Submission in response to the Department of Health's Discussion Paper

First Principles Review

of the

Indemnity Insurance Fund (IIF) Schemes

October 2017

1. Executive Summary

The medical indemnity schemes have served the Australian community well since they were introduced following the crisis of the early 2000s. Doctors have been able to access medical indemnity cover and there has been stability in claims costs and in doctors' premiums. This has helped maintain patient access and ensured ongoing support for patients' rights under common law.

Medical indemnity has historically been volatile in Australia and abroad and its volatility remains an ongoing risk. The medical indemnity schemes brought stability to a system that was in crisis. In our view the schemes should be retained; introducing uncertainty into this sector is counterproductive and if the schemes were removed, it is not clear how the system would respond in the event of another period of crisis.

Many of the schemes represent a societal support to doctors and their patients. The schemes help ensure that patients are compensated in the event of medical negligence, help manage financial volatility, and also support other policy objectives. Avant believes the schemes provide good value for money and supports their continuation, although we recommend a number of improvements.

Our position on each of the schemes is in summary:

Premium Support Scheme

The Premium Support Scheme (PSS) is of particular value to doctors practising obstetrics and those in rural and remote areas. We recognise the role of this scheme in mitigating concerns that high medical indemnity premiums for some areas of medicine will be a disincentive for doctors to practise in these areas.

The PSS acts as a "stabiliser" for doctors' year-on-year premiums, and as such provides an important protection against shocks and changes which affect the overall system. We therefore support the PSS continuing.

The scheme is somewhat unwieldy and inefficient to run. However, if the Department of Health will be looking to run down the PSS, it is on balance not considered worthwhile to suggest substantial changes to the administration of the Scheme, since it would take a long time for efficiency gains to offset the cost of implementing changes.

Universal Cover

A core tenet of the current medical indemnity arrangements is the concept of Universal Cover, whereby all Australian doctors have access to medical indemnity coverage for private practice. Without Universal Cover, lack of access to insurance cover might act as a barrier for some doctors to be able to practice. We believe that such a mechanism is beneficial to the health industry because it is better for the medical regulators and professional standards bodies to be determining which doctors can practice, rather than medical indemnity providers.

The current system is not actually helpful to medical indemnity insurers. Instead it comes at some cost. All insurers who benefit from any of the government schemes should be required to participate.

The current system is not optimal or fair. It is not optimal because it incentivises medical indemnity providers to withdraw cover from poorly performing doctors rather than work with them to make their practice safer. It is unfair because Avant serves as the Insurer of Last Resort for 75% of medical practitioners, yet Avant's overall share of the market is much lower.

For these reasons, Avant considers that the current arrangements are not equitable or sustainable, and Avant would not enter into a future universal cover arrangement under these conditions.

We propose that the framework be revised to improve outcomes, which can be achieved at no cost to the government. We propose that all registered providers of medical indemnity insurance be required to offer cover to any doctor who applies, on actuarially supported terms, as well as run off cover should the doctor leave for another insurer. Restrictions should be adjusted to allow insurers to charge a premium that better reflects the practitioner's risk, to help act as an incentive to encourage doctors and their insurer to work together to improve safety and reduce the risk of an error or claim.

High Cost Claims Scheme

The High Cost Claims Scheme is a fundamental element of the current arrangements which supports a stable medical indemnity environment, with the Government sharing an element of the risk above a threshold with the private sector. Any changes to the scheme will have a direct impact on doctors' premiums, which must be passed on to patients, and contribute to sector volatility which might prove counter to the long term stability of the sector and hence the provision of health care.

The government can provide the small portion as required by the HCCS more efficiently than the global reinsurance market, since it does not need to hold backing risk capital and can broadly influence the Australian medico-legal environment and its costs. Sharp swings in private reinsurance costs, and private reinsurance failure, contributed to the indemnity crisis in the early 2000s.

The High Cost Claims Scheme was introduced in 2002 but has yet to be tested in a time of a stressed medical indemnity market. The Government would be unwise to make changes and risk a reversion to the problems that arose in 2000-2002 should the medico-legal cycle turn, as history around the world has demonstrated that it will in time. The HCCS represents very good value for money, in terms of the significant stability it brings to the system for relatively little cost. Avant strongly supports the continuation of the HCCS.

Exceptional Claims Scheme

The Exceptional Claims Scheme (ECS) is one of the key foundations of the medical indemnity system in Australia, and must be retained. It provides certainty to doctors and patients that for exceptionally large claims they will not be faced with the prospect of policy

limits being exhausted. In addition the ECS provides stability and security to medical indemnity insurers and to the wider health system. If the ECS were to be withdrawn, it is not clear that the private insurance and reinsurance markets would be able to provide this same protection on a reliable, stable and sustainable basis. Some insurers may not be able to offer cover above $20 million which could lead to some doctors facing catastrophic losses and may impact their willingness to provide services. Even if a private sector solution were available, it would be at a significant cost for doctors and patients, due to the significant risk capital and resultant capital costs which would be required to support it.

Given the low (nil) cost to date of the ECS we see this as a good government policy that should be continued.

Run-off Cover Scheme

We support the Run-Off Cover Scheme (ROCS) but we think that it could be improved further to ensure patient protection. Although the ROCS provides protection to doctors and patients in many cases, there remain situations where doctors and their patients may not be covered by medical indemnity insurance. We recommend that all doctors be required to secure run-off cover whenever they cease practice, and also be required to secure retro cover whenever they resume practice (if not already covered by run-off).

