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ABN 61 791 545 059

Level 24, 91 King William Street  
Adelaide South Australia 5000

Telephone 08 8113 5312  
Facsimile 08 8233 5858

Mr Keith Chapman  
Australian Prudential Regulation Authority  
Sent via email to: GIRFPF@apra.gov.au

Dear Mr Chapman

**Re: Refinements to the General Insurance Prudential Framework Discussion Paper**

**Executive summary**

1. The Medical Indemnity Industry Association of Australia (MIIAA) represents over 70 percent of the market for insurers specialising in long tail medical malpractice insurance business.
2. The MIIAA supports the intention underpinning the reforms announced by the Minister for Revenue and Assistant Treasurer on 3 May 2007 which describes amendments to the Insurance Act 1973. That overarching intention is described by the Minister 'to enhance protection for Australian consumers and businesses from unauthorised direct offshore foreign insurers (DOFIs)'.
3. That announcement also states that APRA were to develop a modified prudential framework to complement the changes to the Insurance Act. This submission responds on behalf of the MIIAA to APRA's discussion paper 'Refinements to the General Insurance Prudential Framework' dated 31 July 2007.
4. The MIIAA expresses no opinion on the majority of APRA's discussion paper, but wish to make a submission on one section.
5. We understand that APRA have indicated to one of our members that their intent is that the proposal entitled 'Capital recognition of reinsurance recoverables older than 12 months' on page 13 is intended to apply to both reinsurance recoveries owed in respect of paid claims and estimated reinsurance recoveries in respect of outstanding claims

liabilities. This was subsequently confirmed in APRA's Public Affairs email of 5 September stating 'that reinsurance recoverables in this proposal relate to all liabilities for outstanding claims, including case estimates, IBNR and IBNER claims as well as reinsurance recoverables against payments already made by an insurer'.

6. The MIIAA submits that this section proposes amendments to the prudential framework that are not only inequitable, but will immediately reduce the capital strength of the medical indemnity industry, encourage concentration risk and increase the price of purchasing reinsurance.
7. In our view this section does not 'complement the changes to the Insurance Act' but attempts to introduce a new dimension to regulation that has the potential to isolate the Australian insurance and reinsurance industry from the rest of the world, create a barrier to competition, and disadvantages long tail classes and in particular the medical indemnity industry.
8. The MIIAA does not accept the assertion that 'Reinsurance recoverables from foreign reinsurers not authorised by APRA pose a greater credit risk than APRA authorised reinsurers' nor that 'reinsurance recoverables become less certain as time passes', neither of these assertions are supported by any reasoning in the proposal.
9. The global reinsurance market has always been utilised by Australian insurers, and medical indemnity insurers in particular. Placing reinsurance globally brings with it the advantages of diversity of risk across political and geographic boundaries, access to a large, mature and experienced market, and security based on the strong financial performance of global reinsurers with diversified portfolios. The advantages of continuing to participate in this global market far outweighs any perceived advantages afforded by this proposal to the Australian insurance and reinsurance industry.
10. If this section is implemented it will partially erode the effect of the package of reforms to the medical indemnity industry implemented by the Federal Government between May 2002 and May 2004.
11. The Medical Indemnity Policy Review Panel's report dated 22 February 2007 prepared by Minister Abbott's review panel states at paragraph 106 'The effective provision of medical indemnity coverage is a long-term business. Claims are often made many years after the relevant incident occurred, and the economic and social environment in

which a claim is paid can differ significantly from that which existed when the cover was provided. For this reason it is important that the framework surrounding the industry be as stable as possible to let experience and understanding of the issues develop effectively'.

