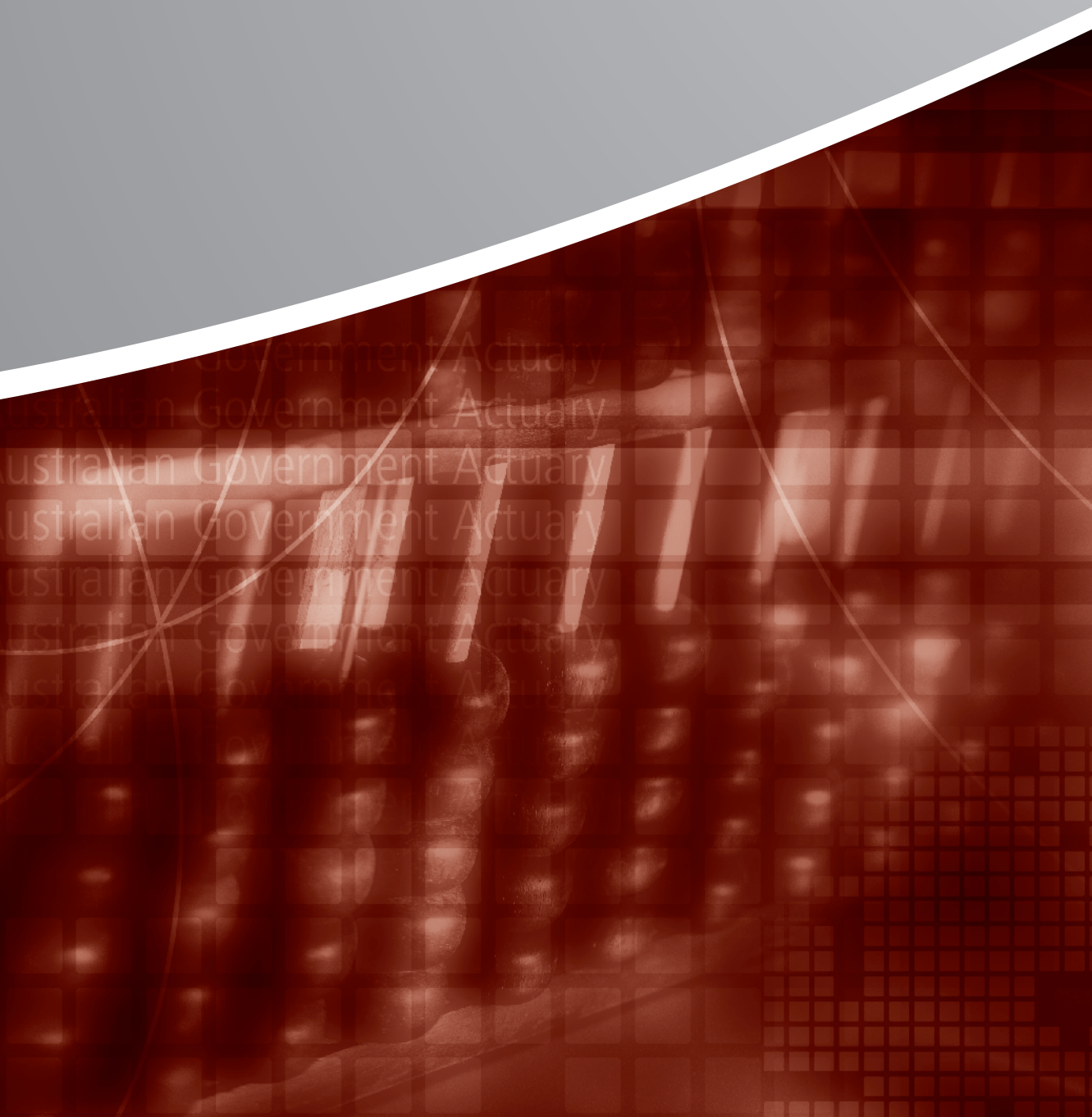
Australian Government

Australian Government Actuary

Evaluation of the Stability & Affordability of Medical Indemnity Insurance



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Evaluation of the Stability & Affordability of Medical Indemnity Insurance

ISBN 978-1-925832-13-6

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BACKGROUND AND SCOPE

The Australian Government Actuary (AGA) has been commissioned by The Department of Health to undertake an independent actuarial review of the Indemnity Insurance Fund (IIF). This report is in response to the *Medical and Midwife Indemnity Legislation Amendment Act 2019* (Amendment Act), which requires the Minister for Health to prepare and table a report which evaluates the stability of the medical indemnity insurance industry and the affordability of medical indemnity insurance. A copy of this report is to be tabled in each House of Parliament by 28 February 2021.

The Indemnity Insurance Fund comprises nine government assistance schemes that provide medical and professional indemnity support for privately practising medical practitioners, allied health professionals and eligible midwives.

This report reviews the experience of the IIF schemes against the objectives of supporting the stability of the medical indemnity insurance industry, affordability of premiums and ensuring the availability of medical indemnity insurance to privately practising medical practitioners, allied health professionals and eligible midwives. This has been completed by examining a range of data sources, including data provided to government for the ongoing management of the IIF, data submitted by insurers to APRA and data provided by insurers specifically for this report. Data available to complete this report examines the market experience prior to the impact of the COVID-19 pandemic.

This report has been prepared by the Australian Government Actuary. It is intended to meet the requirements of Amendment Act to assess the stability and affordability of medical indemnity insurance. Any proposed use of this report which goes beyond its stated purpose should be discussed with the AGA.

IIF SCHEMES

The IIF schemes have contributed to the stability, affordability and availability of medical indemnity insurance in a number of ways:

- The High Cost Claim Scheme (HCCS) and the Allied Health High Cost Claim Scheme (AHHCCS) act to reduce the volatility of net claims costs for individual insurers. This has the direct effect of supporting the stability of the insurance industry by reducing the volatility of insurer's financial results, which also has the consequent effect of improving the affordability of insurance.

- The Run-Off Cover Scheme (ROCS) and Midwife Professional Indemnity Run-off Cover Scheme (MPIROCS) have ensured the availability of insurance for medical practitioners and midwives who retire from private practice. In addition, they have

also reduced the volatility of the insurers' claims costs by removing a material portion of long tailed claims, which can often be quite large given the positive correlation between claim size and the length of delay in reporting claims.

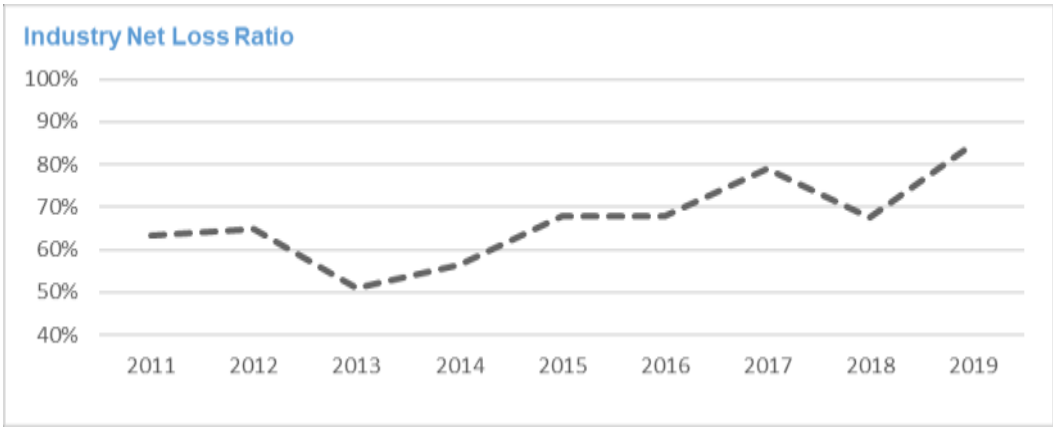
- The incurred but not reported (IBNR) Scheme supported the stability of the insurance industry in 2002, and has continued to support the availability of insurance for medical practitioners whose past incidents were not adequately provisioned for at the time.
- The Exceptional Claims Scheme (ECS) and the Allied Health Exceptional Claims Scheme (AHECS) have supported the availability of cover to the general public above an insurer's contractual limits.
- The Premium Support Scheme (PSS) has supported the affordability of insurance for some medical practitioners[1].
- The Midwife Professional Indemnity Scheme (MPIS) has supported the availability of insurance to privately practicing midwives.

FINDINGS

Industry Stability

Medical indemnity insurers have enjoyed a period of stability and capital strength over the past decade. Direct contributions have been made by the IIF, most notably through the run-off cover schemes and the HCCS.

The industry's net incurred claims have averaged 68% of net earned premium and has ranged between 51% and 85% in the period 2010/11 to 2018/19.



[1] PSS is administered by a contract arrangement until 30 June 2020. From 1 July 2020, the PSS requirements are embedded in the Amendment Act.

The highest year was the most recent, 2019. It continues the trend of the net loss ratio increasing over the last six years. Lower interest rates and the changes to the HCCS threshold are two industry wide factors that will have contributed to higher loss ratios in recent years. Insurers may also be choosing to operate with a higher net loss ratio in recent years, transitioning from a capital rebuilding phase early in the life of the IIF to one of capital management.

Consistent with the above trend, insurers have experienced a positive average profit margin of 13.8% of gross earned premium since 2010/11. However, the average over the past 5 years has reduced to 5.4%. The latter being more in line with what was achieved by the general insurance industry as a whole. In 2019, whilst the net loss ratio was worse than earlier years, the profit margin was in line with the average of the last five years.

Insurers enjoy strong capital positions, relative to the minimum capital that is required under APRA's general insurance prudential standards. Sound capital positions will further serve industry stability in the future.

Average reinsurance expenses as a proportion of gross written premium (GWP) have reduced and are lower than for the general insurance industry. The capacity of reinsurance available in the market and the number of reinsurers has also remained adequate over time. Insurers have reinsurance arrangements in place which have been broadly consistent over time. However, reinsurance markets can change and the fact that this trend has occurred to date does not mean it can be assumed to continue indefinitely.

These observations are drawn from the industry level data and data published by each specialist insurer. Whilst they are relatively high-level observations of the experience of the industry, the data does indicate that the industry is enjoying a period of stability and profitability. This is not to say that the future will be without challenges. For example, at the time of writing this report, the industry is managing challenges regarding an increasing upward trend in claims costs, a period of lower investment returns, and a range of additional issues arising from the COVID-19 pandemic.

The HCCS has contributed to the stability of the medical indemnity insurance market, however limitations in the data make the calculation of some measures of how this has contributed, beyond the HCCS payments made from year to year, difficult. The HCCS reduces the volatility of insurer's net claims costs. This increases the stability of the industry. In turn, there is expected to be a flow on effect to improving the stability of premiums.

The HCCS has also made a material contribution to reducing the net claims costs of insurers, particularly in respect of some of the larger, higher risk, medical speciality groups. In turn, this should have the effect of improving the general affordability of insurance, but particularly so for these higher risk groups.

AFFORDABILITY

The available premium data infers that affordability, measured by premiums (including membership fees) expressed as a percentage of income, has improved for many medical professionals, with the median premium reducing significantly since their peak in the early 2000s and remaining relatively stable from 2010 to 2019.

Over the last 10 years, the median premium as a proportion of income has remained at approximately 2% to 3%. For the higher cost specialities such as gynaecology and obstetrics, there has been a small decline in the median premium when compared to income over the last 10 years. Recent claims trends suggest that historical improvements in affordability are unlikely to continue in the short term.

The HCCS has contributed to improved affordability and currently reduces gross premiums by approximately 11% to 14%.

Improved affordability is consistent with the available data on the PSS which shows fewer professionals (in terms of both number and claim rate) are claiming relief from high premiums through the PSS. Annual PSS payments have fallen substantially from their peak in 2006/07. The proportion of claims against the PSS from targeted groups (rural GPs and certain grandfathered professionals) whose claims do not rely on premiums exceeding a proportion of private practice income is increasing. Data from 2019 show that 73% of all policies have premiums below 4% of income and 95% of policies have premiums below 10% of income. The equivalent figures from 2007 were 62% and 89%.

AVAILABILITY

The ROCS, MPIROCS, IBNR, ECS and AHECS have contributed to the availability of medical indemnity insurance in Australia.

The number of ROCS-eligible medical practitioners and Commonwealth supported midwives have grown to 17,431 and 14 respectively as at 30 June 2019. We have not sought to determine whether the private insurers could provide similar run-off covers in the absence of the scheme. ROCS effectively provides a government guarantee that all eligible claims will be paid once a medical professional has ceased practice. This should provide the public with confidence in their ability to obtain adequate compensation in the event of medical malpractice, after a medical practitioner or midwife responsible for the malpractice has ceased practicing. This confidence is expected to be greater than had similar cover been provided by a private insurer. The same argument applies to the ECS.

The number of midwives eligible for the MPIS is 244 as at 30 June 2019. Historically, midwife professional indemnity cover was only available to midwives practising in hospitals. The main reasons for the lack of cover available to privately practising midwives are that they represent a small premium pool and there is a lack of accurate and up-to-date data on likely claims costs. Without the MPIS, therefore, insurers may be less inclined to offer such covers, thus making it more difficult for privately practising

midwives in Australia to obtain adequate cover, as required by legislation. In turn, this would undermine the maternity care options available to Australian women.

The IBNR scheme provides access to claims where United Medical Protection (UMP) would otherwise have become insolvent in 2003. Under the IBNR, $111 million of claims have been reimbursed by the Commonwealth as at 30 June 2019, including associated claims handling expenses. In addition, $17 million was reimbursed in respect of these claims under the HCCS.

Finally, the Amendment Act requires all medical indemnity insurers to provide universal cover to medical practitioners, and explicitly ensures the eligibility of allied health professionals to the IIF by creating their own equivalent versions of HCCS and ECS. Private sector employee midwives are also eligible for cover under the AHHCCS and AHECS from 1 July 2020.

UNCERTAINTY

Data available to complete this report examines the market experience prior to the impact of the COVID-19 pandemic. Impacts on insurers may include the changing nature of medical practitioners' practices during the pandemic, impacts on asset values, and impacts on insurers' operations (e.g. remote working) in terms of processing and assessing claims. Whilst we have no evidence that suggests this will impact the stability of the market, it is prudent to note this additional uncertainty at this time.

Guy Thorburn FIAA
Australian Government Actuary
4 September 2020

1 INTRODUCTION

1.1. During the 1990s, medical defence organisations came under increasing financial pressure as a result of increasing levels of claim payments and were forced to make calls on their members for additional funds. In 2002, Australia's largest medical defence organisation (MDO), United Medical Protection (UMP), collapsed. During this period, the affordability of medical liability insurance was an increasing issue for practitioners. In 2004, the Australian Government introduced a package of schemes including the HCCS, ECS, PSS, and ROCS (now known as the Indemnity Insurance Fund) to assist medical practitioners in acquiring affordable professional indemnity cover.

1.2. In 2006, the Government implemented as series of tort law reforms to liability claims to further support improving the affordability of liability insurance.

1.3. The Indemnity Insurance Fund (IIF) was established in 2011 to consolidate seven existing government assistance schemes providing medical and professional indemnity support for privately practising medical practitioners and midwives. The schemes were established between 2003 and 2010 to stabilise the medical indemnity insurance industry and address market failure after UMP was placed into provisional liquidation in May 2002.

1.4. The Australian Government Actuary (AGA) has been commissioned by The Department of Health to undertake an independent actuarial review of the Indemnity Insurance Fund (IIF). This report is in response to the *Medical and Midwife Indemnity Legislation Amendment Act 2019* (Amendment Act), which requires the Minister for Health to prepare and table a report which evaluates the stability of the medical indemnity insurance industry and the affordability of medical indemnity insurance. A copy of the report is to be tabled in each House of Parliament by 28 February 2021.

1.5. The objective of this report is to undertake an analysis of the stability of the medical indemnity insurance industry and the affordability of medical indemnity insurance. Essentially, this report is reviewing the experience of the IIF schemes against their objectives of supporting the stability, affordability and availability of medical indemnity insurance to medical professionals and midwives. These objectives support the ability of the medical profession to continue to provide private services to the Australian public.

1.6. This report has been prepared by Guy Thorburn as the Australian Government Actuary, in conjunction with the Office of the Australian Government Actuary, for the Department of Health.

2 BACKGROUND

2.1 INDUSTRY OVERVIEW

2.1.1 Medical indemnity insurance is a form of liability insurance that indemnifies medical practitioners against financial loss from actions that are brought against them as a result of the performance of their professional medical duties.

2.1.2 Medical practitioners who undertake private medical practice in Australia purchase medical indemnity insurance from private sector underwriters. Six private sector underwriters were operating in Australia at 30 June 2019. They were Avant Insurance Limited owned by Avant Mutual Group Limited (Avant), MIPS Insurance Pty Ltd owned by Medical Indemnity Protection Society (MIPS), MDA National Insurance Pty Ltd owned by MDA National (MDAN), Medical Insurance Australia Pty Ltd owned by Medical Insurance Group Australia (MIGA), Guild Insurance (Guild) and Berkshire Hathaway Specialty Insurance Company (BHSI). Of these, all but Guild and BHSI are specialist insurers, writing only medical indemnity and closely related insurance policies. The *Fourteenth Report on the costs of the Australian Government's Run-Off Cover Scheme for medical indemnity insurers* reported that the specialist insurers provide cover to over 98.5% of the market, by premium.

2.1.3 Claims are lodged against a medical practitioner when there is a breach, or perceived breach, of a professional standard of care when treating a patient. Roughly 2,000 negligence claims might be expected annually in respect of private medical practice in Australia, however there can be substantial variation from year to year. A number of claims will be successfully defended.

2.2 THE INDEMNITY INSURANCE FUND

2.2.1 In May 2002, the largest medical indemnity provider in Australia, UMP was placed into provisional liquidation. This resulted in a potential lack of medical indemnity cover for many doctors. At this time, medical practitioners were experiencing significant increases in the cost of medical indemnity cover that were charged across all providers. The Australian Government responded by introducing a number of reforms aimed at ensuring a viable and ongoing medical indemnity insurance market. The reforms required medical indemnity insurance to be provided as an insurance contract (rather than the discretionary basis that it was previously provided). This required providers to establish insurance companies under the supervision of the Australian Prudential Regulation Authority (APRA). In addition, a number of measures, including premium subsidies and assistance with high cost claims were introduced. These measures are known as the Indemnity Insurance Fund (IIF).

2.2.2 The IIF comprises nine government assistance schemes that provide medical and professional indemnity support for privately practising medical practitioners, health professionals and eligible midwives. Most of the schemes were established by the *Medical Indemnity Act 2002* (the Act) and became operational between 2003 and 2004.

2.2.3 Two new mirror schemes have commenced from 1 July 2020 for allied health practitioners[2] with the same level of support under the HCCS and ECS. The Government's intent for separating the Medical Practitioners from the Allied Health Schemes is to provide greater transparency for the purposes of claims and data reporting. The Department confirms that the eligibility and claiming requirements for the Allied Health High Cost Claims Scheme (AHHCCS) and Allied Health Exceptional Claims Scheme (AHECS) align with the HCCS and ECS, with no additional regulatory burden imposed on insurers.

2.2.4 The priorities of the IIF are:

(1) To promote **stability** in the medical indemnity insurance industry;
(2) To keep premiums **affordable** for doctors; and
(3) To ensure **availability** of professional indemnity insurance for eligible medical professionals and midwives.

2.2.5 Whilst the IIF is referred to as a "fund", there is no special purpose fund that is receiving contributions and funding the government's obligations. The IIF is paid for by appropriations from consolidated revenue on a net cash flow basis. In 2016, the ANAO reported that total expenditure since inception totalled $450 million. The total expenditure to 30 June 2019 was $835 million (including $23 million PSS and $18 million ROCS administration costs reimbursed to the insurers). This figures exclude internal administration costs incurred by the Government.

2.3 Elements of the Indemnity Insurance Fund

2.3.1 The nine schemes within the IIF are summarised in the following table.

Scheme	Objective and Key Features
Incurred but not reported (IBNR) Scheme	**Objective:** To ensure cover that had been purchased by medical practitioners continue to be available where insurers had failed to provision properly for those claims at 30 June 2002. **The Government pays** medical indemnity liabilities (including the costs related to managing claims) that were incurred but not reported as at 30 June 2002. Avant Group is the only participant in the scheme. **The Government receives** no further income for these claims.

[2] The Government will maintain support for high cost claims and exceptional claims made in respect of allied health practitioners practising in professions accredited by the Australian Health Practitioner Regulation Authority (AHPRA). It will not include self-regulated health related professions.

Scheme	Objective and Key Features
Premium Support Scheme (PSS)	**Objective:** To assist in the provision of affordable cover. **The Government pays** a subsidy on the component of the medical indemnity premiums that exceeds 7.5% of a medical practitioner's gross private medical income. Subsidies are administered by insurers and the Government reimburses the administration costs. The applicable subsides have reduced over time, as follows: a) from 2004 to 1 July 2012, 80 per cent; b) on or after 1 July 2012 and before 1 July 2013, 70 per cent; c) on or after 1 July 2013, 60 per cent. In addition, some medical practitioners receive subsidies through a grandfathered arrangement and rural doctors are subject to different eligibility tests[3]. **The Government receives** no income to fund this scheme.
High Cost Claim Scheme (HCCS) and Allied Health High Cost Claim Scheme (AHHCCS)	**Objective:** To improve **affordability** by reducing insurer's claims costs and reducing the amount of reinsurance insurers need to fund large claims. Indirectly, this acts to help insurers' capital positions and reduce premiums. **The Government pays** medical indemnity insurers 50 per cent of the claim cost over $500,000 up to the limit of the medical professional's cover. Claims that exceed the insurance contract limit (generally $20 million) can trigger the ECS. The $500,000 threshold has varied over time. The threshold that applies is dependent on the date the claim was notified to the insurer. For claims notified from 1 January 2003 to 21 October 2003, the threshold was $2,000,000. For claims notified from 22 October 2003 to 31 December 2003, the threshold was $500,000. For claims notified from 1 January 2004 until 30 June 2018, the threshold was $300,000. The Government increased the threshold for claims notified from 1 July 2018 to $500,000. **The Government receives** no income to fund this scheme.
Exceptional Claim Scheme (ECS) and Allied Health Exceptional Claim Scheme (AHECS)	**Objective:** To improve **availability** of cover by removing risk from medical practitioners for very high claims so that medical practitioners are not personally liable. The scheme may also improve **stability** by enabling medical indemnity insurers to limit their liability to a contract limit, with the ECS and AHECS meeting the cost of claims in excess of the limit.

[3] As a special arrangement for procedural GPs working in rural areas, the PSS will cover 75% of the difference between premiums for these doctors and those for non-procedural GPs in similar circumstances (i.e. same location, same income and same insurer). Rural procedural GPs are eligible for PSS regardless of whether they meet other PSS eligibility criteria.