The current 5% levy appears to be higher than needed to fund the ROCS scheme. We propose a reduction to 3%. The Government Actuary should give annual advice about the adequacy of the levy. We also propose that the ROCS scheme could provide a safety net for injured patients who might fall through the cracks in the system, for example where a doctor does not have compulsory medical indemnity cover and may have insufficient assets to cover the cost of a claim.

IBNR Scheme

The IBNR scheme acts as reinsurance for any unfunded claims from before the industry change to claims-made cover (the change was completed in 2003). The scheme has been triggered only once, for UMP in 2003. The value and fairness of this was reviewed in detail through the “Review of competitive neutrality in the medical indemnity insurance industry” (Rogers 2005). In response, the Government imposed a Competitive Advantage Payment on UMP, and all UMP’s obligations for the IBNR scheme were subsequently settled in 2006. UMP’s IBNR scheme claims are winding down favourably at well below the cost expected at the time of the settlement, and we expect them to continue to run-off with no issues.

The IBNR scheme is still theoretically active and could be triggered again if another medical indemnity insurer were to have unfunded claims from the pre-claims-made period. Although this may seem unlikely given the current benign claims environment and the financial strength of insurers, the scheme is still a valuable protection mechanism against a major systemic shock, and should be retained until all pre-claims-made medical indemnity liabilities have fully run off.

2. About the indemnity insurance schemes

Indemnity Insurance Schemes: Avant's position

The medical indemnity schemes have served the Australian community well since they were introduced following the crisis of the early 2000s. Doctors have been able to access medical indemnity cover and there has been stability in claims costs and in doctors' premiums. This has helped maintain patient access and ensured ongoing support to patient's rights under common law.

Medical indemnity has historically been volatile in Australia and abroad and its volatility remains an ongoing risk. The medical indemnity schemes brought stability to a system that was in crisis. In our view the schemes should be retained; introducing uncertainty into this sector is counterproductive and if they the schemes were removed, it is not clear how the system would respond in the event of another period of crisis.

Many of the schemes represent a societal support to doctors and their patients. The schemes help ensure that patients are compensated in the event of medical negligence, help manage financial volatility, and also support other policy objectives. Avant believes the schemes provide good value for money and supports their continuation, although we recommend a number of improvements.

What other information is relevant to an assessment of the current environment and the success of the schemes in achieving the desired outcomes?

Any consideration of the success of the schemes must give proper attention to the performance of the broader tort liability system. Although the schemes have delivered genuine benefits, the broader tort law reform program has been a key driver of system improvement, and also poses the major future risk to the system. All tort law systems have historically shown cycles of behaviour and costs, and it must be expected that the common law system in Australia will in the future come under pressure again from increasing claims and costs.

Over the past several years, tort law trends have levelled out, and there are now emerging signs of pressure on common law awards. This pressure could lead to a turn in the civil liability and tort claim cycle, which would once again stress the affordability and stability of medical indemnity. These pressures include expanded judicial findings of non-economic damages, increased class action activity and funding innovations, more aggressive advertising and client recruitment by plaintiff law firms. Recent experience in the UK and some states in the US has shown how premiums can rise steeply where there has not been tort law reform or it has eroded or been wound back.

It is crucial that regulators, insurers and other system stakeholders focus both on the regulatory schemes, and on the broader trends in the civil liability system, and prioritise efforts to keep liability costs under control.

Are the current arrangements the most efficient and cost-effective way to support the affordability and availability of insurance? If not, what changes would you suggest and why? Where should Government target its efforts and resources?

The medical indemnity schemes were introduced as part of a package of measures including legal reforms and changes to the governance of the medical indemnity industry. As the consultation paper outlines, these reforms together have been effective, as they have led to greater legal certainty, decreased claims, and stable insurance premiums.

Although it is difficult to assess the separate impact of the schemes by themselves, Avant believes that they have been fundamental to recovery of the medical indemnity system. Further, it is crucial to appreciate the protective value of the schemes going forward. While the environment has improved since the early 2000s, Avant believes that in the future the cycle will turn (as it always has before in Australia and overseas), and the schemes will prove to be of much more value than they have already. It is important that the schemes remain in place to safeguard against a future shock or period of crisis.

The schemes represent good value for money. In particular they offer the following advantages over private reinsurance:

a. Economies of Scale: a single central government approach, delivered alongside private market coverage, can offer more efficiency than fragmented market solutions;

b. Feasibility: some schemes (such as the Exceptional Claims Scheme) cover risks for which reliable and stable private sector solutions can be difficult to obtain at the same system cost as these schemes;

c. Capital Intensity: some schemes (such as the High Cost and Exceptional Claims schemes) cover risks where private sector solutions would be prohibitively expensive due to intensive capital requirements, which means that a government scheme approach results in a genuine cost savings across the system.

3. Premium Support Scheme and Universal Cover

Premium Support Scheme: Avant's position

The Premium Support Scheme (PSS) is of particular value to doctors practising obstetrics and those in rural and remote areas. We recognise the role of this scheme in mitigating concerns that high medical indemnity premiums for some areas of medicine will be a disincentive for doctors to practise in these areas.

The PSS is the main "stabiliser" for doctors' year-on-year premiums, and as such provides an important protection against shocks and changes which affect the overall system. We therefore support the PSS continuing.

