. However, given the long funding time horizon that is appropriate for the Scheme, a short-term deficit in the Notional Account is not a cause for concern. As a result of this, there is no strong reason to maintain a risk margin in the liability estimates.

4.2.12 Table 5 below sets out the cashflow statement of the Notional Account for 2005-06.

Table 5: Cashflow statement of the Notional Account 2005-06

Cashflows — Run-Off Cover Scheme Notional Account 2005-06	
Income	\$'000
ROC support payments (received 31 December 2005)	9,634
ROC support payments (received 30 June 2006)	15,203
Notional interest	1,010
Expenses	
ROC indemnity payments	0
Administration cost payments to MIIIs (including implementation fees and 2004-05 and 2005-06 compliance costs)	4,654
Net cashflow	21,192

4.2.13 Table 6 below sets out the balance sheet of the Notional Account as at 30 June 2006.

Table 6: Balance sheet of the Notional Account as at 30 June 2006

Balance sheet — Run-Off Cover Scheme Notional Account as at 30 June 2006	
Assets	\$'000
Cash as at 1 July 2005	13,998
ROC support payments (receivable 31 December 2006)	9,845 ^(a)
Net cashflow	21,192
Government commitment to fund opening liability	8,000 ^(b)
Total	53,035
Liabilities	
Paid by MIIIs but not yet recovered from Medicare Australia	709 ^(c)
Notified to MIIIs but not yet paid by them	2,596 ^(d)
Incurred but not yet notified to MIIIs	39,411 ^(e)
Claims handling expenses	2,910 ^(f)
Total	45,626

(a) AMIL payment received 31 December 2006 discounted to 30 June 2006.

(b) Discussed in paragraph 4.2.17.

(c) Based on estimates provided in relation claims/incidents notified to MIIIs and MDOs by 30 June 2006.

(d) Based mainly on estimates provided by industry actuaries.

(e) Based on estimates provided by industry actuaries and models developed within this office.

(f) Based on 5 per cent of 'grossed up' ROC indemnity payments (to allow for the impact of the HCCS).

4.2.14 The Notional Account at 30 June 2006 has disclosed an estimated surplus of around \$7 million. Note that full credit has been taken in the assets of the Notional Account for ROC support payments due to be received from AMIL on 31 December 2006. Generally, the estimated surplus position should be regarded as highly uncertain.

4.2.15 The estimated liability of the Scheme at 30 June 2006 is based on a blend of estimates provided by industry actuaries and estimates derived from models developed within this office. It is highly uncertain and is likely to remain so for a number

of years. Appendix 4 provides a high level reconciliation of the liability estimate as at 30 June 2005 with the current estimate.

4.2.16 The liability to make ROC indemnity payments will be partly funded by the Government. As noted above, the Government will fund the costs of claims made by those practitioners who were eligible for cover at the commencement of the Scheme. It is not possible to estimate this component of the liability with any precision. However, for the purpose of this report, the overall liability (about \$46 million) has been assumed to be split in the following way to give broad consistency with the results of our own model.

- \$8 million in respect of practitioners eligible for the Scheme as at 1 July 2004; and
- \$38 million in respect of practitioners who were not eligible for the Scheme as at 1 July 2004.

4.2.17 The estimate in respect of practitioners who were eligible at start-up has been revised slightly from the previous report, broadly in line with the approach described in paragraph 4.1.10. The actual value of the Government obligation will not be known for a number of years. Estimates will become more reliable with time. The apportionment of the liability is very subjective. However, we regard the approach taken as satisfactory for the current purpose.

4.2.18 As actual experience unfolds and ROC indemnity payments are made, it will be necessary to attribute these payments accurately to either the opening liability (Government funded) or the new liability (practitioner funded) in order to preserve the integrity of the Notional Account. Indeed, the 2004-05 report foreshadowed that, at future reviews, separate accounting of the Government funded and practitioner funded components of the Scheme might be appropriate. Again at this review, both components have been combined to give an overall picture of the Scheme.

4.2.19 Finally, it is appropriate to provide a benchmark projection of the liabilities of the Scheme. Table 7 below sets out estimates of the liabilities of the Notional Account at the end of each of the next five financial years. The purpose is to illustrate the short-term development of the Scheme. There is very substantial uncertainty in these estimates. The numbers shown are in nominal dollars and have not been discounted to give values in today's terms. The numbers in the table below differ in nature from those provided in the previous report. In particular they have been adjusted to include an allowance for indirect claims handling expenses (CHE).

Table 7: Projected balance sheet liabilities of the Notional Account

Year ending 30 June	Liability (\$'000) ^(a)	New accrual (\$'000) ^(a)	Interest cost (\$'000)	Payments (\$'000) ^(a)
2006	45,626	-	-	-
2007	65,402	17,708	3,750	1,681
2008	87,296	18,859	4,997	1,962
2009	110,217	20,085	6,338	3,502
2010	134,733	21,391	7,758	4,632
2011	160,715	22,781	9,269	6,068

(a) ROC indemnity payments plus CHE.

