



Australian Government
Australian Government Actuary

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

2020-21 financial year



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Table of Contents

1	INTRODUCTION	5
2	BACKGROUND	6
2.1	<i>MEDICAL INDEMNITY INSURANCE</i>	6
2.2	<i>BRIEF HISTORY OF PRIVATE MEDICAL INDEMNITY INSURANCE IN AUSTRALIA – THE LEAD-UP TO THE RUN-OFF COVER SCHEME</i>	8
2.3	<i>WHAT IS THE RUN-OFF COVER ARRANGEMENT?</i>	9
3	DATA	11
3.1	<i>DATA COLLECTION</i>	11
3.2	<i>DATA VERIFICATION</i>	11
3.3	<i>NUMBER OF ELIGIBLE PRACTITIONERS</i>	12
3.4	<i>NUMBER OF CLAIMS ELIGIBLE FOR RUN-OFF COVER INDEMNITY PAYMENTS</i>	17
3.5	<i>AMOUNT OF RUN-OFF COVER INDEMNITY PAYMENTS</i>	18
3.6	<i>RUN-OFF COVER SUPPORT PAYMENTS</i>	20
4	FINANCIAL MANAGEMENT OF THE RUN-OFF COVER SCHEME	24
4.1	<i>2020-21 CASH FLOW</i>	24
4.2	<i>EXPERIENCE AND MODEL</i>	24
4.3	<i>RESULTS: PROJECTED RUN-OFF COVER COMMONWEALTH CONTRIBUTIONS</i>	27
4.4	<i>RESULTS: LIABILITY AT 30 JUNE 2021 & NOTIONAL ACCOUNT</i>	29
4.5	<i>RESULTS: PROJECTED LIABILITIES OF THE SCHEME</i>	33
4.6	<i>ACTUARIAL MANAGEMENT</i>	34
	APPENDIX 1: ELIGIBLE PRACTITIONERS AND RUN-OFF COVER SCHEME CONTRACTS	35
	APPENDIX 2: RUN-OFF COVER SCHEME CLAIMS	37
	APPENDIX 3: RUN-OFF COVER SUPPORT PAYMENTS	38
	APPENDIX 4: LIABILITIES AT 30 JUNE 2021	39
	APPENDIX 5: PROJECTED LIABILITIES AND CASH FLOWS	44

APPENDIX 6: HIGH COST CLAIMS..... 60

1 INTRODUCTION

1.1.1 This report has been prepared to comply with certain requirements of the *Medical Indemnity Act 2002* (Medical Indemnity Act). Section 34ZW of the Medical Indemnity Act provides for a report on aspects of the Run-Off Cover Scheme (the Scheme) to be published each year on the Department of Health's website. The report is required to contain a statement of the:

- number of persons eligible for membership of the Scheme
- total Run-Off Cover indemnity payments (ROC indemnity payments) paid by the Commonwealth during the financial year, including claims handling and administration expenses
- total Run-Off Cover support payments (ROC support payments) paid to the Commonwealth during the financial year
- a projection of the Commonwealth's liabilities in relation to amounts of Run-Off Commonwealth contributions in future financial years.

1.1.2 This is the seventeenth report that has been prepared under section 34ZW of the Medical Indemnity Act. It relates to financial year 2020-21. The sixteenth report was published on 10 June 2021¹. The requirement for the report to be tabled in Parliament was removed after the fifteenth report.

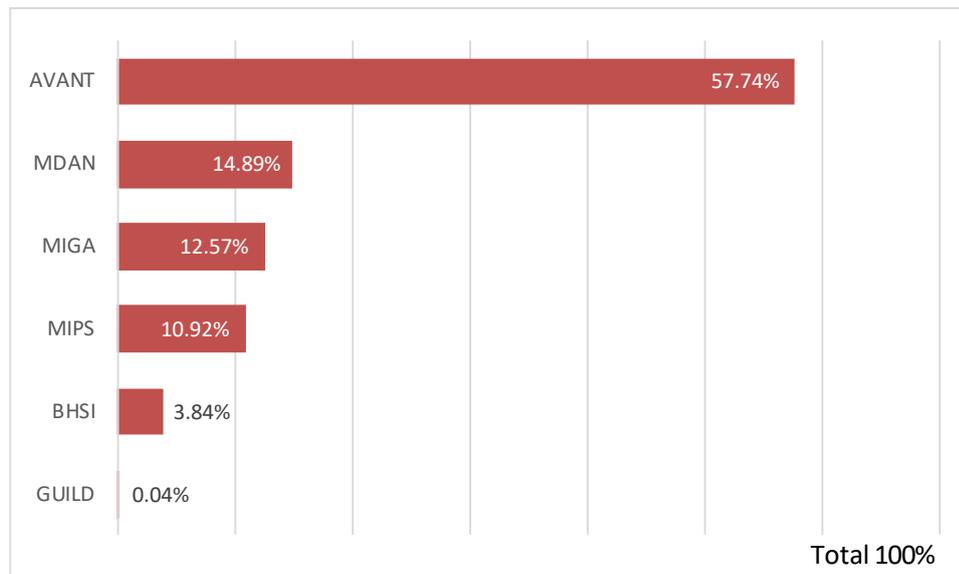
¹ www.aga.gov.au/publications/insurance

2 BACKGROUND

2.1 MEDICAL INDEMNITY INSURANCE

- 2.1.1 Medical indemnity insurance is a form of professional indemnity insurance. It covers practitioners for their professional negligence.²
- 2.1.2 Medical practitioners who undertake private medical practice in Australia generally purchase medical indemnity insurance from private sector underwriters.³ This report considers the six private sector underwriters operating in Australia during 2020-21. They were 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) distributed by Tego Insurance. Figure 1 below illustrates the market shares of these private underwriters calculated on the basis of premium data provided by them.

Figure 1: Market share of medical indemnity insurers



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- 2 Medical indemnity insurance can also cover other costs such as those associated with appearing at coronial inquiries.
- 3 On the other hand, many employed practitioners such as medical practitioners practising solely in a hospital will be indemnified by their employer against negligence.

- 2.1.3 Medical negligence claims are initiated by, or on behalf of, patients against medical practitioners. Roughly 2,000 claims of negligence might be expected each year in relation to private medical practice in Australia. However, there can be substantial variation from one year to the next. It is difficult to project the number of medical indemnity claims with any precision. A significant number of claims will be successfully defended.
- 2.1.4 The cost of medical negligence claims is highly variable since the claims relate to bodily injury. The cost of a medical negligence claim to the insurer comprises of damages which are payable to the plaintiff, any of the plaintiff's legal costs which the insurer is obliged to pay, and the insurer's own costs of defending and managing the claim. According to the data obtained from the National Claims and Policies Database (NCPD) in 2017, while most claims are finalised for less than \$100,000, a small number of claims are large (around 6 per cent of claims cost more than \$500,000). These large claims have a significant impact on the overall cost of medical indemnity insurance. The NCPD data shows that around 65 per cent of the cost of all finalised medical indemnity claims relates to claims which are larger than \$500,000.
- 2.1.5 The medical indemnity claim process can be long. Years can elapse between the date of a negligent medical incident and the date that legal action against the practitioner is initiated. It is not unusual for claims to then take several years to finalise after they have been initiated. It is common for the whole process to take more than five years for a single claim. The cost of a claim depends significantly on economic and judicial conditions prevailing at the time the claim is finalised (paid), rather than at the time of the medical incident or the time that the claim is made.
- 2.1.6 All of these factors make medical indemnity insurance difficult for an insurer to underwrite. It is hard to forecast claim numbers and claim sizes reliably. Moreover, much of the cost is likely to relate to a small minority of the claims, which adds further uncertainty. As a result, it is difficult to know how much premium to charge and how much money to hold in reserve to pay claims. For these reasons, a robust private market in medical indemnity insurance requires professional and disciplined underwriting and management.

2.2 BRIEF HISTORY OF PRIVATE MEDICAL INDEMNITY INSURANCE IN AUSTRALIA – THE LEAD-UP TO THE RUN-OFF COVER SCHEME

- 2.2.1 Historically, medical indemnity cover was provided to Australian medical practitioners in private practice by medical defence organisations (MDOs). MDOs were not licensed insurers and were therefore not subject to prudential regulation.
- 2.2.2 Medical indemnity cover was originally provided to practitioners on a so-called 'claims-occurring' basis. Practitioners were protected against claims that might be made in relation to the medicine that they had practised while members of the MDO. Thus, practitioners who had claims made against them after retirement could seek assistance from their MDO provided that they had been members at the time of the medical incident. Medical indemnity is difficult to underwrite on a 'claims-occurring' basis, partly due to the often lengthy delays between the date of medical incident and the time at which a claim is initiated.
- 2.2.3 During the 1990s, most MDOs came under financial pressure as a result of increasing levels of claim payments and were forced to make calls on their members for additional funds.
- 2.2.4 At the same time, most MDOs progressively changed the basis of their cover from 'claims-occurring' to 'claims-made'. In simple terms, claims-made cover provided protection for the practitioner against claims that were made during the period of membership. Thus, to continue to be covered against claims that might emerge in relation to past medical practice, a medical practitioner had to continue their MDO membership. Professional indemnity insurance is generally provided on a 'claims-made' basis.
- 2.2.5 In 2002, Australia's largest MDO, United Medical Protection (UMP), was placed in provisional liquidation. Following this, steps were taken to stabilise the medical indemnity industry.
- 2.2.6 Since 1 July 2003, medical indemnity insurance has been required to be provided to Australian practitioners by insurers licensed under the *Insurance Act 1973* and prudentially supervised by Australian Prudential Regulation Authority (APRA). This has ensured a more disciplined approach to risk management and has reduced the risk of failure of a medical indemnity provider.
- 2.2.7 Consistent with more disciplined risk management, all medical indemnity insurance is now provided on a 'claims-made' basis. Consequently, medical practitioners have to maintain insurance in order to remain covered against

claims that might emerge, even when they are no longer practising. This form of insurance cover is known as run-off cover. Put simply, run-off cover provides insurance for medical practitioners who have ceased medical practice. The potential lengthy delay between a medical incident and the corresponding claim highlights the need for medical practitioners to maintain run-off cover after ceasing practice.

- 2.2.8 For some medical practitioners, the annual cost of medical indemnity insurance runs into the tens of thousands of dollars. To address problems associated with the cost of run-off cover, including the potential threat to the provision of medical services, a scheme was established by the Australian Government which requires medical indemnity insurers to provide run-off cover⁴ to certain groups of medical practitioners who have ceased private practice. The Scheme was intended to be largely cost neutral to taxpayers whilst not threatening the viability of the insurance companies. This scheme is known as the Run-Off Cover Scheme.

2.3 WHAT IS THE RUN-OFF COVER ARRANGEMENT?

- 2.3.1 The Scheme facilitates the provision of medical indemnity insurance cover to particular groups of medical practitioners who have ceased private medical practice.
- 2.3.2 The rules for the Scheme appear in the *Medical Indemnity (Prudential Supervision and Product Standards) Act 2003* (PSPS Act), the *Medical Indemnity (Run-off Cover Support Payment) Act 2004* (MI ROCSPA) and the *Medical Indemnity Act 2002*. The principal elements of the Scheme are:
- The PSPS Act imposes an obligation on insurers to provide run-off cover to particular groups of medical practitioners who have ceased private practice.
 - The Medical Indemnity Act provides for the Commonwealth to make payments to the insurers to reimburse the costs of eligible run-off claims. These payments are known as ROC indemnity payments.
 - The Medical Indemnity Act provides for the Commonwealth to make other payments to insurers to offset the relevant costs of administering the Scheme that are incurred by insurers.

⁴ The premium for the run-off cover is zero for medical practitioners who have ceased private practice. However, they pay a levy on their premiums during the period of private practice.

- The Medical Indemnity Act also provides for the insurers to make payments to the Commonwealth to ensure that the Scheme is largely cost-neutral to taxpayers. These payments are a levy on insurers' premium income funded by a loading on practitioners' medical indemnity insurance premiums. These payments are known as ROC support payments. The MI ROCSPA sets out the rules for calculating ROC support payments.
- 2.3.3 The Scheme provides for ROC support payments to be made by medical indemnity insurers to the Commonwealth and for ROC indemnity payments to be made by the Commonwealth to medical indemnity insurers (MIIs) and MDOs. Ancillary arrangements provide for payments to cover other costs such as administrative costs.
- 2.3.4 The Scheme provides for ROC support payments to be made by eligible insurers to the Commonwealth and for ROC Commonwealth contributions to be made by the Commonwealth to eligible insurers.
- 2.3.5 An important financial dynamic of the ROC Scheme is the timing mismatch between the payment of ROC support payments by an eligible insurer and the emergence, payment and reimbursement of professional indemnity claims of eligible practitioners who are no longer in private practice. The first ROC support payments were received on 30 June 2011. The ROC Scheme applies to eligible professional indemnity claims that are first notified to eligible insurers on or after 1 July 2010. As a result of inherent delays in the claims process, it is to be expected that the level of ROC support payments will be greater than the level of ROC Commonwealth contributions for many years. This has been demonstrated in the experience of the Run-Off Cover Scheme for medical practitioners. That is, in a cash flow sense, the ROC Scheme is still immature. It will probably take several more years to reach maturity when income from ROC support payments and expenditure on ROC Commonwealth contributions are of a similar order of size.

3 DATA

3.1 DATA COLLECTION

- 3.1.1 For the purpose of preparing this report, certain data was collected from the MIs by Services Australia during late 2021 including:
- details of practitioners who were identified as having become eligible for membership of the Scheme before 30 June 2021
 - details of claims (including incidents) notified to MIs and MDOs by 30 June 2021 which might eventually become eligible for reimbursement under the Scheme
 - details of ROC support payments⁵
 - actuarial estimates of that part of the future claims cost of medical incidents projected to be notified during the 2021-22 to 2025-26 financial years which is expected to be reimbursed under the Scheme
 - actuarial estimates of that part of the future claims cost of medical incidents occurring during 2021-22 which is expected to be reimbursed under the Scheme.
- 3.1.2 This report also utilises other data and information including that which was previously provided to Services Australia for the purpose of section 34ZW of the Medical Indemnity Act.