The scheme is somewhat unwieldy and inefficient to run. The advance nature of the payment based on provisional or estimated information causes complexities and an administrative burden when it comes to recalculation following receipt of the actual data. We also note that writing to each of our members each year about the PSS is unwieldy and the process could be streamlined, which would require changes to the contract.

However, if the Department of Health will be looking to run down the PSS, it is on balance not considered worthwhile to make substantial changes to the administration of the Scheme, since it would take a long time for efficiency gains to offset the cost of implementing changes.

Strengths of the PSS

Are these the key strengths of the PSS? Are there other benefits of the PSS?

Avant agrees with the benefits expressed in the consultation paper.

We would also emphasise an important additional benefit. The PSS is the main "shock absorber" in the system for doctors' year-on-year premiums, and as such provides an important first line of defence for doctors and their patients against rapid rises in claim costs and premiums. Because the reforms of the early 2000s have been so successful, this risk protection benefit of the PSS has not yet been fully tested or realised, but it is an important safeguard in the overall system which should be maintained.

Issues or challenges with the PSS

What role does the PSS play in providing assurance of affordability of medical indemnity premiums?

The PSS provides assistance to approximately 500 members of Avant, and is of particular value to doctors practising obstetrics and those in rural and regional areas. The PSS reduces cost pressure on some doctors today, but perhaps more importantly it serves as a cost "shock absorber" against the risk of future claims cost inflation and premium increases.

What observations could be made about declining participation in the scheme?

At a system level the decline in participation is mainly a result of the success of the reforms in stabilising the medical indemnity system. However, the decline in indemnity claims costs appears to have bottomed-out, and Avant believes the claims cost cycle will turn again. When this happens, PSS participation is likely to rise, and the scheme will serve as an effective safeguard and cost stabiliser for doctors and their patients.

The decline may also be due to a lack of awareness or understanding of the scheme. For those doctors that do show an interest, the complexity and onerous nature of the processes are often obstacles. Our members have expressed the view that the scheme's rules and processes (e.g. audits) can make them feel as though they are distrusted and this is a deterrent to participation.

Given the increased stability of the medical indemnity insurance market, is there a continuing need for a Government scheme to assist eligible medical practitioners with the cost of medical indemnity insurance?

One of the advantages of the PSS is that its cost varies in proportion to its benefit and role in the system. When the medical indemnity claims are in a relatively benign period, PSS utilisation and costs are low, and this is the case today. However, when indemnity claims come under stress again, the PSS will respond by growing and protecting more doctors and their patients against "shock" premium increases. Thus, it is important to evaluate the need for the PSS against its potential during the next adverse claims cycle, rather than the current stability in the system.

If so, is the PSS appropriate for achieving this purpose?

Avant believes that the PSS is an appropriate mechanism for supporting the objectives of the schemes.

Are there changes that could be made to improve the PSS and best achieve the outcomes sought? If not, is there a suggested alternative approach?

There are many other possible models for a scheme such as the PSS, but none we have considered are clearly superior to the current system, and could come at a greater cost.

If the PSS is to continue then there are changes that would improve its administration and the experience for the doctor, including:

- Better leveraging newer technologies, e.g. enabling the scheme to be managed online, removing the statuary declaration process, using call recording to enable over-the-phone declarations/adjustments;
- Streamlining the process, e.g. a one-off opt-in instead of the current annual opt-in which would remove the requirement for an annual statuary declaration;
- Better aligning the three categories of the scheme (PSS, rural and MISS) which currently are confusing both in terms of communicating to the doctor and for transparency of the subsidies;

- A single scheme transaction for the doctor each year – this could be managed a number of ways including:
    - Use income from previous year to calculate and apply the PSS subsidy to the next year's premium (thus retaining the purpose of reducing cost of practicing with upfront subsidy and minimising mid or post policy changes);
    - Remove the annual opt-in process and move to one retrospective amount paid post-policy;
    - Pay subsidy as per now upfront based on 'estimated' income and then use the actual and next year's income as a single subsidy on next year's premium rather than having to adjust both the previous year and future.
- Consider the reporting requirements between government and MDOs – which require a level of manual administration.

Access to subsidy

Does the PSS offer value for insurers and medical practitioners?

As outlined above, the PSS does add value primarily due to the role that it plays in protecting against premium "shocks" for doctors, and acting to reduce the burden of medical indemnity premiums for doctors whose cover is particularly expensive relative to their income.

What are the key reasons that new entrants to the insurance market have chosen not to contract with the Commonwealth in order to offer the PSS?

When the PSS was established all of the existing MDOs signed up so that doctors could benefit from the premium support. Access to the PSS comes with the requirement to offer Universal Cover under the Insurer of Last Resort mechanism, whereby insurers have to offer cover for doctors who have heightened risk indicators. We assume that new entrants have made a commercial decision that the risks associated with Universal Cover obligations outweigh the benefits of the premium support offered by the PSS. It may also be the case that new entrants are targeting the doctor market segments which might benefit the most from the PSS.

If the PSS is to be retained, should access to the PSS continue to rely on the insurer having a contract with the Commonwealth or should this scheme be available to any medical practitioners who meet the eligibility criteria regardless of whether or not their insurer has a contractual relationship with the Commonwealth?

The current system which allows newer entrants not to enter into the PSS contract with its Universal Cover obligations is, as discussed below, fundamentally unfair and unsustainable.

