

**THE STATUS OF THE PRIMARY AND EXCESS MEDICAL MALPRACTICE
MARKET AND THE FUTURE NEED FOR THE
MEDICAL MALPRACTICE INSURANCE ASSOCIATION**

A Report to the Governor and the Legislature
by the
Superintendent of Insurance



Neil D. Levin
Superintendent of Insurance

December 1, 1997



State of New York

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To the Governor and the Legislature:

Pursuant to the directive contained in Chapter 161 of the Laws of 1997, I am pleased to present this report, The Status of the Primary and Excess Medical Malpractice Market and the Future Need for the Medical Malpractice Insurance Association.

Respectfully submitted,

Neil D. Levin
Superintendent of Insurance

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Executive Summary

Status of Primary Medical Malpractice Insurance Market

- Primary coverage (typically \$1 million per occurrence/\$3 million per year) is readily available in New York State for physicians and surgeons.
- New York's primary medical malpractice market is more competitive now than at any time over the past two decades.
- Primary medical malpractice loss experience has improved considerably since the late 1980's, particularly after a series of statutory changes.
- Primary medical malpractice rates have remained stable throughout the 1990's, rising by only 6% from 1990 to 1997. Since 1995, however, rates have declined by 6.2%.
- Due to the presence of the MMIA and applicable declination requirements, surplus lines companies are not permitted in New York's physicians and surgeons medical malpractice market.
- Risk retention groups write some medical malpractice policies; however, their impact on the New York marketplace remains minimal.

Status of Excess Medical Malpractice Insurance Market

- Due to a unique statutory mechanism, first layer excess (\$1 million above primary cover of \$1 million per occurrence) medical malpractice coverage has been readily available for New York physicians and surgeons since 1985.
- Since 1985, hospital-affiliated physicians have been able to obtain "free" first layer excess coverage through the New York State Hospital Excess Liability Pool (the Pool). Premiums for such policies have been paid by a shifting amalgam of hospitals, health insurers and other entities.
- Excess medical malpractice premium rates have declined precipitously in the 1990's for physicians and surgeons. (First layer rates for most specialties are currently below those that were in effect in 1985.)
- Only the MMIA and HANYS Insurance Company were permitted to write the excess coverage for the Pool until 1993, at which time other insurers were permitted to write it, subject to limitations.

Assessing the Medical Malpractice Insurance Association

- For over 20 years, MMIA has filled a niche in the medical malpractice marketplace as New York's "insurer of last resort."
- After years of financial instability in the late 1980's, MMIA's surplus has grown considerably in the 1990's.
- MMIA, like the JUA's currently operating in nine other states, has seen its market share dwindle in the 1990's as the marketplace became more competitive and the experience of the voluntary market improved.
- Approximately 600 (2%) of New York State's 30,000 insured physicians currently purchase primary coverage through MMIA; only an estimated 100 to 200 would encounter difficulties securing such coverage in the voluntary market.
- Other medical malpractice carriers would be willing to write the primary layer for high-risk physicians currently insured through MMIA, provided they received the requisite underwriting and pricing flexibility.
- Although MMIA insures over 2,700 physicians for first layer excess coverage, most would be able to obtain such coverage through other carriers if necessary.

Recommendations

- MMIA should be dissolved: both its underwriting and claims authority should be allowed to expire at the end of the statutory period. However, its authority as a stand-by mechanism should be maintained in case the medical malpractice market should again suffer availability or affordability problems.
- The liabilities arising from the primary and excess policies written heretofore should be assumed by one or more qualified New York State insurers in a loss portfolio transfer arrangement or similar loss transfer mechanism.
- A mechanism should be established to provide primary medical malpractice policies to physicians and surgeons who are unable to obtain coverage. No such mechanism need be made available to other health care providers, such as dentists or podiatrists. Moreover, no such mechanism need be made available for excess coverage.
- In considering the question of whether to renew the excess medical malpractice program of the N.Y. State Hospital Excess Liability Pool, the Legislature should recognize the likelihood that, if freed from regulatory controls, a voluntary excess market could improve and develop

to the extent to which the voluntary primary market has improved and developed and, furthermore, that there is no longer a funding stream available for the Pool.