3.2 DATA VERIFICATION

- 3.2.1 The results in this report rely heavily on information provided by MIs and their actuaries. This information is regarded as the most suitable information available for the current purpose.
- 3.2.2 Steps were taken to ensure, as far as practicable, that the information provided was prepared on a basis suitable for the purpose. Despite this, it is not possible to guarantee that the information provided is free from material error. The information was not independently audited. As was the case in previous years, there were some notable disparities in the data provided. This

5 A database of ROC support payments is maintained by Services Australia.

means that figures and estimates provided in this report need to be treated with some caution.

- 3.2.3 Historically, MII/MDOs have not maintained data in a form which is directly amenable to ROC analysis. For example, it has not been possible to establish a comprehensive list of medical practitioners who were eligible for the Scheme on 1 July 2004. This is not a criticism of the MII. It simply reflects that their business and information systems were not developed with a scheme like the Run-Off Cover Scheme in mind. However, in order to monitor the operation of the Scheme effectively, accurate and timely data is obviously important.
- 3.2.4 A range of assumptions were used by industry actuaries. Guidance was provided as to the nature of the data, calculations and information required. Although some significant assumptions differ by only a few percentage points between actuaries, substantially different estimates of Scheme costs are produced. This is indicative of the highly uncertain nature of estimates of the costs of the Scheme.
- 3.2.5 All insurers were asked to specify whether their data has allowed for the latest changes in legislation as well as the impact of COVID-19. Their responses helped us to determine whether adjustments were appropriate.
- 3.2.6 In general, the results in this report are based on both the estimates provided by industry actuaries and the data provided by Services Australia. We have also had regard to the model developed within this office to determine the amount of the new accrual.

3.3 NUMBER OF ELIGIBLE PRACTITIONERS

- 3.3.1 Appendix 1 sets out the test of eligibility for the Scheme and the process of issuing and notifying compulsory run-off cover to eligible practitioners. Eligible practitioners are entitled to receive notification of the terms and conditions of compulsory run-off cover from their MII. MII are also required to notify Services Australia of the details of the compulsory run-off cover provided.

- 3.3.2 Practitioners performing private practice become eligible for the Scheme by means of permanent retirement⁶, death, permanent disability or maternity leave. In addition, medical practitioners from overseas who have worked in Australia under an appropriate visa become eligible for the Scheme when they have permanently ceased medical practice in Australia and ceased to reside in Australia.
- 3.3.3 There are inherent lags involved in notification of the details of eligible practitioners to Services Australia. As a result, it is only possible to estimate the number of practitioners who have become eligible for the Scheme at any given time. For example, there will often be a delay between the time that a practitioner becomes eligible for the Scheme and the time when the insurer becomes aware of this. It is also likely that an insurer is unsure of the eligibility status of a practitioner from year to year. For example, a practitioner that has not renewed their insurance may, or may not, be eligible for cover. For these reasons, the numbers of eligible practitioners reported by insurers needs to be treated with caution. This report summarises the number of practitioners that have become eligible for the scheme as reported by the insurers. We have also attempted to estimate the total number of practitioners currently eligible at 30 June 2021 by removing the practitioners whose eligibility subsequently ceased⁷ and removing multiple entries. Multiple entries are usually associated with maternity leave taken at different time periods.
- 3.3.4 The number of practitioners who have become eligible for the Scheme in this report is based on:

6 There used to be a three-year waiting period for practitioners who retired under age 65. This has been waived from 1 July 2020 as legislated in the *Medical and Midwife Indemnity Legislation Amendment Act 2019* (Amendment Act).

7 This year, we have not removed practitioners whose eligibility ceased on or after 1 April 2020. This is because the *Medical Indemnity Amendment (Eligible Run-off Claims) Regulations 2020* stipulates a temporary exemption, which allows ROCS eligible practitioners to return to private practice in order to provide treatment during the COVID-19 pandemic without the practitioner losing their eligibility under the ROCS. *Medical and Midwife Indemnity Legislation Amendment (Eligible Run-off Claims) Rules 2022* (the Amending Rules) extends the temporary exemption from 17 May 2022 to 21 October 2022.

- data provided to Services Australia by the medical indemnity industry relating to practitioners identified as having become eligible between 1 July 2004 and 30 June 2021
- industry estimates of practitioners eligible for the Scheme as at 1 July 2004, provided for the purpose of the 2004-05 report.

3.3.5 We have relied almost entirely on the eligibility data provided by the industry. As has been the case in all previous reviews, data changes from year to year and inconsistencies within data undermine the reliability of the information. Table 1 summarises the data provided by the industry with aforementioned adjustments.

Table 1: Run-Off Cover Scheme eligible practitioners

Eligible from	2021	2020
Start up (that is 1 July 2004)	2,112	2,112
2004-05	329	325
2005-06	485	451
2006-07	536	510
2007-08	601	599
2008-09	532	535
2009-10	614	614
2010-11	827	829
2011-12	914	916
2012-13	1,073	1,076
2013-14	1,349	1,354
2014-15	1,404	1,356
2015-16	1,381	1,356
2016-17	1,569	1,571
2017-18	1,769	1,799
2018-19	1,870	1,897
2019-20	2,149	1,861
2020-21	1,404	N/A
Total number of practitioners at 30 June 2021	20,918	19,161

3.3.6 We estimate that at least 20,918 practitioners are eligible for ROCS at 30 June 2021. If a practitioner had multiple entries, we have used the most recent eligibility start date in Table 1. Ordinarily, all practitioners whose eligibility is shown as subsequently ceased in the data are excluded from the above counts. Last year, we also excluded 204 practitioners who appeared to have returned to private practice during 2019-20 as evidenced by their material ROCS contributions during the year. This approach is more closely aligned with the requirement of the Medical Indemnity Act.

3.3.7 However, unlike last year, the ROCS eligible practitioners who returned to private practice since 1 April 2020 for the purposes of COVID-19 should have retained their ROCS eligibility, hence, should not be removed in Table 1. The data shows around 500 practitioners had a ROCS eligibility cessation

date on or after 1 April 2020. Since it may be difficult in practice to distinguish between practitioners who returned for COVID-19 and those who returned for other purposes, and that insurers can amend the data later, it is conservative to assume all practitioners who returned after 1 April 2020 would later be rendered eligible. In Table 1, they have been included in the numbers of currently eligible practitioners. Furthermore, no steps were taken to remove practitioners who were ROCS eligible and also made material ROCS contributions during 2020-21.

- 3.3.8 The estimated number of currently eligible practitioners is subject to considerable uncertainty. The usual delay between the time that a practitioner becomes eligible for the Scheme and the time when the insurer becomes aware of this means that the data is likely to be incomplete.
- 3.3.9 The new entrant experience in 2020-21 is especially uncertain as a result of two factors. On one hand, some medical practitioners might have delayed their resignation or retirement in order to contribute to the nationwide effort to combat COVID-19, as the demand for vaccine administration was especially high. On the other hand, resignations during the preceding three years from those aged under 65 who became eligible for ROCS in 2020-21 under the legislative change⁸ may not have been fully recognised or reported by insurers. These two factors could have led to genuinely fewer new entrants in 2020-21 as well as a delay in the reporting of the backdated new entrants for 2020-21. The actual new entrants in 2020-21 may not be known for several years.
- 3.3.10 Furthermore, it is unclear whether insurers have correctly reported new entrants from resignations in line with the three-year waiting period prior to the legislative change. If the backdated new entrants were already reported by insurers prior to 2020-21, then the expected spike in 2020-21 may never eventuate. Hence, the experience of 2020-21 is not suitable for assessing the performance of our model. This is discussed further in section 4.2.
- 3.3.11 Table 1 shows that that the number of eligible practitioners reported at 30 June 2020, in respect of certain years, decreased by 30 June 2021. Apart from administrative data changes from year to year, this is normally mainly attributable to a proportion of the eligible practitioners returning to private practice. For example, a significant number of practitioners who became eligible through maternity leave would have normally ceased eligibility once they returned to work. This is consistent with our assumption that maternity leave is temporary. However, as discussed above, ROCS eligibility is

⁸ *Medical and Midwife Indemnity Legislation Amendment Act 2019 (Amendment Act)*

temporarily retained for returned practitioners. The downward revision would have appeared much higher were it not for the adjustments we applied to the insurers' data that retained ROCS eligibility for those with a cessation date on or after 1 April 2020. The remaining small differences are probably attributable to administrative data changes.

- 3.3.12 Table 2 illustrates the breakup of new entrants by reason of eligibility, based on the data provided by the MIs. The numbers are not directly comparable with Table 1 as they include all practitioners whose eligibility has subsequently ceased, and they include multiple entries in different time periods. Note that the numbers of practitioners who became eligible have generally increased in recent years, driven by maternity leave and retirement. While maternity leave is likely to constitute a temporary eligibility, retirement most likely gives rise to permanent eligibility. The number of retired practitioners is expected to grow. As was the case in previous years, the "Other" category can be ignored as they are not expected to contribute materially to the cost of the scheme.
- 3.3.13 As discussed above, it is difficult to compare the 2020-21 experience with past years or with our expectation last year, as this year was not only impacted by the usual lag in reporting but also the legislative response to COVID-19 and its impact on practitioners' exit pattern. However, the COVID-19 impact should be temporary. Therefore, we have retained the previous long term eligibility assumptions for our new accrual model. This is discussed in more detail in section 4.2. The eligibility assumptions are subject to review each year, and we will continue to monitor and review the experience.

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

	Industry data									
	2005-12	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21
Retired	2,719	514	672	803	696	845	888	912	979	650
Maternity	1,896	267	295	307	330	330	522	508	540	379
Permanent disability	197	20	31	26	35	28	35	25	16	4
Died	779	128	108	122	105	125	97	107	112	71
Resigned	826	154	212	162	217	182	261	235	227	98
Sub-total	6,417	1,083	1,318	1,420	1,383	1,510	1,803	1,787	1,874	1,202
Other ^(a)	909	336	429	346	358	425	504	543	549	202
Total	7,326	1,419	1,747	1,766	1,741	1,935	2,307	2,330	2,423	1,404

(a) Overseas trained doctors who had permanently ceased practice under a 422 or 457 visa.

3.4 NUMBER OF CLAIMS ELIGIBLE FOR RUN-OFF COVER INDEMNITY PAYMENTS

3.4.1 Appendix 2 describes claims which meet the criteria for reimbursement from the Australian Government through Run-Off Cover indemnity payments. Broadly, MIIs and MDOs are entitled to reimbursement from the Australian Government for the costs of claims which:

- are first notified to the MII or MDO on or after 1 July 2004
- relate to a practitioner who is eligible under the Scheme at the date of notification⁹
- meet the other requirements for 'payable claims'.¹⁰

3.4.2 As at 30 June 2021, MIIs and MDOs had reported 1,156 medical incidents relating to eligible medical practitioners since the commencement of the Scheme. Of these incidents, 499 were shown as 'closed' or 'finalised' with null case estimate¹¹ attached to them, and 42 were shown as 'open' with null case estimate. This leaves 615 incidents where an amount has been or is expected to be paid. They are shown in Table 3.

9 Refer Appendix 1.

10 Refer Appendix 2.

11 Estimate of likely cost to the insurer

Table 3: Reported incidents by year of eligibility

Eligible from	This year's data	Last year's data
Start up (that is 1 July 2004)	17	19
2004-05	12	12
2005-06	13	16
2006-07	14	19
2007-08	11	12
2008-09	18	21
2009-10	41	44
2010-11	29	37
2011-12	17	16
2012-13	50	50
2013-14	21	26
2014-15	28	28
2015-16	37	37
2016-17	62	60
2017-18	86	72
2018-19	87	32
2019-20	37	17
2020-21	19	N/A
missing	16	16
Total number of reported incidents with a case estimate at 30 June 2021	615	534

3.4.1 Table 3 also shows that the practitioners who became eligible in the last two years had the greatest annual increase in the numbers of reported incidents since last year. In theory, this data could be used to analyse the development pattern between eligibility commencement and claims being reported. Furthermore, it could be used to derive claim rates. However, this data appears to have numerous issues including internal consistency issues, inconsistencies between insurers and irregular and significant variations from year to year. Therefore, we have not been able to utilise this data for analytical purposes.

3.5 AMOUNT OF RUN-OFF COVER INDEMNITY PAYMENTS

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

3.5.2 Table 4 illustrates the progress of ROC indemnity payments (including indirect claims handling expenses) since the beginning of the scheme. We have relied on the data provided by Services Australia.

Table 4: Run-Off Cover indemnity payments by year of eligibility

Eligible from	This year's data (\$'000)	Last year's data (\$'000)
Start up (that is 1 July 2004)	8,837	8,837
2004-05	1,168	1,168
2005-06	938	938
2006-07	1,816	1,816
2007-08	2,264	2,256
2008-09	7,838	7,594
2009-10	1,348	1,348
2010-11	4,926	4,894
2011-12	1,718	1,718
2012-13	3,710	3,710
2013-14	2,961	2,542
2014-15	3,470	3,049
2015-16	2,190	1,221
2016-17	8,278	5,935
2017-18	1,628	1,402
2018-19	478	388
2019-20	711	-
2020-21	-	N/A
missing	6,897	1,770
Total Amount of ROC Indemnity Payments at 30 June 2021	61,177	50,586

3.5.3 ROC indemnity payments totalling \$61.2 million (including indirect claims handling expenses) have been made up to 30 June 2021, all of them since 1 July 2007. Specifically, during 2020-21, \$10.6 million in ROC indemnity payments were made.

3.5.4 The Scheme also provides for payments in respect of compliance costs under the ROC Claims and Administration Protocol (section 34ZN of the Medical Indemnity Act). Around \$23.4 million in compliance cost payments have been made to MIs up to 30 June 2021. Based on applications received by Services Australia, we have estimated that a further \$2.3 million relating to periods prior to 30 June 2021 is payable. Table 5 shows the historical compliance costs paid by the Scheme as provided by Services Australia. The payments in 2020-21 include one-off payments to Berkshire Hathaway Specialty Insurance (BHSI) and Guild Insurance Limited (Guild) for costs incurred before 1 July 2020, following legislation that came in force on 1 July 2020¹².

