Medical Indemnity for Doctors

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For much of its history in Australia, the medical indemnity industry, which provides protection for doctors arising from their professional negligence, has been relatively low profile, with indemnity provided to doctors via doctor-owned mutuals (medical defence organisations). However, over the last 6 years this industry has been through an incredible amount of change with insolvencies, compulsory movement to insurance and increased levels of government intervention the order of the day. The last two years has seen some return to stability in the market, although competitive pressures are now building.

This article examines what’s happened in recent years and provides an outlook on the challenges facing the market in the years to come.

Background

Historically medical indemnity cover was provided to doctors in private practice in Australia by medical defence organisations (MDOs). MDOs were not licensed insurers and cover was provided on a ‘discretionary indemnity’ basis. Cover was generally provided on a claims occurring basis.

In early 2002 Australia’s largest MDO, United Medical Protection (United), and its subsidiary insurer, Australasian Medical Insurance Limited (AMIL), were placed into provisional liquidation. The uncertainty that this created, and the Government introduced remedies, have turned the market upside down since that time.

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1 Claims occurring: provides protection for claims that occur during the period of the cover, regardless of when reported. By contrast claims made cover provides protection for claims that are reported during the period of cover. Professional indemnity for most other professions is provided on a claims made basis.
In brief, since 2002 the Federal Government has:

- announced it would provide some assistance to help MDOs with an unfunded IBNR liability\(^2\) to meet the cost of these claims, and that part of the unfunded IBNR would be met by way of additional doctor contributions over a number of years
- required medical indemnity to be provided as an insurance product by licensed insurers from 1 July 2003, thus enabling APRA regulation of the industry. The insurance product is subject to certain minimum product standards (e.g. minimum $5 million of cover)
- required the Medical Indemnity Insurers (MIIs), who are mostly wholly owned by the doctor owned MDOs, to develop detailed funding plans to ensure compliance with APRA minimum capital requirements
- held the Abbott Review in 2003 into the impact of insurance on the industry
- provided increasing levels of support to the industry for large claims such that it now pays 50% of almost all claims in excess of $300,000 (High Cost Claims Scheme, or HCS)
- introduced the Exceptional Claims Scheme, to provide protection to doctors in the event that claims exceed $20 million (the level of cover offered by the MIIs), to be funded by doctors if it is ever activated
- introduced a scheme to provide cover for doctors in the event of death, disablement and retirement over age 65 (the Run-Off Cover Scheme, or ROCS) to be funded by doctors throughout their working lives
- introduced a number of measures to improve affordability of medical indemnity insurance premiums for doctors (the Premium Support Scheme)
- held a second inquiry, the Rogers Review, to review competitive arrangements in the industry following complaints that UMP/AMIL had received an unfair advantage as a result of the package provided to it in 2002 and 2003. This resulted in UMP being required to pay a Competitive Advantage Payment to the Federal Government over a number of years
- monitored premiums across the industry, via the ACCC

\(^2\) Unfunded IBNR liability: The IBNR liability relates to claims that have occurred but not yet been reported for periods where the coverage was on a claims occurring basis. Under the IBNR indemnity scheme, the Federal Government assumed the portion of the IBNR that was ‘unfunded’ as at 30 June 2002, with the costs initially expected to be recovered over time from members. Subsequently the Government agreed to assume a significant portion of the IBNR without repayment from doctors. United was the only MDO that entered the scheme. For United the Scheme covers all matters unreported as at January 2002
• announced, via the Department of Treasury, a review of the Medical Indemnity (Prudential Supervision and Product Standards) Act 2003, particularly in relation to issues of insurance coverage for certain groups of doctors
• commenced a follow up review to the Abbott Review, to examine the effectiveness of the Government’s medical indemnity measures and developments.

All these initiatives have resulted in a huge amount of change for doctors and work for those in the industry. It has also resulted in an industry that’s much stronger financially than it has ever been.

**Type of Cover**

Since 1 July 2003 doctors have purchased insurance contracts that provide claims made cover. The insurance cover typically protects the doctor against both claims from injured patients and also for the legal costs associated with matters such as coronial inquiries and medical board matters. Interestingly, it is still not compulsory for doctors to purchase insurance in every jurisdiction across Australia.

To date all insurers have offered cover with a limit of $20 million per claim. This contrasts with the cover provided in other jurisdictions, particularly the US, where standard cover is typically less than $5 million. The largest award in Australia so far relates to the Simpson vs Diamond case in 2001 that resulted in an award to the claimant of $13 million, although this was subsequently reduced on appeal. A further estimated $2 million was spent on legal costs in defending the claim.

**Issues for Actuaries**

The MII industry is a fascinating one for actuaries. With business written almost exclusively by small mono-line insurers, the volatility associated with long tail classes of business are amplified. The potential impact of one off judgements such as the Simpson case and the recent wrongful life decisions made by the High Court can be profound.