Avant believes that the overall medical indemnity system should be a level playing field for participating insurers. Responsibilities and benefits should generally apply to everyone, and the rules should apply through legislation and regulation rather than individual commercial contracts.

The PSS scheme should be disaggregated from the issue of Universal Cover, and from servicing fees that are paid to insurers to handle the administration of all the schemes.

Are there other changes to the PSS arrangements you would suggest?

The Administration Fee, paid to insurers for the costs incurred by insurers in administering the Premium Support Scheme (PSS), should be reset to reflect updated market shares as per the Run-Off Cover Scheme (ROCS) levy calculation. While the current method of calculating the Administration Fee allows for annual indexation, this calculation does not allow for shifts in the market. The calculation method used prior to May 2013 based on the number of ROCS participants was a more accurate method of deriving the Administration Fee, and Avant supports a return to this calculation method.

We support a review of the Administration Fee, including options for its calculation and we suggest that this review and the legislative changes required to reflect any changes be concluded prior to the expiry of current contracts on 30 June 2018.

Consideration could also be given to whether the premium support is suitable for all specialties, for example cosmetic practitioners or other doctors who largely provide services which are outside of government funding mechanisms.

Eligibility for subsidy and level of subsidy

What evidence or other considerations distinguish the medical profession from other professions which incur substantial premiums and do not receive government subsidies?

The Australian community expects access to medical services in locations and specialities that a purely market based approach may not support. The policy objectives of the PSS are to support premiums such that medical indemnity premiums are not a barrier to their practice and ultimately to patients' access to services.

If there continues to be a scheme providing premium assistance, how can this be best structured and targeted to ensure Commonwealth contributions support the area of greatest priority/need?

There are many other possible models for a scheme such as the PSS, but none we have considered are clearly superior to the current system.

What should be the criteria for subsidy and how should the amount of subsidy be calculated?

The current criteria based on medical indemnity premiums as proportion of income seems sensible. The government may consider an earnings cap on eligibility.

Is 7.5% of gross private income a reasonable threshold for eligibility to the PSS? What is the evidence for this or a different threshold?

Avant believes the threshold is reasonable.

Does there continue to be a need for the PSS to subsidise GPs practicing in rural and remote areas?

The availability of healthcare services is specific geographic areas is a key area of policy concern generally. Although the PSS plays some role in this issue, it is only one of many relevant factors and policy levers. The need for and effectiveness of the PSS must be assessed in the broader context of healthcare need, demand and supply, and health workforce planning and regulation.

Are there other specialities to which different arrangements for subsidy should apply?

Again this issue must be considered in the broader context of healthcare need and supply and health workforce planning and regulation.

Does the differential treatment of MISS practitioners continue to be appropriate?

For reasons of parity we would recommend unifying the MISS and PSS into a single scheme.

Advance payments

If premium subsidies continue to be offered, is it preferable to offer 'advance payment' of a premium subsidy based on an income estimate or should a retrospective payment be made once actual income is known?

Avant would support a move from the current advanced PSS payment to a single reimbursement in arrears. The advance nature of the payment based on provisional or estimated information causes complexities and an administrative burden when it comes to recalculation following receipt of the actual data. While we can see the benefits of a less complex in-arrears payment method, such a change will require substantial investments in systems.

We therefore suggest that a change in the payment method would only be made if the Government is committed to retaining the PSS long-term.

Universal Cover: Avant's position

A core tenet of the current medical indemnity arrangements is the concept of Universal Cover, whereby all Australian doctors have access to medical indemnity coverage for private practice. Without Universal Cover, lack of access to insurance might act as a barrier for some doctors to be able to practice. We believe that such a mechanism is beneficial to the health industry because it is better for the medical regulators and professional standards bodies to be determining which doctors can practice, rather than medical indemnity providers.

However the current system is not actually helpful to medical indemnity insurers. Instead it comes at some cost. All insurers who benefit from any of the government schemes should be required to participate.

The current system is also not optimal or fair. It is not optimal because it incentivises medical indemnity providers to withdraw cover from poorly performing doctors rather than work with them to make their practice safer. It is unfair because Avant serves as the Insurer of Last Resort for 75% of medical practitioners, yet Avant's overall market share is much lower.

For these reasons, Avant considers that the current arrangements are not equitable or sustainable, and Avant would not enter into a future universal cover arrangement under these conditions.

We propose that the framework be revised to improve outcomes which can be achieved, at no cost to the government. We propose that all registered providers of medical indemnity insurance be required to offer cover to any doctor who applies, on actuarially supported terms, as well as run off cover should the doctor leave for another insurer. Current restrictions on pricing should be adjusted to allow insurers to charge a premium that better reflects the practitioner's risk, and to help act as an incentive to encourage doctors and their insurers to work together to improve safety and reduce the risk of an error or claim.

A separate topic which is raised in the discussion paper is the potential role that insurers have in reporting any inappropriate conduct to the Australian Health Practitioner Regulatory Agency. Avant believes it is important to recognise that the primary role of medical indemnity insurers is to protect and defend their doctors, and in this role the protection of confidentiality and privilege is crucial in order for the medical indemnity to work in a fair and effective manner, and to maintain public and professional confidence in the system.

Should universal cover continue to be a feature of the medical indemnity insurance in Australia?