- Although MMIA's financial condition has improved considerably during the 1990's, its asset base remains in a state of flux due to several appropriations by New York State and lawsuits filed by "the Blues" to recover allegedly excessive premiums. In addition, a number of other interested parties are likely to lay claim to MMIA's Stabilization Reserve Fund and to any other remaining MMIA assets. The Department recommends that a valuation be made of the remaining assets of the MMIA before deciding to whom such assets are payable.

THE STATUS OF THE PRIMARY AND EXCESS MEDICAL MALPRACTICE MARKET AND THE FUTURE NEED FOR THE MEDICAL MALPRACTICE INSURANCE ASSOCIATION

I. Introduction and Methodology for Preparation of this Report

This Report responds to the directive contained in Chapter 161 of the Laws of 1997 that the Superintendent of Insurance submit a report to the Governor and Legislature no later than December 1, 1997 concerning primary and excess medical malpractice insurance. The text of the applicable statute is as follows:

§ 10. The superintendent of insurance shall by no later than December 1, 1997 submit to the governor, temporary president of the senate, speaker of the assembly, minority leader of the senate and minority leader of the assembly a report providing the following:

(i) the status of the market for primary and excess medical malpractice insurance; an assessment of the operation of and financing for the program for the providing of excess medical malpractice coverage created pursuant to chapter 266 of the laws of 1986; and recommendations for the improvement of the markets providing primary and excess medical malpractice coverages in this state; and

(ii) an assessment of the future need for the medical malpractice insurance association to provide a market for medical malpractice insurance pursuant to article 55 of the insurance law, including a plan for the dissolution of such association by June 30, 1998, which plan shall include but not be limited to: (a) recommendations for the equitable reassignment to other approved carriers of primary and excess medical malpractice insurance of the association's primary and excess policies providing coverage to physicians and dentists; (b) the return of all remaining association assets; and (c) such other matters as the superintendent shall deem appropriate and necessary.

A special task force within the Insurance Department, ("Department"), was established to begin the study. The members of this task force, chaired by Deputy Superintendent Mark Gardner, were Wayne Cotter, Paul DeRobertis, John Gemma, Patricia Mann, Laurel Presser, Mark Presser, Alan Rachlin and Charles Rapacciuolo. In addition, actuarial consultant Bertram Horowitz participated. The Department solicited the views of the leading insurers currently writing medical malpractice insurance in this State, as well as other interested parties.

In October 1997, letters were sent to all insurers with programs on file with the Department for the various types of medical malpractice insurance, seeking their insights and suggestions. The Medical Society of the State of New York (Medical Society) and the New York Trial Lawyers Association were also contacted in order to obtain their views on this subject.

The insurers were asked to provide the Department with the following information:

- The number of applications received annually, and the number of those applications which were rejected, including the reasons for rejection of the risk;
- the number of policies in force for each limit of liability offered;
- the amount of premiums written for each limit of liability;
- the number of policies which were subject to surcharge or merit rating; and
- the number of policies which were canceled or nonrenewed.

Insurers were also asked to provide suggestions to improve availability and affordability in the medical malpractice insurance marketplace, including specific proposals for increasing their market share.

The Department received replies from all insurers and four other organizations. A copy of each response received from those insurers with significant market shares that met with the Department is attached to this Report in the Appendix.

The Department also had meetings with the top writers of medical malpractice insurance and other insurers, the Medical Society of the State of New York, and the New York State Trial Lawyers Association in October and November 1997. Many of their concerns, ideas and suggestions are reflected in this Report. Each company or organization was represented by members of their respective management teams as follows: **Medical Malpractice Insurance Association:** Richard Martin, Joseph Perino, Joseph Alvear and Alvin White; **Medical Liability Mutual Insurance Company:** Dr. Andrew Patterson, Donald J. Fager and Richard Lutz; **Legion Insurance Company:** Terence Cummings, Andrew Walsh and Martin Tracy; **CNA Group:** James Morris and Ross Bertosi; **Healthcare Underwriters Mutual Insurance Company:** Cathy Place and Gerald Engstrom; **Hartford Insurance Company:** Linda Crookshanks, Alan Putney, Carol Clapp and Richard Dublinski; **St. Paul Companies:** Emmanuel Munson-Regala and Peter Thrace; **Academic Health Professionals Insurance Association:** Martin Kern, Dr. Irving Ladimer, John Lyons and Dai Griffith; **Medical Society of the State of New York:** Dr. Charles Aswad, Laurie Cohen and Gerard Conway; **Physicians Reciprocal Insurers:** Gerald Dolman, Anthony Bonomo, Stanley Zimmerman, Roland Pike and Robert Whitney; **Frontier Insurance Company:** Thomas Dietz, Sam Branham, Lionel Martinez and Jay Adolf; **New York State Trial Lawyers Association:** Gary Pillersdorf and David Golomb; **HANYS Insurance Company:** Mark Morris and Steve Henderson; and **Centre Re:** Joel Klaassen and Louis Heimbach.