4.3 Actuarial management

4.3.1 It is appropriate that the Scheme be subject to ongoing actuarial management.

4.3.2 Regular review of the costs and notional assets of the Scheme will allow the ROC support payment rate to be adjusted from time to time, if necessary. Consideration of that rate is beyond the scope of this report. This report has described a framework for the valuation of Scheme liabilities and established the Notional Account. It is intended that the valuation and accounting framework be applied at each future annual review of the Scheme.



Peter Martin FIAA
Australian Government Actuary

1 March 2007

APPENDIX 1: ROC SUPPORT PAYMENTS

A.1.1 ROC support payments are paid to Medicare Australia in the form of an annual lump sum imposed as a tax on each MII from 1 July 2004. The lump sum is intended to cover the cost of claims and the MIIs' administration and implementation costs.

A.1.2 The amount of support payments is calculated as a percentage of premium income received from contributing practitioners. The calculation rules are set out in the MI ROCSPA and regulations. The tax imposed on each MII is the applicable percentage of the insurer's premium income (section 6) for the applicable contribution year ending on 30 June or an alternative date specified in the regulations (section 5).

A.1.3 All MIIs except for AMIL were required to remit their first ROC support payments on 30 June 2005. Since AMIL's policy year is a calendar year, it was not required to remit ROC support payments until 31 December 2005.

A.1.4 Under section 7, a MII's premium income for the purpose is the sum of all of the premiums paid to the insurer for medical indemnity cover provided for medical practitioners, reduced according to the formula:

Premium income equals

Net premium – Net premium × Applicable percentage ÷ (1 + Applicable percentage)

A.1.5 Net premium is calculated according to section 7 as follows:

- sum of all premiums paid to the insurer during the operation of the Scheme for medical indemnity cover provided for medical practitioners (including subsidy payments made to the insurer on behalf of medical practitioners to assist with the cost of purchasing medical indemnity cover under the Medical Indemnity Premium Support Scheme, section 43(1) Medical Indemnity Act) (subsection (1));
- minus the amount of GST payable (subsection (2)(a)) and the amount of stamp duty payable (subsection (2)(b)) in relation to the premiums;
- plus/minus other payments specified in the regulations.

A.1.6 The applicable percentage is specified in the regulations as 8.5 per cent for all insurers except AMIL which has a higher percentage of 9.5625 per cent. The effect of this is that the ROC support payment is currently calculated as:

- Net premium × 8.5 per cent ÷ 1.085 for all MIIs except AMIL, and
- Net premium × 9.5625 per cent ÷ 1.095625 for AMIL.

APPENDIX 2: ELIGIBLE PRACTITIONERS AND RUN-OFF COVER SCHEME CONTRACTS

Eligible persons

A.2.1 Eligible persons are those who fit one or more of the following eligibility categories at the time the claim (or medical incident) is first notified to the MII or MDO (section 34ZB(2) of the Medical Indemnity Act and *Medical Indemnity Regulations 2003* regulation 12):

- A doctor 65 years or older who has permanently retired from paid medical practice.
- A doctor who has not engaged in paid medical practice during the preceding three years. (Note: unlike other categories, eligibility does not occur immediately upon ceasing practice).
- A legal representative of a deceased medical practitioner (provided that a claim can be made against the deceased's estate).
- A doctor who has ceased paid medical practice due to permanent disability.
- A doctor who has ceased paid medical practice because of maternity.
- An overseas trained doctor who worked under a 422 or 457 visa, has permanently ceased medical practice in Australia and does not reside in Australia.

Provision and notification of compulsory run-off cover

A.2.2 The practitioner's last medical indemnity insurer is required to provide run-off cover to an eligible practitioner under section 26A of the PSPS Act.

A.2.3 The compulsory run-off cover must encompass the same nature and range of incidents as the last medical indemnity cover held by the eligible practitioner (subsection 26A(4)(b)).

A.2.4 Section 26D compels MIIIs to notify eligible practitioners of:

(i) the nature and range of incidents encompassed by the compulsory run-off cover; and

(ii) the terms and conditions on which it is provided.

A.2.5 The compulsory run-off cover is taken to be a contract of insurance between the MII and the eligible practitioner for the purposes of the PSPS Act (section 26E).

APPENDIX 3: RUN-OFF COVER SCHEME CLAIMS

A.3.1 The legislation defines claims broadly. Claims need not involve legal proceedings. Claims may include civil claims for negligence, administrative proceedings, disciplinary proceedings (including those performed by a professional body) and inquiries or investigations into conduct (subsection 4(1) of the Medical Indemnity Act).