Avant supports the concept of universal cover for private medical practice. We do this not because it gives Avant any commercial benefit, but because we believe it is good government policy.

Without universal cover, lack of access to insurance might act as a barrier for some doctors to be able to practice. We believe that a universal cover mechanism is beneficial to the health industry because it is better for the medical regulators and professional standards bodies to be determining which doctors can practices, rather than medical indemnity providers.

If so, should all insurers be subject to universal cover requirements (not just those contracting with the Commonwealth via the PSS)?

Yes, all insurers should be subject to universal cover requirements.

Are there adequate mechanisms for insurers to limit or monitor the practice of medical practitioners that represent higher risk because of inappropriate practice (i.e. through conditions)?

Avant believes that the current mechanisms are necessary and appropriate.

Are the current parameters for universal cover appropriate or should they be changed?

The current universal cover system, where a single medical indemnity insurer in each state is required to offer cover as the Insurer of Last Resort (IOLR), is unfair. It also more importantly provides a strong disincentive for medical indemnity insurers to help doctors improve the safety and risk levels of their practice.

Avant is required to offer cover in NSW, Queensland and Victoria, the three most populous states, where approximately 75% of the medical workforce practise. This is an inequitable distribution and disadvantages Avant in relation to the other medical indemnity insurers, as Avant has 75% of Australia's universal cover doctors, despite an overall market share of only just over 50%.

The IOLR arrangements are also sub-optimal from a policy perspective and allow medical indemnity insurers to offload doctors they deem to be higher risk rather than work with them to normalise their risk. The current insurer has the claims history and knowledge of the doctor's practice and therefore should be best placed to understand the doctor's risk and help them to manage it. The IOLR often has an incomplete picture of the situation and therefore is not as able to help the doctor reduce their risk and deliver better patient care.

Avant proposes an alternative approach to universal cover, which is that all providers of individual private practitioner indemnity should be required to offer cover to all doctors whose registration allows them to practice privately. Coverage terms should be limited by a framework that applies to Universal Cover applicants e.g. medical indemnity insurers can impose conditions for insured to undertake additional training, impose a risk surcharge, etc.

This type of "take all comers" approach is common for other types of mandatory insurance products, and would have the following benefits:

- Reduced risk of "bare" practice – removes or greatly reduces the prospect that patients will be treated by a doctor practicing uninsured while they seek terms from another insurer
- Best and fairest renewal terms – the current insurer understands the risk that the doctor poses and can apply conditions reflective of this.
- Incentive to apply education and risk management - the current insurer should have a duty to assist the doctor in reducing the risk they pose to patients rather than transferring the risk to another insurer who will be in a worse position (at least initially) in looking to influence their risk profile.
- Transition from current (unfair) state-based allocation of Universal Cover obligations to a fairer system and one with better outcomes for the patient, doctor and medical indemnity insurers.

A related issue is that there is currently no requirement for an insurer to offer run-off cover when a doctor is switching insurer. Avant proposes that the current insurer must offer a run-off quote to a doctor switching insurers when requested. This should be offset with removing the existing requirement for the new insurer to offer retroactive cover (although a new insurer may still choose to offer this cover at their option). The benefits of this change would include:

- Best and fairest run-off terms – the current insurer is best placed to price the tail (past practice) exposure (for earlier incidents that have occurred but have not yet been notified) for their insured doctor.
- Incentive for new insurer to manage the ongoing risk – there is greater opportunity for the new insurer to accept the risk without exposure to the tail and to focus on risk education and management to address underlying issues going forward.

Currently there is a limitation on the risk surcharge (capped at 100% of the applicable premium). Does this limitation remain appropriate?

A 100% risk surcharge is not always reflective of the risk generated by a doctor under Universal Cover. Avant proposes increasing the risk surcharge cap from 100% to 400%. The benefits of increasing the cap include:

- A clearer signal to the doctor that their risk is significantly above their peers with whom they share risk through insurance, together with a clearer incentive to improve.
- Reduces cross subsidisation by the rest of the medical indemnity insurer's doctors. It is a fairer system for all participants i.e. patients, doctors and medical indemnity insurers.
- Reduces incentives for medical indemnity insurers to seek to offload doctors who show high levels of risk, as these can be more properly priced for and retained.
- Reduces the risk of portfolio imbalance for individual insurers. This "anti-selection" risk is a significant issue for all insurers and drive financial instability of both individual insurers and the entire insurance system.

These changes come at no cost to the government, but would appear to improve the effective operation of the system.

Doctors in general should not be forced to heavily cross-subsidise individuals with heightened practice risk to the community. This runs counter to the objective of improved provision of healthcare. Instead the pricing limits should be raised to better allow insurers to reflect the doctor's practice risk, and to stimulate improvements in their practice.

4. High Cost Claims Scheme

High Cost Claims Scheme: Avant's position

The High Cost Claims Scheme is a fundamental element of the current arrangements. It supports a stable medical indemnity environment, with the Government sharing an element of large claims risk above a threshold with the private sector. Any reduction to the scheme will have a direct impact on doctors' premiums, which must be passed on to patients, and contribute to sector volatility which might prove counter to the long term stability of the sector and hence the provision of health care.

The government can provide the small portion of HCCS cover more efficiently than the global reinsurance market, since it does not need to hold backing risk capital and can also influence the broader Australian medico-legal risk environment. Sharp swings in private reinsurance costs, and private reinsurance failure, contributed to the indemnity crisis in the early 2000s.

