12th Accident Compensation Seminar 2009 Rising to the Challenge

Melbourne 22nd – 24th November 2009

Institute of Actuaries of Australia

Medical Indemnity Issues for a State Insurer

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Lessons from the early 2000s

- Data is critical
- Public-private interdependencies
- The role of statute and the risks of Federation
- Risk management and incentives – do they work?
- The fragility of markets and pricing
- Pricing and public policy

Medical indemnity liability: the State Insurer experience (1)

- State is the beneficiary of changes in experience, claims and the legal framework. The State has a direct interest in the financial consequences of tort law and controls that law. The State has an unusually complete knowledge of the claims experience of its industry.
- The State's relationship with insureds is different from that of private indemnity insurance. This changes the insurance dynamic.
- State insurers carry increasingly onerous burdens to protect the public balance sheet in times of dynamic change

Medical indemnity liability: the State Insurer experience (2)

- Unique challenges to implement sustainable underwriting frameworks which balance long term viability with the imperative to provide broad coverage to entities and employees within the public health sector
- The State does have a heart – flexing in recognising claims
- Delivering medical indemnity cover through a State captive insurer model provides unique insights into the causes of adverse incidents and the total cost to the State of adverse clinical outcomes
- Impacts of model litigant requirements of Government

Victorian Managed Insurance Authority

- Medical Indemnity cover to public hospitals (including community health services, bush nursing homes etc) and all public hospital employees, for health services provided to public patients.

- Related issues include product liability cover for clinical trials

- VMIA underwritten liabilities exceed $500 million, plus Department of Health liabilities ($270 million), and will approach $1 billion by 2014