A.3.2 A ROC claim is payable to an MII or MDO under section 34ZC in relation to a claim eligible under subsection 34ZB(1) if:

- it was first notified to the MII or MDO on or after 1 July 2004;
- it relates to a person eligible under subsection 34ZB(2) (see Appendix 2);⁷
- it relates to incident(s) occurring in connection with the person's practice as a medical practitioner (see paragraph 34ZB(1)(b));
- either the person is indemnified for the claim by an MII in accordance with section 26A of the PSPS Act, or the person is indemnified under incident-occurring based cover provided by an MDO (paragraph 34ZB(1)(e));⁸ and
- the claim would be paid in the ordinary course of the MII's or MDO's business.

A.3.3 Where these criteria are met, the Commonwealth is liable to pay run-off cover indemnities regardless of whether the MII or MDO has sought private reinsurance (section 34ZF).

A.3.4 Applications for ROC indemnity payments must be made to Medicare Australia (section 36 of the Medical Indemnity Act). They are paid by the CEO of Medicare Australia before the end of the month that immediately follows the month in which the MII applies for the indemnity (section 37).

A.3.5 The Run-Off Cover Scheme operates after the High Cost Claims Scheme (HCCS). Thus, part of the cost of eligible large claims is first met by the HCCS with the rest being picked up by the Run-Off Cover Scheme (subsection 34ZH(2)). The HCCS meets 50 per cent of total costs incurred in relation to an eligible ROC claim exceeding \$300,000.

⁷ Including the legal representative of a deceased doctor.

⁸ Since the time of the previous report, the Medical Indemnity Act has been amended to remove the requirement to have had insurance at the time of the incident.

APPENDIX 4: METHODOLOGY, ASSUMPTIONS AND UNCERTAINTY

Information provided by the MIs

A.4.1 Information was provided by the MIs and MDOs and their actuaries in relation to projected future payments for:

- ROC claims notified as at 30 June 2006; and
- ROC incurred-but-not-reported (IBNR) claims as at 30 June 2005.⁹

A.4.2 Table 8 below summarises the estimated accrued Scheme liabilities as at 30 June 2006. The Scheme liabilities are divided into those attributable to claims notified as at 30 June 2006 and those attributable to IBNR claims as at 30 June 2006.

Table 8: Run-Off Cover Scheme liabilities related to medical incidents prior to 30 June 2006

Liabilities in relation to claims notified as at 30 June 2006	\$3.5 million
Liabilities in relation to IBNR claims as at 30 June 2006	\$42.1 million
Total Scheme liabilities	\$45.6 million

A.4.3 The components of the Scheme liabilities in relation to prior medical incidents as at 30 June 2006 are reconciled to those as at 30 June 2005 in Table 9 below.

9 Collected from the MIs and MDOs by Medicare Australia for the purpose of the 2004-05 report.

Table 9: Reconciliation of Run-Off Cover Scheme liability components with previous report

	(\$'m)
Paid by MIs but not yet recovered from Medicare Australia as at 30/6/2005	0.0
ROC indemnity payments	(0.0)
New paid but not yet recovered	0.7
Paid by MIs but not yet recovered from Medicare Australia as at 30/6/2006	0.7
Incurred but not notified to MIs (IBNR) as at 30/6/2005	28.9
Change interest rate	(1.7)
Expected notifications 05-06	(4.7)
Notional interest	1.3
IBNR at 30/6/2005 which remains IBNR at 30/6/2006	23.8
Notified to MIs as at 30/6/2005	1.5
Paid but not yet recovered	(0.7)
Change in actuarial assumptions	0.4
New notified (from IBNR at 30/6/2005 and 2005-06 accrual)	1.4
Notified to MIs as at 30/6/2006	2.6
2005-06 accrual estimated in previous report	14.6
Expected notifications 2005-06	(0.1)
Change interest rate, correct technical error, modify payment pattern	0.2
Notional interest	0.9
2005-06 accrual which remains IBNR as at 30/6/2006	15.6
Base liability estimate at 30/6/2006	42.7
Claims handling expenses	2.9
Total as at 30 June 2006	45.6

A.4.4 For the purpose of this report, the 30 June 2006 liability has been subjectively apportioned in the following way to give broad consistency with the results of our own model.

- \$8 million in respect of practitioners eligible for the Scheme as at 1 July 2004.
- \$38 million in respect of practitioners who were not eligible for the Scheme as at 1 July 2004.

A.4.5 The actual value of the Government obligation will not be known for a number of years but estimates will become more reliable with time.

A.4.6 Projected payments in relation to medical incidents occurring before 30 June 2005 were aggregated directly from estimates provided by actuaries of the MIs.

Description of the model used to project the accrual of new Run-Off Cover Scheme liabilities after 30 June 2006

A.4.7 The approach involved projecting the expected future ROC indemnity payments for each doctor who was practising as at 30 June 2006. Projection of indemnity payments entailed the projection of:

- incidents which will result in a claim;
- the delay involved in notification of claims;
- the cost of claims after allowing for the HCCS;
- the likelihood of eligibility for the Scheme at the time a claim is notified; and
- the delay involved in the payment of notified claims.

