Australian Government
Australian Accounting Standards Board

AASB Transition Resource Group for AASB 17 *Insurance Contracts*

Medical Indemnity Insurance (MII) forum discussions on Medical Indemnity Government Schemes

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Potential implementation question

The Australian Government provides support for the Medical Indemnity Insurers (MII) and Medical Defence Organisations (MDO) through various government schemes. This paper analyses the AASB 17 treatment of the cash flows arising from the following government funded schemes:
- High Claims Cost Scheme (HCCS);
- Exceptional Claims Scheme (ECS); and
- Run Off Cover Scheme (ROCS).

Paragraph of IFRS 17 *Insurance Contracts*

Relevant sections of AASB 17 Paragraphs 2, 34, B65(k) and Appendix A – refer Appendix B of this paper for extracts.

Analysis of the question

Please refer to Appendix A.

Is the question pervasive?

The government funded schemes are applicable to all medical indemnity insurers and therefore the treatment discussed in the paper will impact all medical indemnity insurers in the market. This paper was discussed at the MII focus group of the AASB TRG on 21 October 2021, where it was agreed the paper should be tabled at the AASB TRG for discussion due to the existence of similar schemes and the desire for consistency of application of AASB 17 to these schemes where relevant.

Appendix A: Treatment of Medical Indemnity Government Schemes under IFRS 17

Background

Introduction

The Australian Government provides support for the Medical indemnity insurers (MII) and Medical Defence Organisations (MDO) through various Government Schemes, in order to ensure medical indemnity insurance remains available and affordable for medical practitioners. These schemes are fully funded by the Government and MII's and MDO's do not need to make a contribution to access these Schemes.

These schemes are legislated in the Medical Indemnity Act 2002.

1. High Claims Cost Scheme (HCCS)

The HCCS is a Government Scheme that subsidises 50% of any high value medical indemnity claims, in order to assist with reducing the medical practitioner's premiums charged by the MII, particularly for high-risk specialties. This is achieved by lowering the MII's total claims payments and reducing the amount of third party reinsurance required by MMI's to fund large claims.

Under the HCCS, the Government Scheme will reimburse the MII with 50% of the claims amount over a certain threshold (e.g. in excess of $500,000), but up to the limit of the practitioner's cover (i.e. the scheme does not cover claims for any amounts due over that limit).

In order for claim payments to be recovered under the HCCS, they must:

- be against a medical practitioner who is indemnified under a medical indemnity insurance contract with the MII;
- relate to an incident (or series of incidents) in connection with the practice by the practitioner of a medical profession; and
- exceed the relevant HCCS threshold.

The MII applies for payment under the HCCS using an online platform (i.e. the Medical Indemnity Online Claims service). There is generally a minor settlement lag between the payment of the total claim to the practitioner by the MII and the reimbursement by HCCS to the MII.

Given that the HCCS is fully funded by the Government, there is no premium charged by the Scheme (i.e. neither the MMI or the medical practitioner makes a contribution to the scheme to fund claims). The HCCS threshold is determined by the date the MII was first notified of an incident or claim. In addition, the HCCS recovery attaches to the year the claim is notified.

Under the existing insurance accounting standard (*AASB 1023: General Insurance Contracts ('AASB 1023")*) the HCCS is accounted for as non-reinsurance recoveries.

2. Exceptional Claims Scheme (ECS)

The ECS is a Government Scheme that funds 100% of claims made against a medical professional which exceed the limit of the medical practitioner's indemnity insurance contract provided by the MII (e.g. 100% of claims that are above the current $20 million limit).
The medical practitioner's claims may exceed the annual limit of their medical indemnity cover in either one large claim, or an aggregate of many claims.

In order to receive payment under the ECS, the claim event (or incident) must be notified under the medical indemnity insurance contract provided by the MII and be within the scope of the medical indemnity contract, with a contract limit to at least the level of the threshold (i.e. the medical indemnity insurance contract provided by the MII would have covered the claim if not for the cover limit).

The ECS is fully funded by the Government and therefore the medical practitioner is not required to make a contribution. The ECS benefits the medical practitioner only and payments are made directly to the claimant on behalf of the insured.

It appears that no claim has currently been made on the ECS.

Under *AASB 1023*, the ECS is currently not accounted for by the insurer.

3. Run-off Cover Scheme (ROCS)

ROCS is a Government Scheme that provides free run-off insurance cover to eligible medical practitioners who leave the private medical workforce (for example permanent retirement from the medical workforce or doctors on maternity leave). The ROCS covers eligible medical practitioners for claim events (or incidents) that occurred whilst they were practicing, but are only known subsequently and reported after they have ceased practice (i.e. the incident occurred before ceasing practice but had not yet been notified to the MII).