The Report that follows represents the views of the Superintendent of Insurance.

A. Scope of Report

As expressly set forth in Chapter 161 of the Laws of 1997, the Superintendent has been directed to submit a report regarding issues related to primary and excess medical malpractice insurance. Accordingly, this report neither addresses nor responds to any issues related to the non-physician classes of insurance which the Medical Malpractice Insurance Association is currently authorized to write.

II. The Status of the Market for Primary and Excess Medical Malpractice Insurance

A. Historical Background

This section describes the recent history of medical malpractice insurance in New York State. Knowledge of past events is necessary to appreciate the situation which gave rise to the creation of the Medical Malpractice Insurance Association (“the MMIA”) in 1975 and its subsequent development.

1. Withdrawal of Employers Insurance Company of Wausau and Argonaut Insurance Company in 1974 and 1975

In 1973, the medical malpractice insurance market in New York State was largely divided between two companies - the Employers Insurance Company of Wausau (“Employers”) and the Professional Insurance Company of New York (“Professional”). Employers wrote about two-thirds of the New York market -- approximately 23,000 of the physicians then licensed in the State -- pursuant to a long-term arrangement with the New York State Medical Society. Professional wrote about 15% of the market, and various other companies wrote the balance.

In the fall of 1973, Professional was placed in liquidation by the Department, pursuant to court order. In December 1973, Employers, which had increased its premiums by some 1,000% during the preceding seven years, announced that it was terminating its entire medical malpractice insurance program in New York, effective April 30, 1974, but subsequently agreed to extend the coverage through June 30, 1974.

It became apparent to the Department that there was a distinct possibility that the Medical Society would not be able to find another carrier and that, if no action were taken, most of the State’s physicians and surgeons would be without insurance, thereby creating a state-wide health care crisis. The Department called a meeting of the insurance industry and urged it to provide a solution on a voluntary basis or face a legislative response. The Department also assisted the Medical Society in drafting legislation to establish a joint underwriting association (JUA), composed of all insurance companies writing liability insurance in New York. The JUA would be required to provide medical malpractice coverage, upon application, to any licensed New York doctor.

A bill for such a JUA was introduced in 1974, at the request of the State Medical Society, but was not enacted. While the bill was pending, the State Medical Society successfully concluded an arrangement with the Argonaut Insurance Company (“Argonaut”), which agreed to insure members of the Society at a rate 93.5% higher than that of Employers. However, only six months later, in December 1974, Argonaut announced its intention to raise its medical malpractice premium rates for physicians by another 196.8% or, in the alternative, to discontinue offering malpractice insurance to members of the Society. Had this increase gone into effect, Argonaut, one year after replacing Employers, would have been charging over five times the last rates charged by Employers.

After the Superintendent of Insurance began administrative proceedings to block the proposed increase,¹ Argonaut agreed to rescind the new rates, but also announced its withdrawal from the New York market for physicians malpractice insurance, effective July 1, 1975.

¹ Rates at this time were on a file-and-use basis and were not subject to the prior approval of the Superintendent before they could be used. However, the Superintendent had the power to challenge a rate so put into effect if, after review, the rate was found to be excessive, inadequate or unfairly discriminatory. Ins. Law (1974), Art. 7-A (since amended and recodified as Art. 23).

Difficulties also arose regarding hospital professional liability rates, and Argonaut decided to withdraw simultaneously from this market as well.

New York State was then faced with a medical malpractice insurance availability crisis of major proportions.

2. Legislation of 1975 and Creation of the MMIA

During the 1975 Legislative Session, a number of bills were introduced to avert the crisis. Governor Hugh L. Carey and the legislative leaders produced a compromise measure, Chapter 109 of the Laws of 1975, which was signed into law on May 22, 1975.