ROC claims

Components of claim cost

A.4.8 For the purposes of the model, a ROC claim includes any eligible claim notified and finalised at direct cost to the MII. Claim costs include all costs which are directly attributable to the claim. Indirect claims handling expenses (CHE) are dealt with separately.

A.4.9 Directly attributable claim costs include damages, plaintiff legal costs to the extent that they are awarded, and defence costs to the extent that they are directly attributable to the claim.

A.4.10 The Scheme pays 5 per cent of the direct cost of each eligible claim to cover CHE. Where an eligible claim is partly covered by the HCCS, the allowance for CHE paid under the Scheme is 5 per cent of the total claim cost, including the portion covered by the HCCS.

Assumptions

A.4.11 Claim experience has emerged in 2005-06 which was lighter than that we expected based on the assumptions in our 2004-05 report. However, a short period of emerging experience shouldn't necessarily be relied on as a guarantee that underlying assumptions are inappropriate for such a long-tail and uncertain line of insurance as medical indemnity. This is especially true in relation to the Scheme, due, for example, to the following factors:

- Run-Off Cover Scheme claims are very long-tail and model projections are particularly sensitive to assumptions.
- The Scheme is relatively immature.
- Systems to facilitate timely and accurate data transfer are still being developed.
- The Scheme commenced immediately after tort reforms were implemented, with the tort reforms being preceded by a period of abnormally high claim rates ('claim spike').

A.4.12 We were reluctant to change the assumptions underlying our model due to these factors.

A.4.13 The main claim and demographic assumptions underlying the long-term Scheme projections have been left largely unchanged for the purpose of this review.

Claim frequency assumptions

A.4.14 Claim frequency and claim size assumptions were made in light of information provided by the actuaries of the MIIIs.

A.4.15 The overall claim frequency was assumed to be 5 per cent. That is, on average each 'at-risk' doctor was assumed to have a 5 per cent chance of being involved in a medical incident in the next year which will result in a future medical indemnity claim. Individual claim frequencies were adjusted based on premium as discussed below.

A.4.16 Practitioners with standard medical indemnity premiums of less than \$1,500 were excluded from the analysis in order to ensure that only genuine 'at-risk' doctors were the focus of the investigation. The excluded group contained interns, trainees and hospital indemnified doctors in some of the data provided by the MIIIs. In all over 56,000 practising doctors have some standard premium. After excluding those doctors with premiums of less than \$1,500 we were left with 33,996 'at-risk' doctors and we have set our claim frequency assumption at 5 per cent to be consistent with this.

Adjustment to individual claim frequencies based on premium

A.4.17 The likelihood of future notifications of ROC claims was projected according to the assumed 'riskiness' of each individual practitioner. The risk of medical indemnity claims posed by each practitioner was determined based on risk categorisation. Practitioners were categorised according to specialisation, age, gender and MII.

A.4.18 The average premium for each risk group was used as a proxy for the risk of medical indemnity claims. The claim frequency for each group was multiplied by the

ratio of the premium for the group to the premium of the entire cohort of 'at-risk' doctors.

A.4.19 Although insurance premiums are broadly determined in line with claim risk, the premium of a group is at best an imprecise proxy for risk. For example, market and financial considerations affect premiums charged. However, given the data available, relative premiums have been assumed to be a reasonable means of categorising practitioners according to their risk of medical indemnity claims for the purposes of this model.

A.4.20 Insurance premiums tend to diminish for practitioners towards retirement age. This supports the suggestion that doctors tend to wind down their practice hours and possibly perform fewer risky medical procedures (for example, surgery) as they approach retirement. The possible reduction in risk towards retirement is apparent from the pattern of relative premiums for 'at-risk' male doctors shown in Figure 6 below. The pattern is less obvious for females, given the low proportion of females in the oldest cohorts.

Figure 6: Relative standard premiums by age for male doctors



Note: The graph includes all male practitioners with premiums of at least \$1,500 from all MIIIs.

A.4.21 The model does not impose an assumed pattern of 'winding down of risky practice' with age. Reduction in claim risk is accounted for in the model to the extent that it is reflected in diminishing premiums.

Claim size assumptions

A.4.22 Claim sizes were assumed to increase with the delay to notification, on the basis that claims which take longer to report tend to be bigger on average for example, cerebral palsy cases.

A.4.23 The assumed claim reporting pattern is shown in Table 10 below. Claim sizes presented in the table do not include allowance for inflation or superimposed inflation. Adjustment for inflation and superimposed inflation is discussed below.

A.4.24 The claim reporting pattern is based on the reporting patterns provided by the approved actuaries of two of the MIIIs.

Table 10: Claim reporting and size pattern

Development year	Proportion of number of claims notified (per cent)	Gross average claim size (\$'000) ^(a)
1	19.8	70
2	20.3	80
3	13.4	80
4	18.8	100
5	9.0	150
6	5.4	150
7	2.9	150
8	2.4	150
9	1.7	150
10	1.8	150
11	1.4	150
12	1.1	150
13	0.8	150
14	0.4	400
15	0.2	400
16	0.1	400
17	0.1	400
18	0.1	400
19	0.1	400
20	0.2	400

(a) Gross average claim sizes presented in the table are intended to be in 2006 dollars and do not include allowance for inflation and superimposed inflation.