12 Section 19 of the Medical Indemnity Regulations 2020.

Table 5: Historical compliance cost payments

Payment year	Compliance cost payments (\$'000)
2005-06	2,842
2007-08	686
2008-09	586
2009-10	639
2010-11	1,284
2011-12	1,392
2012-13	1,233
2013-14	1,224
2014-15	1,597
2015-16	1,563
2016-17	1,502
2017-18	2,258
2018-19	1,689
2019-20	2,509
2020-21	2,416
Total paid at 30 June 2020	23,418

- 3.5.5 The Commonwealth's own administration costs are funded through the Commonwealth budget and are therefore not considered in this report.

3.6 RUN-OFF COVER SUPPORT PAYMENTS

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

- 3.6.2 The amount of the ROC support payments is calculated using a method set out in the MI ROCSPA. Appendix 3 describes the calculation in detail. Very briefly, it is based on:

Applicable rate × (premium income less taxes and charges) ÷ (1 + applicable rate).

- 3.6.3 In 2020-21, the applicable rate was 5 per cent for all insurers.
- 3.6.4 Table 6 summarises the ROC support payments received. The amounts include minor amendments that were made during the relevant year. The total amount received in 2020-21 increased at a similar rate to the previous years. This was generally driven by an increase in the number of contributing practitioners. The average premiums appeared largely

unchanged during 2020-21.¹³ Some parent holding companies of the MIIIs continue to collect membership fees in addition to medical indemnity premiums. The amounts vary widely across the industry and not all insurers have reported the amounts to Services Australia. ROC support payments are not payable on membership fees.

Table 6: Run-Off Cover support payments

	ROC support payments (\$'m)										
	2005-2011	2011-2012	2012-2013	2013-2014	2014-2015	2015-2016	2016-2017	2017-2018	2018-2019	2019-2020	2020-2021
AVANT	71.839	7.175	7.258	8.271	8.338	8.852	9.823	10.743	11.080	11.377	11.630
MDAN	25.431	2.332	2.432	2.624	2.607	2.648	2.546	2.798	2.711	2.935	3.030
MIGA	18.923	2.218	2.422	2.115	2.183	2.413	2.451	2.370	2.504	2.438	2.564
MIPS	18.544	1.781	1.596	1.617	1.613	1.604	1.630	1.676	1.924	2.136	2.209
BHSI	n/a	n/a	n/a	n/a	n/a	n/a	0.080	0.261	0.428	0.594	0.778
Guild	n/a	n/a	n/a	n/a	0.006	0.006	0.007	0.006	0.006	0.006	0.007
Total	134.737	13.506	13.708	14.627	14.746	15.523	16.536	17.853	18.654	19.486	20.217

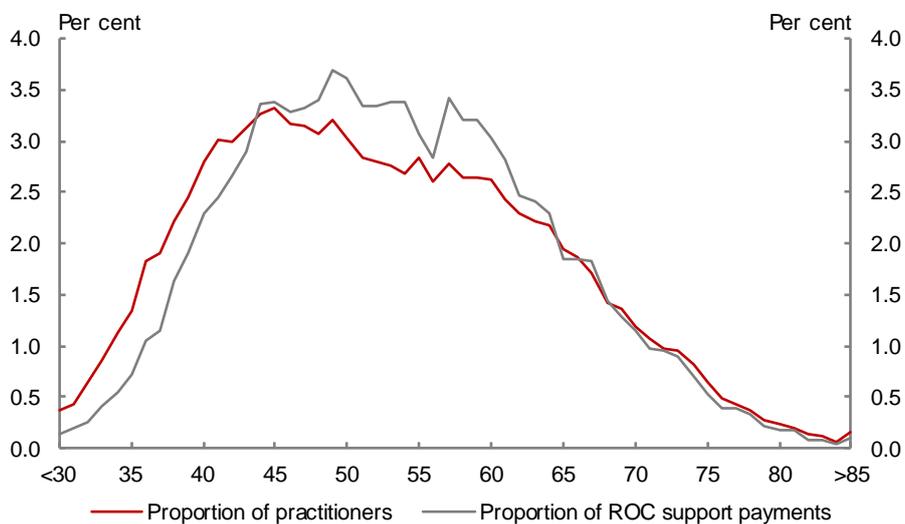
Note: MIGA includes historical payments from Invivo (QBE) and Avant includes historical payments from AMIL and PIICA.

- 3.6.5 To provide full transparency for practitioners, MIIIs are required to attribute ROC support payments to individual policyholders. Each premium notice specifies the amount that has been included in the policyholder's invoice to meet the MII's ROC support payment obligations. All amounts are reported to Services Australia, which maintains a record of each practitioner's total run-off cover credit. Interest is applied to this balance annually in accordance with section 34ZS of the Medical Indemnity Act.
- 3.6.6 Part 2, Division 2B, Subdivision E of the Medical Indemnity Act provides for certain payments, should the Scheme ever be wound up without alternative arrangements being put in place. Medical practitioners who are still practising at the time of the wind up of the Scheme would be entitled to have an amount not exceeding their total run-off cover credit paid to their nominated medical indemnity provider. Practitioners who are eligible for the Scheme at the time of its wind up would not be entitled to any refund but would continue to be covered for any future claims that might emerge.
- 3.6.7 Figure 2 summarises the contribution to ROC support payments by age of practitioner. Note that age and gender were not available for a minority of medical practitioners. The chart is based only on practitioners who paid at

¹³ Compared to last year, one insurer appears to have excluded many small policyholders from ROC support payments. However, the total support payments still increased for this insurer. The average premium of this insurer is now more in line with the other insurers.

least \$1,700 in respect of both medical indemnity premium (net of discounts and loadings) and membership fees during 2020-21. We refer to these practitioners as 'at-risk' medical practitioners. The proportion of ROC support payments is greater than the proportion of practitioners for medical practitioners aged between 40 and 60. This is consistent with this age group being at the peak of their career. For younger practitioners, the chart shows a lower proportion of ROC support payments, reflecting relatively lower risk taking at the start of the career. The chart also reflects a slightly lower level of premiums for older medical practitioners who may tend to wind down their practice hours and possibly perform fewer risky medical procedures (for example, surgery) as they reach more advanced ages.

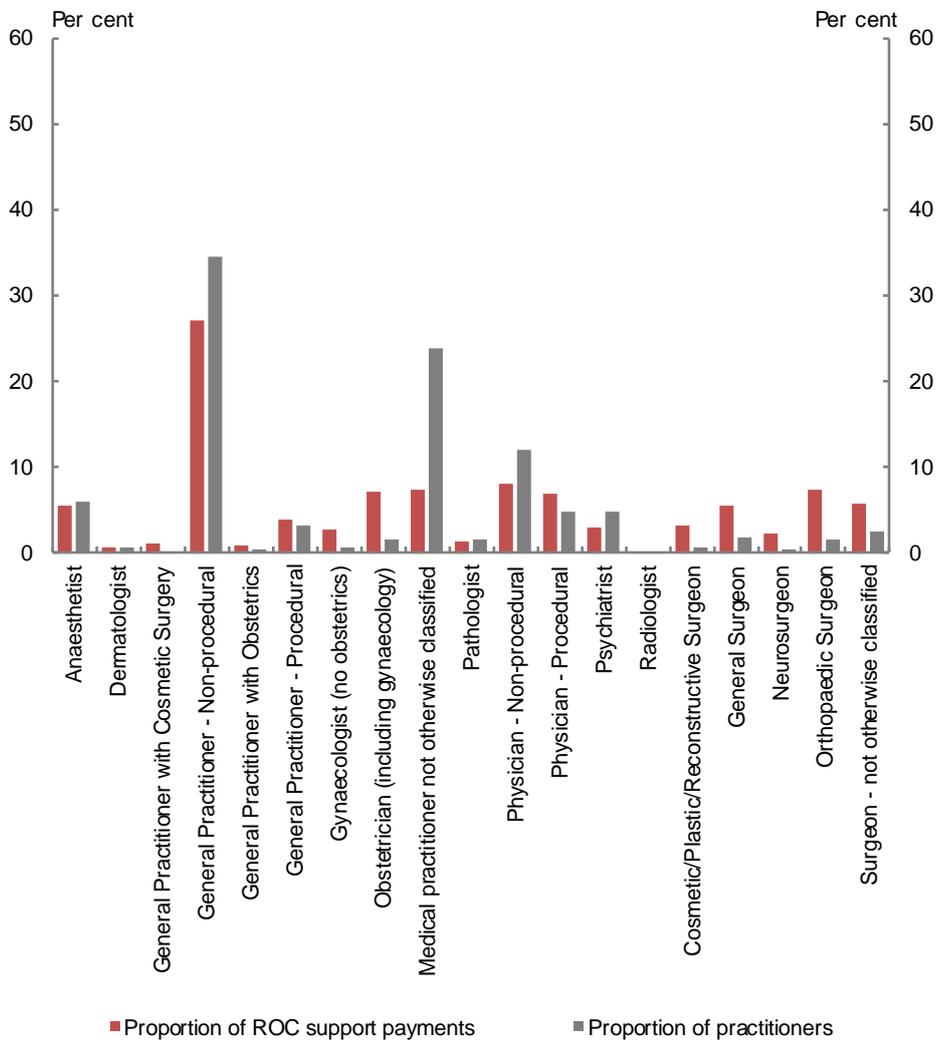
Figure 2: Contribution to Run-Off Cover support payments by age



3.6.8 Figure 3 summarises the contribution to ROC support payments by area of specialty. Specialty codes were not available in relation to a small minority of medical practitioners. As for Figure 2, this chart only includes 'at-risk' medical practitioners.

3.6.9 Medical indemnity insurance premiums tend to be risk-based. Thus, practitioners operating in higher risk areas of specialty are likely to incur the highest premiums and, accordingly, the highest ROC support payment liabilities. The largest ROC support payments are for obstetricians, gynaecologists, neurosurgeons, cosmetic/plastic/reconstructive surgeons, orthopaedic surgeons, and general surgeons. General practitioners – non-procedural have the smallest average ROC support payments. Note that most medical practitioners not otherwise classified (including interns and trainees) are not shown in this chart as they are not included in the 'at-risk' group.

Figure 3: Contribution to Run-Off Cover support payments by specialisation



4 FINANCIAL MANAGEMENT OF THE RUN-OFF COVER SCHEME

4.1 2020-21 CASH FLOW

- 4.1.1 Table 7 sets out the cash flow statement of the Notional Account for 2020-21. As a result of the repeal of the General Interest Charge rate as the applicable interest rate for calculating total run-off cover credits, all past notional interest charges have been recalculated retrospectively in line with the new interest rate as specified in sections 10 of the *Medical Indemnity Rules 2020*. The implications of this change are discussed further in section 4.4.

Table 7: Cash flow statement of the Notional Account FY2020-21

	\$'000
Income	
ROC support payments (received 30 June 2021)	20,217
ROC support payments (in respect of doctors eligible at 1/7/2004 start up)	0
Notional interest	7,356
Expenses	
ROC indemnity payments (in respect of doctors eligible at 1/7/2004 start up)	0
ROC indemnity payments (in respect of doctors eligible post 1/7/2004)	10,590
Administration cost payments to MIs	2,416
Net cashflow	14,567

4.2 EXPERIENCE AND MODEL

Comment on experience during 2020-21

- 4.2.1 ROCS indemnity payments have been relatively low in the past, although payments have exceeded \$4.5m for the past four consecutive years. The spike in 2020 is attributable to one large claim, which has now been fully reimbursed. However, the full year payment of over \$10m in 2020-21 indicates a continuation of the upward trend. The actual payments made by Services Australia in the first six months of 2021-22 is \$5.2m. As was the case in 2020-21, payments were spread over many claims rather than one or two very large claims. This suggests that the scheme may be maturing.
- 4.2.2 In relation to Scheme-eligible claims which had been notified at the time of the previous review (30 June 2020) but not yet paid, actuarial estimates of the corresponding ROC indemnity payments had an undiscounted value then of \$31.5 million (excluding claims handling costs). In 2020-21, claim payments of about \$10.4 million were made by MIs/MDOs relating to these claims (based on industry data). All else being equal, this would suggest a

residual figure at 30 June 2021 of about \$21.1 million. Updated industry estimates put this number at around \$22.3 million (excluding 2020-21 notifications), which is only slightly higher than expected. This implies that the industry estimates for claims notified at the time of the previous review have slightly increased from last year.

- 4.2.3 Based on input from industry actuaries, the previous report estimated the incurred-but-not-reported (IBNR) Run-Off Cover Scheme liability at 30 June 2020 as \$49.6 million (excluding claims handling costs and discounted at 5 per cent per annum). Table 8 sets out the expected new notifications that were implied within that estimate, alongside the most recent estimates. Note that the estimates below have been calculated from projected cash flows discounted at 5 per cent per annum to the middle of each notification year. It shows that the estimates have generally increased materially from last year, especially for 2020-21, where the estimate has been updated based on the actual claims notified during the year. The increase was mainly driven by one insurer. However, these estimates derived from industry actuaries' cash flow projections do not always reconcile with the case estimates provided by the insurers. This highlights the uncertainties with the estimates.

Table 8: Expected new notifications (excluding CHE)

Notification year	This year's data (\$'000)	Last year's data (\$'000)
2020-21	19,251	6,833
2021-22	9,067	7,185
2022-23	9,406	7,551
2023-24	9,814	7,925
2024-25	10,218	8,292

- 4.2.4 The significant increase in the industry's estimated cost of the claims not yet notified at the previous review, including new claims that were notified in 2020-21, contributed to higher projected ROC indemnity payments. The projected ROC indemnity payments are shown in Table 9.