Scheme	Objective and Key Features
	The Government pays 100% of all claims in excess of a threshold, which was initially set at $15 million for claims notified between 1 January 2003 and 30 June 2003, and increased to $20 million for claims notified since 1 July 2003. **The Government receives** no income to fund this scheme.
Run-off Cover Scheme (ROCS)	**Objective:** To ensure insurance is **available** for medical practitioners who have left private practice for medical incidents that occurred during private practice. **The Government pays** the costs of valid medical indemnity insurance claims (including the costs related to managing claims) made against medical practitioners eligible for ROCS including those that have retired, deceased or who are on maternity leave. **The Government receives** a levy to cover the ongoing cost of ROCS over time. The levy is called the ROCS support payment and is paid by insurers to the Government. This is passed on to medical practitioners as a loading on net medical indemnity insurance premiums (as defined in The Amendment Act) whilst they are practicing. The loading was 8.5% for most insurers at commencement (i.e. 2004/05), and has been reduced to 5% since 2008/09.
Midwife Professional Indemnity (Commonwealth Contribution) Scheme (MPIS)	**Objective:** To ensure **availability** of professional indemnity insurance for privately practicing, eligible midwives. **The Government pays** 80% of the claim exceeding $100,000 and 100% of the amount exceeding $2 million. The insurer pays the first $100,000 of each claim and 20% of any amount between $100,000 and $2 million. **The Government receives** no income to fund this scheme.
Midwife Professional Indemnity Run-off Cover Scheme (MPIROCS)	**Objective:** To ensure insurance is **available** for midwives who have left private practice for medical incidents that occurred during private practice. **The Government pays** 100% of each eligible MPIROC claim that is notified after an eligible midwife leaves private practice. **The Government receives** a levy to cover the ongoing cost of MPIROCS over time. This levy is 10% of net premium.

2.3.2 The terms “medical professional” and “medical practitioner” are defined in the *Medical Indemnity Act 2002*. Medical professions specifically include health care related vocations, whilst medical practitioners do not. The terms are used deliberately in the table above. For example, PSS & ROCS apply to medical practitioners, HCCS applies to medical professionals until the establishment of the AHHCCS, which separates allied health professionals from the HCCS.

2.3.3 What appears to be a diverse range of schemes might helpfully be considered in three groups:

- The IBNR scheme serves (primarily) **past** periods. It ensures stability of cover for those doctors who were covered for historical claims at the time of the collapse of UMP, but where the entity had not adequately provisioned for those historical claims. In this way it might be thought of as serving an historical purpose.
- The PSS, MPIS, ECS, AHECS, AHHCCS and HCCS target the stability, affordability and availability of **present** insurance arrangements, i.e. whilst medical practitioners and eligible midwives are working. These schemes support the affordability of premiums by reducing the cost of cover for medical practitioners and eligible midwives. The HCCS and the AHHCCS also support the stability of the insurance industry by reducing the impact of large claims on insurers. The ECS and the AHECS support the availability of protection to medical professionals and the public for damages above insurance policy limits.
- The ROCS and MPIROCS target the affordability and availability of cover for **future** claims that will arise when medical practitioners and eligible midwives retire from private practice. It does this by allowing medical practitioners and eligible midwives to pay a small levy throughout their working life to fund claims that may arise many years into the future, after they retire.

3 DATA

3.1 DATA SOURCES

3.1.1 For this report, we have drawn on a range of existing data sources as well as data specifically provided by medical indemnity insurers.

3.1.2 The data that we have utilised is listed below:

- Data submitted by insurers for the preparation of annual Run-Off Cover Scheme (ROCS) reports and financial statements in relation to medical indemnity liabilities. The annual ROCS reports are completed by the AGA for both doctors and midwives, and use the data and projections from insurers, as well as data supplied by insurers to Services Australia.

- All regulated insurers must provide data to APRA. Reported data includes claims, premiums, reinsurance, underwriting profits and the level of capital held by insurers at the insurance company level. The current dominant market share of specialist insurers, combined with the fact that medical indemnity insurance is the main type of insurance written by those insurers, allows us to gain some insight into the financial position of the insurance industry as it pertains to medical indemnity insurance from the APRA data. In addition to the published APRA data, each insurer has provided historical APRA returns relating to financial performance and prudential capital requirements directly to the AGA. We have used this data to examine trends in profitability and the capital position of specialist insurers.

- To assist in the interpretation of insurers' financial results, insurers have also provided copies of annual reports, information pertaining to their reinsurance arrangements and capital management. We thank the insurers for their assistance in providing this data.

- To assist in analysing changes in the affordability of medical indemnity insurance over time, insurers have provided selected policy data that indicates the changes in premiums over time. We thank the insurers for their assistance in also providing this data.

- Services Australia payments data since the inception of the IIF, including summarised PSS data.

3.1.3 Data has generally been available to permit analysis over the last 10 years. However, as AHHCCS and AHECS schemes have only recently commenced, we were unable to separately analyse the claims experience of allied health professionals.

3.1.4 Where possible, we have undertaken reasonableness checks to ensure reasonable consistency of the data received for the purpose of this report.

3.1.5 For the purposes of preparing this report, it has been necessary for the AGA to maintain confidentiality of some data of some individual insurers. As a consequence, some of the quantitative aspects of our analysis have not been disclosed in this report.

3.2 DATA LIMITATIONS

3.2.1 Throughout various historical reports, including those produced by the AGA and the ANAO, references have been made to the quality and inconsistency of data between various reports. This section summarises the main data limitations identified in the annual ROCS investigations and those that have been identified whilst undertaking this review.

Inconsistencies in data sources

3.2.2 There are some inconsistencies between Services Australia payments data and the insurer cash flow data. While some differences can be explained by the timing mismatch between the payment of claims by insurers and reimbursements from Services Australia, in some instances the insurers' data were clearly erroneous and we had to make certain adjustments after discussion with the company's actuaries, where applicable. This is described in our annual financial reports and mid-year updates on the IIF liabilities.

3.2.3 Minor differences were noted between the PSS subsidies from the insurer policy data provided for this review and Services Australia data for the past ten years, noting that one insurer's policy data was missing PSS subsidies for 2019.

3.2.4 Minor differences were noted between insurer policy data and Services Australia data, in respect of both ROCS levies and membership fees.

Specific data challenges in relation to stability analysis

3.2.5 The ability to monitor the scheme's impact on the stability of medical indemnity insurance is limited to an aggregate insurer by insurer basis. We could not, for example, analyse the impact of HCCS on the stability of claims costs by speciality, or analyse the impact on an occurrence basis.

3.2.6 While the HCCS, ECS and MPIS have contributed to the stability of medical indemnity claims costs, it is difficult to quantify their impact on the stability of premiums. This is because premiums are calculated on a range of factors and the effect of reinsurance, as provided by the IIF, is only one component of the premium.

Specific data challenges in relation to affordability analysis

3.2.7 The ability to monitor the scheme's performance against the objective of affordability has historically been difficult as the medical practitioner's private practice income was not a data item that was collected by the Department. Similarly, limited data has been available with which to monitor the experience of the PSS.

3.2.8 However, for the purpose of this review, insurers have provided private practice income, either directly or by way of a billing band, for around 84% of the medical practitioners who have purchased medical indemnity insurance for their private practice between 2004-05 and 2018-19. This has enabled us to analyse changes in the affordability of medical indemnity insurance over time. However, the results presented are from 2006-07 (due to poor quality of data for 2004-05 and 2005-06). No income data was provided for midwives or allied health professionals.

3.2.9 Certain data fields were missing from some records, which limited our analysis. For example, a few thousand policy records had missing speciality or actual premium amount, and a small number of records had missing year of birth or gender. Where actual premium amount was missing but the expected amount was provided, or the components of the expected amount were provided, we have used these as proxies for the actual amount. In addition, around 37,000 policy records were missing postcode, with the majority of them belonging to policies written prior to 2010.

3.2.10 Insurers' policy data could not be used to adequately identify medical practitioners who operated in a rural or remote area. Instead, we relied on a 2018-19 rural/remote postcode list provided by the Department to identify these practitioners. When compared to the summary Services Australia PSS data, it shows our approach in general identified a slightly higher number of rural/remote medical practitioners. This may also be in part due to some of the postcodes in our data relating to the mailing address instead of the practice address of the practitioner. Affordability analysis by rural status is more reliable from 2010 onwards as there are fewer missing postcodes in the data.

3.2.11 The PSS subsidy was complete and cross validated for most of the past ten years in the insurer data. However, one insurer's PSS data was missing for 2018-19. This means the current impact of PSS on affordability is slightly under-stated.

3.2.12 No policies were identified as being provided under the insurer of last resort arrangements. Consequently, we could not perform specific analysis for policies provided under insurance of last resort arrangements.

4 STABILITY OF THE MEDICAL INDEMNITY INSURANCE INDUSTRY

4.1 STABILITY MEASURES

4.1.1 Ultimately, the stability of the industry is a function of the stability of the insurers operating within the industry. As a consequence, this section of the report primarily focusses on the performance of insurance companies. Where data permits, some additional information is examined to consider the broader groups that insurers operate within and the potential contribution of that wider group to insurer stability.

4.1.2 A number of different factors contribute to the stability of medical indemnity insurers and, in turn, the industry. This includes the stability in the market (as measured by the number of policies and premium income), the stability of claims experienced by providers, and the capital strength of providers.

4.2 MARKET STABILITY

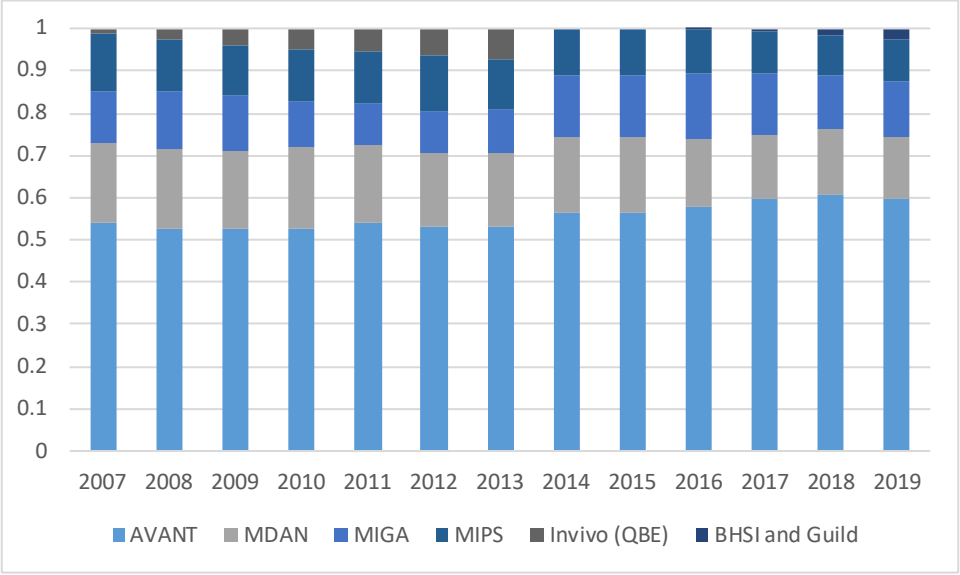
4.2.1 A stable market should contribute to industry stability by ensuring that insurers are not required to deal with volatility in their client base and premium income from year to year. This section examines the stability of policy numbers and premium income from year to year.

Policy Numbers and Market Share

4.2.2 An insurer who manages a stable book of policies that is steadily growing over time is more likely to exhibit stability as it will be servicing a stable membership (policyholder) base. This allows consistent and reliable recovery of operating costs, and gives some consistency in the risk profile of the medical professionals that it is insuring.

4.2.3 Figure 1 shows the insurer's market share in each financial year since 2007. The data is taken from the ROCS reports and is based on the net premium written in each financial year for those policies with a ROCS levy greater than zero. This ensures that only policies relating to medical indemnity insurance for private practice are included. The market share has been relatively stable over time, allowing for some mergers (e.g. Invivo acquired by MIGA) and new entrants (e.g. BHSI). Over the same period, the total number of medical indemnity insurance policies has increased steadily from around 70,000 to around 90,000. Therefore, it is reasonable to conclude that insurers have managed a stable book of policies over time and this is not a source of industry instability.

Figure 1: Market Share by Insurer

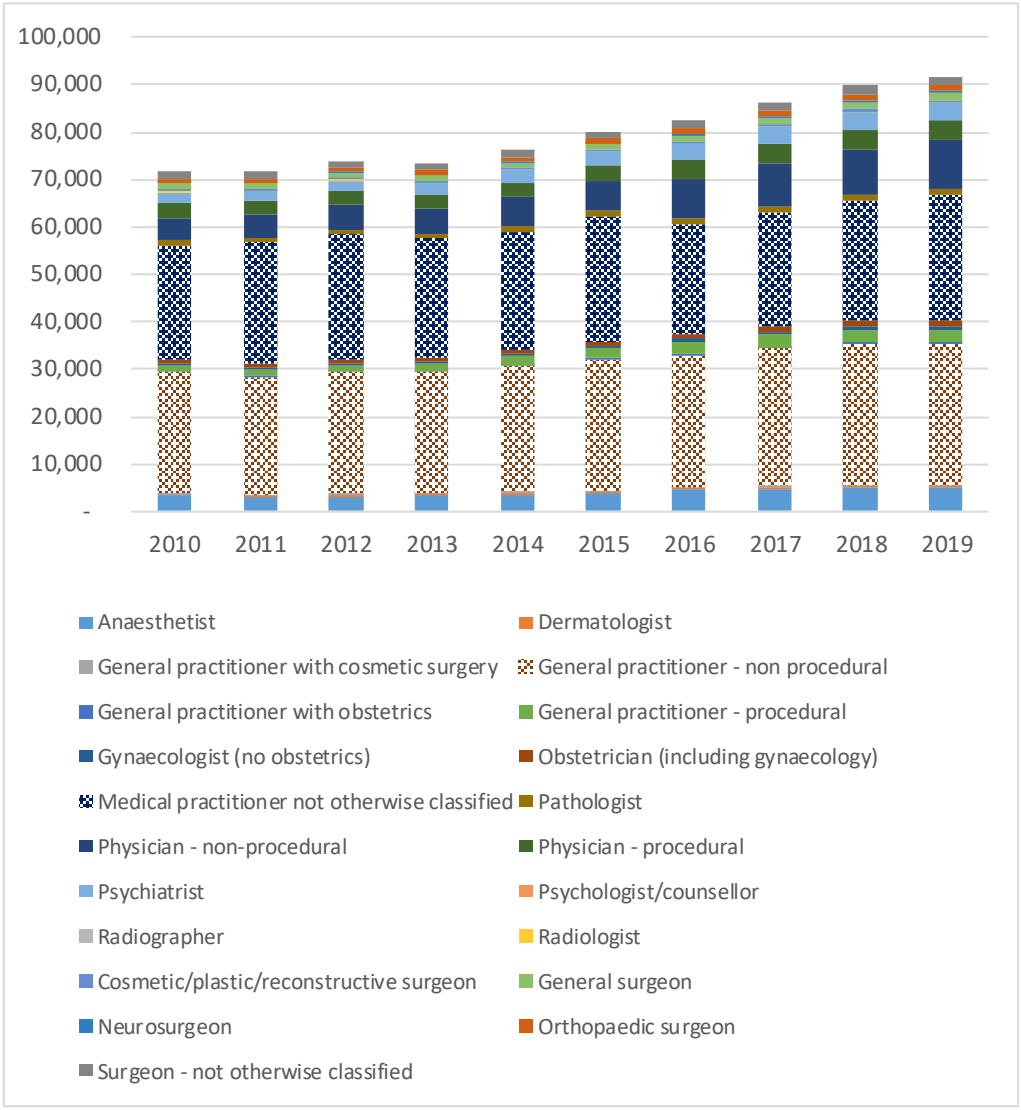


4.2.4 The data for Figure 1 is based on the premium income of policies with a ROCS levy greater than zero, as defined in the relevant Act. This approach targets policies that relate to medical indemnity insurance for private practice. Further, some insurers provide additional benefits to members. Some of these benefits are not medical indemnity insurance benefits and could be provided as a separate policy by some insurers. Focussing on policies with a positive ROCS levy ensures that policies that only provide medical indemnity insurance benefits are included in the policy count.

4.2.5 The industry, and each insurer, have generally enjoyed a relatively stable policy base. Some insurers have advised us that certain movements in the policy number were a result of reclassification of very small policies regarding ROCS contribution. The number of policies by insurer is not disclosed here due to commercial sensitivity.

4.2.6 Figure 2 sets out industry policy numbers by specialty grouping. It is based on the same data as Figure 1.

Figure 2: Policy Numbers by Speciality



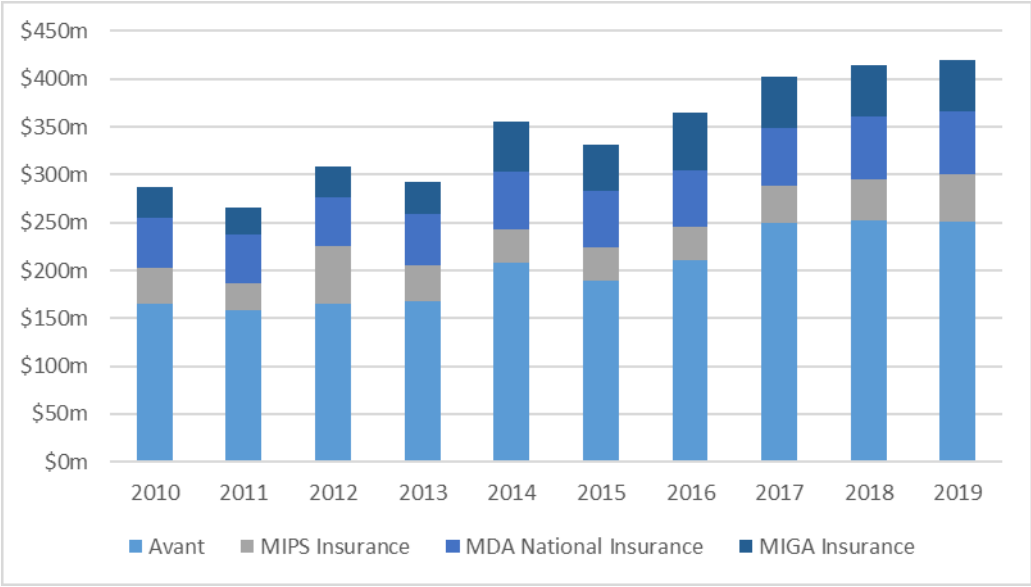
4.2.7 Figure 2 shows that the distribution of policy numbers (with a ROCS levy greater than zero) by practice area has been relatively stable over time. Figure 2 also shows that the largest specialty group is non-procedural general practitioners. The second largest group consists of “medical practitioners not otherwise classified”, which includes students and interns.

Premium Income

4.2.8 As with policy numbers, a stable book of premium income that is steadily growing over time is more likely to support the stability of an insurer over time. Premium income is ultimately the critical resource to fund claims and operational expenses. This section therefore examines the progress of the insurer's gross written premium (GWP) over time. Note that some insurers' parent entities charge membership fees, which can be a significant amount on top of the premiums. As GWP is based on data submitted to APRA by insurers, membership fees are not included in the analysis below.

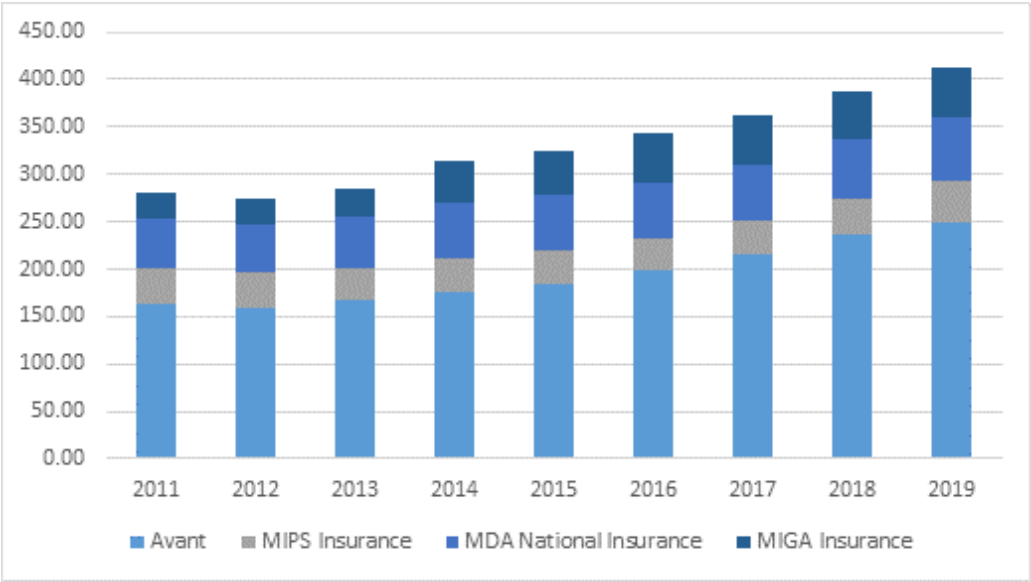
4.2.9 Figure 3 illustrates the progress of GWP over time by the four specialist insurers. This accounts for most of the premium income for the industry, noting the dominant collective market share of the specialist insurers.

Figure 3: Gross Written Premium by Specialist Insurer ($m)



4.2.10 Whilst total GWP was more variable from year to year up to 2015, since 2015 industry premium income has exhibited stable and steady annual growth. Even in these earlier periods, discussions with insurers indicate that variability was generally the result of management initiated actions, and therefore was not a source of instability that would be a concern for the purposes of this report. This is evidenced by the increased stability in the progression of gross premium income when we examine the gross earned premium in Figure 4. GWP reflects the premium that has been paid (in advance, for an insurance contract), whereas earned premium reflects the premium earned over the period for which the insurance was in effect.

Figure 4: Gross Earned Premium by Specialist Insurer ($m)



APRA data will not include membership fees charged by the parent company of some insurers. As membership fees impact upon the affordability of medical indemnity insurance, this is considered further in section five of this report.

4.3 CAPITAL

4.3.1 The second critical resource of an insurer to fund claims, and to meet variability in claims over time, is capital. A well-capitalised insurance industry will be able to absorb volatility in experience from year to year, whilst remaining solvent. Adequately capitalised insurers could therefore be expected to be a characteristic of a stable industry.

4.3.2 We have examined the capital available to the medical indemnity insurers. As all insurers are solvent, we have considered capital strength in three layers. The first is the minimum Prudential Capital Requirement (PCR) to be held, set by APRA to ensure an insurer has adequate capital to meet reasonably expected levels of financial risk. The second layer is the capital the insurer has available in excess of the minimum prudential requirements and the third layer is the capital that may exist in the group holding company. Whilst 'group' capital is not part of the insurer, it is the most likely immediate source of additional capital should the insurer require a capital injection.

Insurers

4.3.3 APRA report on the capital levels of regulated insurers over time. This data is publicly available on the APRA website. Insurers typically publish similar information in their financial reports. Information to support the analysis in this section has been drawn from these sources.

4.3.4 APRA does not report the capital position of a consolidated group of companies (e.g. where the insurer is a subsidiary of a holding company), nor is the capital requirement arising from a single line of business published. Given these limitations, this section primarily presents data for the four specialist insurers that write a majority of medical indemnity insurance separately to that for insurers that write a diversified book of business.

4.3.5 As APRA prudential capital requirements are minimum requirements, we have presented the contribution that capital may make to the stability of the industry by examining the ratio of each insurers' capital to the PCR and then each groups' capital to the PCR. Table 1 sets out the capital held by each insurer as a multiple of the minimum PCR.