A.4.25 Claims cost net of high cost claim indemnities is calculated assuming that the HCCS threshold will change such that a constant proportion of the gross average claim size will be met by the HCCS. Thus, for simplicity, the HCCS threshold is assumed to increase in line with claims inflation over time. The model effectively assumes that 24 per cent of the total discounted claims cost will be met by the HCCS and 27 per cent of the ROC discounted claims cost will be met by the HCCS.

A.4.26 The projected ROC claims cost is very sensitive to the proportion of claims which are assumed to be reported late. The longer the delay between the incident and the claim, the greater the likelihood that a practitioner will be eligible for the Scheme at the time the claim is notified. Thus, a small change in the assumed proportion of late reported claims can have a significant impact on the estimated ROC claims cost.

Probability of a claim falling under the Run-Off Cover Scheme

A.4.27 The model involved projection of the proportion of the total accrual of liabilities which falls under the Scheme.

A.4.28 A practitioner can become eligible for the Scheme by reason of:

- retirement at 65 years and older;
- permanent disability;
- death;
- maternity;
- resignation; or
- satisfaction of other eligibility criteria specified in the regulations.

A.4.29 The probability of becoming eligible for the Scheme was estimated for each practitioner based on their age as at 30 June 2006 and their sex. Note that practitioners do not become eligible by means of resignation until three years have passed since cessation of practice.

A.4.30 The estimated likelihood of practitioners becoming eligible for the Scheme was overlaid on the projected claim notifications to give the projected ROC claim notifications for each practitioner. The expected notified claims cost was multiplied by the likelihood of eligibility in each future year, and summed across all practitioners to arrive at the expected cost of ROC claims notified in that year.

A.4.31 In other words, the total ROC claim notifications were calculated as the scalar product of the vector of claim notifications and the vector of probabilities of Scheme eligibility for each practising doctor in each future year.

A.4.32 It was assumed that on average practitioners who become eligible for the Scheme do so half-way through the financial year.

Demographic assumptions

A.4.33 The probabilities of death and disablement were assumed to be an increasing multiple of the probabilities of death in Australian Life Tables 2000-02 (ALT 2000-02). The probabilities of death were assumed to be 50 per cent of ALT 2000-02 until age 65 whereafter they were assumed to be 90 per cent of ALT 2000-02. The probabilities of permanent disability were assumed to be an increasing multiple of ALT 2000-02 from 20 to 40 per cent from age 25 to 64, and 0 from 64 onwards.

A.4.34 The assumed probabilities of maternity leave were derived assuming that female practitioners each have an average of 1.5 children between ages 28 and 43 and that they take one year of maternity leave for each child. The probabilities of alternative means of Scheme eligibility (particularly resignation and retirement) were inferred from the age distribution of practising doctors.

A.4.35 The probabilities of resignation were assumed to be 0.5 per cent between ages 39 and 51, increasing linearly to 1 per cent at age 56, increasing to 6 per cent at age 60, and increasing linearly to 10 per cent at age 64. The probabilities of retirement were assumed to be 13 per cent between ages 65 and 70, increasing linearly to 41 per cent at age 84. The probabilities of retirement were assumed to be 100 per cent for ages 85 and above, given the negligible effect on the results.

A.4.36 It is instructive to present the probabilities that a practising male doctor will be eligible for the Scheme in future years. The decrement assumptions are summarised in Table 11 in the form of assumed probabilities of being eligible for the Scheme at the end of each of the next 10 financial years for males.

Table 11: Assumed probabilities of eligibility for the Run-Off Cover Scheme over the next 10 financial years for male doctors