Changes to model and assumptions

- 4.2.5 Four years ago, we revised a range of assumptions after considering the NCPD data that we received in 2017. These assumptions still appear reasonable in light of the most recent data. We have not made any changes this year except those described below.
- 4.2.6 The ROCS eligibility probabilities were updated last year to reflect the change legislated in the *Medical and Midwife Indemnity Legislation Amendment Act 2019* (Amendment Act) which waives the three-year ROCS eligibility waiting period from 1 July 2020 for those who resigned from private practice under the age of 65. In theory, this should have caused a one-off

spike in new entrants in 2020-21 because not only are the practitioners who resigned in 2020-21 eligible for ROCS immediately, those who resigned in the previous three years (that is, pre-COVID) would also have become eligible in 2020-21 regardless of whether they re-entered private practice¹⁴. However, this was not reported in the data. Instead, the reported number of new entrants reduced significantly in 2020-21. As discussed in section 3.3, the eligibility data for 2020-21 is likely to be incomplete and could remain incomplete for some time before this assumption can be evaluated.

- 4.2.7 Notwithstanding, temporary movements in new entrants have an immaterial impact on next year's new accrual estimate. For the new accrual estimate, it is the ROCS eligibility status of the practitioner at the time of the claim's notification that is critical. Given the frequent long delays in the notification of medical indemnity claims, the cumulative long term ROCS eligibility probabilities have a far greater relevance than the short-term eligibility probabilities.
- 4.2.8 Furthermore, while the experience of 2020-21 suggests a genuine reduction in new entrants as a temporary response to carry out COVID-19 vaccination administration, the peak of the vaccination roll-out has passed. Thus, it is not unreasonable to expect their exit patterns to gradually return to the long-term upward trend.
- 4.2.9 Considering all the factors above, no adjustments have been made to the long-term ROCS eligibility probabilities.
- 4.2.10 This year, the issue of new entrants is further complicated by the retainment of eligibility for returned practitioners during the exemption period. Note that the potential claims associated with the returned practitioners have been included in our new accrual estimate by making an adjustment to the model's methodology. Instead of overlaying potential eligibility probabilities on future claims, the group that is already eligible has been modelled separately without this overlay. That is, any projected claims associated with this group are assumed to be immediately eligible for the Scheme.

¹⁴ *Medical Indemnity Amendment (Eligible Run-off Claims) Regulations 2020* stipulates a temporary exemption, which allows ROCS eligible practitioners to return to private practice in order to provide treatment during the COVID-19 pandemic without the practitioner losing their eligibility under the ROCS. *Medical and Midwife Indemnity Legislation Amendment (Eligible Run-off Claims) Rules 2022* (the Amending Rules) extends the temporary exemption from 17 May 2022 to 21 October 2022.

- 4.2.11 Last year, an insignificant number of “risky” practitioners appeared to be both eligible and contributing. There were around 2,400 of such practitioners in 2020-21. About half of these practitioners are non-procedural GPs. This is consistent with the expectation that many practitioners returned to administer COVID-19 vaccination. The rest of this population is spread across other specialties, who may or may not have been engaged in low-risk vaccination work.
- 4.2.12 For this year’s new accrual model, we have retained the previous claim rate assumption for the ineligible practitioners. For the eligible practitioners, we assumed their claim rate would be 50% lower. These claim rate assumptions are likely to be conservative, given many practitioners especially GPs, regardless of their eligibility status, were heavily involved in low-risk vaccination work that probably crowded out other higher risk work, and that vaccine related claims will most likely be picked up by the new no-fault COVID-19 Vaccine Claims Scheme.
- 4.2.13 This temporary eligibility exemption for returned practitioners will remain in place until 21 October 2022. Hence, future cash flows and the liabilities of the scheme will continue to be affected by this measure until the cessation. For simplicity, we have assumed it affects the entire 2020-21 and 2021-22 financial years. The simplifying assumption is not unreasonable in the context of the overall uncertainties in the estimate.
- 4.2.14 Appendix 4 sets out the main assumptions and describes the methodology that was used to estimate the liabilities at 30 June 2021. Appendix 5 describes the assumptions and methodology used to project future liabilities. Appendix 6 considers the effect of the High Cost Claims Scheme (HCCS).

4.3 RESULTS: PROJECTED RUN-OFF COVER COMMONWEALTH CONTRIBUTIONS

- 4.3.1 This section sets out a projection of ROC indemnity payments for the next ten financial years. For the reasons described above, the projections should be regarded as indicative only. The data issues referred to earlier in this report also contribute to the uncertainty. The data provided by the industry in late 2021 was broadly consistent with the trend implied in the past payments data provided by Services Australia. The underlying assumptions and methodology are described in Appendices 4 and 5, with the calculations summarised in Table 21. Table 9 below sets out the projections, which are illustrated in Figure 4. The Scheme is not expected to become mature in a cash flow sense for several years. The payments projected below are in nominal dollars and have not been discounted to current dollar values.

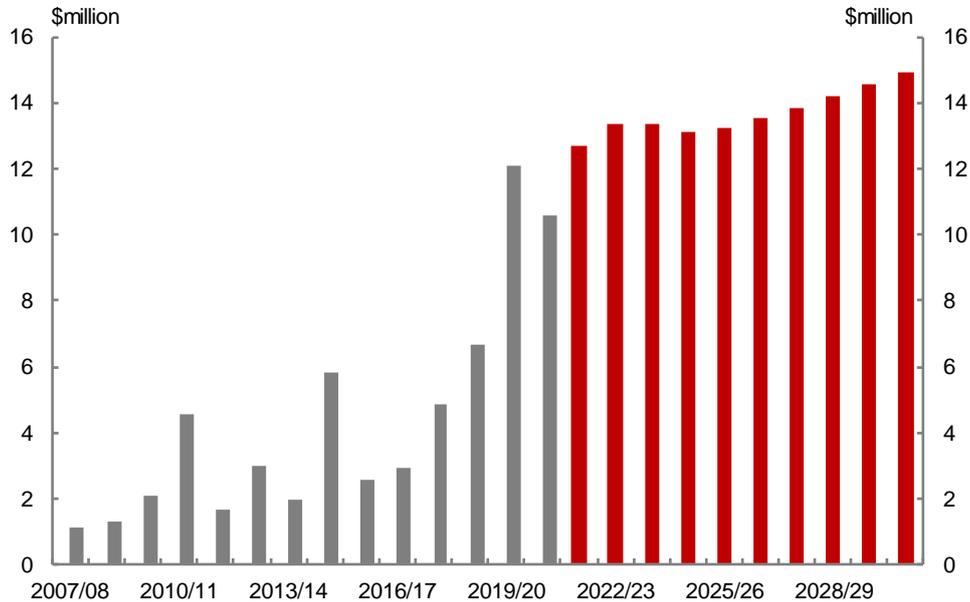
- 4.3.2 While we have received the actual payments to the end of December 2021 from Services Australia, it is inherently difficult to adjust the industry projection for the full year based on half years of actual payments given the lumpy nature of the ROC indemnity payments. The projected payment figure for 2021-22 does not appear inconsistent with the actual payments to the end of December 2021. The projected indemnity payments include indirect costs associated with handling claims, referred to as indirect claims handling expenses (CHE). Note we have not allowed for the impact of potential court closures due to COVID-19, which may delay settlements, and hence payments. All else being equal, this makes our liability estimates slightly conservative.
- 4.3.3 Last year, we commented on insurer's apparent optimism in relation to future years given the spike in payments in 2019-20 and the actual payments to the end of December 2020. Since 2019-20 was the first year that exceeded \$10m and was driven by one single claim, it was not sufficient to ascertain whether the claims costs would persist at the higher level. The full year payment in 2020-21 fell only slightly from the previous year and was spread over many claims. It appears that the latest industry projections have been revised upwards as a result, as shown in Table 8. The resulting cash flow projections appear more realistic.
- 4.3.4 In light of the various changes in experience and legislation as described in section 4.2, further adjustments were made to the liability estimate as at 30 June 2021 as well as new accrual for 2021-22. Accordingly, the projected indemnity payments were also adjusted based on an incident to payment pattern.

Table 9: Projected Run-Off Cover indemnity payments (including CHE)

Year ending 30 June	Projected ROC indemnity payments plus CHE (\$'000)^(a)
2022	12,696
2023	13,378
2024	13,380
2025	13,135
2026	13,250
2027	13,523
2028	13,842
2029	14,199
2030	14,560
2031	14,912

(a) These projected payments do not include ongoing administration amounts payable to insurers under the ROC Claims and Administration Protocol which are different to CHE.

Figure 4: Historical and projected Run-Off Cover indemnity payments (including CHE)



4.4 RESULTS: LIABILITY AT 30 JUNE 2021 & NOTIONAL ACCOUNT

- 4.4.1 The estimation of the Commonwealth’s liabilities under the Scheme is inherently imprecise. The operation of the Scheme is likely to be characterised by a small number of claims of highly variable size. It is not possible to predict the costs of the Scheme with a high level of confidence. For example, the presence of a single very large claim in any given year could have a substantial effect on the total amount of ROC indemnity payments for that year.
- 4.4.2 The liabilities of the Scheme could be measured in several ways. It is normal for insurance-type liabilities to be measured on either a ‘notified’ or an ‘occurrence’ basis. On a notified basis, new liabilities would accrue to the Scheme as new claims were notified. On an occurrence basis, new liabilities would accrue to the Scheme at the time of the occurrence of the medical incidents which were expected to give rise to medical indemnity claims which would attract a ROC indemnity payment.
- 4.4.3 Under the occurrence model, liabilities are recognised more quickly than under the notified model. The occurrence model is more consistent with the notion that the Scheme is ongoing. Accordingly, the occurrence model has

been adopted for this report. The liabilities of the Scheme are therefore taken as the present value of future ROC indemnity payments (including associated insurer claims handling expenses) which relate to medical incidents which occurred before the effective date of valuation.

4.4.4 The Commonwealth's liabilities under the scheme at 30 June 2021 are considered under the following categories:

- Outstanding compliance costs as at 30 June this year
- Scheme eligible claims which had been notified at the time of the review and paid by the MIs, but not yet recovered from Services Australia
- Scheme eligible claims which had been notified to the MIs at the time of the review but not yet paid
- Incurred claims that have not yet been reported to the MIs
- Claims handling expenses.

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

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

4.4.7 The Notional Account is credited with:

- ROC support payments
- amounts to offset ROC indemnity payments which relate to medical practitioners who were eligible at the commencement of the scheme
- notional interest.

4.4.8 Notional interest is credited to the Notional Account to ensure reasonable treatment of the time value of money since ROC support payments are received by Services Australia well in advance of any ROC indemnity payments being made by Services Australia. Last year, notional interest

was applied at the General Interest Charge rate. However, the Amending Rules legislated in July 2021 replaces the existing reference to the General Interest Charge rate with a rate based on the annual change in the Consumer Price Index rate in sections 10 of the *Medical Indemnity Rules 2020*. As a result, all past notional interest charges have been recalculated retrospectively in line with this new interest rate. The notional interest becomes a cost to government, should the scheme be wound up. In this circumstance, contributions are returned to practitioners that are not yet eligible with interest at the prescribed rate. This is discussed further at the end of this section 4.4.

- 4.4.9 On establishment of the Scheme, the Government announced that it would fund the opening liability that was attributable to practitioners who were already eligible for cover under the Scheme at the time of its commencement. Since the commencement of ROC indemnity payments, effect has been given to this commitment by ensuring that the Notional Account is credited annually with amounts to offset any ROC indemnity payments which relate to medical practitioners who were eligible at the commencement of the Scheme.
- 4.4.10 The Notional Account is charged with:
- ROC indemnity payments
 - Payments made under the Medical Indemnity Regulations.
- 4.4.11 The Scheme will also pay an amount to a MII or MDO to cover the indirect costs associated with handling claims, referred to as indirect claims handling expenses (CHE). The Scheme pays 5 per cent of the cost of each claim to cover CHE.
- 4.4.12 Appendix 2 provides more detail on claim amounts eligible under the Scheme.
- 4.4.13 Note that the Scheme 'operates after' the HCCS. The effect of the HCCS is described in detail in Appendix 6.
- 4.4.14 Table 10 describes how an eligible \$1 million claim notified after 1 July 2018 would be funded¹⁵. The total amount paid of \$1,050,000 comprises claim costs of \$1 million and CHE of \$50,000.

15 The High Cost Claim Threshold has changed over time. Details are provided in Appendix 6.

Table 10: Funding sources for a \$1 million claim which is eligible for the Run-Off Cover Scheme

Funding source	Amount
ROC indemnity payment (direct claim costs)	\$750,000
Run-Off Cover Scheme CHE	\$50,000
Run-Off Cover Scheme (Total)	\$800,000
HCCS	\$250,000

- 4.4.15 As noted earlier, the Medical Indemnity Act provides for payment of a practitioner's total run-off cover credit, should the Scheme ever be wound up without alternative arrangements being put in place. Thus, in this event, a large part of the accumulated ROC support payment balance would become a liability of the Scheme. At the same time, since the Scheme liabilities are being measured on an occurrence basis, some of the liabilities of the Scheme would be released, partially offsetting this impact. However, for the purpose of this report, the Scheme has been assumed to be ongoing and the whole amount of the accumulated ROC support payments has been taken to be available to meet relevant ROC indemnity payments.
- 4.4.16 The liability estimates given in this report are central estimates. In broad terms, this means that they are intended to be equally likely to be too high or too low. In particular, it is not intended that the liability estimates contain any margin for risk. Funding considerations for the Scheme are not the same as for private sector insurance arrangements. The objective here is to manage the funding over the long term. Since substantial volatility in the liability estimates is likely from time to time, periods of surplus and periods of deficit in the Notional Account might be expected. However, given the long-time horizon for funding the Scheme, it is appropriate. A short-term deficit in the Notional Account is not a cause for concern. As a result of this, there is no strong reason to maintain a risk margin in the liability estimates.
- 4.4.17 Table 11 below sets out the balance sheet of the Notional Account as at 30 June 2021. Normally, the opening cash balance is the previous closing balance. However, given all past notional interest rate charges have been recalculated, this approach is not appropriate this year. The opening balance below has been calculated as the revised total run-off cover credits less the total administration cost payments and ROCS indemnity payments to MIIIs as at 30 June 2020. All three figures are based on data provided by Services Australia.