Table 1: Ratio of Insurer's Capital to Prudential Capital Requirement

Ratio	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Specialist Insurers										
Avant	3.49	2.78	2.74	2.93	2.92	2.16	2.18	2.20	2.27	2.13
MIPS	3.10	3.09	3.58	4.49	4.90	4.67	5.02	6.05	4.65	5.05
MIGA	2.83	3.00	3.31	3.11	3.17	2.83	2.87	3.15	3.20	3.36
MDA	3.18	3.51	2.80	2.87	2.99	3.21	3.39	3.24	2.76	2.45
Total	3.33	2.94	2.91	3.09	3.14	2.74	2.81	2.92	2.79	2.66
Other Insurers										
Guild	1.78	1.71	2.15	2.05	2.09	2.17	2.13	2.22	2.21	2.28
BHSI						2.44	2.35	1.95	1.72	1.48

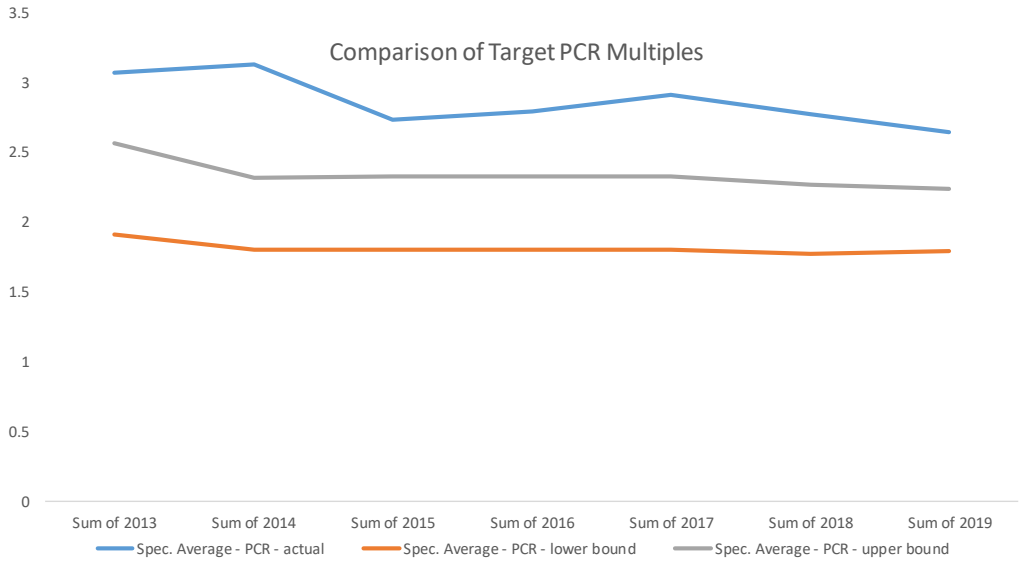
4.3.6 Absolute trends in capital do need to be interpreted with care. Discussions with insurers indicate that movements in capital ratios over time do reflect and can arise from strategic decisions taken by individual insurers. A key observation from this data is that the specialist insurers have consistently exceeded APRA's minimum capital requirements, having held more than twice the minimum level of regulated capital for each of the last 10 years. Diversified insurers have demonstrated slightly lower capital ratios but, have still held capital comfortably above their PCR.

4.3.7 As APRA's prudential capital requirements are risk based, ratios in the above table can move from year to year for sound reasons that may not be obvious when observing the simple movement in the ratio. Risk based capital results in entities that are exposed to higher levels of risk being required to hold higher levels of minimum capital than entities that are exposed to relatively lower levels of risk. This impacts the denominator in the ratio shown in the above table.

Similarly, total capital (the numerator) may change annually as subsidiaries may pay dividends to parent companies or receive capital injections from parent companies.

4.3.8 Whilst it is comforting to observe that all specialist insurers hold capital that is at least twice the prudential minimum, it is reasonable to question whether this is considered a prudent buffer. To this end, APRA require insurers to establish a target capital level. This target quantifies the amount of additional capital insurers will aim to hold over time to ensure they are able to meet the minimum levels in the majority of circumstances. Target capital is generally expressed as a range, within which the insurer seeks to maintain their ratio of total capital to prudential capital over time. Some additional insight may be gained from understanding how the ratio of capital to prudential capital (shown in Table 1 above) compares to the target levels of capital. This is illustrated in Figure 5.

Figure 5: Comparison of Target Prudential Capital Multiples



4.3.9 Figure 5 shows that capital ratios across the four specialist providers are not only above the minimum capital target set by insurers, but also above the maximum levels. The specialist providers have held capital in excess of the upper bound of their target capital consistently since 2013. This may be partly due to the limited ability by their holding companies to raise capital, which is discussed below.

Consolidated Groups

4.3.10 Should an insurer require an injection of additional capital, the most likely immediate source of is the capital available in the broader consolidated group, i.e. holding company capital. The specialist insurers are all wholly owned subsidiaries of a mutual parent (refer Appendix 1). Capital in a holding company

may not be available for the exclusive use of any one specific subsidiary, but it is likely to be the source of capital that is most readily available.

4.3.11 Table 2 shows that the ratio of each group's consolidated net assets (net of any net assets in other regulated entities) to the regulatory capital requirement of each insurer has generally increased over time. Each group's consolidated net assets are sourced from their annual reports.

Table 2: Ratio of Consolidated Net Assets to Prudential Capital Requirement

	2011	2012	2013	2014	2015	2016	2017	2018	2019
Avant	4.37	4.70	4.81	4.86	7.55	7.51	7.77	7.85	7.12
MIPS	5.46	6.71	8.69	9.64	9.75	11.16	12.13	9.74	10.93
MIGA	3.14	3.47	3.70	3.83	3.29	3.27	3.61	3.57	3.67
MDA	4.14	3.74	3.62	3.72	4.13	4.28	4.03	3.51	3.24

4.3.12 As with the earlier capital ratio, this is a simple high-level ratio that should be interpreted with care. Each entity develops a Capital Management Plan, which considers the specific circumstances of that organisation. For example, Avant operates a health fund and that subsidiary will have its own regulatory capital requirements. In this instance, the net assets of the health fund have been excluded when calculating the capital ratio shown above. Nevertheless, care should always be taken when drawing conclusions regarding total published capital levels.

4.3.13 The annual reports and APRA data show that all groups hold capital that is comfortably in excess of the Prudential Capital Requirement of the medical indemnity insurer.

- Avant and MIPS demonstrated strong growth in their capital positions, relative to the minimum regulatory capital that is required, over the period 2011 to 2017.

- MIGA and MDA have typically operated with capital between 3 and 4 times the prudential requirement.

4.3.14 The medical indemnity insurance industry enjoys a strong capital position, which in turn will support industry stability. We also note the limited ability of mutual organisations to raise additional capital through means available to other entities, such as share issues from publicly-listed companies.

4.3.15 Industry profitability and the strength of capital positions has resulted in members being rewarded with enhanced services. The two companies with the strongest capital ratios in Table 3 are also providing additional financial benefits to members. This is documented in Appendix 1 and summarised below:

- Avant Group has allocated $407m to immediate and future dividends through their Retirement Reward Plan. Note that dividends are only paid on

retirement, not during active service. Dividends are expected to be fully franked, when paid.

- Avant reduce renewal premiums through a renewal bonus.

- MIPS provide additional insurance and insurance-like benefits (practice entity protection, personal accident cover and discretionary cover for non-health care legal costs) at no additional charge to members.

These additional benefits suggest the Boards of these companies have confidence in the capital resources of their groups.

4.4 REINSURANCE, HCCS & MPIS

4.4.1 One specific form of financial risk, for which capital is a resource to meet, is claims volatility. Additional strategies to meet the effects of claims volatility exist in the form of reinsurance and, for the medical indemnity insurers, the HCCS and the MPIS. These schemes can be viewed as a form of reinsurance provided by the government under the IIF.

4.4.2 The ECS is deliberately not listed in this section. Under the ECS, the government pays 100% of the amount of any claim in excess of $20m. The ECS operates above the insurers' maximum policy limits. There is no charge for the ECS to insurers. Whilst it may appear as a form of reinsurance that contributes to industry stability, it is more accurate to consider it as ensuring the availability of protection to the public, where insurance does not. As a result, this part of the IIF has been considered further in Chapter 6 of this report. The ECS has not been called upon to meet any claims at the date of writing.

4.4.3 The HCCS contributes to stability as it acts as a form of reinsurance (providing stability to insurers), and it also acts to aid affordability, as there is no charge to insurers for this form of reinsurance. The contribution of the HCCS to stability of the industry will be considered in this section, whilst its contribution to affordability will be considered in the next section.

4.4.4 As the HCCS has been described in Chapter 2 of this report, this section describes the typical forms of reinsurance purchased by insurers and the cost of that reinsurance. The effect of reinsurance and the HCCS on reducing claims volatility is discussed in section 4.5.

REINSURANCE

4.4.5 All insurers supplement the 'reinsurance' provided by the HCCS (and Midwives equivalent scheme) and ECS with reinsurance purchased from private sector reinsurers. The primary purpose of reinsurance is to reduce the financial impact of adverse claims experience. The presence of reinsurance allows insurers to manage larger risks, stabilise financial results in the event of adverse claims experience, reduce risks to the insurer in the event of a catastrophe, and assist

in the diversification of risk. Reinsurance can also be used to assist insurers manage their prudential capital requirements, for example, through a period of growth. However, the stability of the specialist insurers' reinsurance arrangements and strength of capital suggests that this latter approach is not the primary motivation in this market. Private sector reinsurance is therefore expected to contribute to the stability of the medical indemnity insurance market, complementing the contribution made by the HCCS and ECS.

4.4.6 There are two broad types of reinsurance; proportional and non-proportional reinsurance. The following two paragraphs describe the types of reinsurance utilised in this market.

4.4.7 Under proportional reinsurance, the reinsurer receives a proportion of the premium and in return will pay the same proportion of any claim. Where the proportion is fixed, this type of reinsurance is called quota share reinsurance. The reinsurer may also pay a percentage of any premiums it receives back to the direct insurer to assist with direct acquisition and administration costs.

4.4.8 Non-proportional reinsurance may comprise excess of loss reinsurance and aggregate stop loss reinsurance.

- Excess of loss insures a percentage of any individual claim in excess of a predetermined retention limit. Generally, the insurer retains 100% of any claim cost (less any HCCS recovery) for claims below the specified retention limit and the reinsurer covers 100% of the claim (less any HCCS recovery) above the retention limit. This can be varied by specifying a percentage of the claim above the retention limit that the reinsurer may cover. However, we believe that it is market practice to reinsure 100% of claims above the chosen retention limit and to share the relevant component of the HCCS with the reinsurer on eligible claims. All insurers utilise this form of reinsurance with a specified retention limit that is higher than the HCCS retention limit of $500,000.

- While excess of loss insurance protects the insurer from the impact of large individual claims, it will not protect insurers from there being more claims than expected. The costs arising from an accumulation of multiple claims will lead to increased claims costs for insurers through the retained amounts below the retention limit. Some insurers protect themselves from this possibility through the purchase of aggregate stop loss reinsurance, where the reinsurer is liable for a percentage of the insurer's net claims costs in excess of a predetermined limit. The reinsurer's liability is likely to be similarly capped at a maximum level, for example, 50% of up to $25 million of net claims costs in excess of $25 million of net claims costs.

4.4.9 The presence of the HCCS will be a factor that insurers take into account when establishing their reinsurance treaties. The HCCS broadly provides 50% non-proportional reinsurance to the insurer for claims in excess of $500,000. This will impact the amount of reinsurance purchased.

4.4.10 Over time, the broad structure of reinsurance arrangements of each entity has remained relatively consistent. Reinsurance premiums, expressed as a proportion of gross earned premium (GEP), have reduced for all insurers since 2013. Table 3 sets out the reinsurance premium paid as a percentage of gross earned premium, as reported by APRA.

Table 3: Reinsurance

Year Ending	2012	2013	2014	2015	2016	2017	2018	2019
Avant Insurance								
Avant GEP	158.52	167.51	176.60	184.75	198.05	216.17	235.99	249.69
Avant Reinsurance Premium	10.82	11.87	10.83	10.06	12.03	12.19	8.53	9.13
Avant %	6.8%	7.1%	6.1%	5.4%	6.1%	5.6%	3.6%	3.7%
MIPS Insurance								
MPSi GEP	37.90	34.39	34.89	34.69	34.74	34.76	38.34	44.04
MPSi Reinsurance Premium	13.48	19.24	18.15	17.47	17.51	17.49	19.23	21.91
MPSi %	35.6%	55.9%	52.0%	50.4%	50.4%	50.3%	50.2%	49.8%
MDA National Insurance								
MDANi GEP	49.83	53.40	58.61	58.64	59.12	59.12	62.84	65.35
MDANi Reinsurance Premium	5.27	4.57	3.68	3.48	3.21	3.36	3.16	3.25
MDANi %	10.6%	8.6%	6.3%	5.9%	5.4%	5.7%	5.0%	5.0%
MIGA Insurance								
MIGA GEP	28.15	30.32	44.75	46.03	50.89	51.34	50.98	53.60
MIGA Reinsurance Premium	6.65	6.66	8.32	7.16	6.71	6.86	6.33	6.65
MIGA %	23.6%	22.0%	18.6%	15.6%	13.2%	13.4%	12.4%	12.4%
Total of Specialist Insurers								
Total GEP	274.40	285.61	314.86	324.11	342.79	361.38	388.15	412.67
Total Reinsurance Premium	36.21	42.33	40.98	38.17	39.46	39.89	37.25	40.94
Average %	13.2%	14.8%	13.0%	11.8%	11.5%	11.0%	9.6%	9.9%

4.4.11 Insurers can choose to purchase difference levels and types of reinsurance. Each insurer will also have a different levels of exposure to different risks within the industry. Such factors can explain some, if not many, of the differences in reinsurance premiums between insurers. The above table is a high level summary and is, therefore, not a comparison on one insurer's reinsurance costs to another's.

4.4.12 From examining insurers' reinsurance data, we observe that the amount of excess of loss cover has tended to remain relatively stable over time for each insurer. The premium paid for similar cover has typically reduced by around 2% to 3% of GWP since 2012. Based on an examination of each specialist insurer's excess of loss reinsurance arrangements, reinsurance premiums have reduced over time on a "like for like" basis. The average excess of loss retention in this market is around $2.75 million.

4.4.13 Reinsurance does not always reduce in price. The period from 2007 to 2012 generally saw reinsurance premium rates increase. During this period reinsurance programs were adjusted more frequently as companies managed

their total cost of reinsurance. It would not be prudent to assume that the recent trend, whereby reinsurance costs have reduced, will continue in the future.

4.4.14 Reinsurance programs compliment the 'reinsurance' protection provided by the HCCS. Reinsurance programs are designed with the HCCS in mind. The fact that all insurers supplement the HCCS with reinsurance from the private sector suggests that the schemes are not providing excessive cover, relative to the insurers' risk appetites. The general reduction in reinsurance costs also suggests that private sector reinsurance has generally been contributing to improved affordability in recent years.

4.4.15 The percentage of gross earned premium that is spent on reinsurance is lower than the equivalent percentage in the broader general insurance industry. APRA quarterly statistics to 30 September 2019 show a year to date outwards reinsurance expense of approximately 28% of gross earned premium for direct insurers, compared to approximately 10% for the medical indemnity insurers. While the difference is attributable to a number of factors, it is fair to say that medical indemnity insurers spend less on reinsurance than other insurers as they also benefit from the reinsurance benefits provided by the HCCS for no premium[4].

High Cost Claims Scheme

4.4.16 Under the HCCS, the government meets 50% of the cost of any one claim in excess of a predetermined limit. The limit has changed over time. Historical changes are set out in Appendix Two. Most recently, the limit increased from $300,000 to $500,000 on 1 July 2018. The scheme is a form of reinsurance which reduces the volatility of insurer's claims costs over time. As the scheme is provided at no cost to insurers, it also acts to reduce each insurer's net claims costs. This, in turn, supports the affordability of insurance to medical professionals. The effect of the HCCS on the affordability of insurance is considered in the following chapter of this report.

4.4.17 The outstanding liabilities in respect of this scheme are estimated annually and published in the Department's financial statements. The financial statements at 30 June 2019 report that this scheme currently has an outstanding liability of $315 million (discounted at 1.0% p.a.).

Midwife Professional Indemnity (Commonwealth Contribution) Scheme (MPIS)

4.4.18 The rules for this scheme appear in the *Midwife Professional Indemnity (Commonwealth Contribution) Scheme Act 2010* and are described very briefly below. At the time of preparing for this report, Medical Insurance Australia Pty Ltd (MIGA) is the only underwriter that provides Government supported midwife professional indemnity cover to eligible registered midwives. This insurance

[4] Whilst there is no specific premium for the HCCS and ECS, there are universal cover obligations within the IIF. Whilst the financial effect of this obligation is unlikely to be equivalent to the cost of the HCCS it is mentioned here as a reminder that the IIF should be viewed as a whole.

does not cover the delivery of babies outside a hospital other than in emergencies. Planned home births are excluded.

4.4.19 Under this scheme, MIGA is reimbursed for part of the costs of claims notified to MIGA on or after 1 July 2010. MIGA will pay the first $100,000 of each eligible claim; plus 20% of the part of a claim between $100,000 and $2 million. The Government will contribute the remaining 80% of the part of a claim between $100,000 and $2 million (i.e. Level 1 Commonwealth contributions) and will meet 100% of the part of any claim which exceeds the $2 million threshold (i.e. Level 2 Commonwealth contributions).

4.4.20 The Commonwealth has incurred only one claim under this scheme. Data provided by MIGA's actuary (in July 2019) indicated that they anticipate one Level 1 and no Level 2 recoveries on claims notified up to 30 June 2019. The outstanding liabilities in respect of this scheme are estimated annually and published in the Department's financial statements. The liability as at 30 June 2019 on a notification basis was estimated to be $16,000.

4.4.21 Participation in this scheme has been much lower than the estimates made at the beginning of the scheme. 244 midwives participated at 30 June 2019.

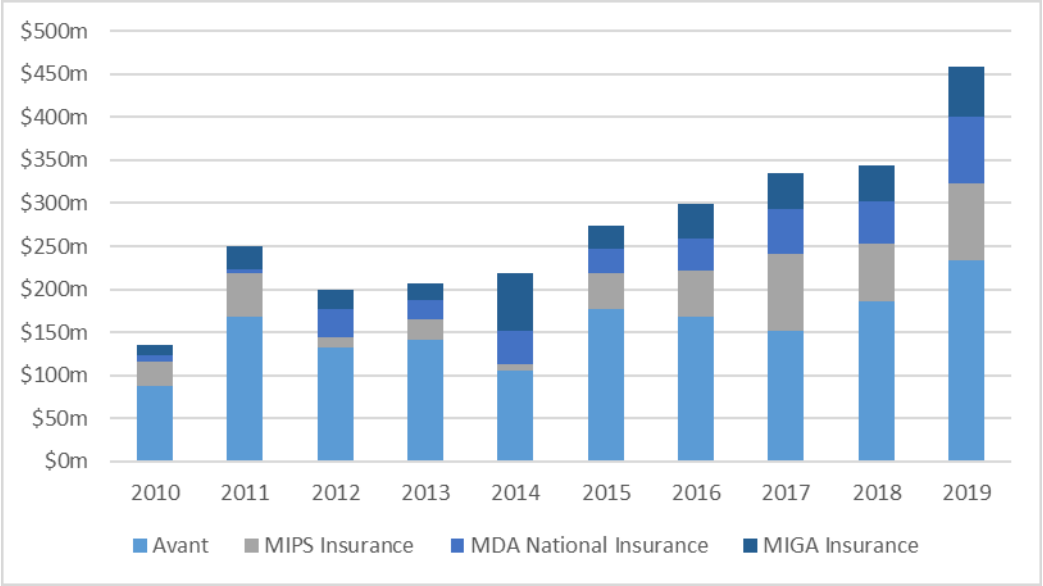
4.5 CLAIMS

Gross Claim Costs

4.5.1 A high level starting point for analysing industry claim experience is to consider the trend in total claims incurred over time. Stable net claims costs support industry stability. We first consider the gross claims costs incurred by the specialty insurers, as reported in their financial accounts. We will then examine the effect of private sector reinsurance and the HCCS on claims costs in order to illustrate the (more stable) net outcomes after the effect of these measures.

4.5.2 Figure 6 illustrates the progress of gross claims costs incurred by the specialist insurers since 2010.

Figure 6: Gross Incurred Claims Cost ($m)



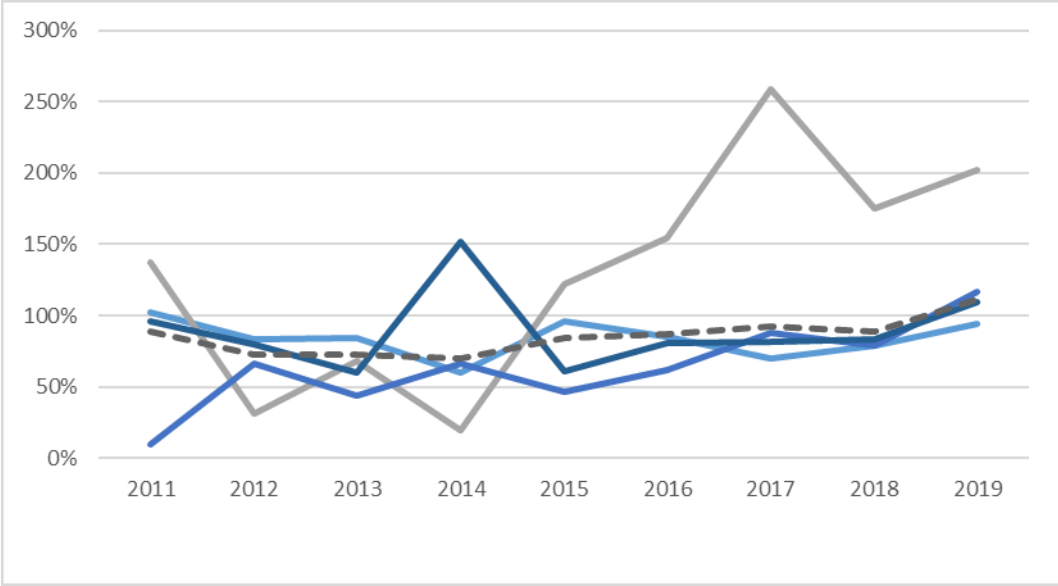
4.5.3 Industry gross claim costs have grown since 2013. Lower interest rates are one industry wide factor that will have contributed to higher gross incurred claims in recent years (to the extent that gross incurred claims rely on discounted future cash flows). Anecdotal evidence also points to an increase in claims initiated by compensation lawyers and some specialities incurring higher numbers of large claims. Whilst these trends are being managed by insurers and are not a current threat to stability, the potential for insurers to reduce premiums in the near term appears lower than it may have been ten years ago.

4.5.4 Individual insurers can appear to experience higher levels of volatility in gross claims costs. This can be attributable to natural claims volatility, but may also be attributable to decisions taken by management to alter the approach to reserving at specific points in time. Both of these features will be present in Figure 6.