An estimated 55% of all claims costs come from less than 5% of claims (source: MIIAA report). Predicting future claims costs is inherently very difficult, with the difficulties exacerbated by the extremely long periods that can arise between occurrence and settlement. Consider for example a baby injured as a result of negligence during delivery: in a number of jurisdictions around Australia this claim could be lodged any time in the next 21 years.

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3 the MIIAA report: “Medical Indemnity Report: An analysis of premium and claims trends for Australian medical defence organisations and medical indemnity insurers from 1995 to 2004 focusing on key specialty groups and large individual losses.” Prepared by Insurance Statistics Australia, May 2005
Combine that with a rapidly changing external environment, including growing awareness of patient rights and tort reform, and predicting claims costs even in a claims made environment can be challenging.

MIIs typically rate doctors according to the claims experience of their specialty grouping. A key challenge for actuaries is obtaining sufficient data to be able to form an opinion on the likely cost of claims within these specialty groups. Increasingly MIIs are looking to other risk factors, such as billing band, state and even gender to assist in the pricing process. In recent years a number of the MIIs have established a database of claims to assist in the monitoring of trends across the industry. This database is externally maintained, so as to ensure independence.

**Government Intervention**

As highlighted above, the MII industry has been subject to very substantial government intervention over the last four years. The primary aim of all these government measures was to stabilise the market and to keep premiums affordable for doctors.

The Medical Indemnity Policy Review (the Abbott Review) in 2003 highlighted a number of key issues for the Government in relation to medical indemnity. The key concerns of that Review were to “secure an affordable, sustainable system of medical indemnity insurance which was fair to patients and taxpayers as well as doctors”. The Abbott Review established the Premium Support Scheme and the Run Off Cover Scheme, as well as extending the High Cost Claims Scheme.

Much of the assistance to the industry has involved forms of monetary assistance from the Federal Government. In particular:

- **The IBNR Indemnity Scheme**: Under the IBNR indemnity scheme, the Federal Government agreed to assume the portion of the IBNR that was `unfunded` as at 30 June 2002. Initially it was intended that the cost of this would be recovered over time from doctors, although the Federal Government ultimately agreed to take on a significant proportion of these costs. United was the only MDO that was required to enter the scheme. The Rogers\(^4\) report indicated that at 30 June 2004 the gross value of United’s IBNR liability was estimated at $356 million. However, the introduction of the HCCS, coupled with payments from doctors and some contributions from United, are expected to reduce the amount contributed by the Federal Government ultimately to around $80 million.

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\(^4\) The Rogers Review: “Review of competitive neutrality in the medical indemnity insurance industry” Published March 2005
• *The High Cost Claims Scheme (HCCS):* meets 50% of the cost of most claims in excess of $300,000. According to the MIIAA report, it is estimated that 55% of the total cost of claims is for claims in excess of $500,000: consequentially the HCCS, announced progressively in 2002 and 2003 (the threshold was originally substantially higher) has had a significant impact in improving the ongoing finances of the MIIs. The Rogers report indicated that the cost of this Scheme, for the 2003/04 year, is estimated at $45.9 million across 4 of the 5 MDO/MII groups.

• *Premium Support Scheme (PSS):* one of the features of the ‘crisis’ in medical indemnity in the early part of this decade was the very high rate of premium escalation (see below). Doctors were concerned that the increasing costs of medical indemnity were potentially forcing some doctors out of the industry. In particular there were concerns about the ability of doctors to work part time and also that the costs of insurance were acting as an impediment to doctors pursuing particular specialties.

  A further outcome of the Abbott Review was that the Premium Support Scheme was introduced where the Government, subject to certain criteria, meets 80% of the excess cost of a doctor’s premium over 7.5% of income. Certain other doctor groups receive support in excess of these amounts (mostly rural doctors and some high risk specialties). For example, a doctor earning $100,000 and paying a gross premium of $12,000 would receive a subsidy of 80%* (12,000-7.5%*100,000) = $3,600. For the 2004 year PSS payments of $16.3 million were made to the doctors of 4 of the 5 MIIs.

In addition to the Government funded Schemes outlined above, the Government has also introduced two further schemes that are doctor funded:

• *The Exceptional Claims Scheme:* This Scheme will meet the excess over $20 million of any claim. This cost will then be reclaimed from doctors by way of a levy. This Scheme has not been triggered.