The MII's grant indemnity to eligible medical practitioners who are eligible for the ROCS based on their last medical indemnity insurance contract (i.e. the medical practitioner's last MII issues a ROCS insurance policy, which is provided on the same terms and conditions, and for the same range of incidents, as the last cover that the eligible medical practitioners had, prior to becoming eligible for ROCS).

The MII manages the claims that emerge under the ROCS. The Government Scheme will pay both the costs of claims and the costs of managing the claims (e.g. a 5% ROCS levy income).

Under the *AASB 1023*, the ROCS is currently accounted for as non-reinsurance recoveries.

Questions and views
Question 1:

Should the HCCS be treated as a separate reinsurance contract held under IFRS 17 or be included in the fulfilment cash flows of the medical indemnity insurance contract?

View 1 – A separate reinsurance contract held

IFRS 17 Appendix A defines a reinsurance contract as:

> "*An insurance contract issued by one entity (the reinsurer) to compensate another entity for claims arising from one or more insurance contracts issued by that other entity (underlying contracts).*"

Proponents of this view argue that the approval of the application for payment (via the Medical Indemnity Online Claims service) is seen a contract under IFRS 17 paragraph 2, being "an agreement between two or more parties that creates enforceable rights and obligations" and that "contracts can be written, oral or implied by an entity's customary business practices".

Under the HCCS, the Government Scheme compensates the MII for a percentage of the claims amount exceeding a threshold and as such, the insurance risk transfers from the MII to the Scheme. The insurance risk transferred would be deemed significant, due to the quantum of the claims amount (i.e. being higher than $500,000) and percentage reimbursed by the Government Scheme (i.e. 50%).

The fact that there is zero premium (i.e. there is no right to receive premium) does not negate the fact the HCCS has an obligation to reimburse claims.

Given the use of the words "to compensate another entity for claims arising from one or more insurance contracts" in the IFRS 17 definition of a reinsurance contract, the HCCS meets the definition of a reinsurance contract as the Scheme is compensating the MII for claims arising from the medical indemnity insurance contract issued by the MII (i.e. the underlying contract).

In addition, proponents of this view argue that the arrangement reflects a reinsurance contract due to the fact that where there are changes in the claims amount that reduces the amount recovered under the HCCS, the Government would expect a refund for those recovered amounts.

Therefore, the MII will treat the HCCS as a reinsurance contract held under IFRS 17. The MII would then identify the cash flows arising from substantive rights and obligations of the HCCS in order to determine the cash flows within the reinsurance contract held boundary.

View 2 – Included in the fulfilment cash flows of medical indemnity insurance contract

Proponents of this view argue that the cash flows arising from the HCCS (i.e. the reimbursement of the claim amount) arise from rights and obligations created by the medical indemnity insurance contract issued by the MII. They argue that the online application for payment under the HCCS is not an insurance contract issued by the Government Scheme.
They believe that the MII retains the full insurance risk transferred from the policyholder and does not transfer the insurance risk to the Government Scheme. Therefore, the right to recover amounts from the HCCS gives rise to potential cash inflows similar to subrogation as mentioned in IFRS 17.B65(k), or a guarantor's right to recover from a debtor. There is also the factor that the HCCS recoveries are based on claims at a practitioner level and claims can, and often do, have more than one practitioner. On claims with more than one practitioner, the expense of the claim is first allocated by the degree of liability per practitioner, then the HCCS recovery is calculated by eligible medical practitioners. The threshold is by practitioner.

In addition, the MII are pricing the medical indemnity insurance contract as if it is a subrogated risk, given that the Government Scheme is taking on the risk (i.e. the HCCS enables the MII to provide affordable indemnity cover for practitioners).

MII Forum views
The general consensus of preparers at the forum (5 members) was in favour of view 2 based on the facts set out above.

It was noted that the proposed treatment outlined in view 2 aligns with the existing accounting treatment.

Question 2

Is the MII required to estimate the future cash flows under the ECS (i.e. include claims covered by the ECS in the IFRS 17 fulfilment cash flows) or not, due to the fact that the risk is always borne by the Government Scheme?

View 1 – The MII is required to estimate the future cash flows of the ECS

Proponents of this view argue that the claim payments to the policyholder are included in the fulfilment cash flows under B65(b) as the cash flows are "future claims for which the entity has a substantive obligation".
IFRS 17.34 states:
"Cash flows are within the boundary of an insurance contract if they arise from substantive rights and obligations that exist during the reporting period in which the entity can compel the policyholder to pay the premiums or in which the entity has a substantive obligation to provide the policyholder with insurance contract services".