12. The MIIAA further submit that this proposal, if adopted, is likely to create an uncompetitive market to meet the reinsurance needs of Australia's medical indemnity insurers.
13. **In short, the MIIAA is of no doubt that should the proposed amendments be made, premiums paid by doctors will inevitably rise as a consequence. This will be a direct result of insurers wishing to maintain regulatory capital, and a less efficient reinsurance market.**

## **Background**

14. In the past 5 years the Federal Government have been active in ensuring stability of the medical indemnity industry, and have a particular interest in ensuring affordability of premiums paid by doctors.
15. On 23 October 2002 the Prime Minister announced the Federal Government's package of measures to address rising medical indemnity premiums and ensure a viable and ongoing medical indemnity insurance market. The Prime Minister also announced that the Australian Competition and Consumer Commission (ACCC) would monitor medical indemnity premiums on an annual basis to assess whether they were actuarially and commercially justified. The ACCC have produced four monitoring reports which are a useful reference for tracking the financial health of the medical indemnity industry and the effect on premiums resulting from the package of measures.
16. The first ACCC report was released on 24 February 2004 by The Minister for Revenue and Assistant Treasurer, Senator Helen Coonan. The press release stated 'The Government's medical indemnity reform package developed over the past 18 months targeted claims and reinsurance costs through a range of measures including a High Cost Claims Scheme to meet half of claims costs exceeding \$300,000 and on-going tort law reform'.

17. The fourth ACCC report was released in March 2007 and made the point that 'As with other types of liability insurance, medical indemnity insurance is often referred to as 'long tail' insurance. This means that many years may pass between the period for which cover was provided and the date when claims are finally settled. This contrasts with most claims for damage to motor vehicles or homes, which tend to be made in the year in which cover is provided, with final settlement usually occurring soon after the claim is lodged. Depending on the statute of limitations, which varies between each state and territory, medical indemnity claims can be made years after an incident, even if the medical practitioner is no longer practising medicine. Although tort law reforms have reduced limitation periods, this long-tail characteristic continues to place considerable pressure on providers of such cover to be able to identify the likely cost of future claims and build this into their pricing (premium) structures.' As identified by Senator Coonan, the Federal Government's aim, particularly with the introduction of the High Cost Claims scheme was to reduce reinsurance costs as well as claims costs both of which are key elements in medical indemnity premium pricing.
18. The fourth ACCC report examined the cost components of the five medical defence organisation owned insurers' total premium pools for the four underwriting years between 2003-2004 and 2006-2007. The reinsurance expense proportion of the aggregated premium pool across the industry fell marginally from 17% to 13% whilst over the same time period claims costs rose from 32% to 45%.
19. Aggregated reinsurance expense for underwriting years 1999-2000 to 2005-2006 was examined. The reinsurance expenses increased from \$53m in 1999-2000 to \$60m in 2000-2001 then fell significantly to \$44m in 2002-2003 and remained constant over the following 3 years with reinsurance expenses in 2005-2006 being \$43m.
20. The report commented that the net asset position of all insurers at 30 June 2006 was an improvement on the position observed the previous financial year. This meant that the majority of insurers no longer needed to build capital through premiums in the 2006-2007 underwriting year. This result has been a significant improvement achieved over the transition period granted for medical indemnity insurers to reach APRA threshold capital levels. It is ironic that the changes proposed would take effect at the end of that transitional period and effectively lead to a significant amount of that capital building effort being of reduced effect from an APRA perspective, despite the medical indemnity organisation owned insurers being significantly stronger.