4.5.5 Examination of the total costs does not provide a perspective of the claims costs relative to premium income and can mask the volatility of claims experienced by individual insurers. To address this, Figures 7, 8 and 9 examine the Loss Ratio for each insurer on various bases. The industry average is included for comparison purposes. Examination of the variability in the loss ratio from year to year provides a perspective on stability.

4.5.6 The Gross Loss Ratio is presented in Figure 7. The Gross Loss Ratio is the Gross Incurred Claims divided by the Gross Earned Premium for the corresponding year. The dashed line represents the Gross Loss Ratio for all specialist insurers, combined. The solid lines represent individual specialist insurers.

Figure 7: Gross Loss Ratio



4.5.7 Figure 7 illustrates that, whilst the gross loss ratio for the industry as a whole has been relatively stable over time, the experience for individual companies can be considerably more volatile. The steady increase in the industry average loss ratio over the last four years, particularly in 2019, is also notable and presents an emerging risk. Factors underlying this trend have been highlighted, as part of the commentary relating to Figure 6 of this report.

4.5.8 Differences in loss ratios across companies will be impacted by differences in claims experience. Other factors impacting the loss ratios may include:

- A different business model, for example charging a higher proportion of revenue (e.g. a membership fee) through the group holding company, which reduces the earned premium received by the insurance subsidiary.

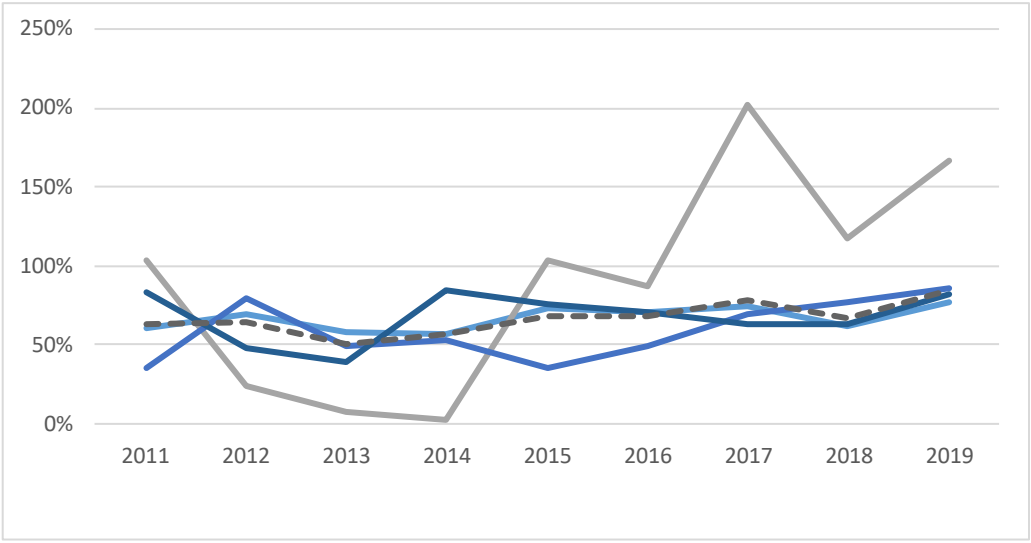
- A different reserving basis, where incurred claims can be assessed at different levels of certainty by different companies. This would impact the timing of emerging losses, and in turn, the loss ratios reported in an individual year.

4.5.9 Whilst an insurer is exposed to the variation in claims represented by the movement in the Gross Loss Ratio over time, an insurer does take steps to protect itself against this variation through the purchase of reinsurance. Insurers are further protected by the presence of the HCCS. As the Gross Loss Ratio does not illustrate these mitigating effects, an insurer's stability is not fully represented by only observing the Gross Loss Ratio. Measures that consider these mitigating factors are discussed below.

4.5.10 Insurers publish net claims costs after the effect of private sector reinsurance recoveries, HCCS and other non-reinsurance recoveries. This permits the

calculation of a Net Loss Ratio. Figure 8 sets out the Net Loss Ratio for each specialist insurer, and for the industry. The Net Loss Ratio is Net Claims (after reinsurance and other recoveries) divided by the Net Earned Premium (earned premium minus earned reinsurance premium).

Figure 8: Net Loss Ratio



4.5.11 The net loss ratio is after the effect of reinsurance and HCCS. Comparison of Figure 7 and Figure 8 shows an improvement in the stability of the loss ratio for all insurers after the effect of reinsurance and the HCCS, as expected.

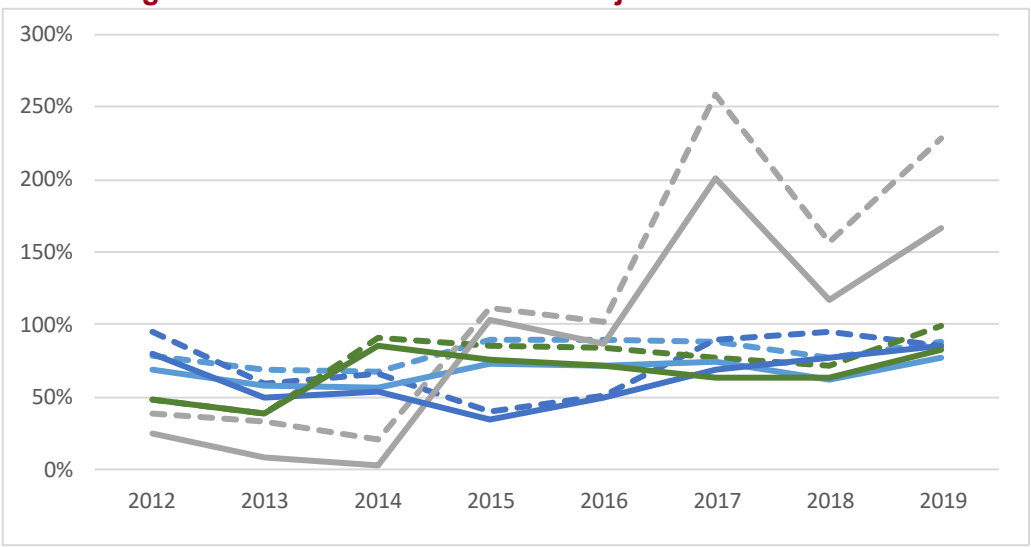
4.5.12 Factors underlying the increasing loss ratios have been commented on, under Figure 6 of this report. An additional factor underlying the increase in the net loss ratio is the increase in the threshold for the HCCS.

4.5.13 To illustrate the singular effect of the HCCS in improving the stability of the medical indemnity insurance industry, we have investigated whether it is possible to adjust the Net Loss Ratio for the HCCS recoveries the insurers incurred in each year. This could be done by increasing the net incurred claims reported by the insurers, by the amount of HCCS recoveries. An indication of the impact of the HCCS on stability is then evident by examining the difference between the adjusted loss ratio and the final net loss ratio from year to year.

4.5.14 Ideally, this calculation requires the calculation of an HCCS incurred amount for each historical year. This requires reliable historical data from insurers when submitting HCCS claims to the Commonwealth as well as historical HCCS payment data from the Commonwealth. On inspection, the available historical HCCS data was not suitable. To provide some indication of the effect of the HCCS on industry stability we have substituted HCCS payments for the HCCS incurred amount. Figure 9 compares the Net Loss Ratio to an HCCS Adjusted Net Loss Ratio. The latter is taken to be equal to the (Net Claims Incurred + HCCS Recovery Paid) / Net Earned Premium. Dashed lines represent the Net

Loss Ratio before HCCS recoveries and the solid lines represent the Net Loss Ratio. Line colours are fixed for each insurer.

Figure 9: Net Loss Ratio v HCCS Adjusted Net Loss Ratio



4.5.15 Whilst the illustration is qualified by the available data, the comparison illustrates the approximate impact of the HCCS in reducing the net claims cost and claims volatility.

4.5.16 The variance of the Adjusted Net Loss Ratio (before HCCS recoveries) is greater than the variance of the Net Loss Ratio (after HCCS recoveries) for all insurers. This confirms that the HCCS supports the stability of the medical indemnity insurance industry, however the effect of this can vary from year to year. The finding is necessarily qualified by the use of HCCS payment data, rather than incurred HCCS data.

4.5.17 The HCCS has reduced the year to year volatility of claims costs for insurers. It has also reduced the gross costs of claims to insurers by approximately 12%, since July 2010. This is based on the data provided by insurers (under s34ZW of the *Medical Indemnity Act 2002*). In the absence of the HCCS, premiums would need to be higher if the industry was to operate at sustainable loss ratios. Through this lens, the HCCS is supporting the affordability of medical indemnity insurance premiums. The contribution of the HCCS to affordability is discussed further in the following chapter of this report.

4.6 PROFIT

4.6.1 Stability of the market size and premium pool, the availability of capital to support variations in experience, the mitigating effects of reinsurance, and the financial support provided by the IIF are all factors that should combine to support the stable emergence of profitability over time. An insurer's financial position is ultimately supported by stable and ongoing profitability. It is therefore appropriate to examine the profitability of the medical indemnity insurance industry over time.

4.6.2 Table 4 shows the total of APRA's financial data for the specialist insurers. The table shows the average of the last 5 years of financial performance data and the proportion of gross earned premium (GEP) of each item.

Table 4: Combined Profit & Loss of Specialist Insurers

Item	Avg. 2011-14	%	2015	2016	2017	2018	2019	Avg. 2015-19	%
Gross written premium	305.24		331.59	364.47	401.91	414.73	420.40	386.62	
Gross earned premium	288.73		324.11	342.79	361.38	388.15	412.67	365.82	
Reinsurance expense	38.27	13%	38.17	39.46	39.89	37.25	40.94	39.14	11%
Net earned premium	**250.46**		**285.94**	**303.34**	**321.49**	**350.89**	**371.73**	**326.68**	
Gross incurred claims	218.46	76%	274.40	299.11	335.19	344.31	458.16	342.23	94%
Reinsurance recoveries	15.67	5%	7.08	15.91	42.18	31.61	50.38	29.43	8%
Non-reinsurance recoveries	55.68	19%	73.29	77.26	39.63	76.18	92.57	71.79	20%
Net incurred claims	**147.11**	**51%**	**194.02**	**205.95**	**253.38**	**236.52**	**315.21**	**241.02**	**66%**
Underwriting expenses	23.30	8%	26.78	29.01	31.94	33.97	37.65	31.87	9%
Underwriting result	**80.05**	**28%**	**65.13**	**68.38**	**36.17**	**80.40**	**18.87**	**53.79**	15%
Investment income	102.46	35%	59.17	48.21	47.47	50.82	85.32	58.20	16%
Other items	-104.68	-36%	-92.21	-100.28	-78.52	-92.31	-80.59	-88.78	-24%
Net profit/loss after tax	**77.83**		**32.09**	**16.32**	**5.12**	**38.91**	**23.60**	**23.21**	
Net profit as % GEP	**27%**		**10%**	**5%**	**1%**	**10%**	**6%**	**6%**	

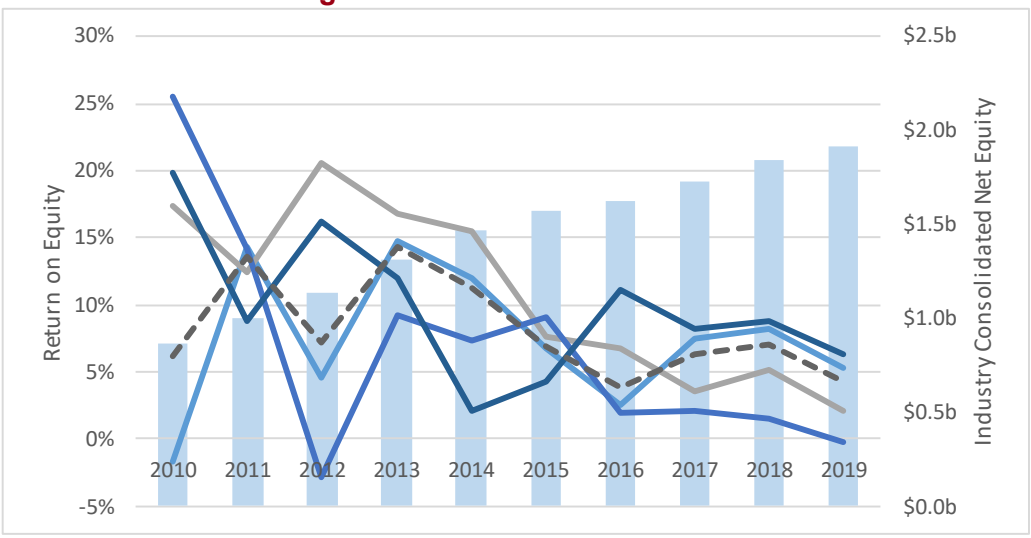
[1] Percentages are as a % of gross earned premium

4.6.3 Table 4 shows that the specialist insurers have written business profitably over the past 5 years, achieving an average net profit of 6.3% of gross earned premium. This is similar to the general insurance industry as a whole, which achieved an average result of 6.9% over the same 5 year period. The margin for medical indemnity insurers has declined relative to the prior 4 year period. This is largely attributable to higher net incurred claims, reduced investment income and reduced 'other' items as a percentage of gross earned premium.

4.6.4 Whilst insurer profitability declined in the most recent 5 year period, relative to earlier periods, the industry has remained profitable in each year. This in turn

will have contributed to the stability of the industry and the strength of its capital position.

Figure 10: Return on Net Assets



4.6.5 Industry profitability can mask the greater variability in the profitability of each group entity. Figure 10 sets out the annual profitability of each consolidated group as a percentage of each groups consolidated net assets.

4.6.6 Figure 10 shows that the industry, represented by the dotted line, has been profitable in every year since 2010. As may be expected, this corresponds with a period of steadily increasing net assets (represented by the bars in the background). Each consolidated group has been profitable on all but three occasions. Where individual groups have generated losses, they have been less than 3% of net assets and losses have not persisted.

4.6.7 Industry Return on Equity has declined over the last ten years. Anecdotal evidence suggests that this is consistent with the industry transitioning from a period early in the IIF, where it was important to build prudential capital, towards a stance that is more akin to managing existing capital.

4.7 FINDINGS

4.7.1 Medical indemnity insurers have enjoyed a period of relative stability over the past decade. Industry net incurred claims have averaged 68% of net earned premium and have ranged between 51% and 85% in the period 2011 to 2019. The highest amount of claims was in the most recent year (2019), which continues the trend of the net loss ratio increasing over the last five years. Lower interest rates and the changes to the HCCS threshold are two industry wide factors that will have contributed to higher loss ratios in recent years. Insurers' may also be choosing to operate with a higher net loss ratio in recent years, transitioning from a capital rebuilding phase early in the life of the IIF to one of capital management in recent years.

4.7.2 Consistent with the above trend, insurers have experienced a positive average profit margin of 13.8% of gross earned premium since 2010/11. However the average over the past 5 years has reduced to 6.3%. The latter being more in line with what was achieved by the general insurance industry as a whole. In 2019, whilst the net loss ratio was worse than earlier years, the profit margin was in line with the average of the last five years.

4.7.3 Insurers enjoy strong capital positions, relative to the minimum capital that is required under APRA's general insurance prudential standards. Sound capital positions will further serve industry stability in the future.

4.7.4 Average reinsurance expenses as a proportion of gross written premium have reduced. They are lower than for the general insurance industry but this is largely due to the free Commonwealth provided HCCS reinsurance cover. The capacity of reinsurance available in the market and the number of reinsurers has also remained adequate over time.

4.7.5 These observations are drawn from the industry level data and data published by each specialist insurer. Whilst they are relatively high-level observations of the experience of the industry, the data does indicate that the industry is enjoying a period of stability and profitability. This is not to say that the future will be without challenges. For example, at the time of writing this report, the industry is managing recent upwards trends in the cost of claims, a period of lower investment returns and changes in experience associated with the COVID19 pandemic.

4.7.6 The HCCS has contributed to the stability of the medical indemnity insurance market. However limitations in the data make the calculation of measures of exactly how this has contributed, difficult. Given the limitations of the data, cash HCCS payments have been used as an approximate guide of the HCCS contribution to the industry.

4.7.7 The HCCS reduces the volatility of insurer's net claims costs. This increases the stability of the industry. In turn, there is expected to be a flow on effect to improving the stability of premiums.

4.7.8 The HCCS has also made a material contribution to reducing the net claims costs of insurers, particularly in respect of some of the larger, higher risk, medical speciality groups. In turn, this should have the effect of improving the general affordability of insurance, but particularly so for these higher risk groups.

5 AFFORDABILITY OF MEDICAL INDEMNITY INSURANCE

5.1 OVERVIEW

5.1.1 This chapter examines the level of premiums paid by medical practitioners over the last 13 years. In section 5.2, we examine the overall level of premiums paid by medical practitioners in nominal terms, for each speciality. Section 5.3 examines trends in affordability by examining premiums as a percentage of private practice income. Results are provided for the industry as well as for the largest and riskiest speciality groups. Two IIF schemes contribute directly to improved affordability; the PSS and the HCCS. The effect of each of these schemes is then considered in sections 5.4 and 5.5, respectively.

5.1.2 This analysis excludes those with ROCS levies less than $80. This is to avoid distortions caused by those with a very low premium, such as students, interns and those who work mainly in the public system.

5.1.3 The data collected to assess the affordability of insurance premiums paid by medical professionals includes information on actual premiums charged as well as reported estimated income or billing bands for individual practitioners. Data was supplied by the medical indemnity insurers for the last 15 years. In addition, we have also been provided with historic PSS payments administered by Services Australia and historic payments in relation to the HCCS, ECS, and run-off cover schemes for medical professionals and midwives.

5.1.4 There are limitations to the analysis presented in the section that the reader should bear in mind:

- Some insurers' parent entities charge membership fees, which can be a significant amount on top of the premiums. Where membership fees are charged, they are a pre-requisite for purchasing a medical indemnity policy; therefore they are relevant in the context of affordability. Furthermore, membership fees can be included in the calculation for premium support under the PSS. For the purpose of examining the affordability of medical indemnity insurance and the impact of IIF in this chapter, these membership fees have been included in the analysis. We have not examined the operations of holding companies (which are not insurers) relative to their insurance subsidiaries or the membership pricing.

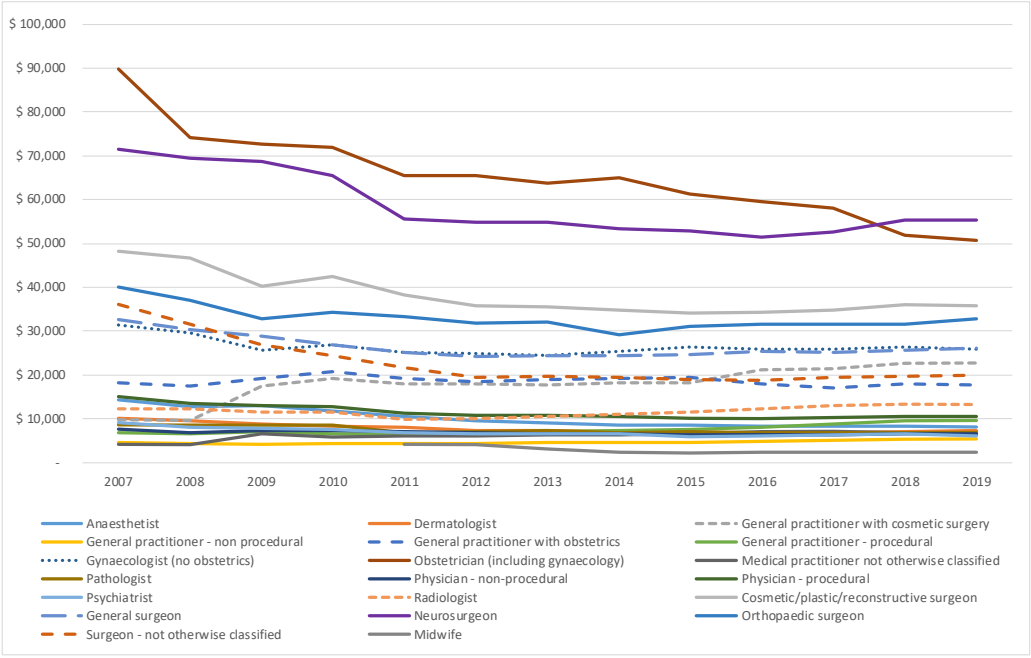
- Some insurers provide other benefits that are not directly related to the medical indemnity insurance of the medical practitioner. Examples are practice insurance or retirement dividend plans. These are strategic choices of the insurer, or the group holding company. The effect of these benefits on premiums has not been quantified in this report.

- Private practice income was not provided for midwives or health professionals.

5.2 Nominal Insurance Premiums

5.2.1 Figure 11 sets out the median premiums in nominal values since 2007, before PSS subsidies. They include membership fees.

Figure 11: Median Premium by Specialty ($ Nominal)



5.2.2 The median premium in nominal terms has remained relatively stable or decreased from 2007 to 2019 for almost all specialities. Only five specialties including certain small subgroups of general practitioners have seen an increase in the median nominal premium, i.e. before adjusting for wage increases, over this period.

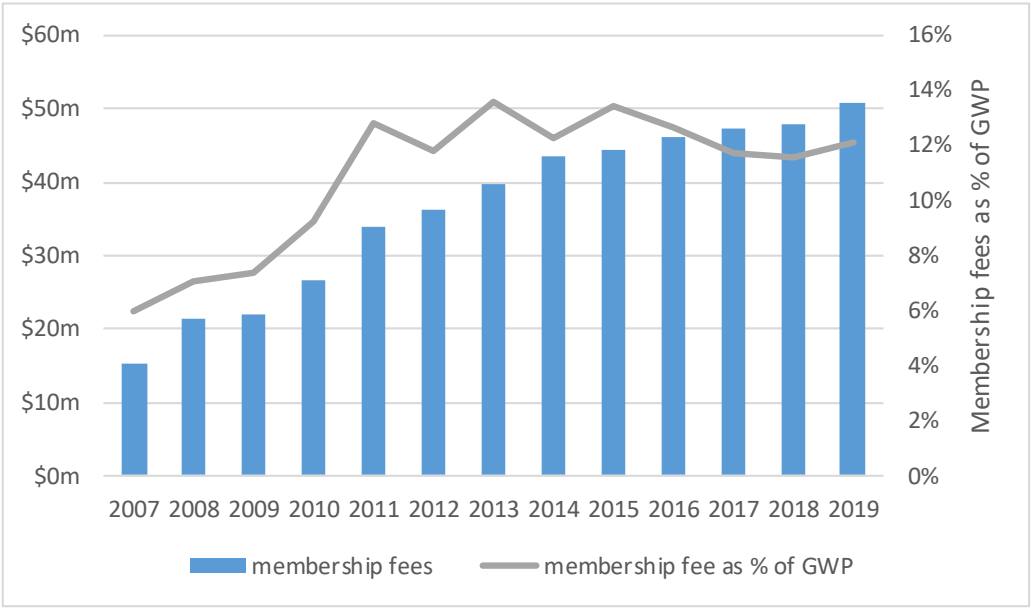
5.2.3 In recent years, premiums have generally been stable, and in some specialties have increased slightly. Apart from the expected effects of inflation, this is consistent with broader industry trends including lower interest rates, a higher HCCS threshold and the claims experience of some specialty groups.