The medical indemnity contract issued by the MII provides coverage for the insured event (i.e. provides insurance coverage), irrespective of the fact that the government funds 100% of the claims once the claims exceed the limit of the medical practitioner's indemnity insurance contract. Under the ECS the claim event must be notified under the medical indemnity insurance contract provided by the MII and be

within the scope of the medical indemnity contract. Therefore, the cash flows of the ECS still arise from the rights and obligations of the medical indemnity insurance contract issued by the MII.

View 2 – The ECS is not a risk undertaken by the MII and is not included in the estimate of future cash flows nor recognised an insurance contract liability under IFRS 17

Proponents of this view argue that the medical indemnity insurance policy issued by MII provided the medical practitioner with cover up to $20 million limit. In the event the medical practitioner has one or more claims that exceed the annual limit of $20 million, the Government Scheme will contribute the amount above the insurance policy limit. As a result, the insurance risk above the $20 million limit was never actually transferred to the insurer and therefore the cash flows above the limit are not within the boundary of the medical indemnity insurance contract.

In addition, the application and payment processes directly affect the practitioners and therefore the MII is not directly involved in the claims process, supporting the fact that the MII does not have additional substantive obligations for claim processing/payment above the limit.

MII Forum views
The general consensus of preparers at the forum (5 members) was in favour of view 2.

Participants in view 2 believe that the medical indemnity policies issued by the insurer have a clear limit of cover and therefore no risk is accepted beyond the limit.

Question 3A

Should the ROCS be treated as a separate reinsurance contract held under IFRS 17, or be included in the fulfilment cash flows of the medical indemnity insurance contract?

View 1 – A separate reinsurance contract held

Under the ROCS, when the medical practitioners have ceased private medical practice and satisfy specified eligibility criteria, the MII issues a ROCS insurance policy (based on the last contract of insurance). Proponents of this view believe the substance of this arrangement reflects the recognition of a new ROCS insurance contract issued by the MII.

In addition, proponents of this view argue that the approval of the application for payment (via the Medical Indemnity Online Claims service) is seen a contract with the Government under IFRS 17 paragraph 2, being “an agreement between two or more parties that creates enforceable rights and obligations” and that “contracts can be written, oral or implied by an entity’s customary business practices”.

Proponents of this view argue that under this arrangement, the MII’s right of recovery from the Government Scheme compensates the MII for claims incurred under the medical indemnity insurance contract, the right of recovery would meet the definition of a reinsurance contract. Appendix A of IFRS 17 defines a reinsurance contract as:

“An insurance contract issued by one entity (the reinsurer) to compensate another entity for claims arising from one or more insurance contracts issued by that other entity (underlying contracts)”.

Therefore, the MII will treat the ROCS as a reinsurance contract held under IFRS 17. The MII would then identify the cash flows arising from substantive rights and obligations of the ROCS in order to determine the cash flows within the reinsurance contract boundary.

View 2 – Included in the fulfilment cash flows of the run-off cover insurance policy

Proponents of this view argue that under the ROCS, the MII's are required to grant indemnity to eligible medical practitioners who are eligible for the ROCS (i.e. the medical practitioner's last MII issues a ROCS insurance policy based on their last contract of insurance). Therefore, any costs of valid claims (including the costs of managing claims) made against the medical practitioner arises from rights and obligations created by the ROCS insurance contract issued by the MII.

Although the MII does not charge a premium to the medical practitioner for the ROCS insurance policy and the MII has a right to recover claim costs from the Government Scheme, the MII retains the full insurance risk transferred from the policyholder and does not transfer the insurance risk to the Government Scheme. Therefore, the right to recover amounts from the ROCS gives rise to potential cash inflows similar to subrogation as mentioned in IFRS 17.B65(k) or a guarantor's right to recover from a debtor.

View 3 – Acting as claims settlement agent

Proponents of this view argue that the MII is purely acting as a claims settlement agent of the Government to manage the ROCS claims on their behalf. They believe that this basis reflects the economic substance of the set or series of insurance contracts.

The ROCS cover is per the last cover provided by the MII (future contract wording changes do not apply) and that MII is responsible for the management. The MII pays the claim and gets a dollar for dollar reimbursement (plus a fee).