Chapter 109, in order to provide a market for medical malpractice insurance to both doctors and hospitals, created the MMIA, a joint underwriting association consisting of all insurers writing personal injury liability insurance in the State (Article 19 of the Insurance Law, later recodified as Article 55).

a. Structure of the MMIA

Chapter 109 provided for the MMIA to be governed by a board of twelve directors. However, in subsequent years, the Legislature increased the number to fifteen and, ultimately, to twenty-one directors, including the Superintendent, ex officio.² The MMIA operates in accordance with a Plan of Operation approved by the Superintendent of Insurance. Amendments to the Plan of Operation may be made by the board, subject to the Superintendent's approval, or shall be made at the direction of the Superintendent.³

Chapter 109 mandated that the MMIA could commence operations once the Superintendent determined that medical malpractice insurance was not readily available in the voluntary market. In June 18, 1975, the Superintendent, after a required consultation with the Commissioner of Health, determined that medical malpractice insurance was not readily available in the voluntary market for physicians and hospitals, and therefore activated the MMIA.

Chapter 109 also provided stand-by authority for the State Insurance Fund to act as a "back-up" for the MMIA, in the event that the MMIA were found to be unconstitutional or had exhausted all its assets. However, this authority was never extended beyond its June 30, 1981 sunset date.

b. Stabilization Reserve Fund

The law also provided for a Stabilization Reserve Fund to pay for deficits that might arise out of the operations of the MMIA. The purpose of the Stabilization Reserve Fund is to reimburse the MMIA, or its members (the insurance companies) in the event of a deficit. In order to accumulate this Stabilization Reserve Fund, the MMIA is required by law to surcharge premiums for the primary coverage by 20%, until the Fund reaches a value of \$50 million.

² Section 5508(a).

³ Section 5503.

Beginning with policy year 1995, the MMIA stopped collecting the 20% additional premium because the fund had reached the \$50 million limit. The value of the fund is continuing to increase based on its investment earnings.

In the Plan of Operation adopted by the MMIA, Article XII, Paragraph 10, provides that upon the termination of the MMIA and the discharge of its liabilities, "any amounts remaining in the Stabilization Reserve Fund shall be distributed to policyholders of the Association in an equitable manner under procedures authorized by the Board and approved by the Superintendent."

c. Other Developments in 1975

To provide for closer oversight of medical malpractice insurance rates, the Superintendent was empowered to require prior approval of all medical malpractice insurance rates (Insurance Law §184(4), recodified as §2305(b)).

In order to provide an alternative to the MMIA, Medical Liability Mutual Insurance Company (MLMIC) was created under the sponsorship of the Medical Society of the State of New York. It was licensed by New York State on May 28, 1975. MLMIC began operations on July 1, 1975, and by mid-1976 covered some 16,000 physicians. At that time, the MMIA insured another 4,000. Both insurers also wrote medical malpractice coverage for a limited number of hospitals.

When it became apparent that many hospitals were faced with the problem of obtaining insurance for incidental liability coverages, such as premises liability and products liability, which had customarily been written as a package with professional liability insurance, further legislation was enacted in 1975, requiring the MMIA to provide incidental liability coverages in connection with professional liability insurance for hospitals (Chapter 477).

3. Legislation in 1976

In 1976, additional legislation (Chapter 955), was enacted which, among other things:

- a. Expanded the board of directors of the MMIA from 12 to 15, to include the Superintendent of Insurance or his representative as a non-voting director, and two representatives of the public;
- b. Subjected the MMIA to the same provisions of the Insurance Law requiring fair treatment of policyholders and claimants which were applicable to property/casualty insurers;
- c. Increased the availability to hospitals of insurance coverage from the MMIA by strengthening the reinsurance mechanism for such coverage. Each hospital became entitled to purchase up to \$1 million coverage for each claimant and \$10 million for all claimants under one policy in any one year, provided that for any policy issued in excess of the primary limits of \$1 million/\$3 million, the MMIA had to obtain reinsurance for such excess coverage. If the MMIA failed to do so, the Superintendent

could order the MMIA to obtain such reinsurance from sources found by him to be available. Reinsurance was not required for the primary limits of coverage; and

- d. Authorized the formation of a mutual insurance company whose policyholders would be limited to hospitals. The legislation set forth requirements for the formation of a mutual insurer organized to provide personal injury liability insurance or property damage liability insurance for hospitals exclusively, and provided the insurer with the power to assess policyholders. The objective of the legislation was to provide an alternative to the MMIA as a source of malpractice insurance for hospitals. (Hospital Underwriters Mutual Insurance Company (HUM) began operations as a result of this provision.)