5.2.4 When nominal premiums are adjusted for private sector Average Weekly Earnings (AWE) as shown in Figure 12, there has been a decrease in real premium rates over this period. The greatest decline appears to be in the most expensive premium brackets. Note that the impact of the reduction in the ROCS levy from 8.5% to 5% of net premium in 2009 appears to have been offset by other factors.

Figure 12: Nominal vs Real Premium

5.2.5 For completeness, Figure 13 shows the membership fees collected by the industry in nominal terms since 2007. The nominal amounts have grown from $15m to $51m over this period, and as a proportion of Gross Written Premium (GWP) it has increased twofold. The amount of membership fees charged varies widely between insurers.

Figure 13: Membership Fees (nominal)

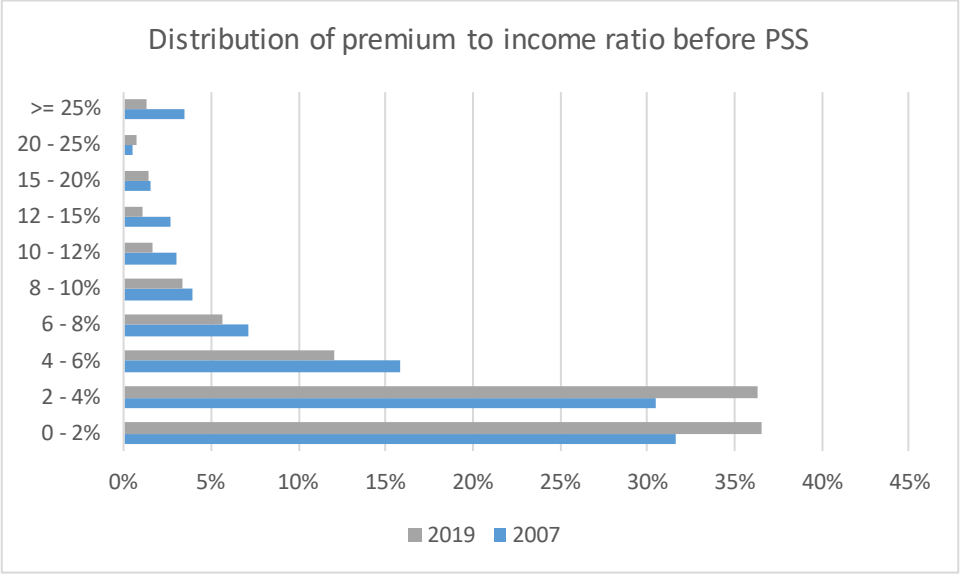


5.3 Premiums as a Percentage of Income

By Industry

5.3.1 Premiums (including membership fees) before PSS subsidies, as a proportion of income, have also declined marginally over time. The median premium was approximately 2.5% of private practice income in 2019. The equivalent percentage in 2007 was 3.1%. Further, more policies now have a premium which is less than 10% of private practice income. Around 94% of all policies paid less than 10% in 2019 compared to 89% in 2007. Most of this reduction occurred early in the period under examination. This proportion has remained around 95% for the past eleven years. Similarly, around 73% of all policies paid less than 4% of private practice income in 2019, compared to 62% in 2007. This proportion has also remained steady for the past eleven years. The distribution of premiums as a percentage of private practice income (before PSS) is shown in Figure 14.

Figure 14: Distribution of premium to income ratio before PSS



By Specialty

5.3.2 Industry averages can mask a changing mix of practitioners over time. To overcome this, analysis has been completed by speciality. Figure 15 and Figure 16 show the median, 25th and 75th percentile results for two of the largest specialties by number of policies. Combined, they account for over 60% of all policies written each year. Membership fees are included in the charts.

Figure 15: Premium for Non-Procedural GPs as a Percentage of Private Practice Income

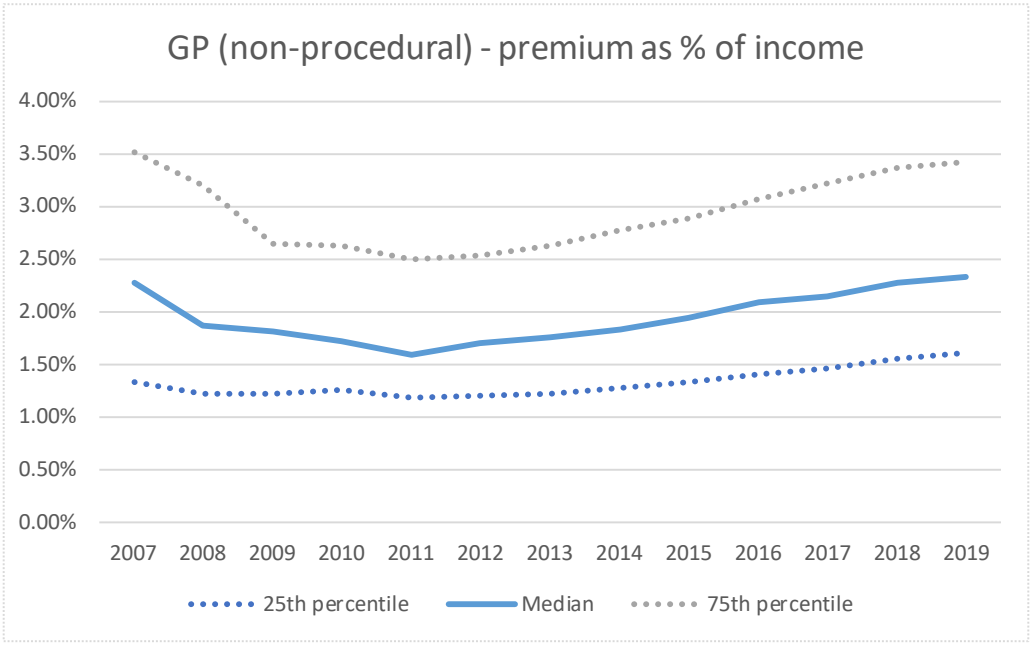
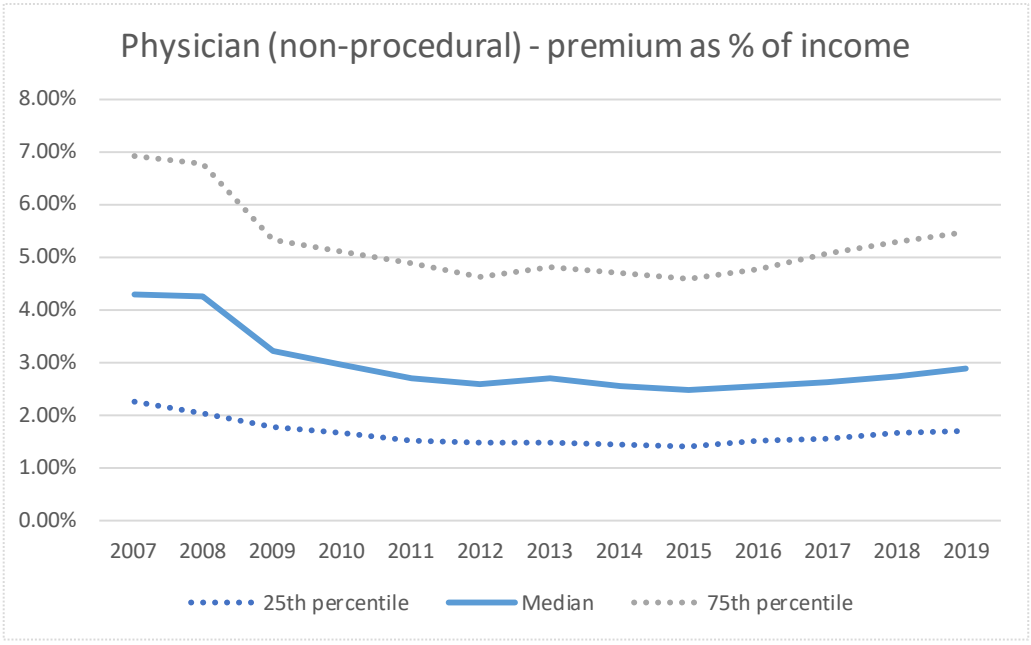


Figure 16: Premium for Non-Procedural Physicians as a Percentage of Private Practice Income



5.3.3 For these two largest groups, the median premium to income ratio before PSS subsidies has remained under 3% for the past ten years. The 75th percentile of this ratio has remained under 3.5% for GP (non-procedural) and under 7% for physician (non-procedural) since 2008. For around 90% of GPs (non-procedural) and around 65% of physicians (non-procedural), premiums are less than 4% of income over this period.

5.3.4 Further analysis of the specialities that pay the higher premiums is also useful. Figure 17 through to Figure 19 illustrate the median, 25th and 75th percentile results for three of the highest cost specialties, that is, where premiums are the highest proportion of private practice income.

Figure 17: Neurosurgeon Premium as a Percentage of Private Practice Income

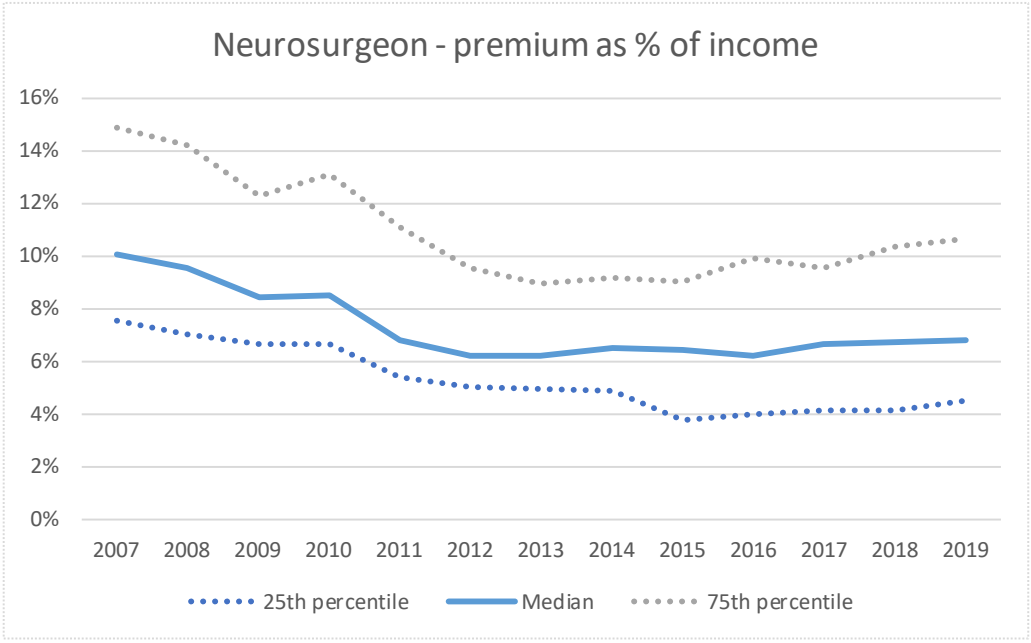


Figure 18: Gynaecologist Premium as a Percentage of Private Practice Income

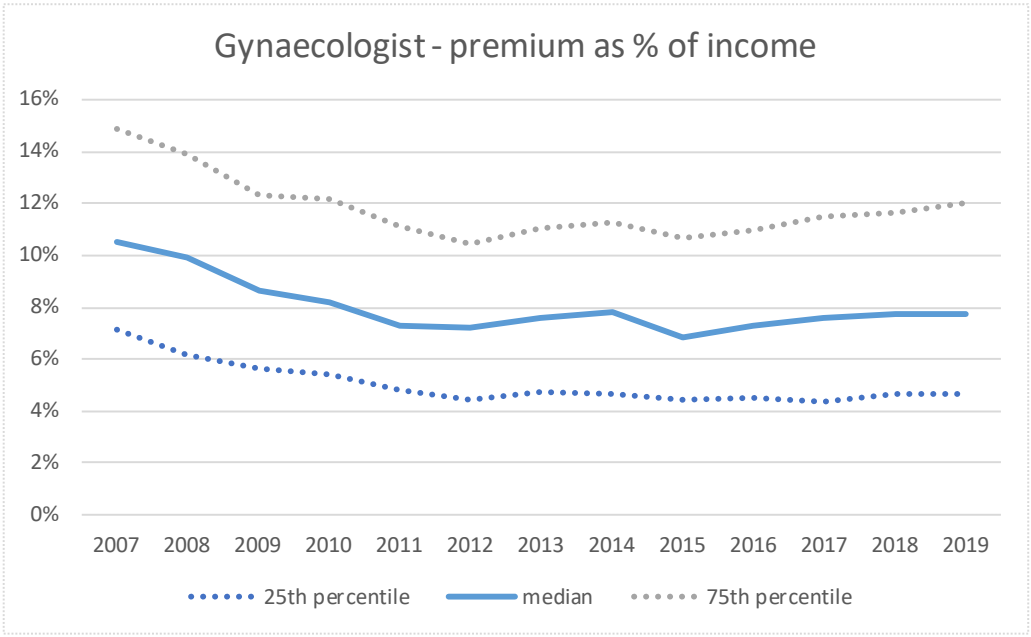
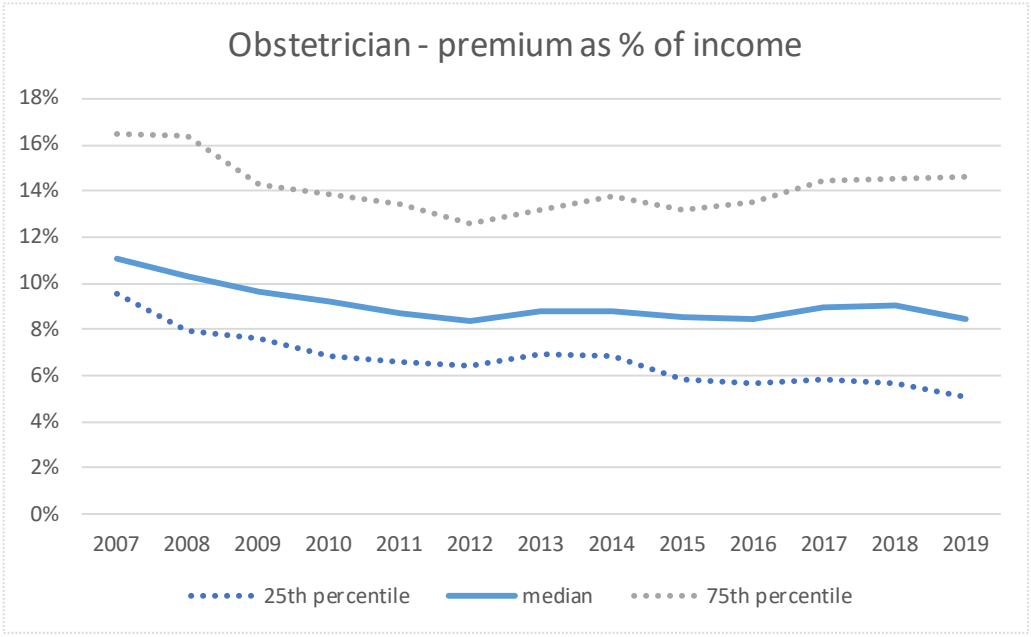


Figure 19: Obstetrician Premium as a Percentage of Private Practice Income

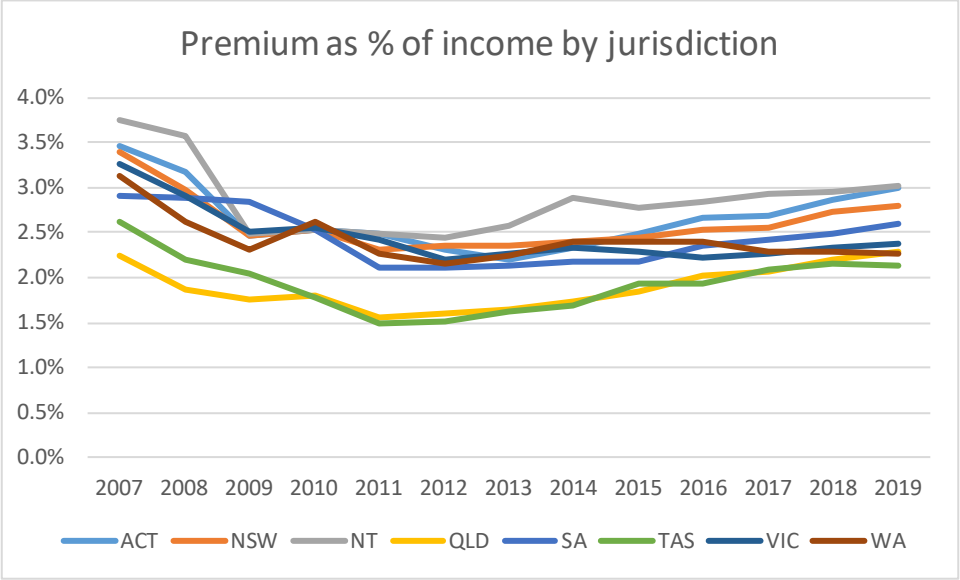


5.3.5 Since 2007, the median ratio of pre-PSS premium to private practice income has fallen for all three specialities. The decrease is also evident across the 25th and 75th percentiles. The range has remained relatively stable over the period. The median ratio is now below 8.5% for the three highest cost specialities. The impact of the PSS is examined in the next section.

Subgroup Analysis

5.3.6 Affordability can also be examined across other factors. Figure 20 examines premium affordability by State. This illustrates that there are differences between jurisdictions (with Queensland and Tasmania consistently being the most affordable). Premiums in the ACT, NT and NSW are the least affordable overall.

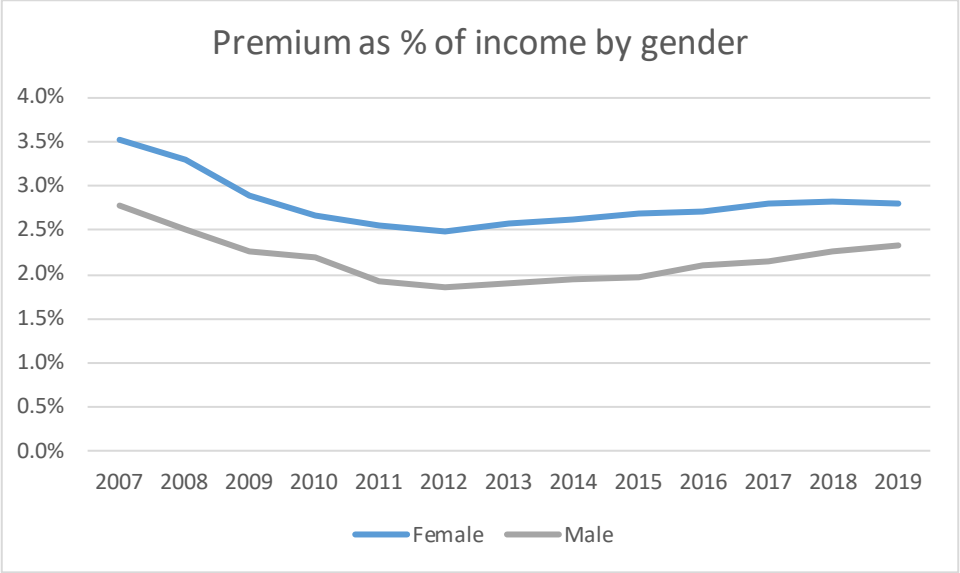
Figure 20: Premium as a Percentage of Private Practice Income by State



5.3.7 Premiums in all states, except Victoria and WA have shown a consistent deteriorating trend since 2013. Some of this increase is attributable to the increase in the HCCS threshold from $300,000 to $500,000. The jurisdictional differences by state may have also impacted the above trends and relativities.

5.3.8 There also appears to be a consistent difference between genders, with female practitioners having on average about 25% higher premium to income ratios than their male counterparts, as shown in Figure 21.

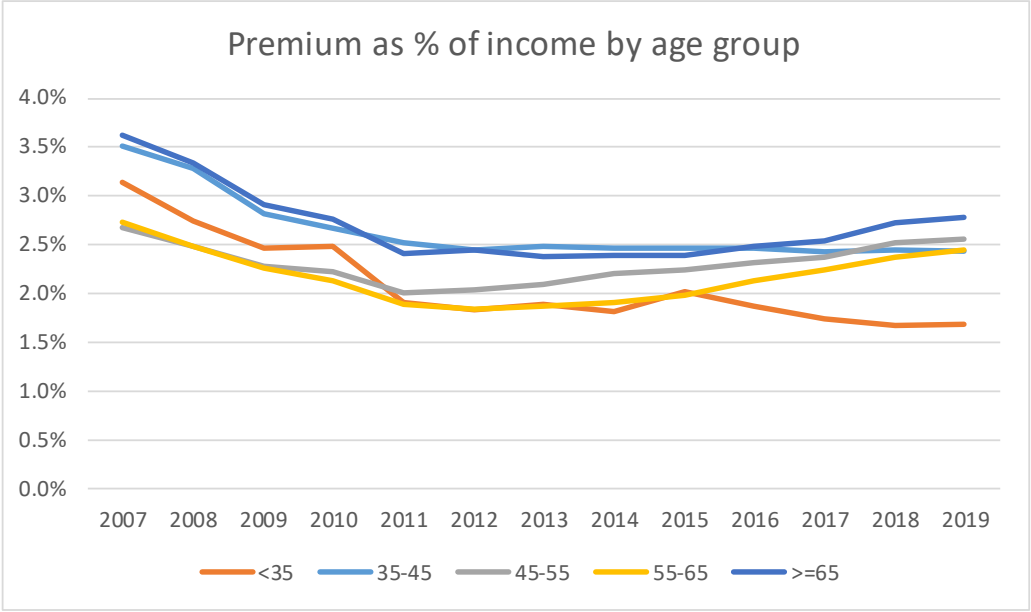
Figure 21: Premium as a Percentage of Private Practice Income by Gender



5.3.9 These differences may be attributable to a different mix of speciality groups by gender or other inherent differences in the mix of practices that would affect the premium. It may also be attributable to differences in income, in particular, the proportion of part time workers, as premiums often have a fixed component to cover operational costs.

5.3.10 There also appears to be a convergence across age groups as shown in Figure 22, except in the case of medical practitioners younger than 35, for which the affordability appears to have significantly improved and is now better than the other age groups.

Figure 22: Premium as a Percentage of Private Practice Income by Age Group



5.3.11 The analyses above have been performed on an industry wide basis due to commercial sensitivity.

Income Analysis

5.3.12 The private practice income is an essential component in the affordability analysis. Given that nominal premiums have remained stable, the affordability of medical indemnity insurance would have improved if income has increased.

5.3.13 Figure 23 shows the nominal income distribution of all medical practitioners in 2019 versus 2007. Figure 24 shows the income distribution of non-procedural GPs. Both charts show an improvement in nominal income over this period, which would be expected due to inflation over this period.