The MII only has control over the administration of the claim but not have control over the amounts paid for claims nor who is eligible for claims. The MII is performing a particular service on behalf of the government, rather than acting in a fiduciary capacity.

Therefore, the accounting for the ROCS contract is outside of the scope of IFRS 17.

MII Forum views
The general consensus of preparers at the forum (5 members) was in favour of view 2 based on the facts set out above.

During the discussion, participants in favour of view 2 noted that the insurer is paying the cash flows and receiving a reimbursement from the Government. However, the insurance risk has not transferred to the Government. Where the insurer does not receive the claims recovery from the Government, the insurer is still liable under the indemnity cover. As such, the ROCS reimbursement is considered part of the fulfilment cash flows.

In addition, participants noted this treatment is appropriately aligned with the risk equalisation treatment in the PHI.

Question 3B

Should the ROCS levy income be treated as part of the fulfilment cash shows under IFRS 17 or be treated as a non-insurance service requiring unbundling and be accounted for under IFRS 15?

View 1 – Included in the IFRS 17 fulfilment cash shows

Proponents of this view argue that the ROCS levy income charged by the MII to the ROCS represents a payment for managing the claims incurred under the free run-off cover and is therefore an integral part of the insurance activities.

The ROCS levy will be treated as part of the fulfilment cash flows under IFRS 17.

View 2 – A non-insurance service accounted for under AASB 15 as other income

Proponents of this view argue that the ROCS levy income received from the Government Scheme is a "fee for service" and represents a "promise to transfer to the policyholder distinct services other than insurance contract services".

Applying paragraph B35 of IFRS 17:

"A non-insurance service that is promised to the policyholder is not distinct if the cash flows and risks associated with the service are highly interrelated with the cash flows and risks associated with the insurance components in the contract and the entity provides a significant service in integrating the non-insurance service with the insurance components".

Proponents of this view argue that the ROCS levy charged by the MII is a distinct non-insurance service, where the MII is performing the management of claims as a service on behalf of the Government Scheme and is therefore not an integral part of the insurance activities.
The MII would therefore apply IFRS 15 and account for the fee for service as other income in the P&L.

View 3

If in View 3 of question 3A, where the MII is acting as a claims settlement agent of the Government, proponents of this view argue that the ROCS levy income represents revenue accounted for under IFRS 15 for performing claims management services on behalf of the Government.

Therefore, the ROCS levy income will be accounted for applying IFRS 15.

MII Forum views
The general consensus of preparers at the forum (5 members) was in favour of view 1 based on the facts set out above.

During the discussion, it was noted that the insurer receives the 5% ROCS levy at the same time that the insurer receives the ROCS claims recovery from the Government.

Question 4

Are there any other similar Schemes arising in the Australian market similar in nature to those discussed, which need to be considered under IFRS 17?

During the discussion, it was noted there is an Allied Health High Cost Claims Scheme (AHHCCS), and it was expected that the discussion held on the HCCS could be referenced to this scheme.

One participant mentioned that the "No fault COVID19 medical indemnity scheme" could be raised.

One participant mentioned the Australian Reinsurance Pool Corporation (ARPC), the terrorism pool, as another industry scheme. However, it was noted that this is not relevant to the medical indemnity industry.

Appendix B: Technical references

AASB 17: Appendix A
Insurance contract - A contract under which one party (the issuer) accepts significant insurance risk from another party (the policyholder) by agreeing to compensate the policyholder if a specified uncertain future event (the insured event) adversely affects the policyholder.
Reinsurance contract -An insurance contract issued by one entity (the reinsurer) to compensate another entity for claims arising from one or more insurance contracts issued by that other entity (underlying contracts)

AASB 17: 2
An entity shall consider its substantive rights and obligations, whether they arise from a contract, law or regulation, when applying IFRS 17. A contract is an agreement between two or more parties that creates enforceable rights and obligations. Enforceability of the rights and obligations in a contract is a matter of law. Contracts can be written, oral or implied by an entity's customary business practices. Contractual terms include all terms in a contract, explicit or implied, but an entity shall disregard terms that have no commercial substance (ie no discernible effect on the economics of the contract). Implied terms in a contract include those imposed by law or regulation. The practices and processes for establishing contracts with customers vary across legal jurisdictions, industries and entities. In addition, they may vary within an entity (for example, they may depend on the class of customer or the nature of the promised goods or services).