## The Australian Reinsurance Industry

21. To our knowledge there are six reinsurers currently classified as APRA-authorized reinsurers. These are Gen Re, Hannover Re, Munich Re, Scor, Swiss Re and Transatlantic Re. Although most have participated at some stage in programs for Australian medical indemnity insurers, only two are major current participants. This is thought to be due to pricing and indexation issues.
22. Members of MIIAA spend approximately half of their yearly reinsurance premium in the global reinsurance market. In practice the majority is in the London market where a portion is underwritten by Lloyd's syndicates, as well as being rated by at least one of the internationally recognised rating agencies of Standard and Poor's, AM Best, Moody or Fitch. Medical indemnity insurers have invested many years in building relationships with strongly rated overseas reinsurers, and vice versa. However the premium earned by the reinsurers from medical malpractice in Australia may not be sufficiently attractive for an overseas reinsurer to become authorised in Australia or to hold assets in Australia for the prolonged period until settlement, which under the proposal would be necessary if the insurer wished to account for that reinsurance asset.
23. The consequences of this proposal may force medical indemnity insurers to buy their reinsurance from a limited group of reinsurers, the majority of which are not current participants in our members' programs and may not wish to be participants in our members' programs. The alternatives available are to continue with reduced regulatory capital or to seek another form of capital to cover the shortfall in reinsurance capital.
24. The proposal would value recoveries greater than 12 months from a global AA rated reinsurer as worthless, yet the same recovery from an A- rated APRA authorised reinsurer would count as an asset. The MIIAA submit that long term stability of a high credit rating is a better indication of the ability to pay rather than the jurisdiction of the reinsurer's assets. The history of HIH is a good illustration of this point.
25. The Reinsurance Management Strategy (REMS) of each insurer contains commentary about minimum ratings for each reinsurer and the avoidance of concentration risk. Due to the limited number of reinsurers within Australia prepared to reinsure medical indemnity risk, there is a reasonable chance that current levels of concentration risk contained within the REMS of medical indemnity insurers would be breached, if the proposal was adopted.

26. Prudential Practice Guide GPG 245 states that an insurer's regular review of its reinsurance management framework and REMS would typically cover the following issues, amongst others, where relevant:

- 'the selection and credit standing of reinsurance counterparties and their capacity to meet obligations' and;
- 'any concentration of reinsurance programs with reinsurance counterparties which could create large exposures or detract from diversification benefits.'

APRA's proposal will disable insurers from complying with APRA's standards.

27. Implementing the proposal seems likely to render offshore outwards reinsurance and retrocession non-viable for APRA authorised insurers and reinsurers of long-tail business. This requirement would tilt the playing field completely in the locally authorised reinsurer's favour and will have significant implications for capacity and price. Additionally we are aware that at least two of the locally authorised reinsurers utilised by medical indemnity insurers currently retrocede the majority of their exposure in overseas (non-APRA authorised) markets. Reducing the diversity of available sources of reinsurance and retrocession cover for long-tail business in this way is a highly undesirable outcome in our opinion. It would be particularly limiting for the medical indemnity insurers, as even in global reinsurance markets it is difficult to attract sufficient participants with appropriately priced premiums to comply with an insurer's REMS in terms of concentration risk and security.

28. The proposal also has not addressed the lengths to which other Prudential Standards have affected reinsurance, for example, the reinsurance documentation requirements under GPS 110. These requirements reduce the risk of non recovery together with the requirement to write-off recoveries for arrangements which are not fully documented after June 2009. Another example are the requirements of the Approved Actuary under GPS 310 to consider the recoverability of reinsurance recoveries as part of the Insurance Liability Valuation.

### **Practical issues and clarification**

29. It was unclear from the discussion paper whether APRA's proposal entitled 'Capital recognition of reinsurance recoverables older than 12 months' on page 13 is intended to apply only to reinsurance recoveries owed but unpaid for more than 12 months in

respect of paid claims or to both reinsurance recoveries owed in respect of paid claims and estimated reinsurance recoveries in respect of outstanding claims liabilities, but APRA have now indicated the latter interpretation is its intent.