Table 11: Balance sheet of the Notional Account as at 30 June 2021

	\$'000
Assets	
Cash as at 1 July 2020	271,838
Net cashflow	14,567
Total	286,405
Liabilities	
Outstanding compliance costs	2,285 ^(a)
Paid by Mlls but not yet recovered from Services Australia	9,482 ^(b)
Notified to Mlls but not yet paid by them	37,203 ^(c)
Incurred but not yet notified to Mlls	69,367 ^(d)
Claims handling expenses	6,420 ^(e)
Total	124,757

- (a) Based on actual and expected payments made by Services Australia in 2021/22 in relation to prior claim years.
- (b) Based mainly on estimates provided in relation to claims/incidents notified to Mlls and MDOs by 30 June 2021.
- (c) Based on estimates provided by industry actuaries.
- (d) Based on estimates provided by industry actuaries and models developed within this office. This figure includes an adjustment of \$6 million. This is described in Appendix 4.
- (e) Based on 5 per cent of 'grossed up' ROC indemnity payments (to allow for the impact of the HCCS).

- 4.4.18 The Notional Account at 30 June 2021 has disclosed an estimated notional surplus of about \$162 million. On one hand, the notional interest increases the notional account balance each year. On the other hand, some of the notional interest becomes a cost to government, should the Scheme be wound up.
- 4.4.19 Note again that no account has been taken for possible payments to practitioners under Subdivision E of the *Medical Indemnity Act*, should the Scheme be wound up without alternative arrangements being put in place. Based on the latest data provided by Services Australia, this amount could be up to \$370 million as at 30 June 2021.
- 4.4.20 Generally, the estimated surplus position should be regarded as highly uncertain. A more accurate estimate of the surplus can be made possible if the ROCS levy balances of the ROCS eligible practitioners could be monitored and supplied by Services Australia.

4.5 RESULTS: PROJECTED LIABILITIES OF THE SCHEME

- 4.5.1 Finally, it is appropriate to provide a projection of the liabilities of the Scheme. Future liabilities under the scheme are projected having regard to the annual rate at which future liabilities will accrue, the payment of claims and the interest that is required to accrue to the (discounted) reserves each year.

4.5.2 Table 12 sets out estimates of the liabilities of the Notional Account at the end of each of the next five financial years. The purpose is to illustrate the short-term development of the Scheme. There is substantial uncertainty in these estimates. The new accrual after 2021-22 will revert to the long-term trend as the temporary ROCS eligibility exemption will cease on 21 October 2022. The numbers shown below have been discounted to the end of the relevant financial year but have not been discounted to give values in today's terms. Detailed actual versus expected analysis is contained in Appendix 4.

Table 12: Projected balance sheet liabilities of the Notional Account

Year ending 30 June	Liability at start-year (\$'000)	New accrual (\$'000)	Payments (\$'000)^(a)	Interest cost (\$'000)	Liability at end-year (\$'000)
2021					124,757
2022	124,757	20,455	12,696	6,943	139,459
2023	139,459	14,914	13,378	7,384	148,379
2024	148,379	15,884	13,380	7,879	158,762
2025	158,762	16,916	13,135	8,456	170,998
2026	170,998	18,016	13,250	9,119	184,883

(a) ROC indemnity payments plus CHE only. Does not include liability in respect of outstanding compliance costs. Refer Appendix 4 for further information.

4.6 ACTUARIAL MANAGEMENT

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



Guy Thorburn FIAA
Australian Government Actuary
24 June 2022

APPENDIX 1: ELIGIBLE PRACTITIONERS AND RUN-OFF COVER SCHEME CONTRACTS

Eligible persons

A.1.1 Eligible persons are those who fit one or more of the following eligibility categories at the time the claim (or medical incident) is first notified to the MII or MDO (section 34ZB(2) of the Medical Indemnity Act and Medical Indemnity Regulations 2003 regulation 12):

- A medical practitioner who has permanently retired from paid medical practice¹⁶.
- A legal representative of a deceased medical practitioner (provided that a claim can be made against the deceased's estate).
- A medical practitioner who has ceased paid medical practice due to permanent disability.
- A medical practitioner who has ceased paid medical practice because of maternity.
- An overseas trained medical practitioner, who worked in Australia under an appropriate visa, has permanently ceased medical practice in Australia and does not reside in Australia.

A.1.2 *Medical Indemnity Amendment (Eligible Run-off Claims) Regulations 2020* stipulates a temporary exemption, which allows eligible persons to return to private practice in order to provide treatment during the COVID-19 pandemic without the practitioner losing their eligibility under the Scheme. This exemption will remain in place until 21 October 2022.

¹⁶ There used to be a three-year waiting period for practitioners who retired under age 65. This has been waived from 1 July 2020 as legislated in the *Medical and Midwife Indemnity Legislation Amendment Act 2019* (Amendment Act).

Provision and notification of compulsory run-off cover

- A.1.3 The practitioner's last medical indemnity insurer is required to provide run-off cover to an eligible practitioner under section 26A of the PSPS Act.
- A.1.4 The compulsory run-off cover must encompass the same nature and range of incidents as the last medical indemnity cover held by the eligible practitioner (subsection 26A(4)(b)).
- A.1.5 Section 26D compels MIIIs to notify eligible practitioners of:
- the nature and range of incidents encompassed by the compulsory run-off cover
 - the terms and conditions on which it is provided.
- A.1.6 The compulsory run-off cover is taken to be a contract of insurance between the MII and the eligible practitioner for the purposes of the PSPS Act (section 26E).

APPENDIX 2: RUN-OFF COVER SCHEME CLAIMS

- A.2.1 The legislation defines claims broadly. Claims need not involve legal proceedings. Claims may include civil claims for negligence, administrative proceedings, disciplinary proceedings (including those performed by a professional body) and inquiries or investigations into conduct (subsection 4(1) of the Medical Indemnity Act).
- A.2.2 A ROC claim is payable to an MII or MDO under section 34ZC in relation to a claim eligible under subsection 34ZB(1) if:
- it was first notified to the MII or MDO on or after 1 July 2004
 - it relates to a person eligible under subsection 34ZB(2) (see Appendix 1)
 - it relates to incident(s) occurring in connection with the person's practice as a medical practitioner (see paragraph 34ZB(1)(b))
 - either the person is indemnified for the claim by an MII in accordance with section 26A of the PSPS Act, or the person is indemnified under incident-occurring based cover provided by an MDO (paragraph 34ZB(1)(e))
 - the claim would be paid in the ordinary course of the MII's or MDO's business.
- A.2.3 Where these criteria are met, the Commonwealth is liable to pay run-off cover indemnities regardless of whether the MII or MDO has sought private reinsurance (section 34ZF).
- A.2.4 Applications for ROC indemnity payments must be made to Services Australia (section 36 of the Medical Indemnity Act). They are paid by the Chief Executive Medicare before the end of the month that immediately follows the month in which the MII applies for the indemnity (section 37).
- A.2.5 The Scheme operates after the HCCS. Thus, part of the cost of eligible large claims is first met by the HCCS with the rest being picked up by the Scheme (subsection 34ZH(2)). Where the total incurred cost of an eligible ROC claim exceeds the HCCS threshold (currently \$500,000), the HCCS meets 50 per cent of the amount by which it exceeds the threshold.

APPENDIX 3: RUN-OFF COVER SUPPORT PAYMENTS

- A.3.1 ROC support payments are paid to Services Australia in the form of an annual lump sum imposed as a tax on each MII from 1 July 2004. The lump sum is intended to cover the cost of claims and the MIIs' administration and implementation costs.
- A.3.2 The amount of support payments is calculated as a percentage of premium income received from contributing practitioners. The calculation rules are set out in the MI ROCSPA and regulations. The tax imposed on each MII is the applicable percentage of the insurer's premium income (section 6) for the applicable contribution year ending on 30 June or an alternative date specified in the regulations (section 5).
- A.3.3 All MIIs except for AMIL were required to remit their first ROC support payments on 30 June 2005. Since AMIL's policy year was a calendar year, it was not required to remit ROC support payments until 31 December 2005.
- A.3.4 Under section 7, a MII's premium income for the purpose is the sum of all of the premiums paid to the insurer for medical indemnity cover provided for medical practitioners, reduced according to the formula:

Premium income equals

$$\frac{\text{Net premium}}{\text{Net premium}} \times \frac{\text{Applicable percentage}}{\text{percentage}} \div (1 + \text{Applicable percentage})$$

- A.3.5 Net premium is calculated according to section 7 as follows:
- sum of all premiums paid to the insurer during the operation of the Scheme for medical indemnity cover provided for medical practitioners (including subsidy payments made to the insurer on behalf of medical practitioners to assist with the cost of purchasing medical indemnity cover under the Medical Indemnity Premium Support Scheme, section 43(1) Medical Indemnity Act) (subsection (1))
 - minus the amount of GST payable (subsection (2)(a)) and the amount of stamp duty payable (subsection (2)(b)) in relation to the premiums
 - plus/minus other payments specified in the regulations.
- A.3.6 For premium payments relating to 2020-21, the applicable percentage is specified in the regulations as 5 per cent for all insurers, and thus the ROC support payment will be calculated as net premium x 5 per cent ÷ 1.05.

APPENDIX 4: LIABILITIES AT 30 JUNE 2021

- A.4.1 The purpose of this appendix is to describe the approach taken (and assumptions used) to calculate the scheme liabilities.
- A.4.2 Claims liabilities have been assessed on an occurrence basis. New liabilities accrue to the Scheme at the time of the occurrence of the medical incidents which were expected to give rise to medical indemnity claims which would attract a ROC indemnity payment. The liabilities of the Scheme in respect of claims liabilities are therefore taken as the present value of future ROC indemnity payments (plus associated insurer claims handling expenses) which relate to medical incidents which occurred before the effective date of valuation.

Summary of Liabilities as at 30 June 2021

- A.4.3 Table 13 summarises the estimated accrued Scheme liabilities as at 30 June 2021. The Scheme liabilities are divided into outstanding compliance costs, those attributable to claims notified as at 30 June 2021, those attributable to IBNR claims as at 30 June 2021 and overall claims handling expenses.

Table 13: Run-Off Cover Scheme liabilities related to medical incidents prior to 30 June 2021 (\$'m)

Outstanding Compliance Costs	2,285
Liabilities in relation to claims notified as at 30 June 2021	
Paid by MIs but not yet recovered from Services Australia	9,482
Notified to MIs but not yet paid by them	37,203
Sub Total	46,685
Liabilities in relation to IBNR claims as at 30 June 2021	69,367
Claims Handling Expenses	6,420
Total Run-Off Cover Scheme liabilities	124,757

- A.4.4 This section describes the approach taken and the key assumptions used in the calculation of the key liabilities shown above.

Outstanding Compliance Costs

A.4.5 MIIIs apply to Services Australia for a refund of the costs of complying with the scheme each year. At the end of any one year the government has a liability for any outstanding compliance costs in respect of the previous years' operation of the scheme, that have not yet been refunded. This liability is generally based on the applications received by Services Australia and estimates by Services Australia in relation to applications that have not been received at the time of writing for compliance costs that have not yet been settled. For this report, the estimate is based on the actual amount that Services Australia has paid to insurers after 30 June 2021 and the expected amount that Services Australia will pay to insurers after 30 June 2021 in respect of previous years' operation. It includes two back-dated payments to Guild and Berkshire Hathaway in respect of previous years' operation as they are now allowed under the legislation.

Liabilities in relation to notified claims

A.4.6 There are two categories of notified claims, those which have been settled by the insurer, but not yet recovered from Services Australia and those that are still being managed by the insurer.

A.4.7 In the case of settled claims, we have compared the insurer past payments (including CHE) with the Services Australia reimbursements as at 30 June 2021. The difference is, by definition, the amount paid by insurers but not yet reimbursed by Services Australia, and it is higher than the corresponding amount derived from the insurer's data provided in late 2021. We have used the higher figure.

A.4.8 Where the claim is still being managed by the insurer, all notified claims have a case estimate placed against them by the relevant insurer. The industry has provided a projection of the expected claims payments based on the relevant year of notification. As with any estimate, it is to be expected that the actual payments that will occur to settle the claim will vary from the claims managers' current estimate.

A.4.9 The projected cash flows in relation to notified but not yet settled claims is discounted using the expected long-term earning rate to determine a net present value as at the valuation date.

Liabilities in relation to IBNR claims

A.4.11 Due to the nature of this type of liability, claims may be notified many years (potentially as long as 20 or more years) after the event that actually gives rise to the claim has occurred. Industry provides a projection of claims that will be notified in each year for the next five years. Given the previous comment, most

of the claims that will be notified next year will have already occurred at the valuation date. Therefore, they are already a liability of the scheme.

A.4.12 Industry provides a cash flow projection of the total cost of expected notified claims for the next five years. These are adjusted as necessary and then extrapolated. A proportion of these claims will have already occurred and therefore form part of the IBNR liability. Further, given that claims can be reported many years into the future, some claims that will be notified beyond this five-year period will also already be part of the IBNR liability.

A.4.13 Taking this into account, the following approach is adopted to derive the IBNR liability from the industry estimate:

- The industry's five-year projection is adjusted as necessary and extrapolated for the next 50 years.
- We apply our observed pattern of the period of delay from an incident occurring to it being reported and being eligible for ROCS to determine the portion of the projected future total claims payments that have already occurred and are therefore already liabilities of the scheme.
- We then apply the observed cash flow patterns to allow for the time it takes to settle claims once notified, and inflation and discount rates are applied to determine the present value of the liability.

A.4.14 This year, we adjusted the IBNR liability upwards by \$6 million. The main reason is that none of insurers appears to have accounted for the immediate access to the Scheme by returned practitioners¹⁷. Furthermore, the latest ROCS eligibility data indicates that the number of currently eligible practitioners could be under-estimated by insurers. The upward adjustment of \$6 million (without CHE) is based on the estimated impact of this temporary exemption on the 2021-22 new accrual. Since this temporary measure commenced in April 2020, the new accrual for the entire 2020-21 was affected by this measure and the impact is

¹⁷ *Medical Indemnity Amendment (Eligible Run-off Claims) Regulations 2020* stipulates a temporary exemption, which allows ROCS eligible practitioners to return to private practice in order to provide treatment during the COVID-19 pandemic without the practitioner losing their eligibility under the ROCS. *Medical and Midwife Indemnity Legislation Amendment (Eligible Run-off Claims) Rules 2022* (the Amending Rules) extends the temporary exemption from 17 May 2022 to 21 October 2022.

assumed to be of a similar magnitude to that estimated on the 2021-22 new accrual.