Figure 23: Income distribution of all medical practitioners

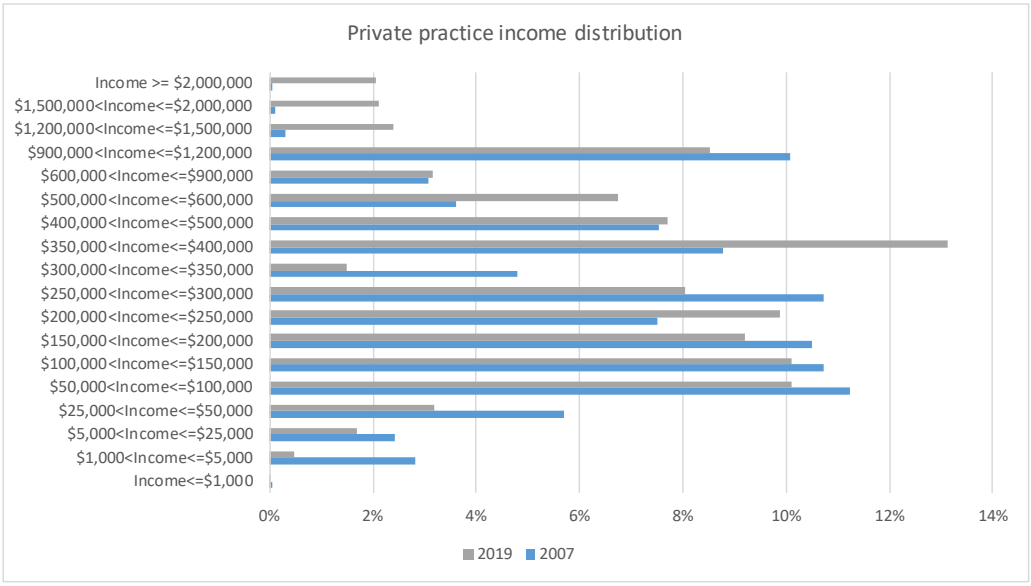
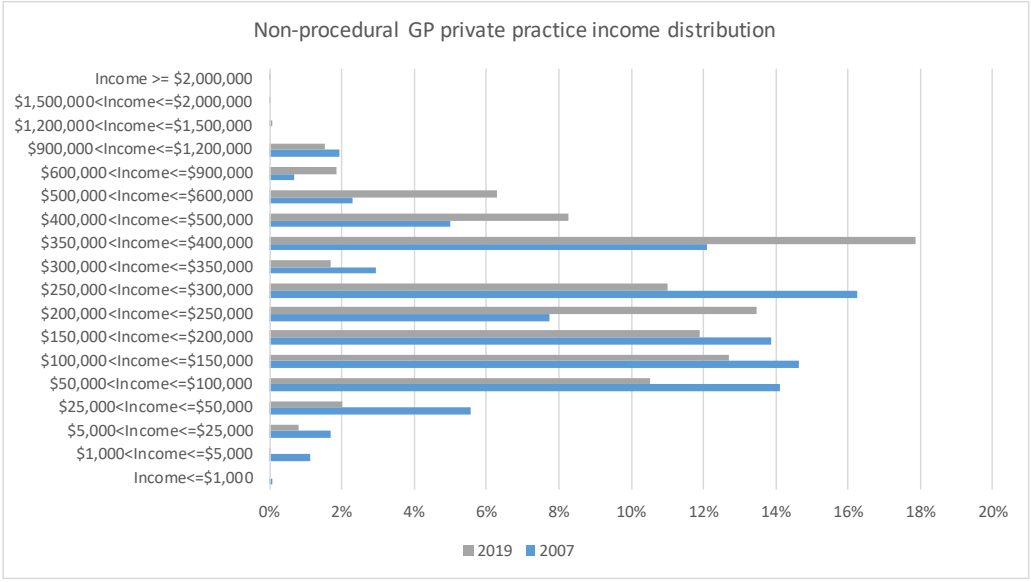
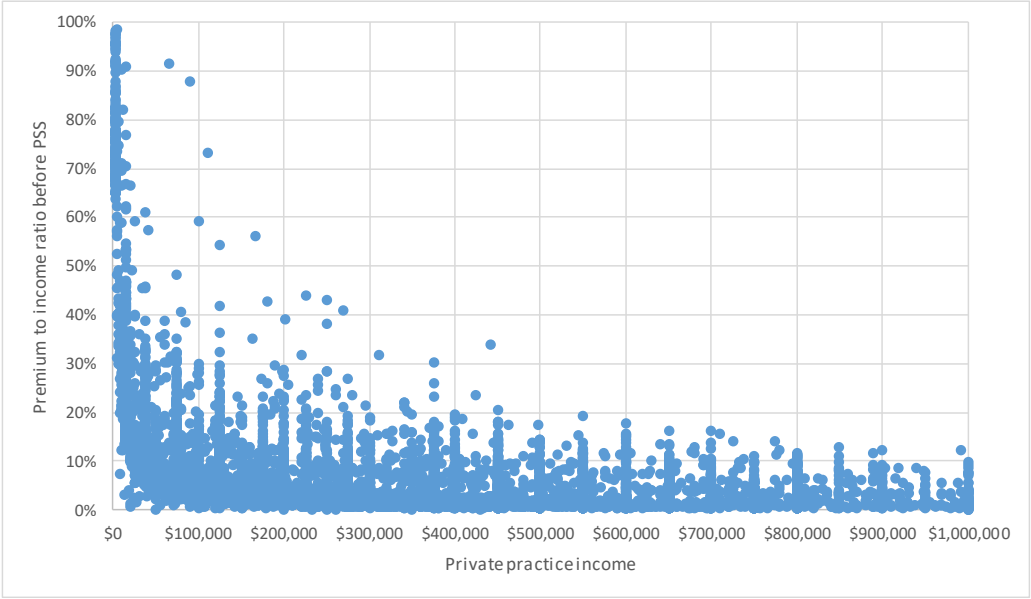


Figure 24: Income distribution of non-procedural GPs



5.3.14 Figure 25 shows the relationship between private practice income and premium to income ratio (before PSS) in 2019. Perhaps intuitively, it confirms that affordability generally improves with income.

Figure 25: Relationship between affordability and income in 2019



5.4 PREMIUM SUPPORT SCHEME

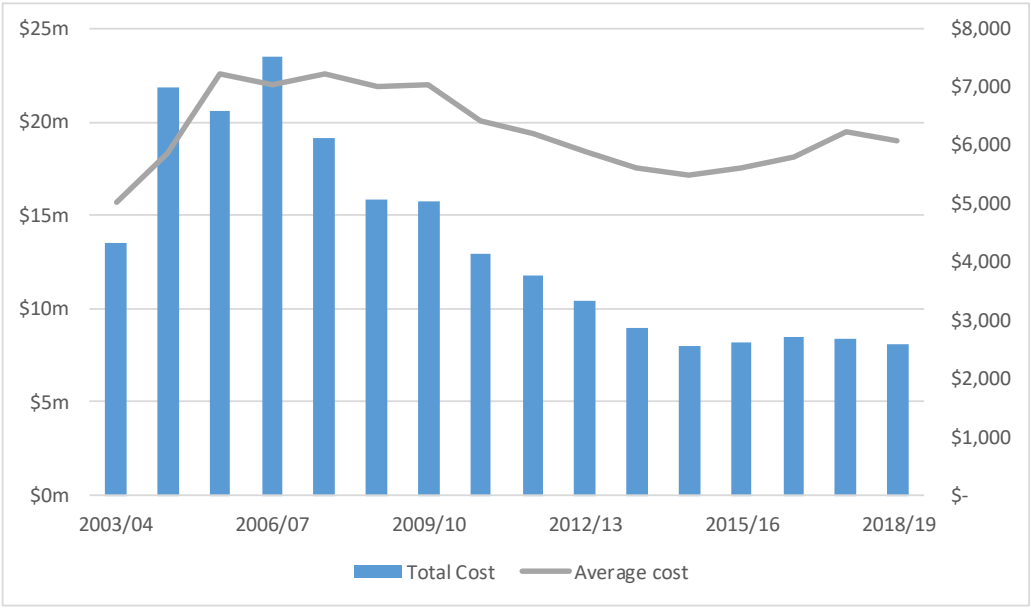
Overall Usage of the PSS

5.4.1 The PSS assists with the affordability of insurance premiums by providing eligible medical practitioners with a subsidy towards their private practice medical indemnity insurance premiums. The PSS provides 60% of the cost of the premium in excess of a threshold set at 7.5% of gross private medical income. For procedural GPs in rural areas a higher subsidy may apply. For this cohort, the PSS provides 75% of the difference between their actual premium and the premium for a non-procedural GP in similar circumstances, regardless of any other PSS eligibility criteria.

5.4.2 Membership fees are included in the calculation of gross indemnity costs, which is used for calculating the PSS subsidy. However, this only applies to practitioners with substantial insurance costs (more than 7.5% of private practice income) and not to a procedural general practitioner practising in a rural area. The calculation of PSS subsidy for a procedural general practitioner practising in a rural area uses their base premium costs, which excludes membership fees.

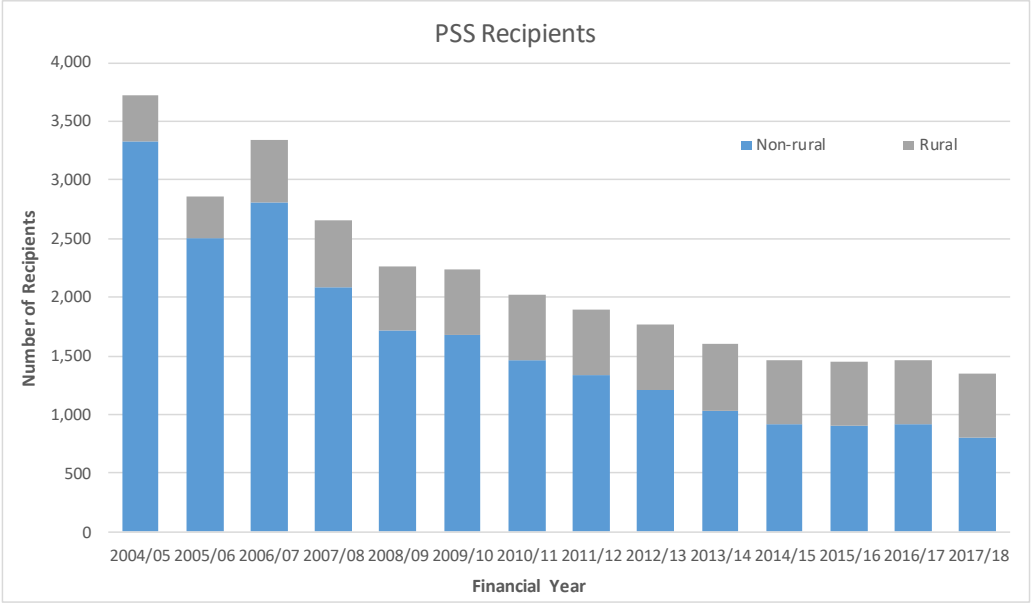
5.4.3 In recent years, the PSS scheme has been accessed less than in the past. Since 2014/15 the total subsidies paid have remained similar, whilst the average subsidy per recipient has increased slightly. Figure 26 shows the total and the average amount of PSS subsidies paid by Services Australia over the last 16 years, excluding administration costs reimbursed to the insurers (note the figure for 2018-19 includes an estimate for one insurer who has not submitted its application at the time the analysis was undertaken).

Figure 26: PSS Payments



5.4.4 The PSS is not accessed equally between medical practitioners or by region. Figure 27 shows the split of policyholders between rural and non-rural regions.

Figure 27: Total recipients over time — rural and non-rural

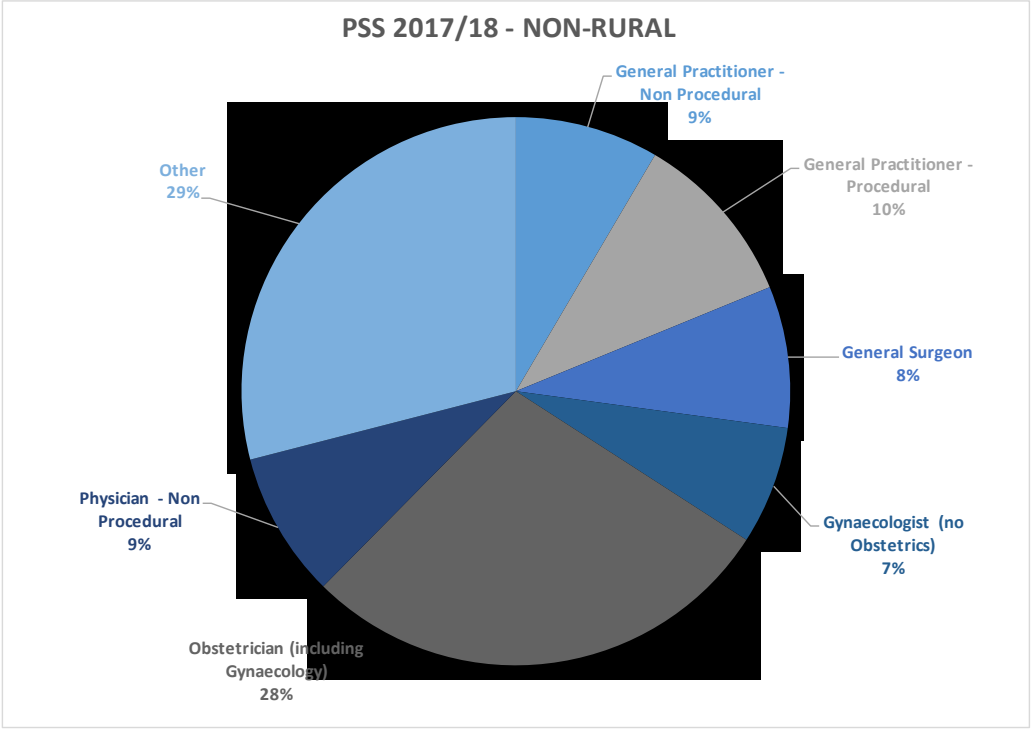


5.4.5 The total number of PSS recipients has reduced over time. Fewer medical professionals are facing premiums in excess of 7.5% of their private practice income. This is consistent with the trend in premiums seen over time where premiums have generally decreased as a proportion of income, particularly for the high cost specialties.

5.4.6 Although the numbers of rural doctors has remained relatively stable over the same period, they have become a larger proportion of the PSS recipients over time. Almost all rural PSS recipients are general practitioners performing additional procedural services or obstetrics. This is to be expected as it is in line with the rural eligibility criteria set out for the PSS.

5.4.7 The non-rural PSS recipients are split across a number of specialty categories, with the largest group (28%) in 2018 being obstetricians including gynaecology. Figure 28 shows the split of non-rural specialties accessing the PSS.

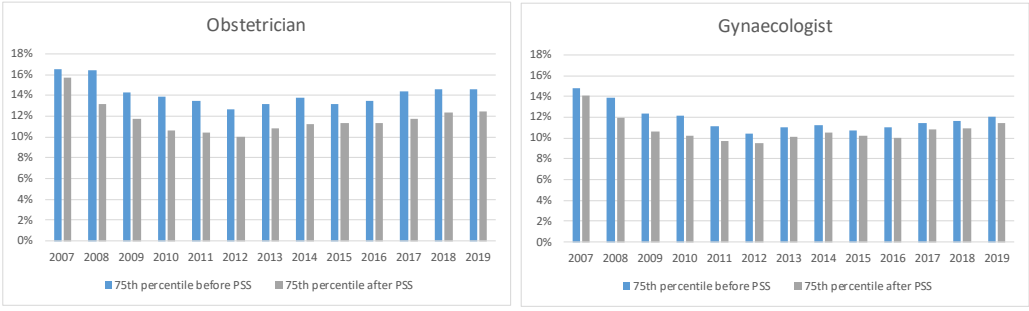
Figure 28: Split of specialities for non-rural PSS policies



Impact of the PSS on Affordability

5.4.8 The impact of the PSS on affordability (as defined by premium as a proportion of private practice income) is most significant for obstetricians and gynaecologists. Figure 29 indicates the impact of PSS on affordability for these specialities.

Figure 29: Impact of PSS on affordability by speciality



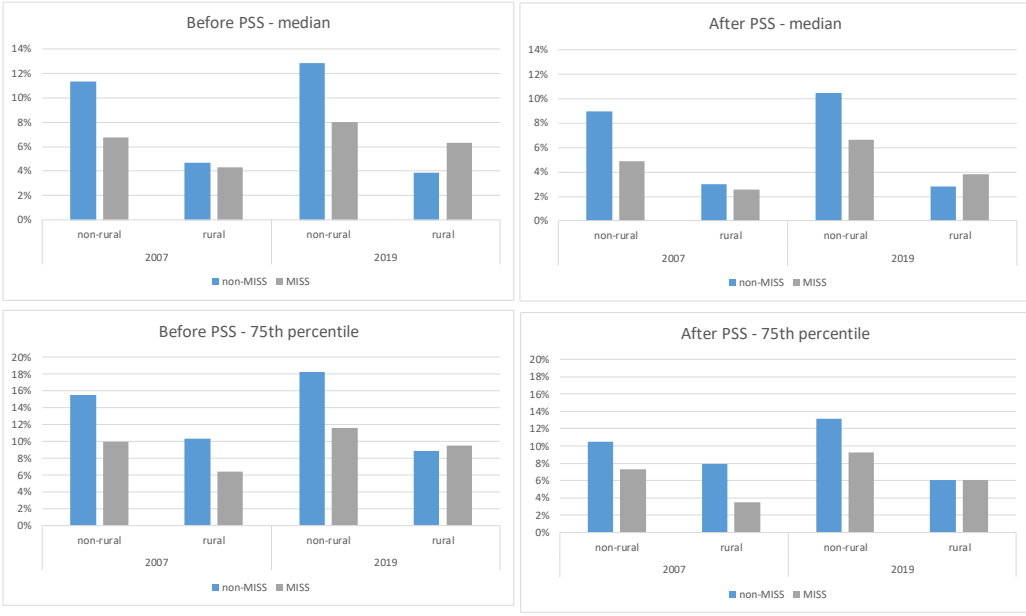
5.4.9 The impact of the PSS on affordability also appears slightly higher for rural and remote practitioners, as seen in Figure 30.

Figure 30: Impact of PSS on affordability by region

5.4.10 For a short time period before the PSS, a similar scheme named the Medical Indemnity Support Scheme (MISS) provided premium subsidies to a selected group of medical practitioners. They were grandfathered when PSS replaced MISS, and their subsidy is the greater of the MISS subsidy or PSS subsidy. Figure 31 shows the differences in affordability influence by the subsidy between MISS and non-MISS participants. Note that only the medical practitioners who have received a premium subsidy are included in this chart, hence the premium to income ratios are much higher than that for the general population. It shows

that this grandfathered group in general have retained a lower premium to income ratio with and without the subsidy when compared to the rest of the PSS participants, except for rural practitioners. It also shows that the PSS had a similar impact on the affordability for both MISS and non-MISS groups in both years. This grandfathered group represents 0.9% of all medical practitioners in 2019, down from 1.5% in 2007. On the other hand, this group represents an increasing proportion of PSS participants, up from 37.5% in 2007 to 40.3% in 2019.

Figure 31: Impact of PSS on Affordability by MISS Status



5.4.11 It is worth noting that the South Australian government also provides a premium subsidy to rural GPs especially those with obstetrics. This further improved affordability for rural medical practitioners. Before the South Australian subsidy, the median and 75th percentile of premium to income ratio for rural former-MISS medical practitioners were slightly higher in 2019 than in 2007, as shown in the charts above. While not shown in the charts above, the difference between 2019 and 2007 becomes negligible after the SA subsidy.

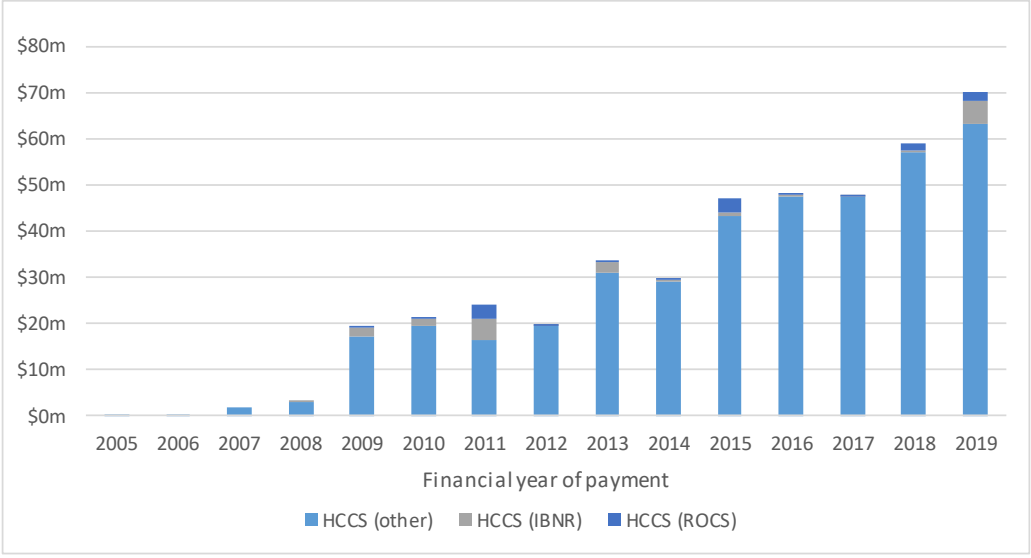
5.4.12 As shown in this section, affordability has generally improved before the PSS subsidies, and the impact of PSS and South Australian subsidies mainly benefited rural and former-MISS medical practitioners. The reduced participation in the PSS over time reaffirms the improved affordability of medical indemnity premiums.

5.5 High Cost Claim Scheme

5.5.1 The HCCS provides 50% of costs for claims to insurers above a threshold claims cost of $500,000. Over the most recent three years, this scheme has provided, on average, $60 million to insurers per year and its impacts on the stability of the industry are covered in previous sections. The HCCS indirectly affects the level of premiums to medical practitioners by limiting the exposure to larger claims costs for insurers and in turn, their reinsurers. A reduction in expected net claims costs through the free reinsurance cover provided by the Commonwealth should reduce the premiums charged by insurers.

5.5.2 Figure 32 shows that the HCCS payments have steadily increased over time and that most payments related to claims outside of the IBNR and ROC Schemes.

Figure 32: HCCS Payments by Financial Year



5.5.3 The following table shows the HCCS payments over time as a proportion of the industry's gross incurred claims and net premium.

Table 5: HCCS Payments

Payment Year	HCCS Total	Gross Incurred Claims	%	Industry Net Premium	%
2007	1,767,226	118,700,000	1%	339,388,000	0.5%
2008	3,190,336	140,452,000	2%	347,621,235	0.9%
2009	19,373,672	242,119,000	8%	289,485,000	6.7%
2010	21,399,995	135,707,000	16%	305,928,000	7.0%
2011	24,011,264	226,179,000	11%	288,267,000	8.3%
2012	19,915,117	237,669,000	8%	283,626,000	7.0%
2013	33,867,832	194,542,000	17%	287,847,000	11.8%
2014	29,971,827	235,750,000	13%	307,167,000	9.8%
2015	47,064,366	238,780,000	20%	309,519,000	15.2%
2016	48,115,652	287,908,000	17%	325,983,000	14.8%
2017	47,877,791	298,944,000	16%	347,256,000	13.8%
2018	59,104,484	367,157,000	16%	374,913,000	15.8%
2019	70,094,253	436,113,000	16%	391,734,000	17.9%
Total	425,753,817	3,160,020,000	13%	4,198,734,235	10.1%
2015-19	272,256,547	1,628,902,000	16.7%	1,749,405,000	15.6%

5.5.4 In the last five years, cash HCCS payments have been approximately 17% of gross incurred claims, which is broadly similar to 16% of the ROCS levied premium. The industry net premium, which is used as the ROCS levy base has averaged 90% of the gross written premium of the specialist insurers over the past 5 years.