30. We understand that APRA intends this restriction to apply to reinsurance recoveries outstanding more than 12 months after the date of occurrence of the claim (whether reported or not). A practical question of how to define when estimated outstanding reinsurance recoveries have been outstanding for more than 12 months needs to be addressed. Actuaries typically allow for some estimated reinsurance recoveries in respect of IBNR/IBNER claims, as well as in respect of known outstanding claims. Thus determining when each component of the total estimate of reinsurance recoveries in respect of total outstanding claims provisions at a point in time had been identified for 12 months would be extremely (if not impossibly) complex.
31. The discussion paper does not consider the treatment of this proposal in respect of current reinsurance arrangements and current outstanding claims liabilities. Immediate application of the proposal from July 2008 would result in a dramatic impact on capital and all medical indemnity insurers' net asset to MCR ratios would fall.
32. Neither does the discussion paper address whether valid rights of set-off would be properly recognised under APRA's requirements. If APRA's intention is that no reinsurance recoveries on liabilities that have been outstanding for more than 12 months from overseas reinsurers be recognised as an asset, then clarification is required on how to deal with future related insurer liabilities (for example adjustment reinsurance premiums) payable to these reinsurers which would normally be set-off in the accounts.
33. All of the uncertainties identified in paragraphs 29 to 32 inclusive make it impossible for an accurate assessment of the precise impact of the proposed changes to be made by individual insurers.

### **Timing Issues**

34. Medical indemnity reinsurance programs require a long lead time in order to develop reinsurance strategies, foster reinsurer relationships and ultimately place the reinsurance program. We therefore ask that APRA provide clarity with respect to the reinsurers not authorised by APRA as soon as possible, and that should APRA decide

to implement changes, a minimum of 12 months lead time is given before any transitional arrangements are to take effect.

### **Apparent rationale behind proposal**

35. The rationale behind the proposal that there be increased investment risk charges applicable to foreign reinsurers is the dismissal of the appeal made by the Australian liquidators of HIH for transfer of assets from England to Australia. APRA's view seems to be that there is a risk that reinsurance recoverables due from a foreign reinsurer may not ultimately be available for distribution in Australia in the event of liquidation. APRA have then proposed that 12 months after booking of the reinsurance asset the risk is even greater and that insurers should assume that no recovery will be available.
36. This conclusion is flawed in our opinion. The application to transfer assets from England to Australia was by the Australian liquidator wishing to transfer funds between related companies, both in liquidation, for the purposes of distribution to Australian creditors. The application was not made as an Australian reinsurance creditor of HIH(UK). It is notable that the liquidation of HIH in Australia has been the only liquidation of a reinsurer to have had a major impact on the medical indemnity insurers in Australia. Although there is a preference under Australian legislation for insurance creditors, limited funds have as yet been made available for distribution and in most cases any potential recoveries have been fully provisioned by the medical indemnity insurers. In most circumstances the insurer and the reinsurer will neither be related, nor in liquidation at the same time. If the Australian insurer is in liquidation then the liquidator remains entitled to the benefit of the reinsurance contract and no foreign insolvency issues appear to arise. If a foreign reinsurer is in liquidation, an Australian insurer would merely prove their claim in that liquidation. The decision does not appear to suggest otherwise. In our view this case does not create or highlight risks commensurate with the controls proposed by APRA.
37. The nature of APRA's proposal appears to suggest a reinsurer in an overseas jurisdiction could liquidate without any prior downgrading of ratings and subsequent provisioning being made by the Australian reinsured. This is highly unlikely. Secondly it suggests that as a result of the UK Court of Appeal judgment that no funds would be made available to foreign creditors. As stated we think this interpretation would not be reality.

38. APRA's principle that the 'prudential framework should recognise the greater credit risk of reinsurance recoverables due from foreign reinsurers' does not take into account the recognition of solvency of reinsurers by local prudential regulators and by international rating agencies which are well resourced to monitor continuing credit ratings of reinsurers.

### **Reinsurance - a global industry**

39. APRA's proposal would effectively make placing Australian long-tail reinsurance business into the international market generally unviable. The impact on the medical indemnity industry both in their capital position as reported to APRA, and their ability to achieve diversified, balanced, fully subscribed reinsurance programs at a reasonable premium would be negatively affected.
40. There is a direct conflict of approach between provisioning of reinsurance assets under the International Financial Reporting Standards (where there must be a valid reason such as downgrade or liquidation in order to provision) and APRA's proposed regulatory reporting requirements.
41. Most medical indemnity insurers have taken advantage of the existence of the High Cost Claims Scheme by effectively reducing their excess of loss reinsurance programs placed into the global reinsurance market. However, if the High Cost Claims scheme were to be abolished the reinsurance capacity, even utilising the global markets, would be stretched. The best possible price is heavily reliant on global market, competition and capacity.