- A.4.15 On the other hand, because the insurers indicated that they have not adjusted cash flow projections for the returned practitioners, the cash flows for past incidents that insurers previously expected to be notified during this exemption period would have remained unchanged. This is consistent with such claims being eligible for the Scheme since the practitioner retained eligibility. Hence, no further adjustment is required for the IBNR liability.
- A.4.16 In accordance with the IBNR liability adjustment, the cash flow projections have also been adjusted.

Claims Handling Expenses

- A.4.17 The Scheme pays 5 per cent of the direct cost of each eligible claim to cover claims handling expenses. Where an eligible claim is partly covered by the HCCS, the allowance for claims handling expenses paid under the Scheme is 5 per cent of the total claim cost, including the portion covered by the HCCS. Claims costs are therefore grossed up by an allowance that represents the proportion of Scheme claims that are paid by the HCCS. This proportion is assumed to be 17% and is unchanged from last year.

Comparison of Actual and Expected Liabilities at 30 June 2021

- A.4.18 In any valuation, it is informative to compare the 'actual' estimated liabilities¹⁸ at the valuation date with that which was expected in the prior review. This can highlight areas where a change in approach, or experience has impacted the results.
- A.4.20 Table 14 compares the 'actual' estimated Scheme liabilities in relation to prior medical incidents as at 30 June 2021 to the 'expected' amounts, which are based on the prior review and expected cash flows during 2020-21. Both the 'actual' and the 'expected' estimated liabilities have been discounted at 5 per cent per annum. For simplicity, the liability for the amount paid by MIs but not yet recovered and claims handling expense allowance are not included.

18 The estimates have been updated with the latest data, experience and assumptions.

Table 14: Actual versus expected liability estimates as at 30 June 2021 (\$'m)

	Actual	Expected	Actual minus expected
Notified but not yet paid	37.2	26.7	10.5
IBNR	69.4	51.8	17.6
Total	106.6	78.5	28.1

A.4.20 The 'actual' estimated liability is about \$28.1 million higher than the 'expected' liability based on the prior review. It is mainly driven by higher estimates provided by industry actuaries in late 2021 pertaining equally to the claims notified but not yet paid as well as the IBNR estimate as at 30 June 2021. The higher estimate for the claims notified but not yet paid is attributable to new notifications during 2020-21 as shown in Table 8. The increase in the IBNR estimate includes the \$6m upward adjustment described in A.4.14.

Uncertainty in the Liability as at 30 June 2021

A.4.21 The greatest uncertainty arises from the nature of the scheme. Run-off cover claims are inherently long-tailed, which means that it can take decades for the scheme to mature in a cash flow sense. In addition, claims cost related to bodily injury is highly variable and tend to be dominated by a small number of large claims. Therefore, it is impossible to estimate the scheme liability with certainty.

A.4.22 Our approach for estimating scheme liability, by necessity, focuses on reasonableness of assumptions, of the methodology and monitoring the progress between projected and actual payments over time.

A.4.23 We have to rely extensively on the high-level cash flow projections provided by industry actuaries. Data often changes significantly year on year, and they can be very different to the historical payment trend as suggested by Services Australia payments data. Attempting to reconcile the two different sources of data is one area of difficulty when estimating run-off cover claims cost.

A.4.24 The IBNR component is also dependent on the assumed notification pattern. This has been updated several times since the beginning of the scheme as more data emerged. This has reflected the shorter notification delays that we have observed. In theory, a shorter notification pattern would imply a lower ROCS liability as the medical practitioner is less likely to have ceased private practice at the time of notification.

A.4.25 Ultimately, uncertainty is evidenced by the fact that the scheme is still relatively immature. Only 615 claims have been notified to insurers that have a case estimate attached to them, and less than 400 claims have had some reimbursement by Services Australia. The limitation in the claims data still dictates our reliance on the industry's projections. There is still insufficient data for a ground-up granular modelling approach.

A.4.26 Last year, the half year payments made by Services Australia to December 2020 compared to the 2019-20 cashflow (which was dominated by one claim) supported the lower payment estimate for 2020-21 as provided by the industry at the time. We also estimated that payments would be slightly reduced in the next few years before rising again steadily. In reality, the full year payments in 2020-21 fell only slightly from the previous year and were spread over many claims. This reflects the increasing number of practitioners who are now eligible for benefits from the ROCS. The half year payments made by Services Australia to December 2021 and the significant increase in the latest industry projections lend credence to a new normal level of ROCS payments. Furthermore, the temporary ROCS eligibility exemption and the recent waiver of the three-year waiting period for those resigned under 65 could potentially increase the payments further.

APPENDIX 5: PROJECTED LIABILITIES AND CASH FLOWS

A.5.1 The Medical Indemnity Act requires that the report include a projection of the Commonwealth's liabilities in relation to amounts of Run-Off Commonwealth contributions in future financial years. This Appendix summarises the results of that projection, describes the methodology and assumptions and discusses the uncertainty in relation to the liability projections.

Summary of Projected Liability

A.5.2 In line with previous reports, we have projected the liabilities forward from the valuation date by taking the liability at the valuation date, adding the interest assumed in the valuation, adding an amount for new accrued claims and deducting payments expected in that year along with their associated claims handling expenses.

A.5.3 Table 15 below sets out estimates of the liabilities of the Notional Account at the end of each of the next five financial years. The purpose is to illustrate the short-term development of the Scheme. There is substantial uncertainty in these estimates. The new accrual after 2021-22 will revert to the long-term trend as the temporary ROCS exemption will end on 21 October 2022. The numbers shown have been discounted to the end of the relevant financial year but have not been discounted to give values in today's terms. The projected liabilities are not too dissimilar from the corresponding amounts presented in last year's report.

Table 15: Projected balance sheet liabilities of the Notional Account

Year ending 30 June	Liability at start-year (\$'000)	New accrual (\$'000)	Payments (\$'000)^(a)	Interest cost (\$'000)	Liability at end-year (\$'000)
2021					124,757
2022	124,757	20,455	12,696	6,943	139,459
2023	139,459	14,914	13,378	7,384	148,379
2024	148,379	15,884	13,380	7,879	158,762
2025	158,762	16,916	13,135	8,456	170,998
2026	170,998	18,016	13,250	9,119	184,883

Description of the model used to project the accrual of new Run-Off Cover Scheme liabilities after 30 June 2021

A.5.4 The approach involved projecting the expected future ROC indemnity payments for each medical practitioner who was practising as at 30 June 2021.

A.5.5 A practitioner can become eligible for the Scheme by reason of:

- retirement
- permanent disability
- death
- maternity
- resignation
- satisfaction of other eligibility criteria specified in the regulations.

A.5.6 The probability of becoming eligible for the Scheme was estimated for each practitioner based on their age as at 30 June 2021 and their gender. Note that, prior to 1 July 2020, practitioners do not become eligible by means of resignation until three years have passed since cessation of practice. From 1 July 2020, this three-year waiting period has been waived. Our model has been adjusted accordingly.

A.5.7 In previous years, the estimated likelihood of practitioners becoming eligible for the Scheme was overlaid on the projected claim notifications to give the projected ROC claim notifications for each practitioner. The expected notified claims cost was multiplied by the likelihood of eligibility in each future year, and summed across all practitioners to arrive at the expected cost of ROC claims notified in that year. It was assumed that on average practitioners who become eligible for the Scheme do so half-way through the financial year.

A.5.8 This year, the above approach is only appropriate for some practitioners. Due to the temporary exemption stipulated by the *Medical Indemnity Amendment (Eligible Run-off Claims) Regulations 2020*, around 2,400 practitioners who earned a sufficient premium in 2020-21 to be considered “risky” were also already eligible for the Scheme.

A.5.9 Compared to the practitioners who are not yet eligible for the Scheme, this group has immediate access to the Scheme. This group was previously insignificant to be modelled separately. But the temporary exemption has made this group material. Hence, we have modelled them separately this year. In essence, no ROCS eligibility probabilities were overlaid on their projected claim notifications. However, this group is likely to have lower claims costs as many carried out low-risk vaccination related work, which is covered by the newly established COVID-19 Vaccine Claims Scheme. Therefore, we have revised down the claim assumptions for this group. The future cessation of ROCS eligibility is very difficult to model and will only reduce the claims costs, hence, has been ignored.

A.5.10 Projection of indemnity payments entailed the projection of:

- incidents which will result in a claim
- the delay involved in notification of claims
- the cost of claims after allowing for the HCCS
- the likelihood of eligibility for the Scheme at the time a claim is notified (if the practitioner is not yet eligible for the Scheme)
- the delay involved in the payment of notified claims.

A.5.11 The total expected future ROC claim notifications were calculated as the scalar product of the vector of claim notifications and the vector of probabilities of Scheme eligibility (if applicable) for each practising medical practitioner in each future year.

RUN-OFF COVER CLAIMS

Components of claim cost

A.5.12 For the purposes of the model, a ROC claim includes any eligible claim notified and finalised at direct cost to the MII. Claim costs include all costs which are directly attributable to the claim. Indirect claims handling expenses (CHE) are dealt with separately.

A.5.13 Directly attributable claim costs include damages, plaintiff legal costs to the extent that they are awarded, and legal defence costs to the extent that they are directly attributable to the claim.

ASSUMPTIONS

Economic assumptions – claims inflation & long-term discount rate

A.4.19 Medical indemnity claims costs tend to increase at a faster rate than general inflation. Claim payments were projected to increase in line with wage inflation plus superimposed claim cost inflation.

- Wage inflation was assumed to be 4 per cent per annum. This is not inconsistent with general expectations of long-term wage growth.
- Superimposed inflation was assumed to be 2.5 per cent per annum. Superimposed inflation refers to the tendency for medical indemnity claim amounts to increase at rates faster than general inflation. Whilst superimposed inflation has been observed in “bursts” the past, the timing is unpredictable. As a consequence, superimposed inflation is typically allowed for with a constant assumption. Due to the limited data, there is some judgement required in selecting this assumption.
- Claim payments were discounted at a rate of 5 per cent per annum. This chosen rate provides consistency with the rate adopted in a number of similar contexts and therefore is suitable from a whole of government perspective at 30 June 2021. This rate is unchanged from last year.

Practitioner population

A.5.14 As noted above, the analysis aims to project the expected future ROC indemnity payments for each medical practitioner who was practising as at 30 June 2021. This starts with the population of medical practitioners who were practicing in 2020-21. This data is provided by the MIIIs and maintained by Services Australia.

A.5.15 Practitioners with total medical indemnity payments (including both medical indemnity premiums net of discounts and loadings plus membership fees) of less than \$1,700 were excluded from the analysis in order to ensure that only genuine ‘at-risk’ medical practitioners were the focus of the investigation¹⁹. The excluded

¹⁹ One insurer’s membership fees were not available in the Services Australia data.

group contained interns and trainees that exist in some of the data provided by the MIIIs. A total of 90,896 practising medical practitioners have paid some medical indemnity payments during 2020-21. After excluding those medical practitioners, we were left with 55,946 'at-risk' medical practitioners. This approach is unchanged from our previous reports. The riskiness threshold has not been indexed since the average premium has broadly remained constant. Note that we have not used a lower riskiness threshold for the eligible practitioners, even though in theory their premiums during the exemption period should have been adjusted downwards to only include new incidents. We have taken this approach due to insufficient information and also because of the conservative claim rate assumption already adopted for this group.

A.5.16 Table 16 summarises the age distribution of the cohort of 'at-risk' practitioners, with the total premium representing a proxy for risk of medical indemnity claims for each age group. This includes around 2,400 practitioners who were already eligible for ROCS in 2020-21 but who also earned a sufficient premium during the year to be considered 'at-risk'. Note that age and gender were not available for a small number of medical practitioners and were randomly allocated.

Table 16: Cohort of 'at-risk' medical practitioners

Age at 30 June 2021	Number 'at-risk'	Total premium (\$'000)	Proportion males (per cent)
<30	66	190	44
30-34	1,850	6,566	48
35-39	5,450	27,805	50
40-44	8,505	58,709	55
45-49	8,914	73,556	58
50-54	7,892	73,522	62
55-59	7,545	67,781	63
60-64	6,570	56,032	67
65-69	4,638	35,719	73
70-74	2,793	20,151	83
75-79	1,226	7,907	86
80-84	406	2,418	89
>85	91	448	92
Total	55,946	430,804	62

Note: Numbers may not add due to rounding. Total premium includes membership fees from some insurers. If membership fees are excluded, total premium across both categories is approximately \$408 million.

Demographic assumptions

A.5.17 Demographic assumptions are required to project the number of eligible medical practitioners in future years from the current population of 'at risk' medical practitioners who are not yet eligible for the Scheme. We have not changed any of the assumptions this year.

- A.5.18 In order to assess the future rate at which liabilities will accrue, we project the expected number of new entrants in the categories that are expected to generate a future liability. Those events that are expected to generate a material liability under the scheme are considered to be retirement, resignation from private practice²⁰, death, permanent disability and maternity leave. We have not projected new entrants in the 'other' category. Historically, practitioners in this category have paid very low premiums. Accordingly, we have assumed that medical negligence claims against them are likely to make an immaterial contribution to the Scheme costs.
- A.5.19 The probabilities of death and disablement are assumed to be an increasing multiple of the probabilities of death in the Australian Life Tables 2015-17 (ALT 2015-17). The probabilities of death are assumed to be 28 per cent of ALT 2015-17 until age 64, 40 per cent from age 65 to 69, and 48 per cent of ALT 2015-17 thereafter. The probabilities of permanent disability are assumed to be 12 per cent of ALT 2015-17 up to age 24, an increasing multiple of ALT 2015-17 from 12.3 to 24 per cent from age 25 to 64, and 0 from 65 onwards.
- A.5.20 Probabilities of maternity leave were assumed for ages between 27 and 44. Each medical practitioner was assumed to take one year of maternity leave for each child.
- A.5.21 Probabilities of resignation were assumed for ages between 29 and 64. It was assumed that the probability decreases with age before increasing again from age 60.
- A.5.22 Probabilities of retirement were assumed for ages between 65 and 89. We have assumed that all medical practitioners will retire before age 71. We have allowed slight differences between males and females based on historical experience.
- A.5.23 It is instructive to combine the above assumptions and present the probabilities that a practising male medical practitioner will be eligible for the Scheme in future years. The decrement assumptions are summarised in Table 17 in the form of assumed probabilities of being eligible for the Scheme at the end of each of the next 10 financial years for males.