4. Entry of Other Insurers

In the following years, although the property/casualty insurers generally did not return to the medical malpractice market, a number of specialty insurers entered the business:

- Hospital Underwriters Mutual Insurance Company (HUM) was licensed on May 26, 1977 to write professional liability and incidental general liability insurance for hospitals;
- Group Council Mutual Insurance Company was licensed on April 1, 1977 to provide professional liability insurance for doctors in the Health Insurance Plan of Greater New York (HIP) medical groups;
- Physicians Reciprocal Insurers (PRI), a domestic reciprocal insurer, was licensed on June 22, 1982 to write professional liability insurance; and
- Frontier Insurance Company, a multi-line insurer, began insuring part-time doctors through the New York Free Trade Zone beginning in 1981. Frontier subsequently received Department approval for its initial filing for full-time physicians, effective September 1983.
- Academic Health Professional Insurance Association, a domestic reciprocal insurer first licensed on 11/27/90. The company was licensed to write excess medical malpractice insurance on 6/29/95.

With the entry of these new malpractice insurers, physicians were no longer faced with the problem of insurance availability that had existed in the mid-1970's. The price and affordability of malpractice insurance subsequently became the central issues.

B. Statistical Information on the MMIA and Related Markets

1. Statistical Summary of the Discounted Surplus of the MMIA

Please refer to the Appendix for a bar graph which illustrates the discounted surplus of the MMIA for the years 1990 through 1994.

In addition, the other major New York physicians and surgeons medical malpractice insurers -- exclusive of the MMIA -- filed a discounted surplus of approximately \$1.5 billion through June 30, 1997. The most recently filed policy year written premium for these insurers is approximately \$0.5 billion. Accordingly, the filed premium to discounted surplus ratio is approximately 0.40, which is indicative of strong insurer solidity and substantial capacity to absorb additional business.⁴

2. Statistical Summaries of the Primary and Excess Programs of the MMIA and the MMIA's Competition

Please refer to the Appendix for tables containing comparisons of the premiums and policies written for physicians and surgeons by the MMIA and other medical malpractice insurers.

3. Statistical Summaries of the Rate Changes for the Primary and Excess Medical Malpractice Insurance Programs in New York, 1985 - 1997

Please refer to the Appendix for two bar graphs that illustrate the history of rate changes for physicians and surgeons medical malpractice insurance (primary & first-layer pool) in New York from 1985-1997.

4. Risk Retention Groups

There are currently twelve risk retention groups that are providing primary medical malpractice insurance in New York. For the year ending December 31, 1996, these groups wrote a total of \$6,443,478 in premiums.

III. An Assessment of the Operation of and Financing for the Program for the Providing of Excess Medical Malpractice Insurance Created Pursuant to Chapter 266 of the Laws of 1986.

In 1985, New York State faced a second medical malpractice insurance crisis. Rate levels for physicians' malpractice coverage had been increasing by more than 15% a year since 1974, when the previous crisis had occurred. By 1985, medical malpractice insurance rates were more than five times greater than those in 1974.⁵ Physicians were also greatly concerned that the policies they were purchasing, although covering up to \$1 million per claim with an aggregate

⁴ These figures have been obtained from the filed Segregated and Surcharge Account Exhibits for : HANYS Member Hospitals Self Insurance Trust; HANYS Insurance Company, Inc.; Medical Liability Mutual Insurance Company; Frontier Insurance Company; Group Council Mutual Insurance Company; and Physicians Reciprocal Insurers. While the aggregate New York experience is indicative of overall financial soundness, the experience presented above should not be construed as evidence of financial well-being for any particular insurer.

⁵ See New York State Insurance Department Report, A Balanced Prescription for Change, (April 1, 1988), at page 52, ("A Balanced Prescription").

claim limit of \$3 million per year, would still prove insufficient in the face of the growing number of multi-million dollar verdicts and settlements. They thus viewed the purchase of higher limits of coverage under the tort system as necessary, yet unaffordable.