### **Government policy**

42. The Federal Government has been clearly concerned about the long term stability of the medical indemnity industry and recognises their own contribution to the improvements in the financial status of most of the medical indemnity insurers. The true value of the Government reforms is undeveloped at this point in time.
43. It is worth quoting directly from the report of the Medical Indemnity Policy Review Panel dated 22 February 2007 which states:

- 'The HCCS has been implemented and is operating as intended. It has reduced the net cost of claims to insurers and boosted solvency, making it easier for insurers to meet APRA's prudential requirements. It has also significantly reduced insurers' liabilities and created a framework in which the amount and level of reinsurance required by providers may be reduced.'
- 'It is intended that the government will continue to review, in close consultation with the medical profession and insurers, the need for direct financial support and large claims arrangements as State/Territory law reforms and the other elements of the medical indemnity package impact on the availability and cost of medical indemnity insurance. The need for this measure will also be affected by stabilisation within global reinsurance markets.'
- 'However, the medical indemnity package is in its relative infancy and the gains that have been made so far still need to be secured. The Panel cautions against complacency and firmly believes that the package of measures must be safeguarded. If the pillars of the package remain in place and reforms are not wound back in the foreseeable future, the Panel is optimistic about the longer-term viability of the industry and the security it affords doctors and the wider Australian community.'

## **Conclusion**

44. In recent years APRA has made significant changes that positively impact on reinsurance risk, for example, the Reinsurance Management Strategy, reinsurance documentation requirements and the role of the approved actuary in considering reinsurance recoverability. Combining all these elements together with the higher proposed risk charges are in our opinion sufficient without the additional measure of writing off totally reinsurance recoveries outstanding more than 12 months from reinsurers not authorised by APRA.
45. MIIAA is opposed to the proposal to eliminate capital recognition of reinsurance recoveries older than 12 months from foreign reinsurers as:
  - Medical malpractice reinsurance is not available from a sufficiently diverse range of authorised reinsurers in Australia.

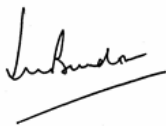
- The Australian market is unlikely to be sufficiently large or profitable to attract reinsurers prepared to retain funds in Australia for the time required to settle long tail claims.
- If retrospective the proposal will have an instantaneous effect on reducing the APRA-reported solvency of medical indemnity insurers, notionally equivalent to the majority of overseas reinsurers on a particular insurer's program being immediately and simultaneously liquidated with no assets available for distribution. This would create a large artificial difference between a greatly reduced solvency reported to APRA, and the largely unaffected IFRS accounts which provide a realistic assessment of an insurer's financial position.
- Higher premiums for doctors will be inevitable and will undermine the effect of existing government schemes and reform.

46. The lack of clarity in the discussion paper over the detail of the proposal, particularly how the 'outstanding for 12 months' will be measured suggests to us that greater consultation needs to be conducted for both insurers and APRA to understand where the real risks of offshore reinsurance lie and to address those risks, rather than to take a blanket approach which is highly detrimental to long tail insurers, especially those who specialise in this sector.

47. We will willingly work with APRA to find solutions which address risk without damaging the Federal Government's and the medical indemnity industry's significant effort in bringing stability to Australia's health system.

If you have any questions regarding this submission, please contact Ellen Edmonds-Wilson, MIAA CEO on 08 8113 5312 or [ellen@miaa.com.au](mailto:ellen@miaa.com.au).

Yours sincerely



Dr Jonathan Burdon  
Chairman