The High Cost Claims Scheme was introduced in 2002 but has yet to be tested in a time of a stressed medical indemnity market. The Government would be unwise to make changes and risk a reversion to the problems that arose in 2000-2002 should the medico-legal cycle turn, as history around the world has demonstrated that it will in time.

The HCCS represents very good value for money, in terms of the significant stability and support it brings to the system for relatively little cost. Avant strongly supports the continuation of the HCCS.

Strengths of the HCCS

Are these the key strengths of the HCCS? Are there other benefits of the HCCS?

The High Cost Claims Scheme is a fundamental element of the current arrangements which supports a stable medical indemnity environment.

Scope of the HCCS

Does there continue to be a need for Government to subsidise insurers though contributing to the cost of high claims (so as to provide certainty and reduce pressures on claims)?

The recent changes announced by the government of increasing the threshold of the HCCS from $300,000 to $500,000 will lead to an increase in premiums of 5%, which we anticipate will be passed onto patients. In addition, modelling undertaken in May 2014 on the impact of the cessation of the HCCS indicated that complete removal of the HCCS would result in an estimated 25% increase in net claims costs. The impact on Avant members would be highly uneven, with higher risk specialties bearing a large portion of the subsequent required premium increases.

Not only would removal of the HCCS lead to an increase in premiums for doctors and costs for patients, but it would also increase total overall health system costs. This is because the HCCS would have to be replaced by either private reinsurance or by increased levels of risk capital held by insurers, which would require higher servicing profit margins. The current system where there are government supports to the private market is therefore more cost efficient than a purely private sector arrangement. Due to the capital intensity of any private sector alternative, the HCCS (together with the ECS) is a governmental solution that provides overall net benefits to patients and doctors which are significantly beyond what could be realised under any other system.

Should the scope of the HCCS be limited to medical practitioners?

(We have no comment.)

If not, what is the evidence of the need for these schemes with respect to other registered health care vocations?

(We have no comment.)

How could the HCCS better align with the business practices of medical practitioners or otherwise be improved?

Avant believes that the current configuration of the HCCS aligns well with medical business practices.

Threshold above which the Commonwealth contributes

Is the threshold above which the Commonwealth contributes appropriate?

The level of the HCCS threshold is a key parameter which affects the level of risk protection of the scheme. Avant believes that this threshold is appropriate.

What would be the likely impacts of any changes to the HCCS?

Any reduction in HCCS cover would directly lead to an increase in costs for insurers, premiums for doctors, and healthcare costs for patients and other funders.

Any reduction in risk protection from the HCCS would also require all medical indemnity insurers to increase the amount of private reinsurance they purchase, or to increase their level of risk capital (and thus increase the profit margins which cover the cost of this capital), or to raise their risk appetite levels under prudential regulation. All of these response options would have adverse impacts on doctors and their patients, either from increased premiums or increased risk.

Costs covered by the HCCS

Is Government involvement in providing this type of reinsurance appropriate, given the availability of commercial insurance and reinsurance?

As outlined above, the government can provide the small portion of HCCS cover more efficiently than the global reinsurance market, since they do not need to hold backing risk

capital and can influence the Australian medico-legal environment. Sharp swings in private reinsurance costs, and private reinsurance failure, contributed to the indemnity crisis in the early 2000s.

The High Cost Claims Scheme was introduced in 2002 but has yet to be tested in a time of a stressed medical indemnity market. The Government would be unwise to make changes and risk a reversion to the problems that arose in 2000-2002 should the medico-legal cycle turn, as history around the world has demonstrated that it will in time.

How should claimable costs be defined? What alternative definition would be practical, effective and reasonable?

Medical indemnity insurance serves several crucial purposes in the broader healthcare system:

1) to ensure a source of funds to indemnify patients who suffer a loss through injury from medical negligence or malpractice,

2) to protect doctors against the costs they would otherwise incur from such claims, and

3) to help to stabilise the costs and availability of medical care for all patients.

Avant medical indemnity insurance policies only cover claims which are related to the provision of healthcare, and claim cost benefits cover only the costs doctors would incur from these claims. All of these benefits offset genuine costs to the doctor and thus affect the cost and price of healthcare provided to the patient. Thus, all claim cost benefits under Avant insurance policies help to achieve the core purposes of medical indemnity insurance.

Avant supports taking a design and administration approach to the HCCS which mirrors standard commercial reinsurance practice. This includes a “follow the fortunes” approach to coverage, whereby the HCCS should mirror the underlying cover of the insurer. It also includes the use of basic commercial common sense for issues such as recovery documentation.

What other issues around claims and eligibility need clarification? Please provide examples and suggestions for inclusion in any future guidance material.

Claims eligibility for the HCCS should follow the eligibility of the underlying insurance cover. The alignment of interest between the insurer and the HCCS administrators serves as an effective control for HCCS access.

What other changes could be made to the HCCS to improve its effectiveness, efficiency and value for money while ensuring it continues to meet the scheme objectives and to reflect current insurance arrangements?

The HCCS represents very good value for money and is an effective support for stability of the industry and for keeping premiums affordable for doctors. Avant supports keeping the HCCS in its current form.

