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Inquiry into Disability Care and Support
MIGA comments on the Draft Report 2011

We refer to the Productivity Commission's Draft Report released in February 2011 where submissions were sought in relation to a number of key issues.

MIGA is a specialist insurer offering a range of medical indemnity insurance products and associated services to the health care profession across Australia. We insure doctors, health care companies, privately practising midwives and medical students. We have significant experience in the management of claims for catastrophic injuries and long term care costs.

Our submission is only in response to the questions raised in Chapter 16, A National Injury Insurance Scheme, as they relate to medical indemnity insurance for doctors. We have not specifically considered the issues of medical indemnity arrangements for other groups such as private hospitals or midwives.

In the attached Paper we have provided detailed information explaining our views and recommendations in relation to interim funding for the NIIS and the definition of medical accident.

In summary our recommendations are:

1. Funding for the NIIS

- Given the uncertainty around cost and funding, a working group be established to actuarially assess the expected costs and the funding impact at an industry level. This will assist all parties to provide more informed commentary on the proposals
- Existing Federal Government arrangements for doctors remain in place (i.e. High Cost Claims Scheme and Premium Support) until such time as there is more certainty around the cost of the new Scheme and what costs will be removed from existing medical indemnity insurers
- Funding of NIIS should be transitioned over a reasonably long period (e.g. at least 5 years) with incremental increases in levies, starting at a relatively low level, reflecting that costs will not be fully transferred or incurred from day one and it will take some time for them to mature
    - This will assist in managing affordability of premiums for doctors
    - It is possible for medical indemnity insurers to calculate the incremental costs to assist with setting this levy
- The funding from doctors may need to be re-assessed in the event that there is a material increase in the overall cost of the Scheme and the level of funding required by doctors i.e. a phased approach still has problems if the ultimate cost to doctors (premium plus levy) is much higher than the current cost

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- Any levy should be incorporated into a doctor's total indemnity insurance cost for the purposes of determining their eligibly for premium support from the Federal Government. This will assist to some extent with management of affordability of premiums

- Consideration be given to reducing the ROCS levy, for example from 5% to 3% (we believe at the reduced level ROCS will continue to be adequately funded as claims costs are running at close to this level). This would need to be confirmed with the Australian Government Actuary.
    - The 2% "gap" can be used to fund the NIIS in the first couple of years.

This strategy allows for minimal impact on the medical profession by gradual implementation allowing for greater certainty in costs and their allocation to be assessed over time.

2. Definition of Medical Accident

MIGA recommends that:

- A review group of key stakeholders be established to work through the key issues and agree a workable definition

- The criteria for determining a medical incident be as simple as possible:
    - We would recommend that injury caused from expected known risks, all unexpected and unusual outcomes are included in the definition of medical accident and NIIS
    - This recommendation is subject to acknowledgement that the range of catastrophic injuries will be significantly in excess of those that doctors are currently liable for and fund via their medical indemnity insurance premiums. This would have implications for funding of medical accidents within the NIIS and the contribution by government would need to be adequate to reflect the broad approach applied.

- More consideration be given to issues in relation to possible exclusions for discretionary consumption, genetic factors and underlying health conditions:
    - Further analysis of the practicality or otherwise of administering these aspects needs to be assessed prior to including them or otherwise in the criteria for determining coverage of medical accidents under the NIIS.

There are other recommendations we have made in relation to the start date, dealing with cross jurisdictional issues and review dates, which are outlined in the following.

MIGA is committed to working with the Productivity Commission and other key stakeholders to progress these issues to ensure a seamless and efficient implementation of the Scheme.

Please do not hesitate to contact us if we can be of further assistance.

Yours sincerely

Mandy Anderson
Managing Director and CEO

Interim funding for the NIIS

The Commission has sought feedback on practical funding arrangements for funding catastrophic medical accidents under the NIIS.

Issues assessed by MIGA

MIGA has considered two issues in relation to funding:

- What will be the cost of the scheme in terms of medical accidents in relation to doctors
- What does this mean in terms of funding and what are the options to fund these costs?

Cost of the Scheme

We note the assumption made about the cost of the NIIS and in particular the component that could relate to medical accidents.

As an insurer with a significant data base of claims we have been able to model expected costs and provide the following information.

a) Are expected savings in legal expenses achievable?

The Productivity Commission Report suggests that one funding source will be 'savings' from less legal costs in the system (suggests up to 30% of claims costs).