²⁰ The three-year waiting period has been waived from 1 July 2020 as legislated in the *Medical and Midwife Indemnity Legislation Amendment Act 2019* (Amendment Act). This has been allowed for in our model.

Table 17: Assumed probabilities of eligibility for the Run-Off Cover Scheme over the next 10 financial years for male medical practitioners

Year ending	Age at 30 June 2021						
	30-Jun	20	30	40	50	60	70
2022	0.0002	0.0553	0.0146	0.0089	0.0118	0.0924	0.2725
2023	0.0004	0.0651	0.0192	0.0128	0.0203	0.1770	0.4729
2024	0.0007	0.0748	0.0239	0.0169	0.0291	0.2669	0.6199
2025	0.0009	0.0825	0.0285	0.0211	0.0380	0.3476	0.7273
2026	0.0012	0.0902	0.0318	0.0254	0.0425	0.4366	0.8055
2027	0.0014	0.0961	0.0351	0.0299	0.1994	0.5141	0.8623
2028	0.0017	0.1019	0.0385	0.0346	0.2548	0.5817	0.9032
2029	0.0020	0.1077	0.0420	0.0394	0.3067	0.6469	0.9325
2030	0.0222	0.1127	0.0455	0.0445	0.3553	0.7096	0.9534
2031	0.0421	0.1176	0.0491	0.0503	0.4040	0.7706	0.9681

A.5.24 The resulting number of practitioners who are expected to become eligible in 2021-22 is set out in Table 20.

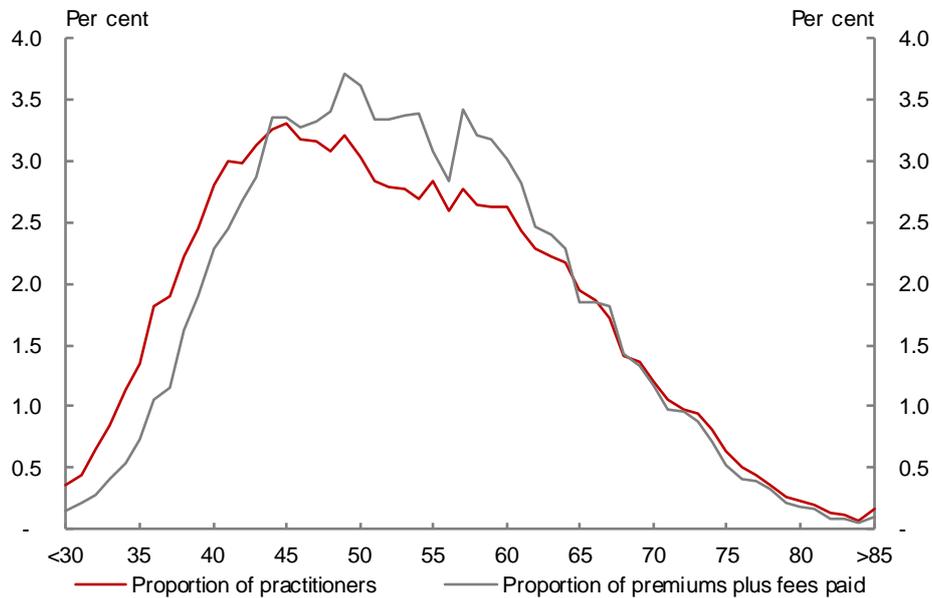
Population average claim frequency

- A.5.25 The overall claim frequency for the ‘at-risk’ population was assumed to be 4 per cent. That is, on average each ‘at-risk’ medical practitioner was assumed to have a 4 per cent chance of being involved in a medical incident in the next year which will result in a future medical indemnity claim.
- A.5.26 Unlike last year, this assumption was only applied to the practitioners who were not yet eligible for the Scheme. For the practitioners who were already eligible for the Scheme, the claim frequency was assumed to be 2 per cent. This is because around half of the latter population were non-procedural GPs who probably carried out low-risk vaccination work and the related claims costs will be picked up by the newly established COVID-19 Vaccine Claims Scheme. Some of the other returned practitioners may have also been involved in vaccination work, as the exemption was intended for practitioners who returned with COVID-19 being the sole reason. On the other hand, the premiums for this group in theory should have only included new incidents, as opposed to including all new notifications under the usual claims-made basis. Therefore, this group in theory should have lower premiums than the other practitioners with the same “riskiness” for new incidents. However, there is insufficient data to ascertain whether the insurers adjusted the premiums for this group. Overall, the claim frequency of 2 per cent is still likely to be conservative.
- A.5.27 For practitioners who were not yet eligible for the Scheme, the claim frequency assumption of 4 per cent is likely to be conservative as well, since not only returned non-procedural GPs carried out low-risk vaccination related work.
- A.5.28 Finally, individual claim frequencies were then adjusted based on premium as discussed below. This approach has not been changed from our previous reports.

Individual claim frequencies based on premium

- A.5.29 The likelihood of future notifications of ROC claims was projected according to the assumed 'riskiness' of each individual practitioner. The risk of medical indemnity claims posed by each practitioner was determined based on risk categorisation. Practitioners were categorised according to specialisation, age, gender and MII.
- A.5.30 The average premium for each risk group was used as a proxy for the risk of medical indemnity claims. The claim frequency for each group was multiplied by the ratio of the premium for the group to the premium of the entire cohort of 'at-risk' medical practitioners.
- A.5.31 Although insurance premiums are broadly determined in line with claim risk, the premium of a group is at best an imprecise proxy for risk. For example, market and financial considerations affect premiums charged. However, given the data limitations, relative premiums have been assumed to be a reasonable means of categorising practitioners according to their risk of medical indemnity claims for the purposes of this model.
- A.5.32 Insurance premiums tend to diminish for practitioners towards retirement age. This supports the suggestion that medical practitioners tend to wind down their practice hours and possibly perform fewer risky medical procedures (for example, surgery) as they approach retirement. The possible reduction in risk towards retirement is somewhat apparent from the pattern of relative premiums for 'at-risk' medical practitioners shown in Figure 5. Note that age and gender were not available for a small number of medical practitioners and were randomly allocated.

Figure 5: Relative premiums by age for 'at-risk' medical practitioners



Note: The graph includes all practitioners with total payments (including membership fees) of at least \$1,700 from all MIIs.

Individual claim frequencies based on assumed wind down of risky practice

- A.5.33 The relative premiums of older medical practitioners appear to indicate a reduction in risky practice as medical practitioners approach retirement. Consistent with this, industry actuaries have also suggested that medical practitioners tend to wind down riskier elements of their practice as they approach retirement. However, relative premiums may not capture the full extent of the reduction, since premiums are calculated on a claims-made rather than claims-occurring basis.
- A.5.34 We have continued the practice of assuming that medical practitioners wind down their risk exposure from age 60, at a rate that is reflected in the premiums shown above. Premium relativities are augmented with a wind down from age 60 according to the exponential formula $0.8^{(\text{age}-59)}$. This is unchanged from last year.
- A.5.35 This assumption is very subjective and is not amenable to objective validation. Nonetheless, it does not appear unreasonable considering observed claim experience.

Claim size

- A.5.36 Claim sizes are assumed to increase, the longer the delay from the incident occurring until it is notified to the insurer. This is on the basis that claims which take longer to report tend to be bigger on average. One example is cerebral palsy cases.
- A.5.37 The assumed claim reporting pattern is shown in Table 18 below. Assumed claim sizes presented in the table do not include allowance for inflation or superimposed inflation.

Table 18: Claim reporting and size pattern

Development year	Proportion of number of claims notified (per cent)	Gross average claim size (\$'000)
1	33.0	110
2	25.0	125
3	14.0	140
4	10.0	155
5	6.0	170
6	3.3	185
7	2.5	200
8	2.0	215
9	1.0	230
10	0.7	245
11	0.6	260
12	0.5	275
13	0.4	290
14	0.3	305
15	0.2	320
16	0.1	335
17	0.1	350
18	0.1	365
19	0.1	380
20	0.1	395

(a) Gross average claim sizes presented in the table are intended to be in 2021 dollars and do not include allowance for inflation and superimposed inflation.

- A.5.38 The projected ROC claims cost is sensitive to the proportion of claims which are assumed to be reported late. The longer the delay between the incident and the claim, the greater the likelihood that a practitioner will be eligible for the Scheme at the time the claim is notified. Thus, the Scheme's costs are dominated by the small proportion of claims which are notified very late.
- A.5.39 The average claim size was assumed to be around \$140,000. This was unchanged from last year given there was no definitive claim size inflation in the latest industry data. We review this assumption periodically based on the NCPD data.

A.5.40 Each year, we also sense check our model's new accrual estimate against the industry's estimate.

Impact of the High Cost Claim Indemnity on claim size

A.5.41 The claims cost net of the HCCS indemnities is calculated assuming that the HCCS threshold will change such that a constant proportion of the gross average claim size will be met by the HCCS. Thus, for simplicity, the HCCS threshold is assumed to increase in line with claims inflation over time.

A.5.42 The model effectively assumes that around 17 per cent of the ROC discounted claims cost will be met by the HCCS. This is explained in more detail in Appendix 6.

Payment patterns – notification to settlement

A.5.43 ROC indemnity payments in relation to medical incidents occurring after 30 June 2021 were projected assuming the payment patterns from the point of notification to the point of settlement, as set out in Table 19 below. This payment pattern was unchanged from last year.

Table 19: Payment pattern assumed

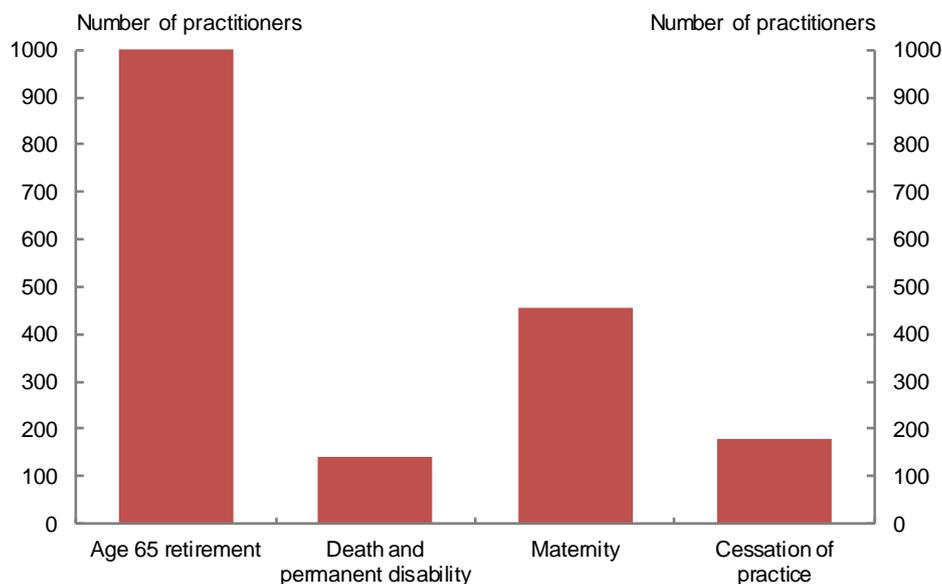
Delay from notification to payment (year)	Proportion of claim costs paid (per cent)
1	8.20
2	18.54
3	19.21
4	15.87
5	12.86
6	8.56
7	6.07
8	4.72
9	1.83
10	1.32
11	0.92
12	0.76
13	0.27
14	0.21
15	0.16
16	0.13
17	0.11
18	0.10
19	0.09
20	0.07

PROJECTION RESULTS

Projection of new entrants

- A.5.1 We have applied the demographic assumptions to the 'at-risk' population to project the new 'at-risk' medical practitioners expected to join the scheme in future years. Where the date of birth or gender was not available for a practitioner, these were assigned randomly according to the age and gender distribution of 'at-risk' medical practitioners.
- A.5.2 Figure 6 depicts the number of 'at-risk' practitioners projected to become eligible for the Scheme by various means during the 2021-22 financial year. Due to the waiver of the three-year waiting period from 1 July 2020, we projected a one-off spike in the number of new entrants by resignation in 2020-21, as it covers resignations that occurred in four years (i.e. 2017-18 to 2020-21 inclusive). Going forward, the number of new entrants by resignation was expected to revert to historical levels. However, COVID-19 and its related policy responses will continue to affect the exit pattern in the short term.

Figure 6: Projected entries of 'at-risk' practitioners to the Run-Off Cover Scheme based on decrement assumptions



- A.5.3 In addition to the above eligibility categories, medical practitioners from overseas who have worked in Australia under an appropriate visa also become eligible for the Scheme when they have permanently ceased medical practice in Australia and ceased to reside in Australia. We have not projected the number of new entrants from this category because we were advised at the start of the Scheme that these practitioners had historically paid very low premiums. Accordingly, we

have assumed that medical negligence claims against them are likely to make an immaterial contribution to the Scheme costs. We have not been able to review this assumption as these practitioners cannot be identified in the data provided to us.

A.5.4 The numbers of practitioners projected to enter the Scheme are in line with the long-term historical numbers (excluding 'Other') provided by the insurers as shown in Table 20. It allows multiple entries by counting practitioners who regained eligibility after cessation.