AASB 17: 34
Cash flows are within the boundary of an insurance contract if they arise from substantive rights and obligations that exist during the reporting period in which the entity can compel the policyholder to pay the premiums or in which the entity has a substantive obligation to provide the policyholder with insurance contract services (see paragraphs B61–B71). A substantive obligation to provide insurance contract services ends when:

(a) the entity has the practical ability to reassess the risks of the particular policyholder and, as a result, can set a price or level of benefits that fully reflects those risks; or
(b) both of the following criteria are satisfied:
    (i) the entity has the practical ability to reassess the risks of the portfolio of insurance contracts that contains the contract and, as a result, can set a price or level of benefits that fully reflects the risk of that portfolio; and
    (ii) the pricing of the premiums up to the date when the risks are reassessed does not take into account the risks that relate to periods after the reassessment date.

AASB 17: B65(k)
Potential cash inflows from recoveries (such as salvage and subrogation) on future claims covered by existing insurance contracts and, to the extent that they do not qualify for recognition as separate assets, potential cash inflows from recoveries on past claims.

Medical indemnity Act 2002

Division 2—High cost claim indemnity scheme

Subdivision A—Introduction

28 Guide to the high cost claim indemnity provisions

(1) This Division provides that a high cost claim indemnity may be paid to an MDO or insurer that pays, or is liable to pay, more than a particular amount (referred to as the ***high cost claim threshold***) in relation to a claim against a person in relation to an incident that occurs in the course of, or in connection with, the practice by the person of a medical profession, other than practice as an eligible midwife.

Division 2A—Exceptional claims indemnity scheme

Subdivision A—Introduction

34A Guide to the exceptional claims indemnity provisions

(1) This Division provides that an exceptional claims indemnity may be paid in relation to a liability of a person if:

(a) the liability relates to a claim against the person in relation to an incident that occurs in the course of, or in connection with, the practice by the person of a medical profession (other than practice as an eligible midwife), being a claim that has been certified as a qualifying claim; and

(b) the liability exceeds the amount payable under an insurance contract that has a contract limit satisfying the relevant threshold.

Division 2B—Run-off cover indemnity scheme

Subdivision A—Introduction

34ZA Guide to the run-off cover indemnity provisions

(1) This Division provides that a run-off cover indemnity may be paid in relation to a liability of a medical practitioner if the liability relates to an eligible run-off claim.

(2) This Division also provides for the determination of a Run-off Cover Claims and Administration Protocol that can deal with other matters relating to eligible run-off claims.

Subdivision B—Run-off cover indemnities

34ZC Circumstances in which run-off cover indemnities are payable

(1) A run-off cover indemnity is payable to an MDO or a medical indemnity insurer under this section if:

(a) an eligible run-off claim is made that relates to an incident, or a series of related incidents, that occurred in the course of, or in connection with, a person's practice as a medical practitioner; and

(ab) at the time the claim is first notified to the MDO or medical indemnity insurer, the person is a person to whom subsection 34ZB(2) applies; and

(b) in the case of an MDO—the MDO makes, or is able to make, a payment in relation to the claim:

(i) under an arrangement, with the MDO or someone else, under which the MDO is able to indemnify the person in relation to claims made by or against the person while he or she is a person to whom subsection 34ZB(2) applies; and

(ii) in the ordinary course of the MDO's business; and

(c) in the case of a medical indemnity insurer—the insurer makes, or is liable to make, a payment in relation to the claim under a contract of insurance under which the insurer is liable to indemnify the person in relation to claims made by or against the person while he or she is a person to whom subsection 34ZB(2) applies; and

(d) the MDO or medical indemnity insurer was first notified of the claim, or of facts that might give rise to the claim on or after 1 July 2004; and

(e) the MDO or medical indemnity insurer applies to the Chief Executive Medicare for the run-off cover indemnity in accordance with section 36.

Australian Government Department of Health Website

How will the HCCS reduce practitioners' premiums?

This scheme helps to produce downward pressure on premiums, particularly for practitioners in high-risk specialties by:

- lowering the amount medical indemnity insurers have to pay out; and
- reducing the amount of reinsurance medical indemnity insurers need to buy to fund large claims.

Why is there only a 50% payment for the excess of high cost claims?

The subsidy has been restricted to 50% (of the insured amount) to ensure that medical indemnity insurers bear some of the risk of high payouts for medical negligence.

How is the ECS different from the High Costs Claims Scheme?

The ECS covers claims above the insurance contract limit andallows for payments directly to practitioners, whereas the HCCS assists medical indemnity insurers with the cost of claims they manage. These differences are reflected in:

- the ECS application and payment processes directly affect practitioners; and
- that there are requirements for defence of the claim to be conducted prudently and for a legal practitioner to assess the reasonableness of a settlement amount.