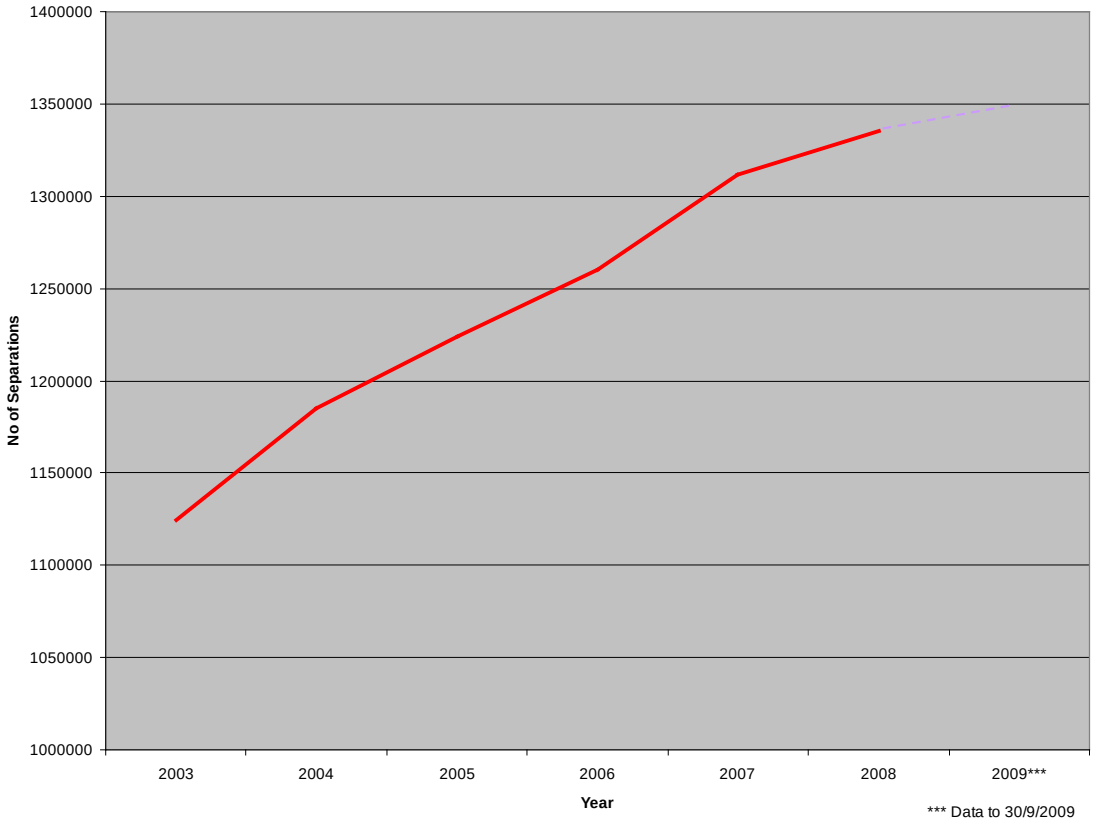
Victorian Managed Insurance Authority

- Approximately 700 claims raised, and 50,000 adverse incident reports received each year
- Wide coverage with limited exclusions, all employees covered automatically
- Liabilities are wholly underwritten by the State, without access to Federal government support, but are affected by Federal policies and initiatives
- Lack of risk selection heavily weights portfolio towards large and catastrophic losses

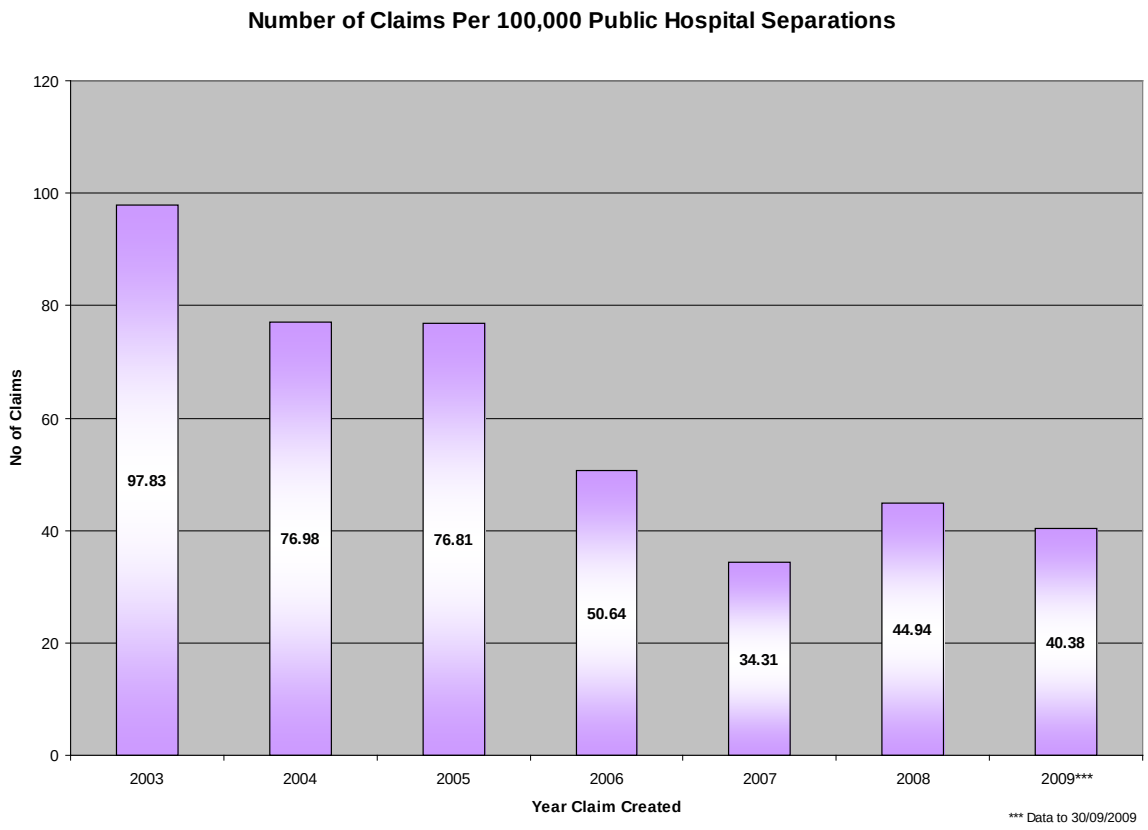
Public sector claims experience

- Total public sector liabilities are increasing
- Exposure growth is outstripping growth in claims frequency
- Liability drivers still reflect traditional MI risk exposures
- Long tail claims are resolving sooner
- Regardless of clinical specialty involved, most MI liabilities arise in the context of obstetric and paediatric treatment, including emergency departments.