We do not believe savings of this level can be realized because:

- In MIGA's experience, the proportion of legal expenses for catastrophic claims to total cost is closer to 20%
- In medical indemnity claims, where liability is often in dispute, most of the legal costs are incurred in determining negligence – these legal costs will not 'disappear' as there will still be significant claims for non care costs where determination of negligence will remain an issue
- Having considered these issues, we believe the legal savings will be no more than in the order of 5%.

b) What are the expected costs of the new scheme

We have completed financial modelling against closed claims files to understand whether the assumed costs in the Report are able to be validated and to calculate what we believe are the expected costs of the Scheme. Our modelling is only in relation to medical accidents for doctors.

We have made the following key assumptions. Whilst there is some uncertainty regarding these assumptions, we believe that in aggregate they provide a reasonable indication of the "order of magnitude" of the financial impact of the Scheme. Much more detailed analysis is required in order for the impact to be more definitively assessed. This will only be possible once there is more clarity regarding which matters will be in/out of the Scheme.

Assumptions

- Catastrophic claims are those costing more than $1 million across all heads of damage
- The extra "no fault" catastrophic injuries caught by NIIS will be equal to the number of catastrophic claims currently paid by medical indemnity insurers (this is below the NZ experience across all claims and could be understated, potentially materially)
- For catastrophic claims, the medical and care costs are approximately 60% of the claims costs in excess of $1million (this has been our historical experience)

Interim funding for the NIIS cont...

- The amounts that MIGA has historically paid for care costs for catastrophic cases will be 30% higher under NIIS – we believe these costs are currently artificially reduced through liability discussions and settlement negotiations which focus on the total cost across all heads of damages and therefore costs on average may be higher once one component is isolated
- Legal savings of 5% of the claims cost will be achieved for catastrophic matters
- We will achieve savings in reinsurance (through the transfer of liabilities) and that this saving is expected to be at "technical" terms, such that the prices vary downwards in proportion to the costs removed from the medical indemnity system. In practice this may be difficult to achieve, in the short term at least particularly as the impact of the new Scheme will not be retrospective and there is no guarantee for reinsurers as to the reduction in their exposure.

We have extrapolated our data and experience to an industry level to reflect the costs across all medical indemnity insurers. This assumes MIGA's experience would be mirrored across the industry.

c) Estimated cost of medical accidents

Our modelling shows that, looking only at the medical indemnity insurance component for doctors, the potential total cost of the scheme is as follows (note, this does not include the costs borne in the public or private hospital sectors, which would be in addition to this).

The cost of claims that are expected to be transferred to the NIIS from medical indemnity insurers	**$30m**
The cost of no fault matters not previously covered – assumed to be 100% of existing costs	**$30m**
Potential savings in legal expense	($3m)
Potential total cost of the scheme – in relation to medical accidents for doctors	**$57m**

This means the extra cost to be funded would be

If the High Cost Claims Scheme is maintained in its current form[1]	**$27m**
If the High Cost Claims Scheme is removed in full[2]	$54m

Notes:
1. This is the $30 million of extra cost from the inclusion of no fault matters less the $3 million saving in legal expenses
2. The additional $27 million cost is an estimate of the value of the HCCS support that would remain after the NIIS

Interim funding for the NIIS cont...

d) What does this mean in terms of funding by doctors

If the costs of funding the medical accident component of the NIIS are fully transferred to doctors, the impact on them might be in the following order of magnitude. Note that these estimates were developed with the support of our actuary.

Basis	Possible levy
Without allowing for the cost of no fault matters, and assuming no change to the HCCS, the projected cost to doctors is almost unchanged	Nil This reflects that the lower reinsurance premiums and savings in legal costs cover the increased cost of care under the NIIS
Including the cost of no fault matters	12%
If the HCCS were fully removed and including no fault matters	25%

Our modelling shows that:

- In the short term, and until there is more certainty around costs; the funding for the NIIS cannot be from within the existing premium pool of medical indemnity insurers. The expected costs are in excess of current costs funded by medical indemnity insurers. This is mainly driven by:
  - The additional cost that will be added through no fault matters being covered
  - The expected savings in legal expenses will not be at the level assumed

- The NIIS could only be funded by an additional loading on existing premiums, which might need to be 12% or more once the Scheme is mature.

e) Issues MIGA's modelling do not allow for

There is significant uncertainty in any modelling. Key issues that could change the outcomes of the modelling completed by MIGA are:

Matters that could increase the assumed costs
If the cost of the non-care component of "at fault" claims previously covered by medical indemnity insurers increases, because by separating care costs from other heads of damage the negotiated "compensation" for non-care costs may be at a higher level
If the broader definition of medical accident and the introduction of no fault means there are more catastrophic costs in the system, that is, in excess of our assumed doubling of current costs
If disciplinary and investigative matters increase in frequency if an injured person feels their rights are reduced under the new Scheme (we understand this has been the experience in other no-fault jurisdictions)
If the assumed savings in reinsurance costs do not eventuate or take longer to emerge
The cost of implementing and administrating the NIIS by the State governments has not been allowed for in the modelling. This is likely to increase the overall cost of the fund, over and above the amount that will be transferred from medical indemnity insurers. The administration costs of medical indemnity insurers are very unlikely to reduce because they will still be managing the same level of claims - it's only the quantum of the claims that will reduce.