Physicians lobbied strongly for the enactment of changes in tort law, demanding either a significant dollar limitation on awards for “pain and suffering” or an absolute dollar limit on the total tort recovery by any victim of medical malpractice. Although several other states, (*e.g.*, Indiana and California), had enacted such tort limitations, the New York State Legislature would not impose comparable restrictions.⁶ In lieu of “caps,” the Legislature required hospitals to purchase an additional \$1 million/\$3 million layer of malpractice coverage for their attending physicians and dentists who requested this excess coverage and who had purchased \$1 million/\$3 million of primary coverage from an authorized insurer.⁷ However, practitioners, hospitals and insurers were all not satisfied with this compromise, since each group believed that higher limits of physician coverage would serve to create a larger target, which in turn would result in higher settlements and verdicts.

In addition, despite a decade of substantial premium increases, by 1985 most actuaries believed that many medical malpractice insurers were either insolvent or on the brink of insolvency.⁸ To further exacerbate the situation, medical malpractice insurers, demonstrated an inability to purchase appropriate reinsurance for such excess medical malpractice coverage.⁹ The Department viewed the financial condition of the medical malpractice insurers, absent such reinsurance, as extremely uncertain. In any event, retention of the full amount of excess coverage would have placed them in violation of the limitation in the Insurance Law that no one risk could exceed 10% of an insurer’s surplus.¹⁰ There thus existed little or no capacity among authorized medical malpractice insurers to accept the substantial amount of additional business that was projected to be generated by the hospitals’ purchase of physicians excess coverage.

As a result, the MMIA wrote the major portion of the excess coverage for the 1985-1986 policy year, which was the first year hospitals had to purchase such excess coverage. In that year, a consortium of hospitals that were required to purchase the coverage for their physicians established an excess program through the Hospital Association of New York State (since renamed the Healthcare Association of New York State), known as HANYS Trust, which insured a substantial portion of this excess business.¹¹ HANYS Trust was eventually replaced by HANYS Insurance Company. The consortium relied upon the capacity of its member hospitals to support this venture.

⁶ While the Legislature did not enact dollar “caps” on recoveries, it did pass a number of significant changes in 1985 and 1986 to reduce malpractice costs, including changes relating to the following subjects: periodic payment of judgments; reduced contingent fees; elimination of duplicate recoveries from future collateral sources; penalties for frivolous claims and defenses; streamlining of pre-trial discovery; closer scrutiny of physicians by hospitals; limitations on the doctrine of joint and several liability for non-economic loss; and tightening of the standard for appellate review of judgments. See L. 1985, ch. 294, and L. 1986, ch. 266.

⁷ L. 1985, ch. 294, §19.

⁸ The Legislature demonstrated its concern about the solvency of such insurers by prohibiting the Superintendent from seeking rehabilitation or liquidation of a domestic insurer writing primarily medical malpractice insurance solely on the ground that such insurer was insolvent or financially impaired (Ins. Law §2343(c)). This prohibition has been extended over the years and will continue at least until June 30, 1998 under current law.

⁹ The MMIA, as a joint underwriting association established by statute, was essentially comprised of all of the liability insurers licensed in New York. Its capacity is virtually equivalent to that of the entire insurance industry. Thus, to purchase reinsurance to spread its risk, although permissible, would be unnecessary.

¹⁰ Ins. Law, §1115.

¹¹ See A Balanced Prescription, pp. 30-35, for further historical background.

In 1986, the excess insurance coverage program was reconstituted and a “hospital excess liability pool” was established by statute under the direction of the Superintendent of Insurance and the Commissioner of Health.¹²

A. History and Operation of the New York State Hospital Excess Liability Pool

1. History - Chapter 266 of the Laws of 1986 reconstituted the program whereby every general hospital in New York State which maintained facilities for providing emergency medical care was required to provide excess medical malpractice insurance coverage with limits of liability of \$1 million/\$3 million for all physicians or dentists primarily affiliated with each respective hospital; provided, however, that such physicians or dentists had to have in-force an individual primary policy from an insurer licensed in this State. Such primary medical malpractice insurance was to provide for coverage in amounts of no less than \$1 million for each claimant and \$3 million for all claimants under such policy.

This program was annually extended by enabling legislation to the current policy year. In accordance with Chapter 266 of the Laws of 1986, the Commissioner of Health and the Superintendent of Insurance were required to oversee the Hospital Excess Liability Pool and, from funds available in such Pool, purchase excess medical malpractice insurance coverage or equivalent excess coverage or reimburse hospitals where they purchased equivalent excess coverage for eligible physicians and dentists.

This Pool is not a licensed insurer and does not maintain a store of funds, but acts as a conduit for the flow of funds from the payers to the insurance carriers which provide excess medical malpractice insurance coverage.