5. Exceptional Claims Scheme

Exceptional Claims Scheme: Avant's position

The Exceptional Claims Scheme (ECS) is one of the key foundations of the medical indemnity system in Australia, and must be retained. It provides certainty to doctors and patients that for exceptionally large claims they will not be faced with the prospect of policy limits being exhausted. In addition the ECS provides stability and security to medical indemnity insurers and to the wider health system. If the ECS were to be withdrawn, it is not clear that the private insurance and reinsurance markets would be able to provide this same protection on a reliable, stable and sustainable basis. Some insurers may not be able to offer cover above $20 million which could lead to some doctors facing catastrophic losses and may impact their willingness to provide services. Even if a private sector solution were available, it would be at a significant cost for doctors and patients, due to the significant risk capital and resultant capital costs which would be required to support it.

Given the low (nil) cost to date of the ECS we see this as good government policy that should be continued.

What are the benefits of the ECS given the absence of claims made under the scheme?

The ECS has not yet been triggered in Australia, yet the risk of very high cost claims remains, particularly in an environment of increasing claims costs overall. The removal of the ECS would have a significant impact on the risk faced by doctors and patients as it removes a pillar of certainty that would be difficult or impossible for medical indemnity insurers and their reinsurers to replicate.

To what extent does the scheme influence the limits of insurance applied by insurers?

Insurance policies under Australian Prudential Regulation Authority (APRA) regulation require the inclusion of appropriate policy limits. Higher policy limits can be offered but this is at a high relative cost as insurers and reinsurers must charge for their capital, which increases in line with the risk and volatility of the insured policies.

The limit of indemnity under Avant's Practitioner Indemnity Insurance Policy is $20 million, which is standard in the market, and is the attachment point of the ECS.

To what extent does Government involvement in providing this type of insurance provide certainty for the sector?

Removal of the ECS has the potential to have a significant impact on both practitioners and patients. If there is an incident for which the potential liability is greater than $20 million, the practitioner's assets will be at risk, and/or the patient may be at risk of recovering nothing if the claim amount exceeds the practitioner's assets.

Although the National Disability Insurance Scheme is expected in future to provide reasonable and necessary supports to significantly and permanently disabled patients, common law rights to sue have so far been retained in full, leaving the legal liability risk for

the doctor unchanged. This means that even with a fully rolled out NDIS there is still the potential for damages over $20 million to be incurred.

Should the scope of the ECS be limited to medical practitioners?

(We have no comment.)

If not, what is the evidence of the need for this scheme with respect to health professionals (and allied health professionals)?

(We have no comment.)

Is the ECS best administered by the Commonwealth?

Avant believes that the ECS scheme, administered by the Commonwealth, is the best solution to high layer claims risk in the current system.

As outlined above, the government can provide high layer claims coverage more efficiently than the global reinsurance market, since it does not need to hold backing risk capital and can influence the broader risks in the Australian medico-legal environment.

Doctors would still need the high layer protection provided by the ECS if the scheme were removed. However, any transfer of these costs to the private sector would result in a significant increase in overall costs, since private insurance or reinsurance for this high layer would have high risk capital requirements with commensurate capital return costs. Unlimited cover is generally not available in the private market, making some form of high-layer government protection necessary in order to fully protect doctors and patients.

Due to the capital intensity and uncertainty of availability from the private sector, the ECS is a governmental solution that provides overall net benefits to patients and doctors which are significantly beyond what could be realised under any other system.

6. Run-off Cover Scheme

Run-off Cover Scheme: Avant's position

We support the Run-Off Cover Scheme (ROCS) but we think that it could be improved further to ensure more complete patient protection.

Although the ROCS provides protection to doctors and patients in most cases, there remain situations where doctors and their patients may not be covered by medical indemnity insurance.

We recommend that all doctors be required to secure run-off cover whenever they cease practice, and also be required to secure retro cover whenever they resume practice (if not already covered by run-off).

We also propose that the ROCS scheme could provide a safety net for injured patients who might fall through other potential cracks in the system, for example where a doctor does not have compulsory medical indemnity cover and does not have sufficient assets to cover the costs of a claim.

The current 5% levy appears to be higher than needed to fund the ROCS scheme. We propose a reduction to 3%. The Government Actuary should give annual advice about the adequacy of the levy.

Does there continue to be a need for the ROCS?

Yes the ROCS needs to continue. The change from a claims occurrence to a claims made coverage trigger has been one of the key components of medical indemnity reform, and appropriate run-off cover arrangements are a key factor for any successful claims made insurance model.

The current system works well and does so at no cost to the government - we therefore do not recommend change. Should the ROCS be eliminated or reduced, then it is likely that some doctors will not continue their cover, which might see some patients unable to obtain compensation from medical malpractice. This could damage confidence in the overall healthcare system.

If so, is the Commonwealth best placed to manage and administer the ROCS or could it be administered by insurers or others?

The current ROCS system has some advantages:

1) cover is available for all doctors who cease practice,
2) the cost is spread over the period of active cover (through the levy),
3) the "burden" of the cover doesn't fall to the last active insurer, so ROCS cover is not a disincentive for MDOs to cover late-career doctors, and

4) ROCS cover and claims are administered by the private insurers, which have a good service infrastructure for this purpose.

It is difficult to envisage a viable private insurance coverage alternative to the government ROCS scheme. If the private insurers were required to offer ROCS, then they would have to collect the fair premiums for the cover. However, many doctors might not be able afford to pay the fair premium of ROCS cover after they retire, since their claims risk and exposure is a function of their past practice but their income in retirement would be reduced. Spreading the cost of ROCS over the longer life of the active cover, which is how the current system works, would be difficult, as this would create a mismatch between the premium collection during the claims occurrence exposure period and the future claims-made run-off cover, especially since these coverage periods might sit with different insurers.