5.5.5 It should be noted that the percentages in Table 5 understate the level of Commonwealth provided HCCS support. This is because it compares cash HCCS payments in a year with gross incurred claims. To gauge the true level of HCCS support, the incurred HCCS liability for a year should be compared with the gross incurred claims for that year. Unfortunately, reliable information on incurred HCCS liabilities for a particular year is not available and we have used cash HCCS payments as a proxy for incurred HCCS liabilities. Cash HCCS payments lag incurred HCCS liabilities as liabilities arise when the risk is incurred, whilst claims may be notified and settled many years later. Very roughly, we estimate that, had we had access to reliable information on incurred HCCS liabilities for the last five years, the percentages shown would have been about one to two percentage points higher.

5.5.6 The proportion of total claims costs that are met by the HCCS will reduce in the near future as the increase in the HCCS threshold takes effect. The historical averages set out above do not take into consideration the recent increase in the HCCS threshold from $300,000 to $500,000. Normal patterns of claim settlement will mean that even the 2019 claims in the table above will have been eligible for the $300,000 threshold. AGA analysis at the time the threshold changed estimated that the HCCS recoveries by insurers may reduce by around 28%. This would suggest that, going forward the HCCS payments to insurers are expected to be approximately 12% of gross incurred claims and 11% of Net Premium (the ROCS levied premium) for that year.

5.5.7 This suggests that the HCCS improved affordability by reducing gross premiums by approximately 17% to 20% prior to the threshold increasing. Going forward this percentage may reduce to around 11% to 14%, following the increase in the HCCS threshold.

5.6 COMMENTS

5.6.1 Overall, affordability as measured by premiums as a proportion of private practice income has improved since 2007 for most policyholders.

5.6.2 The HCCS has contributed to improved affordability and has reduced gross premiums by approximately 17% to 20% in recent years. Following the recent increase in the threshold for this scheme we estimate that this effect will reduce to around 11% to 14%.

5.6.3 Premium support has been accessed by fewer practitioners over time, with a large reduction in the non-rural practitioners accessing the scheme. This is consistent with the trends seen for high cost specialities where premium as a proportion of income has declined over time thus leading to fewer policyholders with premiums in excess of 7.5% of income. The level of rural practitioners accessing the PSS has remained relatively stable and is comprised largely of general practitioners who also perform procedural or obstetric services.

6 AVAILABILITY OF MEDICAL INDEMNITY INSURANCE

6.1 INDEMNITY INSURANCE FUND

6.1.1 There are elements of the IIF that do not directly address industry stability or improved affordability of medical indemnity insurance. These elements are perhaps better described as addressing the availability of medical indemnity insurance. For example, Run Off Cover Scheme (ROCS) ensures that the public have the protection provided by run off cover after the professional has retired, passed away, or migrated out of Australia. ROCS therefore ensures protection is available to the public when it may not be possible to address the complaint directly with the medical professional. The ECS provides protection to the public should damages exceed $20 million (a typical upper limit of available indemnity policies). In a slightly different manner, the IBNR scheme provides availability to claims where the company (UMP) would otherwise have become insolvent in 2003.

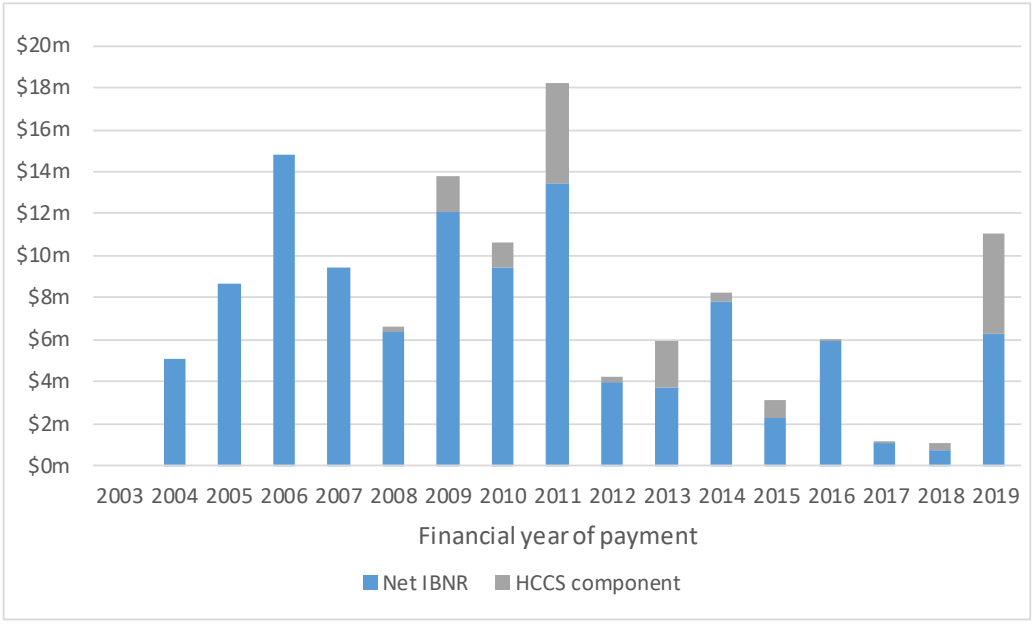
6.1.2 As these aspects of the IIF do not directly address aspects of stability and affordability, they have not been fully canvassed in the earlier chapters of this report. For completeness, they are addressed in this chapter.

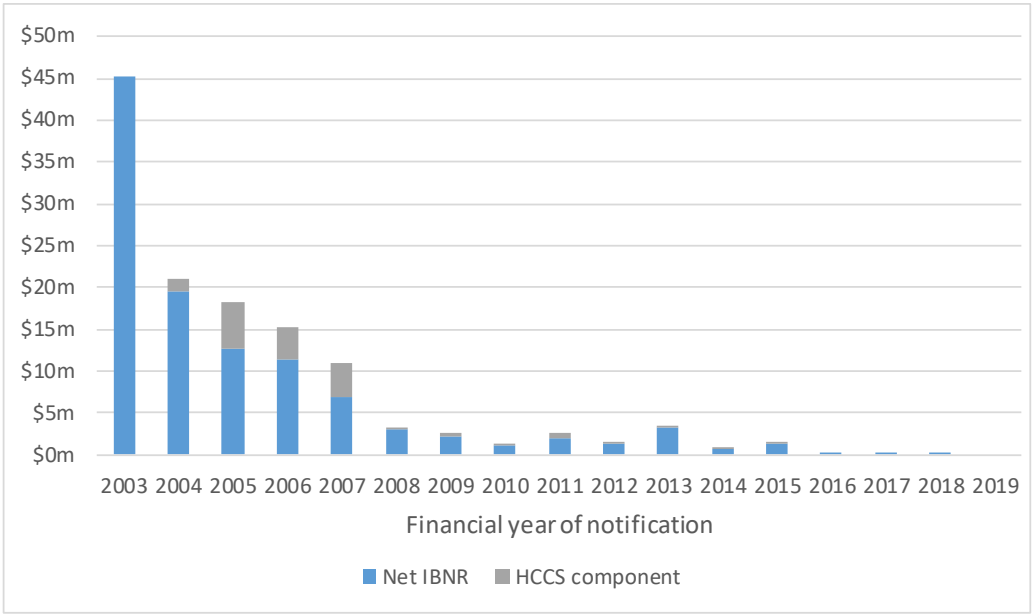
6.2 INCURRED BUT NOT REPORTED SCHEME

6.2.1 The Incurred but not Reported (IBNR) scheme contributes to the availability of insurance for medical practitioners who purchased cover for periods prior to 30 June 2002. Prior to 2003, when United Medical Protection (UMP) was placed into provisional liquidation, these medical practitioners had purchased policies that included cover on a claims-incurred basis. This meant that they had paid for policies that should have covered them for claims that were incurred during the policy period. The provisional liquidation of their insurer meant these claims would not have been met had the government not stepped in. This action provided stability to the insurance industry as it relieved UMP (now a subsidiary of Avant) of a specific liability to assist the company return to solvency.

6.2.2 Only Avant participates in the IBNR scheme, through its subsidiary UMP. The scheme reimburses the full costs of claims that were incurred prior to 30 June 2002 to UMP as they are paid plus 5% of the total claim costs to cover claims handling expenses (CHE). Figure 33 shows the total benefits paid over recent years (including CHE) by financial year of notification and by financial year of payment. Figure 33 illustrates the natural decline in claims costs since the introduction of the scheme as only incidents that occurred prior to 2002 are covered under the scheme. It also illustrates the contribution of the HCCS to reducing the volatility in claims costs from year to year. Note that the large payment in 2019 relates to one single event that occurred in 1996 and was notified in 2005. In this case, the delay from incident to payment was more than 20 years.

Figure 33: IBNR Claims Costs





6.2.3 A total of $111m has been paid under the IBNR Scheme to 30 June 2019, including the 5% claims handing expenses. In addition, around $17m HCCS has been paid in respect of these same claims.

6.2.4 Figure 33 shows the cost of claims notified since 2008 has been lower than $5m a year, and this has reduced to less than $200,000 a year since 2016. This declining trend is expected to continue. The outstanding liabilities in respect of this scheme are estimated annually and published in the Department's financial

statements. The financial statements at 30 June 2019 report that this scheme currently has an outstanding liability, including claims handling expenses, of $12 million (discounted at 1.0% p.a.). In January 2020, we reviewed this estimate based on the most recent data received from Avant, and the estimate was unchanged.

6.2.5 Beyond this regular review of the outstanding liabilities, there is no further monitoring of this scheme. The scheme is not operated by an APRA regulated insurer, so there is no additional APRA reporting where companies regularly submit their accounts.

6.2.6 Whilst the benefit of the scheme to the insurer is self-evident, this scheme largely serves a historical purpose. The scheme is not relevant to the cover currently offered to practising medical practitioners.

6.3 RUN-OFF COVER SCHEME

6.3.1 The ROCS should be viewed separately from other schemes.

6.3.2 This scheme provides long term insurance to medical practitioners where claims arise (generally) after the medical practitioner retires or ceases private practice. Practitioners currently pay a 5% levy to government throughout their working life and, in return, receive insurance cover after they cease to earn an income from private medical practice.

6.3.3 ROCS provides a means for medical practitioners to confidently fund the cover they need for claims that may arise after they cease private practice. In contrast to the situation before 2002, medical practitioners can now pay their premium for this cover to the Commonwealth with confidence that claims will be met when required. There is an increasing need for this type of cover as the number of medical practitioners becoming eligible is cumulative.

6.3.4 While some run-off covers are underwritten by insurers, they only cover the three-year waiting period between resigning from private practice and becoming eligible for the Commonwealth ROCS. The Amendment Act waives this waiting period, thus placing greater importance on ROCS.

6.3.5 Claim size generally increases with the length of delay, and 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, thus making such covers difficult to price. We have not sought to determine whether the private insurers could provide similar run-off covers in the absence of the scheme. ROCS effectively provides a government guarantee that the eligible claims will be paid, thus providing the public confidence in their ability to obtain adequate compensation in the event of medical malpractice. This confidence is expected to be greater than had similar cover been provided by a private insurer.

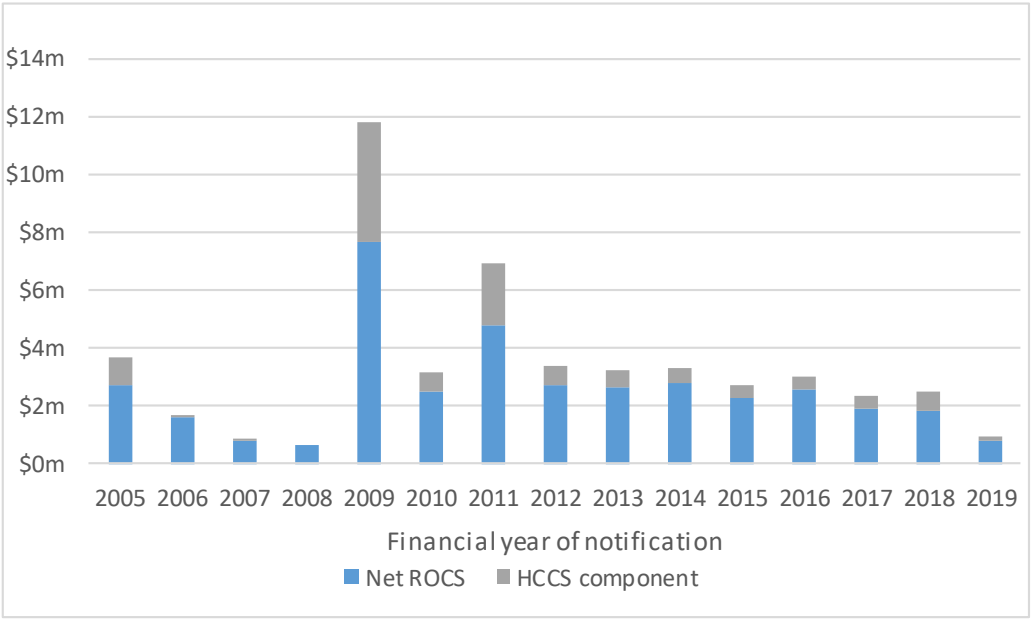
6.3.6 In addition to providing availability of run-off covers and instilling public confidence in medical services, ROCS also reduces the volatility of the insurers'

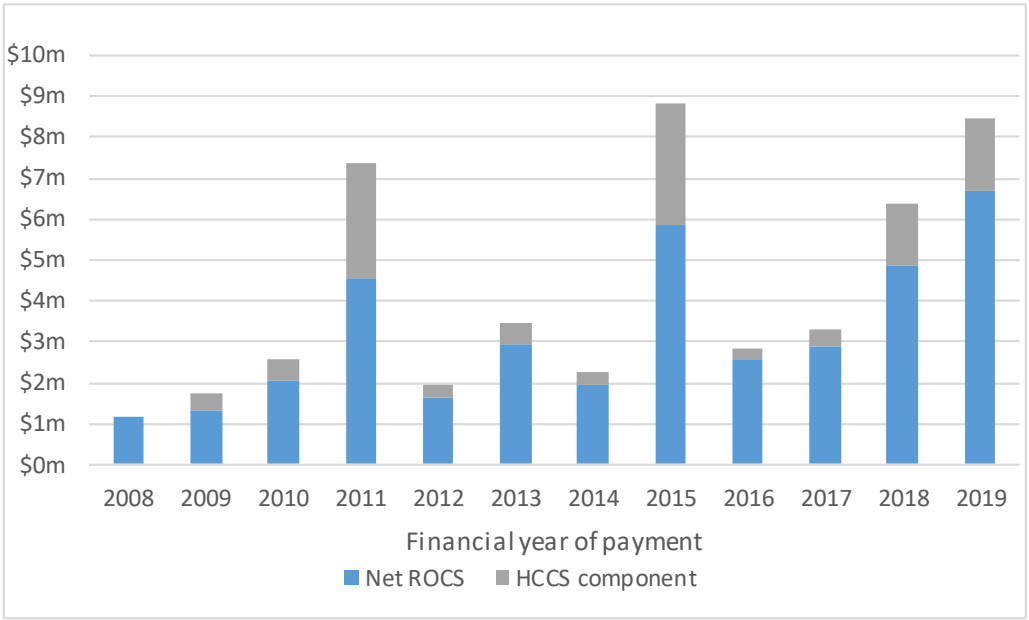
claims costs by removing a material portion of long tailed claims, if they were covered by insurers. This volatility can be quite large given the positive correlation between claim size and the length of delay.

6.3.7 As the Commonwealth is accruing liabilities under this scheme, it is a requirement that I report on the scheme annually. The fifteenth report was tabled in August 2020 and all past reports are available on the website of the Australian Government Actuary. Readers of this report seeking detailed analysis over the history of this scheme are referred to those reports.

6.3.8 Figure 34 sets out the progress of claims incurred under ROCS by financial year of notification and by financial year of payment. As the cost of large ROCS claims are partially met by the HCCS, Figure 34 illustrates each component of ROCS incurred claims cost.

Figure 34: ROCS Claims Costs





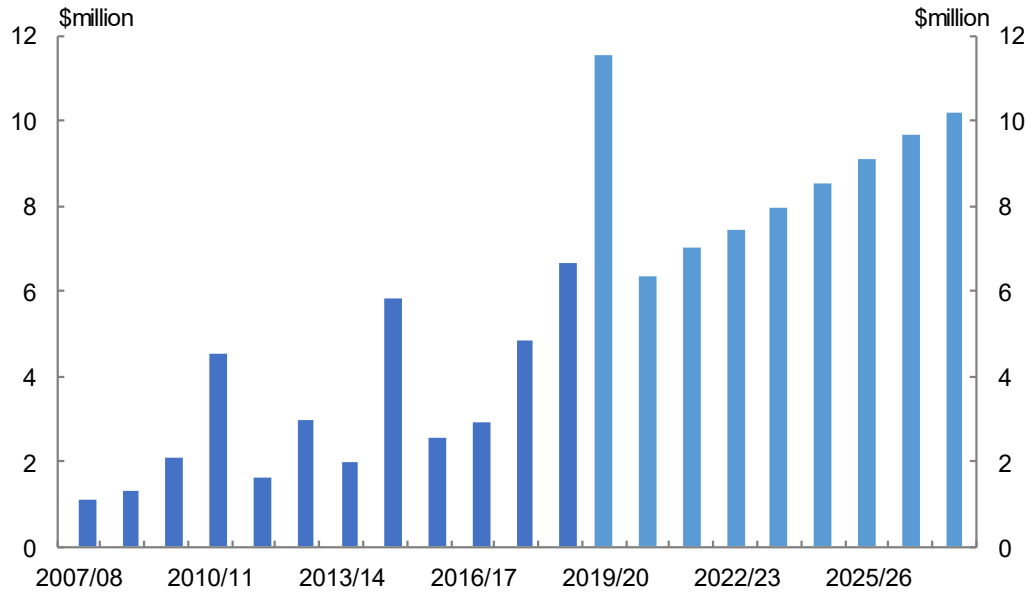
6.3.9 Around 17,500 medical practitioners have become eligible for ROCS as at 30 June 2019. However, there is uncertainty regarding the accuracy of this number due to difficulties in tracking the eligibility of doctors across multiple insurers over time. This is discussed in the ROCS reports.

6.3.10 As the number of medical practitioners eligible for the scheme is much lower compared to the HCCS, the scheme has a much lower number of claims than under the HCCS. Consequently, the volatility of cash costs to the

Commonwealth from year to year is greater. Over the past 3 years to 30 June 2019, the Commonwealth has paid an average of $4.8m per year in net ROCS claims (including CHE). The amount paid in the first six months of 2019-20, however, has already exceeded $5m, highlighting the volatility of the costs of this scheme.

6.3.11 Claims costs are expected to increase significantly in future years as more medical practitioners become eligible. Those becoming eligible now are also likely to have more years of medical practice under the scheme. This in turn increases their exposure to potential claims. Figure 35 sets out the historical and projected future ROCS claims payments sourced from the fifteenth report into ROCS.

Figure 35: Historical and Projected ROCS Claims Costs



6.3.12 The outstanding liabilities in respect of this scheme are estimated annually and published in the Department's financial statements. The financial statements at 30 June 2019 report that this scheme currently has an outstanding liability, including claims handling expenses, of $103 million (discounted at 1.0% p.a.). In January 2020, we reviewed this estimate based on the most recent data received from the insurers, and the estimate was slightly reduced to $98 million (discounted at 1.1% p.a.).

6.3.13 In addition to the liabilities noted above, should ROCS ever be wound up and not replaced by a similar scheme, the government is required to refund past ROCS levies with interest where the medical practitioner is not yet eligible to claim. The total amount of ROCS levies and accumulated interest are monitored by Services Australia and is currently approximately $350 million. However, as the data is currently inadequate for accurately assessing the eligibility status of the individual medical practitioner, the exact liability that would arise in the event of the government determining that the scheme is wound up is not known.

6.3.14 In return for the government assuming liability for ROCS claims, insurers pay a premium to the government. This is referred to as the ROCS levy. The ROCS levy is currently set at 5% of net premiums as defined in The Amendment Act. The number of medical practitioners contributing to ROCS stands at around 92,000 as at 30 June 2019.

6.4 EXCEPTIONAL CLAIMS SCHEME

6.4.1 Under the Exceptional Claims Scheme (ECS), the government meets the excess costs of all claims above the maximum policy limits (which is typically up to $20 million). No claims have been paid under this scheme. No levies are received by the government in respect of this scheme. The limit of $20 million has been constant since 1 July 2003.

6.4.2 Whilst the scheme has not yet been called upon, the effect of this scheme is to provide protection to the public where a claim as defined by the Act exceeds the upper limit of the insurance industry's capacity.

6.4.3 It remains to be seen whether private reinsurers could offer an alternative to the ECS. Given the cost incurred under the ECS to date is nil, the cost of alternative private reinsurance may be insignificant. However, the capital and the profit margin required by reinsurers for underwriting such covers will translate into a minimum premium even in the absence of any likely claims. Moreover, reinsurers may be reluctant to offer the same unlimited coverage currently provided by ECS.

6.4.4 Similar to ROCS, the advantage of a government guarantee can equally be said about the ECS. That is, the ECS provides the availability of a government guaranteed upper layer of insurance cover given the usual contract limit of $20 million, thus providing the public confidence in their ability to obtain adequate compensation in the event of medical malpractice.

6.5 MIDWIFE PROFESSIONAL INDEMNITY SCHEME (MPIS)

6.5.1 All privately practising midwives in Australia are required to purchase professional indemnity insurance. However, only one insurer (i.e. MIGA) currently provides this cover and it is effectively subsidised through the Midwife Professional Indemnity Scheme, which operates in a similar fashion to the HCCS.

6.5.2 Historically, midwife professional indemnity cover was only available to midwives practising in hospitals. The main reasons for the lack of cover available to privately practising midwives are that they represent a small premium pool and there is a lack of accurate and up-to-date data on likely claims costs.

6.5.3 Without the MPIS, therefore, privately practising midwives in Australia may find it extremely difficult to obtain adequate cover, thus undermining the maternity care options available to women.

6.5.4 The number of eligible midwives that have participated in the scheme stands at 244 as at 30 June 2019.

6.5.5 The outstanding liabilities in respect of this scheme are estimated annually and published in the Department's financial statements. The financial statements at 30 June 2019 report that this scheme currently has an outstanding liability of $16,000, based on one claim notified to date.

6.5.6 Since the level of participation in the MPIS has been much lower than expected, the Commonwealth is unlikely to accrue significant liabilities under the scheme in the medium term.