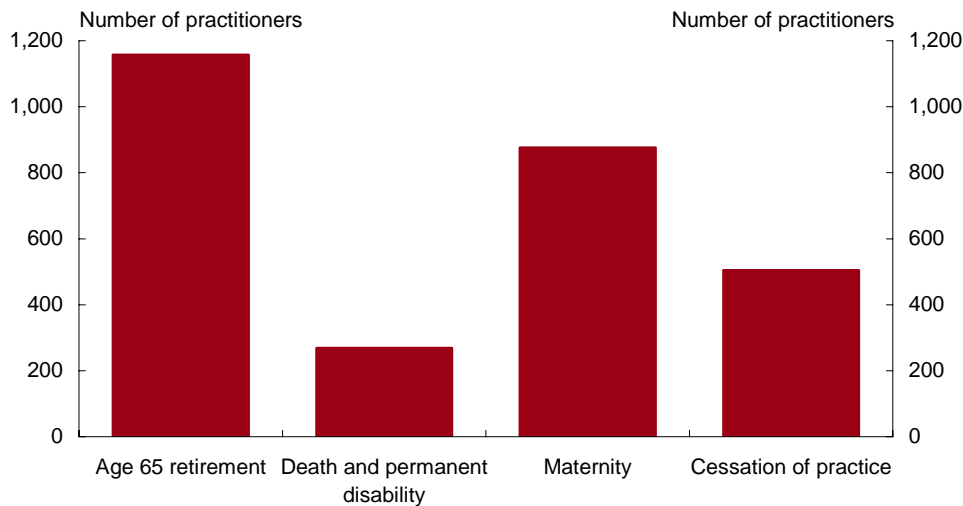
Year ending 30 June	Age at 30 June 2006						
	20	30	40	50	60	70	80
2007	0.0008	0.0009	0.0012	0.0026	0.0074	0.1510	0.3876
2008	0.0016	0.0017	0.0025	0.0054	0.0157	0.2982	0.6403
2009	0.0024	0.0026	0.0039	0.0086	0.0248	0.4356	0.7983
2010	0.0032	0.0035	0.0104	0.0169	0.0934	0.5590	0.8925
2011	0.0040	0.0045	0.0170	0.0256	0.1672	0.6656	0.9458
2012	0.0048	0.0054	0.0236	0.0355	0.3528	0.7543	1.0000
2013	0.0056	0.0064	0.0303	0.0466	0.5043	0.8254	1.0000
2014	0.0064	0.0074	0.0371	0.0590	0.6260	0.8801	1.0000
2015	0.0073	0.0085	0.0441	0.0726	0.6811	0.9206	1.0000
2016	0.0081	0.0097	0.0511	0.0875	0.7286	0.9494	1.0000

A.4.37 The model is very sensitive to the assumed resignation and retirement decrements and the calibration of these decrements is very important. The model is somewhat less sensitive to death and permanent disability decrements since

resignation and retirement are assumed to be more likely means of eligibility. The model is not particularly sensitive to maternity decrements as doctors on maternity leave are only eligible for the Scheme for the period of leave which is assumed to be one year.

A.4.38 Figure 7 below depicts the number of practitioners projected to become eligible for the Scheme by various means during the 2006-07 financial year. Although doctors will become eligible for the Scheme during 2006-07 by way of cessation of practice (having ceased practice during 2003-04), the number below refers to doctors who will actually become eligible during 2009-10.

Figure 7: Projected entries to the Run-Off Cover Scheme based on decrement assumptions



A.4.39 The number of practitioners projected to enter the Scheme by reason of retirement and maternity leave were substantially higher than the number provided by the insurers for the 2004-05 and 2005-06 financial years (see Figure 2).

A.4.40 It is possible that the information provided by the MIs under-represented the number of practitioners who became eligible for the Scheme during 2004-05 and 2005-06 by way of age retirement. Alternatively, the assumed retirement rates may be too high. The concept of retirement might be less clear-cut for a private medical practitioner than for, say, a general workforce employee. This point will require close scrutiny in future years, and also in the administration of the Scheme.

A.4.41 In the case of maternity leave, it may be that the information provided by the insurers under-represented the number of doctors taking maternity leave, that doctors have less children than the general population, or that doctors who become pregnant are less likely to take maternity leave for a complete premium year. However, the

assumed probabilities of maternity leave have not been adjusted given that they do not have a major effect on the estimate of the accrual of Scheme liabilities during 2006-07.

A.4.42 Where the date of birth was not available for a practitioner, an age was assigned randomly according to the age distribution of all 'at-risk' doctors.

Payment patterns, inflation and discounting

A.4.43 ROC indemnity payments in relation to medical incidents occurring after 30 June 2006 were projected assuming the payment pattern in Table 12 below.

A.4.44 This payment pattern differs slightly from what was assumed last year. While last year's assumed pattern was based on our broad understanding of typical experience, this current pattern is based more directly on payment patterns assumed by industry actuaries.

Table 12: Payment pattern assumed

Delay from notification to payment (years)	Proportion of claim costs paid (per cent)
1	3.15
2	15.41
3	20.10
4	19.53
5	10.07
6	8.73
7	6.78
8	5.45
9	4.02
10+	6.74

Economic assumptions

A.4.45 Medical indemnity claim costs tend to increase at a faster rate than general inflation. Claim payments were projected to increase in line with wage inflation plus superimposed claim cost inflation.

- Wage inflation was assumed to be 4 per cent per annum. This is not inconsistent with general expectations of wage growth.
- Superimposed inflation was assumed to be 2.5 per cent per annum. Superimposed inflation refers to the tendency for medical indemnity claim amounts to increase at rates faster than general inflation. Bursts of superimposed inflation have been observed in the past. Despite this, superimposed inflation is typically allowed for with a constant assumption. For this exercise, an allowance of between 2 per cent and 5 per cent

per annum might be reasonable. We have adopted an assumption towards the lower end of this range, having regard to the potential impact of the various tort reforms that have taken place over the last few years.