Interim funding for the NIIS cont...

Matters that could reduce the assumed costs
If savings of greater than the assumed 5% are achieved on legal costs
If, notwithstanding the broader definition of medical accident and the introduction of no fault, there are less catastrophic costs in the system than our assumed doubling of current costs

MIGA recommendations

MIGA recommends that:

- Given the uncertainty around cost and funding, a working group be established to actuarially assess the expected costs and the funding impact at an industry level. This will assist all parties to provide more informed commentary on the proposals

- Existing Federal Government arrangements for doctors remain in place (i.e. High Cost Claims Scheme and Premium Support) until such time as there is more certainty around the cost of the new Scheme and what costs will be removed from existing medical indemnity insurers

- Funding of NIIS should be transitioned over a reasonably long period (e.g. at least 5 years) with incremental increases in levies, starting at a relatively low level, reflecting that costs will not be fully transferred or incurred from day one and it will take some time for them to mature
    - This will assist in managing affordability of premiums for doctors
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- The funding from doctors may need to be re-assessed in the event that there is a material increase in the overall cost of the Scheme and the level of funding required by doctors i.e. a phased approach still has problems if the ultimate cost to doctors (premium plus levy) is much higher than the current cost

- Any levy should be incorporated into a doctor's total indemnity insurance cost for the purposes of determining their eligibly for premium support from the Federal Government. This will assist to some extent with management of affordability of premiums

- Consideration be given to reducing the ROCS levy, for example from 5% to 3% (we believe at the reduced level ROCS will continue to be adequately funded as claims costs are running at close to this level). This would need to be confirmed with the Australian Government Actuary.
    - The 2% "gap" can be used to fund the NIIS in the first couple of years.

This strategy allows for minimal impact on the medical profession by gradual implementation allowing for greater certainty in costs and their allocation to be assessed over time.

Definition of Medical Accident

The Productivity Commission has sought feedback on an appropriate criterion for determining coverage of medical accidents under the NIIS.

Background

The criteria for determining coverage of medical accidents is within the proposed structure of the NIIS which is essentially a no fault scheme. Because of the move to no fault, coverage will be much broader than the range of claims that insurers currently manage under medical indemnity policies. In the current environment medical practitioners are only liable for claims for which they are found to be negligent.

The Commission has indicated that it envisages the NIIS would consider the following in the determination of a medical accident:

- The injury being catastrophic in severity
- The outcome from medical treatment being sufficiently unexpected or unusual
- Possible exclusions relating to discretionary consumption of medical services, for example some plastic surgery or consumption of health services abroad
- Exclusion of catastrophic disabilities where the treatment or care was provided in a timely and appropriate manner and there was no clear reason for the condition, other than a genetic factor or underlying health condition.

The Commission has also indicated the involvement of an administrative, expert panel to make timely and efficient decisions in particular to identify injuries that are:

- An unexpected or unusual outcome of treatment
- Either wholly or substantially the result of an underlying health condition rather than the medical treatment itself.

The Commission has noted that the impact of an underlying health condition is particularly difficult for birth cases, particularly cases of cerebral palsy.

Issue to be considered

In MIGA's view, the following issues need to be considered when determining the criteria for defining a medical accident:

a) *Known risks of medical treatment*

The Commission has not indicated how lifetime support and care will be provided where the catastrophic injury has resulted from a known risk of the medical treatment provided. As it is not included in the consideration of NIIS, these cases will presumably fall into the NDIS.

Medical indemnity claims can often be in relation to injury from a known risk of the medical treatment. In these cases the doctor's negligence, or otherwise, in appropriately seeking the patient's consent to the treatment is under question.

If the NIIS intends to include all matters where the medical practitioner is negligent, the question of appropriate consent will need to be determined prior to the matter being considered under NIIS or being dealt with under NDIS.

Definition of Medical Accident cont...