6.5.7 At this point, the scheme still excludes homebirth, with an exemption to enact this in place until December 2021.

6.6 Midwife Professional Indemnity Run-off Cover Scheme (MPIROCS)

6.6.1 Similar to the ROCS for medical practitioners, this scheme provides long term insurance to eligible midwives where claims arise (generally) after the midwife retires or ceases private practice. Eligible midwives currently pay a 10% levy to government throughout their working life and, in return, receive insurance cover after they cease to earn an income from private medical practice.

6.6.2 MIGA is the only participating insurer to date.

6.6.3 As the government is accruing liabilities under this scheme, it is a requirement that I report on the scheme annually. The ninth report will be tabled in 2020 and all past reports are available on the website of the Australian Government Actuary. Readers of this report seeking detailed analysis over the history of this scheme are referred to those reports.

6.6.4 In addition, the outstanding liabilities in respect of this scheme are estimated annually and published in the Department's financial statements. The Commonwealth has not incurred any payment under this scheme. Data provided by MIGA's actuary (in late 2019) indicated that they do not anticipate any MPIROC recoveries on claims notified up to 30 June 2019 and that only 14 midwives have become eligible for this scheme. The liability as at 30 June 2019 was estimated to be nil.

6.6.5 Similar to the ROCS for medical practitioners, should the MPIROC Scheme ever be wound up and not replaced by a similar scheme, the government is required to refund past MPIROC levies with interest where the midwife is not yet eligible to claim. The total amount of MPIROC levies and accumulated interest are monitored by Services Australia and was approximately $252,000 as at 30 June 2019. However, the exact liability is unknown as the data has similar shortcomings as described for the ROCS for medical practitioners.

6.6.6 Since the level of participation in the MPIS has been much lower than expected, the Commonwealth is unlikely to accrue significant liabilities under the MPIROC Scheme in the medium term.

6.7 Other Measures

6.7.1 In addition to the above, the availability of medical indemnity insurance is further enhanced by the Amendment Act.

6.7.2 The Amendment Act requires all medical indemnity insurers to provide universal cover to medical practitioners, whereas currently only the insurers that have a contractual arrangement with the Commonwealth for the PSS.

6.7.3 The Amendment Act has also clarified the eligibility of health professionals (currently covered under the HCCS and ECS) and private sector employee midwives not currently covered under the MPIS. From 1 July 2020, allied health professionals will have access to the allied health high costs claims scheme (AHHCCS) and the allied health exceptional claims scheme (AHECS) in respect of incidents that occurred on or after 1 July 2020. Pre-1 July 2020 incidents will continue to be covered under the existing HCCS (noting that allied health professionals do not currently have access to the ECS).

APPENDIX 1: INDUSTRY PARTICIPANTS

OVERVIEW

A.1.1 As at 30 June 2019 six private sector underwriters are providing MII in Australia. They are Avant Mutual Group Limited (Avant), Medical Indemnity Protection Society (MIPS), MDA National (MDAN), Medical Insurance Group Australia (MIGA), Guild Insurance (Guild) and Berkshire Hathaway Specialty Insurance Company (BHSI). Of these all but Guild and BHSI are specialist insurers, writing only medical indemnity insurance. The *Fourteenth Report on the costs of the Australian Government's Run-Off Cover Scheme for medical indemnity insurers* reported that the four specialist insurers write 98.5% of the market, by premium. Guild and BHSI are both relatively new entrants to the market.

AVANT MUTUAL GROUP

A.1.2 The Avant Mutual Group is a mutual medical defence organisation that was originally established in 1893. In practice it comprises a mutual holding company that owns a subsidiary called Avant Group Holdings Limited (AGHL). This, in turn, holds a number of subsidiaries, including the insurance subsidiary called Avant Insurance Limited. Avant Insurance Limited is APRA regulated and provides MII. As this report focusses on the stability and affordability of medical indemnity insurance, this report primarily focuses on Avant Insurance Limited. As the insurer sits within a wider group, the stability of the insurer can be supplemented by the financial strength of the holding company and, in some circumstances, subsidiaries within the wider group.

A.1.3 As Avant Insurance Limited is a fully owned subsidiary of AGHL, dividends may be payable from the insurer to AGHL. Similarly, the holding company may subscribe capital to the insurer, within its capacity to do so from retained earnings. For example, AGHL has undertaken to provide up to $102 million of capital to AIL in the event that AIL's regulatory capital adequacy multiple falls below 1.5[5]. Historical reported capital positions of the consolidated entity and insurer are shown in the table below.

[5] 2018-19 Financial Report

Year Ending	2011	2012	2013	2014	2015	2016	2017	2018	2019
Avant									
Consolidated Net Assets	693.30	724.59	840.27	947.73	1013.84	1032.89	1105.60	1192.90	1251.40
- Other Regulated Entities			28.57	15.84	19.59	18.20	21.12	21.40	29.10
= Balance of Consolidated Capital	693.30	724.59	811.70	931.89	994.25	1,014.69	1084.48	1171.50	1222.30
MII Capital Base	442.00	422.34	493.32	560.64	284.70	294.99	307.50	338.30	366.55
MII Regulated Capital	158.77	154.06	168.66	191.94	131.74	135.05	139.66	149.27	171.70

A.1.4 Other subsidiaries can also indirectly contribute to the financial resources that are available to the insurer. For example, Avant Group Holdings Limited also owns a health insurer, Doctor's Health Fund (DHF). On the one hand, DHF could divert group resources away from the medical indemnity insurer. Should DHF's regulatory capital ratio fall below its target of 1.5 AGHL has agreed to provide additional support of up to $7 million[6]. On the other hand, a profitable subsidiary can support the resources available to the insurer, for example, through dividends to the holding company.

A.1.5 UMP is also a subsidiary of Avant Group Holdings Limited. UMP is not a registered insurer and provides IBNR cover, utilising the IBNR scheme.

A.1.6 Mutual organisations do not raise capital through shareholders. Capital is generally accumulated through retained earnings over time. Generally dividends are not payable. Avant advertises it has two mechanisms that provide a benefit to longer serving members.

- Avant Insurance Limited provides a premium refund to members based on years of membership. As this is declared by the Board annually in arrears, it appears to be a form of profit share to members. The level of the reward in 2019 was 4% of premium for membership terms up to 5 years, increasing to 12% of premium for membership in excess of 16 years[7].

- Avant provides a Retirement Reward Dividend. The Avant board (i.e. the group board) reviews the financial strength of the group and allocates an amount of retained earnings to a notional "Retirement Reward Plan". Retiring doctors receive a share of the plan. The dividend is expected to be fully franked, and once declared, is not recoverable by the company. Future dividends are not guaranteed. The plan commenced in 2014. During the year, Avant had notionally contributed an extra $24.5 million to the pool, bringing the total to $407 million. $9m in fully franked dividends was paid to retiring members from the plan[8].

A.1.7 Cover is free for medical students and risk rated premiums are charged to practicing doctors.

6 2018-19 Financial Report
7 www.avant.org.au/Loyalty-Reward-Plan
8 2018-19 Annual Report

Additional Services

A.1.8 In addition to MII, Avant advertises that it provides a range of advice and support services to members.

A.1.9 Avant offers medico-legal advice and assistance to insured health practitioners and students. The service is staffed by 70 claims managers, solicitors and doctors nationally. The service is provided 24 hours a day, 365 days a year. This service appears to be a free service to members provided through Avant Mutual.

A.1.10 Avant offers practice indemnity cover for the payment of an additional premium. Complimentary cyber insurance is provided to practice indemnity policyholders[9].

A.1.11 Avant offers life insurance to members through Doctors Financial Services. Products are developed by Noble Oak Limited, a demutualised Friendly Society in which Avant has a shareholding.

A.1.12 Avant Mutual Group also offers travel insurance to members. This is provided by the holding company taking out a group policy with external insurers. A premium is charged to members should they wish to effect travel insurance.

MII Scheme Reporting

A.1.13 Avant Financial statements[10] report that ROCS levies are included in reported premiums and a corresponding ROCS expense is recognized in the insurance company.

A.1.14 Amounts received from government schemes are shown as “other recoveries”, not reinsurance recoveries. The schemes are the High Cost Claims Scheme (HCCS), Run-off Cover Scheme (ROCS), Incurred But Not Reported (IBNR) scheme and the Exceptional claims scheme.

MEDICAL INDEMNITY PROTECTION SOCIETY (MIPS)

A.1.15 The Medical Indemnity Protection Society Limited (MIPS) was formed in 1988 as a not for profit organization. Since 1 July 2003 medical indemnity insurance has been provided through a wholly owned subsidiary, MIPS Insurance Pty Ltd (MIPSi). MIPS Insurance Pty Ltd is regulated by APRA.

A.1.16 Mutual organisations do not raise capital through shareholders. Capital is accumulated through retained earnings over time. This is the case with MIPS. As MIPSi is a fully owned subsidiary of MIPS, dividends may be payable from the insurer to the holding company. Similarly, the holding company may subscribe capital to the insurer,

[9] www.avant.org.au/pmip/
[10] 2018-19 Financial Report

within its capacity to do so from retained earnings. Historical reported capital positions of the consolidated entity and insurer are shown in the table below.

Year Ending	2011	2012	2013	2014	2015	2016	2017	2018	2019
MIPS									
Consolidated Net Assets	150.77	185.36	219.43	255.84	276.00	295.08	305.85	322.20	328.85
- Other Regulated Entities									
= Balance of Consolidated Capital	150.77	185.36	219.43	255.84	276.00	295.08	305.85	322.20	328.85
MII Capital Base	85.50	98.82	113.51	130.05	132.30	132.68	152.57	153.63	152.01
MII Regulated Capital	27.63	27.63	25.26	26.54	28.33	26.44	25.21	33.07	30.09

A.1.17 No dividends are paid by the holding company. The Society's constitution prohibits the payment of dividends.

A.1.18 MIPSi provides cover to all members through three group insurance policies:

1 A medical indemnity insurance policy provided by MIPSi. Cover is free for medical students. The 2019 annual report states MIPS covers 21,518 student members. Risk rated premiums are charged to practicing doctors and take into consideration the current and three prior years of medical practice[11].

2 Practice Entity Policy provided by MIPSi. Cover to all eligible members for no additional cost. This policy provides cover for claims against a member's practice entity and/or any administrative or management staff that work in the practice. It does not cover other insured healthcare providers or students. It is not possible to identify practice entity policies separately from medical indemnity insurance policies in the APRA statistics.

3 Personal Accident Policy provides lump sums to certain members in the event of specified accidental injury, sickness or death, loss of registration, funeral expenses, credit card protection and other listed events. Travel protection is provided where travel is to undertake an approved healthcare placement outside Australia Cover is free.

Additional Services

A.1.19 In addition to MII, MIPS reports that it provides a range of advice and support services to members that are all provided within the doctor's membership for no additional charge.

A.1.20 MIPS offers clinico-legal advice and assistance to members at no additional charge. The service manages over 4,000 contacts annually and is provided by clinicians,

[11] www.mips.com.au/Membership/pricing

professional support officers and legal practitioners. The service is provided 24 hours a day, 365 days a year.

A.1.21 MIPS provides cyber protection through a policy effected with CFC Underwriting to eligible members for no additional cost.

A.1.22 "MIPS Protections" provides discretionary assistance for non-healthcare matters arising from professional practice, not otherwise covered by insurance.

MDA NATIONAL

A.1.23 MDA National Limited (MDAN) is a mutual that was formed in 1925. Medical indemnity insurance is provided through a wholly owned subsidiary, MDA National Insurance Pty Ltd (MDANi). MDANi is regulated by APRA.

A.1.24 As MDA National Insurance is a fully owned subsidiary of the mutual, dividends may be payable from the insurer to the mutual holding company. Similarly, the holding company may subscribe capital to the insurer, within its capacity to do so from retained earnings. Historical reported capital positions of the consolidated entity and insurer are shown in the table below.

Year Ending	2011	2012	2013	2014	2015	2016	2017	2018	2019
MDA National									
Consolidated Net Assets	136.10	132.25	144.97	156.03	170.93	174.34	178.10	180.86	180.31
- Other Regulated Entities									
= Balance of Consolidated Capital	136.10	132.25	144.97	156.03	170.93	174.34	178.10	180.86	180.31
MII Capital Base	115.36	98.88	114.84	125.54	132.75	138.03	142.97	142.15	136.55
MII Regulated Capital	32.90	35.35	40.03	41.99	41.35	40.75	44.16	51.48	55.72

A.1.25 No dividends are paid by the holding company.

A.1.26 MDA National Insurance provides medical indemnity and practice indemnity policies. A separate premium is charged for cover under each policy. MDANi also arranges cyber risk cover for medical practices through an external insurer, this cover is provided at no additional charge to MDANi practice indemnity policyholders up until 30 June 2020.

Additional Services

A.1.27 In addition to MII, MDA National reports that it provides a range of advice and support services to members that are provided for no additional charge. Services include risk management, education, health/wellbeing support and 24 hour medico-legal advice.

MEDICAL INSURANCE GROUP AUSTRALIA

A.1.28 Medical Insurance Group Australia (MIGA) is a mutual that was formed in 1899. It comprises a holding company known as the Medical Defence Association of South Australia Limited (MDASA). Medical indemnity insurance is provided through a wholly owned subsidiary, Medical Insurance Australia Pty Ltd (MIA). MIA is regulated by APRA.

A.1.29 As MIA is a fully owned subsidiary of the mutual, dividends may be payable from the insurer to MIGA. Similarly, the holding company may subscribe capital to the insurer, within its capacity to do so from retained earnings. For example, the June 2019 annual report noted that the Board of MDASA approved a capital transfer of $9.7m to MIA. Historical reported capital positions of the consolidated entity and insurer are shown in the table below.

Year Ending	2011	2012	2013	2014	2015	2016	2017	2018	2019
MIA									
Consolidated Net Assets	79.80	93.91	105.83	107.97	112.64	125.85	136.57	149.01	158.74
- Other Regulated Entities									
= Balance of Consolidated Capital	79.80	93.91	105.83	107.97	112.64	125.85	136.57	149.01	158.74
MII Capital Base	76.29	89.63	88.75	89.36	97.14	110.22	118.85	133.77	145.10
MII Regulated Capital	25.44	27.05	28.58	28.16	34.27	38.43	37.78	41.76	43.20

A.1.30 No dividends are paid by the holding company.

A.1.31 Medical Insurance Australia provides medical indemnity and practice indemnity policies to members. Practice indemnity policies attract their own premium. MIA also provides cover to eligible privately practising midwives under the Commonwealth Government's midwives insurance schemes.

Additional Services

A.1.32 In addition to MII, MIGA reports that it provides a range of advice and support services to members that are provided for no additional charge. Services include risk management, education and health/wellbeing support. Members who complete 10 CPD points under the risk management program may be eligible for a 10% discount on their insurance premium in the following year[12].

A.1.33 MIGA offers medico-legal advice and assistance to members at no additional charge. The service is provided 24 hours a day, 365 days a year.

A.1.34 Qantas points, discounted business insurance and discounted business education are also provided[13].

[12] www.miga.com.au/education/risk-management-program
[13] www.miga.com.au/miga-plus

GUILD INSURANCE

A.1.35 Guild Insurance Limited (Guild) is not a specialist medical indemnity provider. It provides a range of professional indemnity, business insurance, workers compensation and personal insurance products to customers. Guild provides medical indemnity insurance to selected medical professions. Indemnity policies are also provided to medical practices.

A.1.36 The website states that Guild insurance supports professional associations through the payment of referral fees for certain products and services[14].

A.1.37 As medical indemnity is not reported separately, financial data associated with this specific category of insurance is not reported.

Additional Services

A.1.38 In addition to MII, Guild reports that it provides access to Meridian Lawyers, a professional indemnity legal team, along with tools and resources to help avoid a claim. The 2019 Annual Report states that Guild Group Holdings Limited owns 50.25% of Meridian Lawyers Limited, with 24.75% being held by the employee share scheme.

BERKSHIRE HATHAWAY SPECIALTY INSURANCE COMPANY

A.1.39 Berkshire Hathaway Specialty Insurance Company (BHSI) is a new entrant to the market. They appear to offer policies to a wide range of medical and health professionals. They do not collect membership fees.

[14] www.guildinsurance.com.au/professional/dentists

APPENDIX 2: SCHEME HISTORY

A.1.40 Individual Schemes have altered over time. This appendix summarises some of the key features of some of the schemes and how they have changed over time.

IBNR SCHEME

A.1.41 The IBNR Scheme was introduced through the *Medical Indemnity Act 2002*. It was later amended by the *Medical Indemnity (IBNR Indemnity) Contribution Amendment Bill 2004*.

A.1.42 A table of key features is set out below.

Key Feature	Description
Premiums Received	2002: IBNR contribution of 50% of the premium paid in 2000/01 was expected to be paid by all doctors excluding: • members of UMP/AMIL who are 65 and over; • members who at the beginning of an IBNR contribution year have a physical, intellectual, psychiatric or sensory impairment of 20 points or more under the Impairment Tables in Schedule 1B to the Social Security Act 1991; • members who die during an IBNR contribution year; • the estates of deceased members; • members who did not practise in Australia after 31 December 2001; • members who have a medical income on or after the financial year starting 1 July 2001 that is less than $5,000 per financial year; • student members as at 30 June 2000; • members who have purchased comprehensive insurance cover for all incidents covered by the IBNR scheme; and • salaried medical practitioners employed in the public sector, or with arrangements where their private medical income is returned to those hospitals as long as their private medical income, outside of that returned to hospitals, is less than $5,000. Issuance of IBNR invoices was met with threats of resignation by doctors and an 18 month moratorium was implemented on all invoices aver $1,000 whilst a policy review was completed[15].

[15] *Medical Indemnity (IBNR Indemnity) Contribution Amendment Bill 2004*; Regulation Impact Statement

Key Feature	Description
	1/7/2005: UMP support payment will be the lessor of 50% of their 2000-01 premium, 2% of their gross Medicare billable income or $5,000. Transitional arrangements were introduced for payments from 1/7/2003. For the 2003-04 contribution year the maximum payable was $1,000. For 2004-05 the maximum payable was $3,000. The government expected to recoup approximately 25% of the costs of the scheme at this time. 2007: IBNR Payments ceased.
Claims Paid	100% of claims that were incurred prior to 30 June 2002.

A.1.43 In addition to the payments from doctors, the Commonwealth commissioned a review of competitive neutrality in the medical indemnity insurance market[16]. The review found that the assistance given to UMP through the IBNR scheme resulted in a competitive advantage. Legislation was introduced to levy a competitive neutrality payment on United's insurer. UMP provided a settlement to the Australian Government of $56 million. This was paid in the 2005/06 financial year.

PREMIUM SUPPORT SCHEME

A.1.44 The Premium Support Scheme was introduced at the time the IBNR contribution was amended through the *Medical Indemnity (IBNR Indemnity) Contribution Amendment Bill 2004*. When the scheme was introduced, it was estimated it would cost an additional $100 million in support to medical practitioners over four years.

A.1.45 A table of key features is set out below.

Key Feature	Description
Premiums Received	2004: As the PSS is designed to address premium affordability no premiums are collected for the PSS. The PSS was introduced noting that, before Government subsidies, some 7,600 doctors (18 per cent of doctors working under Medicare) are paying more than 10 per cent of their Medicare billable income (including gap payments) on medical indemnity premiums[17]. The scheme came into operation on 1 July 2004, with transitional arrangements offering an equivalent level of assistance to insurers for the six months beginning

[16] Rogers, 2005

[17] *Medical Indemnity (IBNR Indemnity) Contribution Amendment Bill 2004*; Regulation Impact Statement

Key Feature	Description
	1 January 2004. The scheme is effected through a contract between each specialist insurer and the Commonwealth. 2019: The *Medical and Midwife Indemnity Legislation Amendment Act 2019* removes the contractual basis of this scheme and transitions it to a legislative basis. As a consequence the scheme is now available to all medical indemnity insurers.
Benefits Paid	Where a doctor's gross medical indemnity costs exceed 7.5% of gross private medical income, the Commonwealth pays a percentage of the cost of the premium beyond the threshold. This percentage was: a) from 2004 to 1 July 2012, 80 per cent; b) on or after 1 July 2012 and before 1 July 2013, 70 per cent; and c) on or after 1 July 2013, 60 per cent. Medical practitioners operating in rural areas are eligible for the subsidy regardless of whether their premium exceeds the 7.5% income threshold. Premium support payments made under the Medical Indemnity Support Scheme (MISS) are grandfathered, with doctors who were eligible under MISS receiving the greater of the MISS subsidy or PSS subsidy. Under MISS, doctors in the following areas of practice were covered: procedural GP, procedural GP Registrar, specialist obstetrician, and neurosurgeon. Support payments varied by specialty and income.

RUN OFF COVER SCHEME

A.1.46 In 2004 the regulation impact statement of the IBNR Indemnity Bill noted that the Government had regulated to require MDOs/MIIs to offer run-off cover for up to six years for retiring doctors. It also noted that this did not mean that every doctor can easily afford run-off cover. Nor did it provide certainty to doctors or their patients beyond the six-year period. A new run off cover vehicle was introduced with the intention it would operate at a nil net cost to government over the long term on a present value basis.

A.1.47 A table of key features is set out below.

Key Feature	Description
Premiums Received	Should the scheme wind up with no alternative arrangement being established, the Commonwealth is to refund premiums, with interest, to those that are not yet eligible for ROCS cover.
Claims Paid	2004: All eligible claims first notified to MIIs on or after 1 July 2004, after any HCCS and ECS payments. Insurers are obliged to give eligible doctors medical indemnity cover on the same terms and conditions, and for the same range of incidents, as the last cover that they had prior to becoming eligible for the scheme. 2019: The *Medical and Midwife Indemnity Legislation Amendment Act 2019* clarifies eligibility for the Run-off Cover Scheme (ROCS) and permits immediate access for medical practitioners retiring before the age of 65.

HIGH COST CLAIMS SCHEME

A.1.48 A table of key features is set out below. Note that a mirror scheme for allied health professionals commenced from 1 July 2020. They were covered by the HCCS hitherto.

Key Feature	Description
Premiums Received	Nil
Claims Paid	Claims notified between 1 January 2003 and before 22 October 2003: 50% of claims in excess of $2 million. Claims notified from 22 October 2003 and before 1 January 2004: 50% of claims amounts above $500,000 and below $20 million. Claims notified from 1 January 2004 and before 1 July 2018: 50% of claims amounts above $300,000 and below $20 million. Claims notified from 1 July 2018: 50% of claims amounts above $500,000 and below $20 million.

EXCEPTIONAL CLAIMS SCHEME

A.1.49 A 2005 Treasury report on competitive neutrality stated that the exceptional claims scheme covers doctors for the cost of medical indemnity claims that exceed the limit of their contract of insurance. For the scheme to apply the doctor must have medical

indemnity insurance cover of at least $15 million for the period 1 January to 30 June 2003 and $20 million for the period from 1 July 2003. Where the doctor has a contract of insurance that has a limit higher than the threshold, the scheme applies above the contract limit.

A.1.50 Claims can be either a single very large claim or an aggregate of claims that together exceed the contract limit.

A.1.51 Note that a mirror scheme for allied health professionals commenced from 1 July 2020.