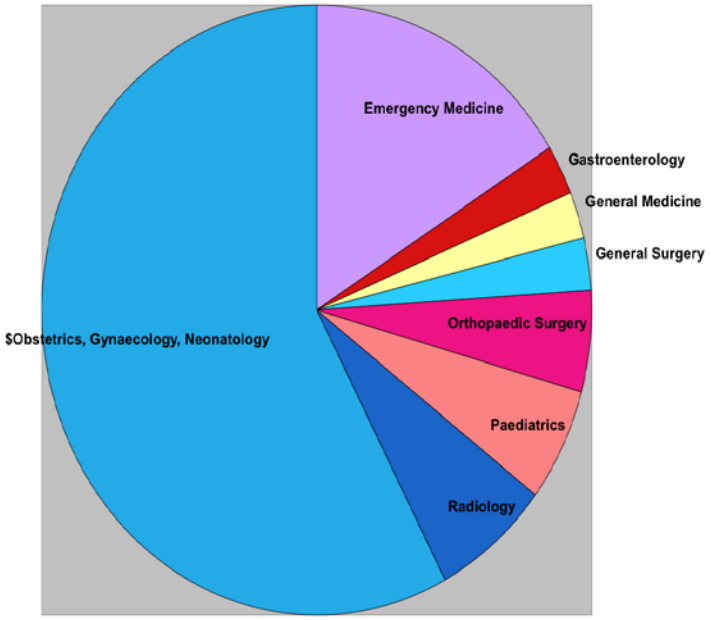
Public Hospital Separations by Calendar Year (excl. emergency departments)



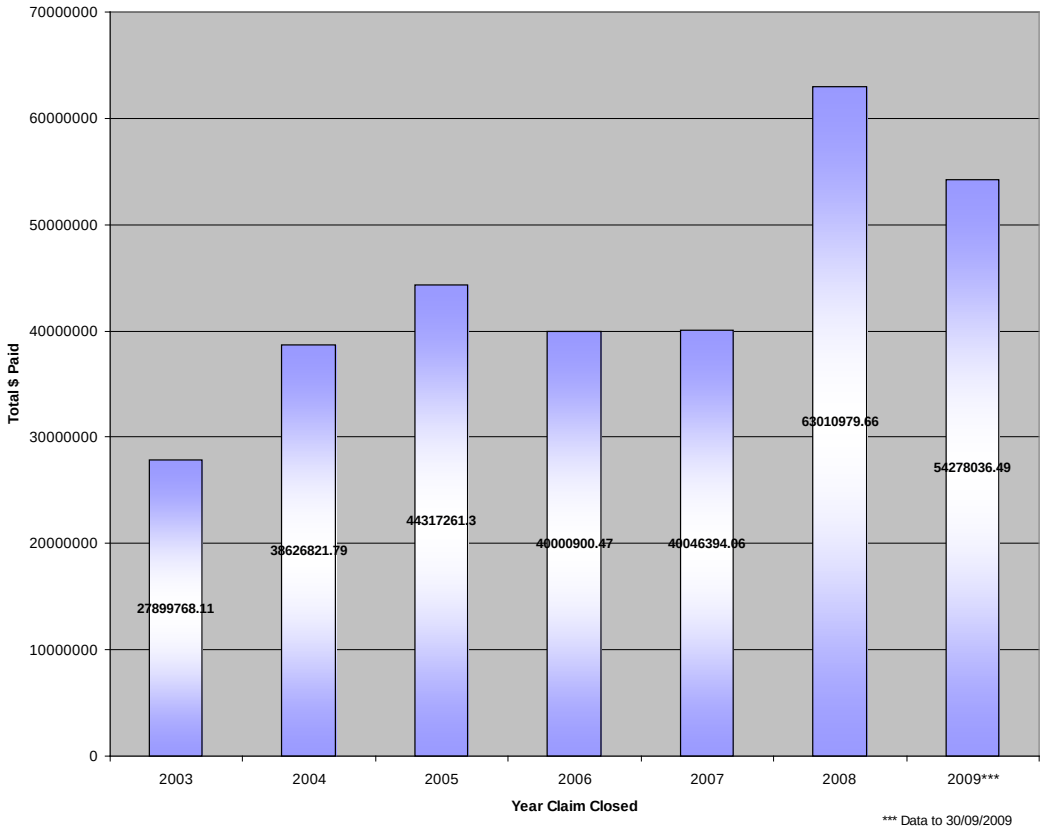
Claims raised per 100,000 public hospital separations