If the scheme is more appropriately managed by others, how could it be transitioned?

Avant supports the continuation of the government ROCS scheme.

Are there any improvements that could be made to the scheme to make it more efficient and effective (regardless of who manages the scheme)?

There are occasionally instances where doctors practice without valid medical indemnity insurance cover, or where patients otherwise "fall through the cracks" of the insurance system (e.g. through administrative error). Avant recommends that the scope of the ROCS scheme be expanded to cover such instances. Should a patient suffer injury from an uninsured doctor, then the ROCS scheme would be available to compensate the patient, although the scheme should retain the right to recover costs from the doctor.

ROCS cover should be mandatory and automatic for doctors ceasing practice. Currently, doctors are not required to take run-off cover (although insurers are required to offer it) and can be uninsured for their tail. Patients are the ones who are ultimately most at risk in such cases.

At the administrative level when submitting a ROCS application it is a requirement that the insurer includes a Medicare ROCS statutory declaration signed by the doctor. The statutory declaration includes details of the doctor's ROCS category, their date of retirement and confirmation of the date of notification for the relevant claim. The doctor is required to complete, and arrange to have the declaration witnessed. This can place an additional burden on a doctor who is elderly or disabled.

In lieu of the Statutory Declaration from a doctor, we would propose being able to include the following documentation to support the claim:

- The doctor's initial correspondence to Avant advising of the claim; and
- The doctor's correspondence advising of their retirement date

The process of collating applications is also onerous:

- It involves a manual process requiring the copying of numerous documents which are then submitted via the Government's secure email portal which unfortunately has a

very small memory quota. Using the portal is hardly more efficient than photocopying and sending by Express Post.

- If there is a data discrepancy (usually 1 to 2 cents) leading to a refund in Avant's favour, we are required to amend the application which is time consuming and onerous. An agreement with DHS to pay Avant the lower amount would be ideal.
- A Claims Transaction Report (CTR) is sent with each application which is a list of all the payments made on the claim. As these are Excel documents, it may be helpful if DHS were provided with an Excel version which would enable them to use the data instead of recreating it. A PDF copy could also be sent.
- In contrast, the process for private reinsurance is much less onerous. The reinsurers only require a CTR (no invoices), settlement documents and an updated report to process a recovery.

We propose changing the administrative rules and processes to be more commercially sensible and efficient, similar to how private reinsurance operates.

Are the data collection requirements associated with ROCS reasonable and appropriate?

While we consider the data collection requirements to be generally reasonable and appropriate, there would be advantages in using newer technologies to make the processes more efficient. There is also a high frequency of data transfers with the Commonwealth which could be streamlined.

Should any changes be made to eligibility or the other requirements for payable claims?

Avant supports the current approach, which is that claims eligibility and coverage matches the final expiring insurance policy in force when the doctor ceased practice. (This "follow the fortunes" approach should also be more clearly adopted for the HCCS.)

Consideration could also be given for parental leave, more broadly than the current maternity leave eligibility.

Are there any improvements that could be made to clarify which medical practitioners and which claims are eligible for ROCS?

ROCS cover should apply automatically once a doctor ceases practice and no longer takes out private indemnity cover. The cover should be automatic from the time that the doctor advises that they have ceased practice.

Is the ROCS support payment set at an appropriate level? If not, why, and what would be an appropriate level?

The 5% ROCS levy appears to be too high. We propose a reduction to 3%. There is insufficient transparency about the adequacy of the levy and of government ROCS provisions. The annual government actuary review of ROCS funding should include a clear

analysis and evaluation of the relative adequacy of the ROCS levy and a recommendation for the level of the levy going forward.

Does the allowance paid to insurers for ongoing administrative costs continue to be necessary and, if so, is it set at an appropriate level?

The current administrative cost reimbursement approach is reasonable and should be continued.

7. Incurred But Not Reported Claims Scheme (IBNR)

IBNR Scheme: Avant's position

The IBNR scheme acts as reinsurance for any unfunded claims from before the industry change to claims-made cover (the change was completed in 2003). The scheme has been triggered only once, for UMP in 2003. The value and fairness of this was reviewed in detail through the "Review of competitive neutrality in the medical indemnity insurance industry" (Rogers 2005). In response, the Government imposed a Competitive Advantage Payment on UMP, and all UMP's obligations for the IBNR scheme were subsequently settled in 2006. UMP's IBNR scheme claims are winding down favourably at well below the cost expected at the time of the settlement, and we expect them to continue to run-off with no issues.

The IBNR scheme is still theoretically active and could be triggered again if another medical indemnity insurer were to have unfunded claims from the pre-claims-made period. Although this may seem unlikely given the current benign claims environment and the financial strength of insurers, the scheme is still a valuable protection mechanism against a major systemic shock, and should be retained until all pre-claims-made medical indemnity liabilities have fully run off.

Does there continue to be a need for the IBNR?

The scheme is still a valuable protection mechanism against a major systemic shock, and should be retained until all pre-claims-made medical indemnity liabilities have fully run off.

If so, are there are any improvements that could be made to make the scheme more efficient and effective?

We consider that the Scheme is functioning adequately as it runs off.