A.4.46 Claim payments were discounted at a rate of 6 per cent per annum. This is slightly higher than the rate that would have applied had we adopted precisely the same approach as last year. However, the chosen rate remains broadly consistent with the yield on Commonwealth bonds at 30 June 2006. Moreover, it provides consistency with the rate adopted in a number of similar contexts and therefore is suitable from a whole of government perspective.

Data summarising the cohort of 'at-risk' doctors

A.4.47 Table 13 summarises the age distribution of the cohort of 'at-risk' practitioners, with the total premium representing a proxy for risk of medical indemnity claims for each age group.

Table 13: Cohort of 'at-risk' doctors

Age at 30 June 2006	Number 'at-risk'	Total premium (\$'000)	Proportion males (per cent)
<30	48	174	60
30-34	1,131	4,698	53
35-39	3,679	30,731	65
40-44	5,339	52,400	67
45-49	6,089	56,998	69
50-54	5,760	53,166	72
55-59	4,789	47,186	80
60-64	3,590	37,926	85
65-69	2,008	18,627	90
70-74	887	5,616	92
75-79	468	2,256	94
80-84	168	718	95
85-	40	161	93
Total	33,996	310,655^(a)	74

(a) Numbers may not add due to rounding.

Estimate of the projected accrual of new ROC liabilities during the 2006-07 financial year provided by the actuaries of the MIIIs

A.4.48 An estimate of the projected accrual of ROC liabilities during the 2006-07 financial year was provided by each of the actuaries of the MIIIs; these summed to \$9.8 million. This is less than the estimate of \$15.6 million (roughly 9 per cent of the estimated accruing claims cost for 2006-07) published in last year's report, which was

based on our model. Estimates provided by industry actuaries varied from 2 per cent to 8 per cent of estimated claims cost for individual insurers.

A.4.49 Industry estimates of Scheme accrual appear to be quite different from one another, varying from about 2 per cent to 8 per cent of total claims cost (Scheme accrual plus non-Scheme accrual). However, it is worth noting that these apparently very different estimates represent an assumed difference between non-Scheme claim accrual of about only 6 per cent. Thus, the high estimate of 8 per cent is consistent with an assumption that 92 per cent of the claims cost will fall outside of the Scheme while the low estimate of 2 per cent is consistent with an assumption that 98 per cent of the claims cost will fall outside of the Scheme.

Projection of future Run-Off Cover Scheme costs

A.4.50 Table 14 below summarises the next 10 years' ROC indemnity payments which were aggregated to derive the projected Scheme costs in future years.

Table 14: Calculation of projected ROC indemnity payments

Year ending 30 June	Medical incidents pre 1 July 2006			Medical incidents post 30/6/2006 Total (\$m) ^(a)	Grand total (\$m)
	Notified as at 30/6/2006 (\$m)	IBNR as at 30/6/2006 (\$m)	Total (\$m)		
2007	1.2	0.5	1.7	0.0	1.7
2008	0.5	1.4	1.9	0.1	2.0
2009	0.5	2.7	3.2	0.3	3.5
2010	0.4	3.5	3.9	0.7	4.6
2011	0.4	4.0	4.4	1.7	6.1
2012	0.3	4.8	5.1	3.3	8.4
2013	0.2	5.4	5.7	5.4	11.0
2014	0.2	5.7	5.9	7.8	13.6
2015	0.1	5.4	5.5	10.4	15.9
2016	0.1	4.9	5.0	13.2	18.2

(a) Numbers presented in the 2004-05 report were incorrectly shown in discounted values. They also excluded claims handling expenses.

Note: The costs of notified and IBNR claims do not always sum to the total cost of medical incidents pre 1 July 2006 due to rounding.

Uncertainty in relation to liability projections

A.4.51 The projected ROC indemnity payments summarised in Table 14 are subject to uncertainty which relates to:

- data in relation to the claiming behaviour of eligible practitioners;
- substantial random variation associated with medical incidents and the notification of claims from year to year;
- calibration of the model claim size and claim frequency assumptions to the underlying claim process (medical indemnity liabilities are characterised by few claims associated with large random variation such that a wide range of results can be obtained with equal statistical validity);
- the possibility that doctors approaching retirement might cut down on their practice hours and possibly engage in less 'risky' practice (for example, less surgery) to a greater extent than allowed for in the model;
- sensitivity of the model to the proportion of late-reported claims;
- sensitivity of the model to the decrement assumptions;
- the possibility that not all Scheme eligible claims have been identified and that recoveries will be more diligently pursued later in the claim process; and
- recent tort reforms in a number of jurisdictions with the possible effect of 'bringing forward' claims and distorting recent claim experience.

A.4.52 The information provided by the actuaries of the MIs and MDOs relied on broadly similar valuation models. The range of assumptions adopted by industry actuaries reflects the substantial uncertainty involved in estimating liabilities of the Scheme.

A.4.53 It must be emphasised that different results can be obtained from different yet equally plausible models and assumptions. Again, this is a common issue with liabilities of this nature.