Medical Indemnity Claims Drivers



Gross MI claims paid by calendar year



Underwriting Challenges for State MI insurers

- New and emerging systemic and particular risks are covered automatically, with limited requirements for coverage endorsements and no risk selection capability
- Gross premium pool for the public health sector is technically rated and heavily influenced by claims experience
- Breadth and ease of access to cover can potentially affect assessment of premium adequacy:
  - (i) increased clinical risk exposures only impact premiums once claims experience flows through
  - (ii) medical practitioners are automatically insured, and contact with MI insurer is generally only in the event of a claim
- Vast amount of adverse incident and claims data poses unique challenges to identify and respond to systemic and particular risks within the public health system

Internal and external governance and the captive insurer framework

- Increasingly sophisticated clinical and internal health governance environment demands agility in insurance response:
  - (i) Demarcation between public and private coverage for practitioners
  - (ii) Use of outsourced services (radiology, pathology) by public hospitals
  - (iii) Public patients treated in private facilities
  - (iv) Coverage for peer reviews in public hospitals

- Legislative environmental impacts on State insured liabilities subject to constant change: e.g.: *Coroners Ct 2008* (commenced 1 November 2009):
  - (i) Revised definition of reportable deaths to include deaths not reasonably expected by treating medical officer
  - (ii) Maternal and child deaths must be referred to Consultative Council on Obstetric and Paediatric Mortality and Morbidity
  - (iii) Clarification of obligation on practitioners to report reportable deaths and provide any information requested by Coroner

Public Policy interrelationship with the captive Medical indemnity insurer model

- Imperative to avoid drifting into a “lazy monopoly”:
  - (i) Temptation to rely upon sovereign guarantee
  - (ii) Self sustaining captive model requires vigorous identification of new and emerging potential claims liabilities
  - (iii) “Entity” cover needs innovative relationship management to ameliorate risk of captive being perceived as a funding pool

- Relative simplicity of the captive insurance and claims management model belies the complexity of the structures required to link clinical risk management with insurance service delivery:
  - (i) Identifying escalation points for systemic and particular risks
  - (ii) Using premium allocation models to link entity portfolio performance to premiums for insurable risks

Distinguishing between State captive role and broader public policy imperatives

- State interest is to maintain separation between claims and litigation processes and broader social imperatives
- Captive insurer responses to the management of large and catastrophic claims will potentially expose the State to cost shifting
- For example:

  a) Approximately 600 – 700 infants born with cerebral palsy each year, average incidence in Victoria 1.61 per 1000 births, or 112 infants affected by cerebral palsy

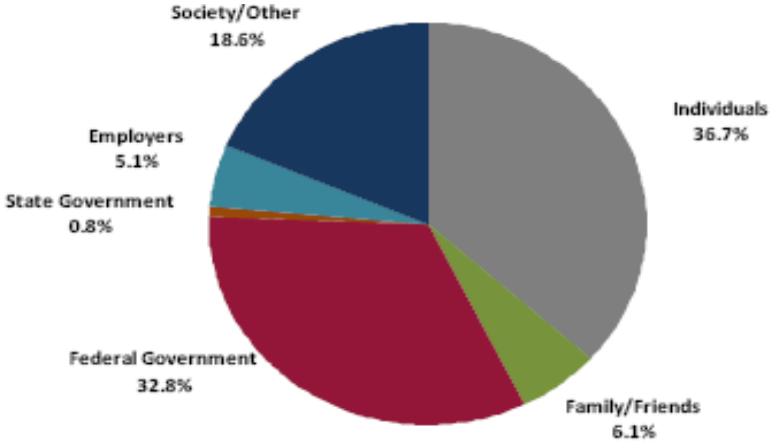
  b) In 2007, the financial cost of cerebral palsy alone was $1.47 billion, or 0.14% of GDP, of which $300 million alone related to gratuitous care indirect and direct health and support service costs

c) Incidence expected to remain stable as population increases

d) Major consequences if science challenges established arguments re causation

Catastrophic claim costs distribution

- Ageing population and increasing number of young people with disabilities will continue to impact upon budgeted per capita disability care funding
- An increase in the proportion of cost borne by the State directly would have incremental effect



- Claimant expectations for adverse clinical outcomes to be offset by compensation payments would heavily impact upon the State, and upon the viability and utility of the captive insurer model