It would be extremely inefficient if an administrative, expert panel had to determine, not only, if the risk is known, sufficiently unknown or unexpected but also if the doctor is negligent in seeking appropriate consent from the patient. If the patient is seeking damages from the doctor for heads of damage other than lifetime care and support needs, the question of negligence will need to be considered in both the legal proceedings and the NIIS.

b) *Sufficiently unexpected or unusual*

It is not clear how an administrative, expert panel would be able to determine and apply objective criteria for causation and level of sufficiency for 'unexpected' or 'unusual' outcomes. These issues are often the subject of debate in legal proceedings and medical expert opinion on these matters is often contradictory.

It is also not clear how decisions of the administrative, expert panel will be contested and the impact this will have on the timeframes in which services are provided to the patient

c) *Genetic factor or underlying health condition*

It is not clear how an administrative, expert panel would apply objective criteria in relation to what constitutes 'substantially' in the context of the cause of a catastrophic disability. Apportionment of the cause between medical treatment and a genetic factor or underlying health condition will need to be decided.

It may also be important for there to be a mechanism where patients can contest decisions by the administrative, expert panel if they disagree with the decision of the panel.

d) *Possible exclusions*

It is not clear how the possible exclusion in relation to discretionary consumption will be defined or managed. Clarity would need to be provided in relation to the following:

- Which procedures will be excluded
- How will it be determined if consumption of the procedure was discretionary
- If injury occurs in the adjustment or correction of a previous procedure which would be considered discretionary, will the subsequent injury also be excluded
- What process will be for decisions in relation to discretionary consumption be contested?

e) Arbitrage

If any of the criteria used in determining a medical accident for the purposes of the NIIS result in uncertainty, and if timeframes for the provision of services or the level of services are inconsistent between the NDIS and the NIIS, there will be the potential and motive for patients to arbitrage between the two schemes. This will result in inefficiencies in the process and potential inequities.

Definition of Medical Accident cont...

MIGA recommendation

We are aware that our submission on this issue raises more questions than it answers. This is because defining medical accident and then managing its interpretation is inherently complex.

MIGA recommends that:

- A review group of key stakeholders be established to work through the key issues and agree a workable definition
- The criteria for determining a medical incident be as simple as possible:
  - We would recommend that injury caused from expected known risks, all unexpected and unusual outcomes are included in the definition of medical accident and NIIS
  - This recommendation is subject to acknowledgement that the range of catastrophic injuries will be significantly in excess of those that doctors are currently liable for and fund via their medical indemnity insurance premiums. This would have implications for funding of medical accidents within the NIIS and the contribution by government would need to be adequate to reflect the broad approach applied.
- More consideration be given to issues in relation to possible exclusions for discretionary consumption, genetic factors and underlying health conditions:
  - Further analysis of the practicality or otherwise of administering these aspects needs to be assessed prior to including them or otherwise in the criteria for determining coverage of medical accidents under the NIIS.

Other recommendations

There are a range of other issues that we believe need to be considered in the implementation of NIIS. Most of these mean there is significant uncertainty around the timing of implementation of the NIIS by 2012.

Other issues we believe need to be considered are:

Start date

- The proposed structure of the NIIS means it may not be "true no fault" for all medical accidents as some will be intended to ultimately be captured by the NDIS
- The risks of incomplete implementation are high if it is rushed – the matters to resolve are extremely complex and need time to ensure implementation is as efficient and clear as possible
- Due to the complexity around the funding and the need to spend more time on defining matters such as medical accident, plus the need to address cross jurisdictional issues (as per the following) MIGA recommends that a start date no earlier than 2015 is set for both Schemes.

Cross jurisdictional issues

- The proposed structure of the NIIS assumes that medical treatment or care is provided by doctors which is delivered and compartmentalized at a State level. This is not always the case. Doctors often work across State boundaries and tele-medicine, for example, is increasing. All medical indemnity insurers in Australia provide cover Australia wide and insure doctors in most, if not all, jurisdictions.
- There is some risk, if State levies are not consistent, that the administrative process of managing them will be too complex and the structure may incentivise jurisdiction shopping
- We recommend that levies for funding the NIIS should be consistent across all States, but we also recognize the potential for levies to be higher based on different relativities of risk between States.

Review dates

- In the case of medical accidents, MIGA recommends that the 2020 review of the NIIS/NDIS should be an interim review as there will not be sufficient time (assuming implementation in 2015) to observe the true impact of the schemes given that matters relating to medical accidents (and error) take many years to emerge and be fully understood (for example, for obstetrics matters)
- We recommend that a further review should be undertaken in 2025 to better determine the efficacy of the outcomes
- If not already contemplated, MIGA recommends that the Australian Federal Government Actuary be involved in this process, working closely with medical indemnity insurers