• *The Run Off Cover Scheme (ROCS):* Prior to the change to claims made insurance most doctors were provided with, in effect, claims incurred indemnity. The move to claims made raised particular challenges around the funding, and protection of, claims made against doctors after their retirement, death or disablement. One of the outcomes of the Abbott Review was the formation of ROCS which, in return for a levy paid throughout a doctors’ life (currently set at 8.5% of premium) provides ‘run-off’ cover on the occurrence of these events (and maternity leave) for ‘free’. Claims subject to ROCS will continue to be administered by the MIIs, with the Government providing a reimbursement for these claims from the accumulated doctor contributions. Again, while providing significant protection for doctors, this has also improved the balance sheets of the MIIs.
The Last Two Years

The last two years have seen a huge amount of work going on ‘behind the scenes’ to bed down the changes announced in the two years prior to this, with some matters still to be resolved. At the time of writing, despite ROCS having been in place since 1 July 2004, few if any ROCS policies have been issued due to complexities in the legislation, regulation and practical issues around implementation.

In early 2005 the Federal Government commissioned Graham Rogers to prepare a report to inquire into whether the assistance the Federal Government had given to the medical indemnity insurance industry had created a bias in the industry that has benefited some players more than others and, if so, to advise on options to redress the imbalance (the Rogers Review). This review was prompted by concerns expressed by a number of MIIs that United had gained an unfair competitive advantage as a result of the assistance provided to it by the Federal Government.

The Rogers report found that:

1. The assistance given by the Government had different impacts on different insurers from time to time but they did not have any systemic competitive bias. The measures had been extremely valuable in stabilising the industry.
2. The specific assistance to United in taking over its past ‘incurred but not reported’ (IBNR) liabilities had resulted in a competitive advantage to its insurer, AMIL.
3. AMIL’s premiums were well below those of its competitors.
4. There was no clear evidence that this competitive advantage had been translated into predatory pricing in specific targeted areas.

As a result of the Rogers Review, United are currently making payments to the Government to fund part of their IBNR support over a number of years (estimated as $59 million according to United’s June 2005 accounts) thus further reducing the net Government contribution to the IBNR Indemnity Scheme to $80 million.

Regulatory Oversight

All this Government support has come at a cost to the insurers. Not only have MDOs had to make the very rapid transition to being insurers offering direct insurance contracts to doctors, with all the complexities and regulations that this entails (regular APRA reporting, meeting APRA corporate governance requirements, FSRA compliance, etc), they have also been subject to a number of additional layers of regulatory oversight. For most MIIs this increased complexity has required significant additional investment in staff, claims systems, processes and corporate governance.
Examples of the additional oversight include:

1. **ACCC Monitoring of Premiums:** For the three years ending June 2005 MIIs were required to submit actuarial and commercial pricing reports to the ACCC, and the ACCC has produced detailed Monitoring Reports on premiums. As part of the Federal Budget in May 2006 it was announced that the ACCC’s role has been renewed for a further three years. The scope of the ACCC’s role has been to assess whether the premium rates charged by MIIs are ‘actuarially and commercially justified’. To date premium rates have met these criteria.

2. **Funding Plans:** the MII industry as a whole was basically insolvent less than 5 years ago, with expected liabilities exceeding the assets of the industry. Corresponding with the move to insurance, the Government provided the MIIs with an extended period to build up the capital required to operate their industry at a reasonable level of solvency. In exchange for this ‘grace period’ MIIs have been required to submit annual Funding Plans to APRA, outlining how they are progressing against their capital plans and what their expectations are for future capital accumulation. MIIs are now well capitalised and have clearly exceeded any minimum capital targets (see below).

3. **Financial Condition Reports:** One area where Government oversight of the MII has been ahead of the rest of the general insurance industry has been in the area of Financial Condition Reports (FCRs). For most insurers, 2006 will be the first year that an FCR will be completed, however MIIs have had to complete an FCR for each year since 2003. MIIs have generally found FCRs to be a useful tool for both management and the Board in terms of highlighting key risks to the business.

**How Big is the Market?**

The medical indemnity insurance market is relatively small. Total premium income for the year ending 30 June 2005 was around $300 million – about 2.2% of the total direct general insurance market in Australia (source: APRA Half Yearly Statistical Bulletin as at June 2005).
Over the last 8 years premiums (including subscriptions\(^5\)) have more than doubled. In addition, in the years ending June 2000 and June 2001 all of the MDOs except MDAWA and MPS Tasmania (now part of the MIPS group) placed a ‘call’ on members, where doctors were required to pay an additional year’s subscription to the MDO under the mutual rules. These calls were made primarily to fund the IBNR provisions which were placed on the balance sheets at around this time\(^6\).

At 30 June 2005 there were five private underwriters in the market:

1. AMIL – owned by United
2. Health Professional Insurance Australia (HPIA) – owned by MIPS (based in Victoria)
3. MDA National Insurance (MDANI) - owned by MDAWA
4. Medical Insurance Australia (MIA) – owned by MDASA
5. Professional Indemnity Insurance Company of Australia (PIICA) – owned by MDAV.