Table 20: Run-Off Cover Scheme historical and projected new entrants by reason of eligibility

	Industry data										Model	
	2005-12	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	
Retired	2,719	514	672	803	696	845	888	912	979	650	1,003	
Maternity	1,896	267	295	307	330	330	522	508	540	379	455	
Permanent disability	197	20	31	26	35	28	35	25	16	4	28	
Died	779	128	108	122	105	125	97	107	112	71	114	
Resigned	826	154	212	162	217	182	261	235	227	98	177	
Sub-total	6,417	1,083	1,318	1,420	1,383	1,510	1,803	1,787	1,874	1,202	1,777	
Other ^(a)	909	336	429	346	358	425	504	543	549	202	-	
Total	7,326	1,419	1,747	1,766	1,741	1,935	2,307	2,330	2,423	1,404	1,777	

(a) Overseas trained medical practitioners who had permanently ceased practice in Australia under an appropriate visa.

A.5.5 Normally, we compare the projected numbers of new entrants from previous year's model to the actual numbers of new entrants in order to evaluate the appropriateness of the demographic assumptions. However, this assessment is complicated this year by two factors.

A.5.6 Firstly, the waiver of the three-year waiting period should have caused a one-off jump in new entrants in 2020-21 because not only are the practitioners resigned in 2020-21 eligible for ROCS immediately, those who resigned in the previous three years (that is, pre-COVID impact) would also have become eligible for ROCS in 2020-21 regardless of whether they re-entered the workforce to combat COVID. However, this does not appear to have eventuated. Instead, the number of new entrants reduced significantly. It is probable that the insurers have not recognised this change or updated the eligibility data for 2020-21 in line with the new legislation. The 2020-21 experience appears incomplete and is likely to remain incomplete for some time before this assumption can be evaluated.

A.5.7 Secondly, some medical practitioners might have delayed their resignation or retirement in order to contribute to the nationwide effort to combat COVID-19, as the demand for vaccine administration was especially high and the health sector experienced a general staff shortage.

- A.5.8 These two factors could have led to genuinely fewer new entrants in 2020-21 as well as a delay in the reporting of the backdated new entrants for 2020-21. The actual new entrants in 2020-21 may not be known for a few years.
- A.5.9 Notwithstanding, temporary movements in new entrants have an immaterial impact on next year's new accrual estimate. For the new accrual estimate, it is the ROCS eligibility status of the practitioner at the time of the claim's notification that is crucial. Given the frequent long delays in the notification of medical indemnity claims, the cumulative ROCS eligibility probabilities over the long term have a far greater relevance than each year's eligibility probabilities.
- A.5.10 Furthermore, while the experience of 2020-21 suggests a genuine reduction in new entrants as a temporary response to combating COVID, the peak of the vaccination roll-out has passed by around December 2021. Thus, it is not unreasonable to expect practitioners' exit patterns to gradually return to normal.
- A.5.11 Considering all the factors above, no adjustments have been made to the ROCS eligibility assumptions.
- A.5.12 The eligibility assumptions are subject to review each year, and we tend to update the assumptions when there is sufficient evidence to support a fundamental shift in experience.

Projection of future Run-Off Cover Scheme costs

- A.5.13 We rely heavily on industry projections of future cash flows to determine the value of outstanding notified claims as well as future IBNR claims. Each insurer prepares a projection of cash flows associated with notified claims and a projection of their expected future cash flows for claims expected to be notified over the next five years.
- A.5.14 There is limited opportunity to independently review the industry projections noted above. This year we reviewed the historical actual payments data up to 31 December 2021 provided by Services Australia and compared this to the industry projections. In addition, the Amendment Act is expected to increase future cash flows as resigned medical practitioners will become eligible for ROCS earlier, from 1 July 2020. This impact appears to have been allowed for in the data provided by the industry in late 2021.
- A.5.15 However, adjustments to industry's cash flow projections were necessary this year to be consistent with our upward adjustments on the industry's liability estimate as at 30 June 2021 as well as the new accrual estimates for the duration of the temporary ROCS exemption period. An incident to payment pattern derived from our new accrual model has been used to spread the additional liability and new accrual adjustments over future cash flow projections.

A.5.16 We have not allowed for the possible impact of potential court closures due to COVID-19 which could delay settlements hence payments.

A.5.17 Table 21 summarises the next 10 years' ROC indemnity payments which were aggregated to derive the projected Scheme costs in future years.

Table 21: Calculation of projected Run-Off Cover indemnity payments

Year ending 30 June	Medical incidents pre 1 July 2021			Medical incidents post 1 July 2021	
	Notified as at 30 June 2021 (\$m)	IBNR as at 30 June 2021 (\$m)	Total (\$m)	Total (\$m)	Grand total (\$m)
2022	11.8	0.9	12.7	0.0	12.7
2023	10.2	2.8	13.0	0.4	13.4
2024	7.6	4.9	12.5	0.9	13.4
2025	5.1	6.5	11.6	1.6	13.1
2026	3.4	7.7	11.0	2.2	13.3
2027	2.2	8.3	10.5	3.0	13.5
2028	1.5	8.5	10.0	3.9	13.8
2029	0.9	8.6	9.5	4.7	14.2
2030	0.6	8.2	8.8	5.8	14.6
2031	0.4	7.7	8.1	6.8	14.9

Note: numbers may not add up due to rounding.

Uncertainty in relation to liability projections

A.5.18 The projected ROC indemnity payments summarised in Table 20 are subject to uncertainty which relates to:

- the claiming behaviour of eligible practitioners
- substantial random variation associated with medical incidents and the notification of claims from year to year
- calibration of the model claim size and claim frequency assumptions to the underlying claim process (medical indemnity liabilities are characterised by few claims associated with large random variation such that a wide range of results can be obtained with equal statistical validity)
- the extent to which medical practitioners approaching retirement might cut down on their practice hours and possibly engage in less 'risky' practice (for example, less surgery)
- sensitivity of the model to the proportion of late-reported claims
- sensitivity of the model to the eligibility assumptions

- the possibility that not all notified Scheme eligible claims have been identified by insurers and that recoveries will be more diligently pursued later in the claim process
- tort reforms in several jurisdictions with the possible effect of 'bringing forward' claims and distorting claim experience.

A.5.19 The information provided by the actuaries of the MIIIs and MDOs relied on broadly similar valuation models. The range of assumptions adopted by industry actuaries reflects the substantial uncertainty involved in estimating liabilities of the Scheme. It must be emphasised that different results can be obtained from different yet equally plausible models and assumptions. Again, this is a common issue with liabilities of this nature.

A.5.20 The uncertainty is heightened this year from the impact of COVID-19 on the nature of medical practitioner's work and the impact of the corresponding legislative responses on potential claims costs. For example, telehealth has taken on a greater importance and carries its own unique and less-understood claims risks. The legislative responses include the temporary exemption for returned practitioners as well as the newly established COVID-19 Vaccine Claims Scheme. These factors coincide with the waiver of the three-year waiting period for eligibility through resignation, thus could have masked the impact of this permanent change. In addition, insurers may not have fully recognised the impact of the legislative changes in reporting the eligible practitioners to Services Australia and in identifying all notified Scheme eligible claims. For the above reasons, the new normal level of claims costs and new entrants will not become apparent until the temporary factors associated with COVID-19 have completely subsided and the insurers have fully adjusted to the new environment.

APPENDIX 6: HIGH COST CLAIMS

The High Cost Claims Scheme

- A.6.1 The HCCS is part of the broader package of Australian Government measures announced on 23 October 2002 that were designed to address problems with the medical indemnity insurance industry.
- A.6.2 The HCCS is governed by Division 2 of Part 2 of the Medical Indemnity Act. Under the HCCS, MIIIs and MDOs are reimbursed for part of the costs of large claims notified to them on or after 1 January 2003.
- A.6.3 The HCCS meets 50 per cent of the excess above the threshold (currently \$500,000) of the cost of individual large claims, before the operation of the Scheme.
- A.6.4 The HCCS threshold and the percentage used to calculate the amount of indemnity can be changed by way of regulation. The HCCS threshold has been changed by way of regulation as follows:
- \$2 million for claims notified between 1 January 2003 and 21 October 2003
 - \$0.5 million for claims notified between 22 October 2003 and 31 December 2003
 - \$0.3 million for claims notified between 1 January 2004 and 30 June 2018, and
 - \$0.5 million for claims notified from 1 July 2018.
- A.6.5 For example, for a claim which costs \$1 million notified on 1 April 2012, the HCCS will pick up:

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

Data collection

- A.6.6 Services Australia collects data in relation to the HCCS, in addition to the Scheme data described in section 3. They provide some insight into the likely profile of large medical indemnity claims.
- A.6.7 Data collected in relation to the HCCS include:
- details of claims/incidents notified to MIIIs and MDOs by 30 June 2020 which might lead to recoveries under the HCCS

- actuarial estimates of that part of the cost of claims relating to incidents which occurred before 30 June 2021 and are expected to be recoverable under the HCCS
- an estimate of that part of the future claims cost of medical incidents notified during the 2021-22 to 2025-26 financial years which is expected to be recoverable under the HCCS.

Analysis of large claims

- A.6.8 A small proportion of medical indemnity claims are larger than \$500,000. These high-cost claims have a noticeable influence on the total cost of medical indemnity each year.
- A.6.9 According to the data collected, as at 30 June 2021, 2,679 claims/incidents had been notified to MIIIs and MDOs which were expected to be covered by the HCCS. They all have either a case estimate or an amount reimbursed attached to them.
- A.6.10 The cost estimates available for HCCS claims/incidents represent total case estimates, including amounts already paid as at 30 June 2021. This figure is around \$2,058 million. Of this, around \$942 million is estimated to be recoverable from the HCCS (including past recoveries). These estimates should be viewed with caution given a range of data issues apparent with the industry data. Services Australia data shows that \$569 million has been paid by 30 June 2021, compared to \$542 million as shown in the industry data.
- A.6.11 The HCCS data provides a reasonable, but imprecise, measure of the likely profile of large medical indemnity claims.
- A.6.12 The distribution of estimated costs of HCCS-eligible claims notified between 1 January 2004 and 30 June 2021 is shown in Table 22. The distribution is presented in terms of the proportion of total estimated claim cost attributable to each claim size band and tends to be relatively stable. For example, about 29 per cent of the total estimated cost of HCCS-eligible claims was attributable to claims expected to cost above \$2.0 million, compared to 30 per cent in last year's data.

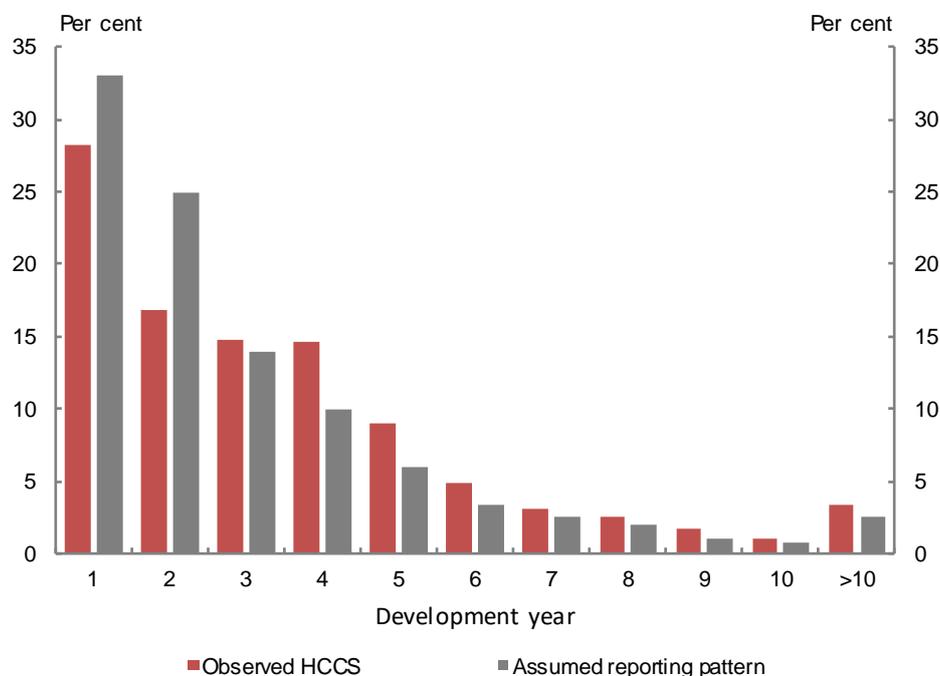
Table 22: Distribution of High Cost Claims Scheme-eligible claims

Claim size (\$'m)	Proportion of claims cost (per cent)
0 to 0.3	N/A
0.3 to 0.5	17
0.5 to 2.0	54
>2.0	29

Relevance of High Cost Claims Scheme data to the Run-Off Cover Scheme

A.6.13 The HCCS data illustrates the pattern of delay between a relevant negligent medical incident and the date that a large claim/incident is notified to the MII or MDO. The claim reporting pattern (based on claim numbers) observed in relation to HCCS claims is compared in Figure 7 to the general medical indemnity claim reporting patterns assumed for the purpose of undertaking the Scheme cost analysis. Note that the HCCS eligible claims included were notified between 1 January 2004 and 30 June 2021, with an applicable threshold of \$0.3 million prior to 1 July 2018 and \$0.5 million thereafter.

Figure 7: High Cost Claims Scheme claim reporting pattern



A.6.14 Claims which take longer to report tend to be bigger on average. In addition, the longer the delay involved in notifying a claim, the more likely the claim will be notified at a time when the practitioner is eligible for the Run-Off Cover Scheme.

A.6.15 Thus, the small proportion of large claims made against retired practitioners will have a marked impact on the total cost of the Scheme.

A.6.16 The proportion of HCCS recoverable for ROC claims will increase with the delay in reporting, and the assumed proportions are listed in Table 23. These have not been changed since the last review.

Table 23: Proportion of High Cost Cover Scheme recoverable

Development year	Proportion of HCCS recoverables (per cent)
1	10.0
2	12.0
3	13.0
4	15.0
5	16.0
6	17.0
7	18.5
8	18.7
9	18.9
10	19.0
11	19.1
12	19.2
13	19.3
14	19.4
15	19.5
16	19.6
17	19.7
18	19.8
19	19.9
20	20.0