Model sensitivity to the proportion of late-reported claims

A.4.54 The projection of ROC indemnity payments is particularly sensitive to the proportion of late-reported claims assumed in the model.

A.4.55 By way of illustration, the reporting pattern in Table 10 assumes that the average delay between medical incident and notification of a claim/incident is 3.8 years, regardless of claim size. If the reporting pattern is shortened by 0.3 years, then the projected accrual of new medical indemnity liabilities reduces from \$184.0 million to \$175.5 million (a reduction of only 5 per cent). However, the Scheme liabilities during 2006-07 reduce from \$16.6 million to \$13.8 million (a reduction of 17 per cent).

APPENDIX 5: HIGH COST CLAIMS

The High Cost Claims Scheme

A.5.1 The High Cost Claim Scheme (HCCS) is part of the broader package of Australian Government measures announced on 23 October 2002 that were designed to address problems with the medical indemnity insurance industry.

A.5.2 The HCCS is governed by Division 2 of Part 2 of the *Medical Indemnity Act 2002*. Under the HCCS, MIIs and MDOs are reimbursed for part of the costs of large claims notified to them on or after 1 January 2003.

A.5.3 The HCCS meets 50 per cent of the excess above the threshold (currently \$300,000) of the cost of individual large claims, before the operation of the Run-Off Cover Scheme.

A.5.4 The HCCS threshold and the percentage used to calculate the amount of indemnity can be changed by way of regulation. The HCCS threshold has been changed by way of regulation as follows:

- \$2 million for claims notified between 1 January 2003 and 21 October 2003;
- \$0.5 million for claims notified between 22 October 2003 and 31 December 2003; and
- \$0.3 million for claims notified 1 January 2004 and later.¹⁰

A.5.5 For example, for a claim which costs \$1 million notified on 1 April 2005, the HCCS will pick up:

$$50 \text{ per cent} \times (\$1,000,000 - \$300,000) = \$350,000$$

Data collection

A.5.6 Medicare Australia collects data in relation to the HCCS, in addition to the Scheme data described in Section 3.

A.5.7 Data collected in relation to the HCCS include:

- details of claims/incidents notified to MIIs and MDOs by 30 June 2006 which might lead to recoveries under the HCCS;

¹⁰ Since the Run-Off Cover Scheme commenced on 1 July 2004, the relevant HCCS threshold is currently \$300,000.

- an estimate of that part of the cost of claims which were notified to MIs and MDOs by 30 June 2006 which is expected to be recoverable under the HCCS; and
- an estimate of that part of the future claims cost of medical incidents notified during the 2006-07 to 2009-2010 financial years which is expected to be recoverable under the HCCS.

Relevance of HCCS data to the Run-Off Cover Scheme

A.5.8 A small proportion of medical indemnity claims are larger than \$300,000. These high-cost claims have a noticeable influence on the total cost of medical indemnity each year.

A.5.9 Claims which take longer to report tend to be bigger on average. In addition, the longer the delay involved in notifying a claim, the more likely the claim will be notified at a time when the practitioner is eligible for the Scheme.

A.5.10 Thus, the small proportion of large claims made by retired practitioners will have a marked impact on the total cost of the Scheme.

Analysis of large claims

A.5.11 HCCS data collected by Medicare Australia provide some insight into the likely profile of large medical indemnity claims.

A.5.12 According to the data collected, as at 30 June 2006, 184 claims/incidents had been notified to MIs and MDOs which were expected to be covered by the HCCS.

A.5.13 The cost estimates available for HCCS claims/incidents represent total case estimates, including amounts already paid as at 30 June 2006. Most of the estimated total cost of claims of \$198.2 million is attributable to estimates of outstanding cost provided by claims managers, with only \$18.8 million having already been paid as at 30 June 2006.

A.5.14 The HCCS data provides a reasonable but imprecise measure of the likely profile of large medical indemnity claims.

A.5.15 The distribution of estimated costs of HCCS-eligible claims notified by 30 June 2006 is shown in Table 15. The distribution is presented in terms of the proportion of total estimated claim cost attributable to each claim size band. For example, about one quarter of the total estimated cost of HCCS-eligible claims was attributable to claims expected to cost between \$0.3 million and \$0.5 million.

Table 15: Distribution of HCCS-eligible claims

Claim size (\$'m)	Proportion of claims cost (per cent)
0 to 0.3	N/A
0.3 to 0.5	23
0.5 to 2.0	45
>2.0	33

A.5.16 The HCCS data illustrates the pattern of delay between a relevant negligent medical incident and the date that a large claim/incident is notified to the MII or MDO. The claim reporting pattern observed in relation to HCCS claims is compared to the claim reporting pattern assumed for the Scheme in Figure 8. Note that all HCCS claims/incidents are included for the purposes of this analysis, regardless of the applicable HCCS threshold.

Figure 8: HCCS claim reporting pattern