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\(^5\) Subscriptions are the amounts paid to the MDOs. Prior to insurance, the subscription paid to the MDO was akin to an insurance premium. MDOs now charge an amount to doctors (typically less than $1,000) in order for the doctor to access insurance and other services provided by the MDO.

\(^6\) Prior to this time, many MDOs did not have the IBNR liability on their balance sheets. It was argued that due to the discretionary nature of the coverage, liability for claims not yet reported could be denied, hence the IBNR liability was not required to be placed on the balance sheet. A ruling of the Urgent Issues Group in 2002 required IBNR liabilities to be on the balance sheets of MDOs from then.
All these underwriters are owned by MDOs, who in turn are mutuals owned by their doctor members. Each of these underwriters is dominant in their home state, but all write business throughout Australia.

In November 2005, QBE entered the market via an underwriting agency, Invivo Medical Pty Ltd. To date Invivo has concentrated on the NSW and Queensland markets and particularly on low to medium risk specialties.

AMIL is the largest player in the medical indemnity market, although its share of the market has fallen over the last five years due to the difficulties it experienced in 2002 and 2003.

![Chart: MII Market share by Members 2005](image)


It’s very difficult to obtain accurate member statistics from the MDOs, as some published figures include students, some exclude them, etc. The Australian Institute of Health and Welfare (AIHW) have published figures on the Medical Labour Force in 2003 suggesting there were around 56,000 doctors at that time. This figure includes doctors not covered by the MDO/MIIs (primarily doctors working exclusively in the public sector or who are non-practising).

Combining the most recently available premium figure ($309 million) with doctor numbers of 56,000 would suggest average premiums per doctor of around $5,400. As ever, averages only tell a fraction of the story and high risk specialties such as obstetrics and neurosurgery pay substantially higher premiums than groups such as non-procedural GPs. The Third Monitoring Report produced by the ACCC (December 2005) indicated that average premiums in 2005/06 were expected to be around $2,500 for non-procedural GPs and almost $50,000 for obstetricians.
Financial Position of the Industry

When United and AMIL were placed into provisional liquidation in 2002 the medical indemnity industry as a whole was, in effect, insolvent, with expected liabilities exceeding assets by a significant margin. The Government announcement that it would provide financial assistance to any MDO with an unfunded IBNR provision resulted in the industry showing a position at 30 June 2002 where assets and liabilities were almost in balance as shown below – note the large increase in assets between June 2001 and June 2002 is primarily due to the Government’s announcement.

Chart: MDO/MII Assets and Liabilities

Since 2002 the industry has built up substantial additional capital. In particular the MIIs have been building capital in line with the APRA requirement that they become fully funded and have a long term target of 150% of the minimum capital required (MCR). The chart below shows just how quickly the industry has responded to the requirement to build capital. Figures on the chart are actual to June 2004 and forecast since that date. Figures extracted from the 30 June 2005 Statistical Bulletin from APRA show that total MCR coverage for the industry was 203% at 30 June 2005.

7 The IBNR liabilities are reducing over time as claims are reported. No new IBNR liability is accruing due to the change to claims made coverage.
There have been a number of factors that have driven this astonishing turn around:

1. The run off of United/AMIL’s claims provisions has been considerably more favourable than was first envisaged
2. There were substantial premium increases in 2002 and 2003 across the industry, with premium increases of up to 50% (source: MIIAA report)
3. The introduction of HCCS and ROCS has removed some liability from the industry’s balance sheet – particularly reducing the IBNR from claims incurred periods
4. The move to claims made insurance provided an additional buffer in MII premiums.

It is worthwhile remembering at this point that a substantial portion of the capital in the industry has been built up from doctors premiums and subscriptions, with the remainder coming from the various Government initiatives.

What of the Future?

There are currently two reviews of the MII industry being undertaken by the Federal Government.

The Treasury review was commissioned to investigate whether some of the minimum product requirements should be applied across the whole industry or whether some exemptions could be applied. This report could result in some changes to the basis of cover for doctors, but any changes are not expected to be implemented until mid 2007.
At the time of the Abbott Review in 2003, there was a commitment to review the changes implemented 12-18 months down the track to ascertain whether they had had the desired impact on the market in terms of creating some certainty. This review commenced in December 2005 and is expected to report by mid 2006.

As outlined in this article, the last two years have been profitable ones for the industry, as they have been for many classes of insurance across Australia. The solvency position for the industry as a whole is now well in excess of statutory minimums. Doctors have also seen some relief in premiums, with average premium rate reductions of around 5% per annum over the last couple of years.

The appearance of a new player adds to the competitive pressures that have long been a feature of the medical indemnity market. It remains to be seen what impact they will have on the market but at the very least they can be expected to sharpen the focus on the prices charged to doctors.

All in all while the industry has been on an incredible ride over the last five years it seems that the challenges for it will keep on coming, just in a different form.