2. Management - Subsection 5 of Section 18 of Chapter 266 of the Laws of 1986 allows the Superintendent of Insurance and the Commissioner of Health to delegate the administrative responsibilities to a pool administrator. By an agreement dated December 16, 1986, (retroactively effective to July 1, 1986), the Superintendent and Commissioner appointed HANYS Services, Inc. (“HSI”), as administrator of the Pool.

HSI is a for-profit corporation and wholly-owned subsidiary of the Healthcare Association of New York State, a non-profit association of hospitals whose members represent more than 90% of all participants in the Pool. The agreement with HSI provides that HSI will develop a schedule for the payment of premiums to insurers that is consistent with the receipt of funds by the Pool and will transmit appropriate premium payments to insurance carriers.

On November 1, 1989, HSI entered into an agreement with HANYS Insurance Management Company (HIMCO, Inc.), a New York for-profit corporation. HIMCO, Inc. assists HSI in performing its responsibilities as Pool administrator.

3. Funding - The funding of the Pool was, until June 30, 1997, provided by adjusting the established inpatient rates of a general hospital, as defined in Article 28 of the New York Public Health Law, to reflect the cost of excess insurance coverage allocated to such general hospital. The premiums due to the insurance carriers for excess insurance coverage of a general hospital were allocated by the Health Department among various charge payer groups, which include Medicare, Medicaid, Article 43 Insurance Law Corporations, insurers which provide No-Fault

¹² L. 1986, ch. 266, §18. The program has been extended and modified a number of times, most recently by L. 1997, ch. 161, to June 30, 1998.

and Workers' Compensation coverages, and others, including health maintenance organizations and direct pay patients. It is to be noted that the federal government did not participate in the program; the premiums allocated to Medicare inpatients were reallocated proportionately among the other payers.

Part of the payers' cost was paid directly to the Pool by Article 43 Insurance Law Health Service Corporations (Blue Cross plans) and affiliated Article 44 Public Health Law Health Maintenance Organizations for the account of the hospitals. The remainder was paid to the hospitals by unaffiliated health maintenance organizations operated in accordance with Article 43 of the New York Insurance Law and Article 44 of the New York Public Health Law, and all other third-party payers. The hospitals were then required to pay these amounts, as well as amounts reflecting self-pay patients, to the Pool.

The allocation of excess insurance premiums among payers and the billing of hospitals were initiated by hospitals submitting their physicians' applications for coverage to those insurers which were authorized to provide excess medical malpractice insurance in New York. Currently, there are six insurers authorized to provide excess medical malpractice insurance in New York.

These insurers are as follows:

- (1) Medical Malpractice Insurance Association ,
- (2) Medical Liability Mutual Insurance Company,
- (3) HANYS Insurance Company,
- (4) Academic Health Professionals Insurance Association,
- (5) Physicians' Reciprocal Insurers and
- (6) Frontier Insurance Company.

An insurer would then submit a premium bill for each individual hospital to the Pool. HSI, as Pool administrator, combined premium billings for all insurers into a master premium bill. This master premium bill was submitted to the New York State Department of Health for allocation among the payers based upon a medical malpractice claims survey.

Hospital contributions for each policy year, (July 1st through June 30th), were arrived at by the application of the factors established by the Superintendent pursuant to Regulation 101 (11NYCRR70) to the primary premiums for all participating physicians and dentists who had designated the relevant hospital as their primary hospital.

In August 1986, the Commissioner of Health amended Chapter 11 of Title 10 of the Official Compilation of Codes, Rules and Regulations of the State of New York by adding Subchapter M, Part 91, to provide that premiums due the Pool from general hospitals were to be paid monthly, and were to be 1/12th of each hospital's respective allocated premium. Moreover, each of the payers required to fund the Pool was to contribute their proportionate share of the cost of excess malpractice insurance on a monthly basis.

In 1997, the Legislature, in Chapter 161, required that the MMIA pay the entire premium for the program for the 1997-1998 policy year. If the MMIA fails to make this payment from its surplus, a special franchise tax is to be imposed upon all property/casualty insurers to accumulate funds to pay the premium.

B. Establishment of Rates; Loss Experience

Pursuant to Section 40 of Chapter 266 of the Laws of 1986 (most recently extended by Chapter 161 of the Laws of 1997), rates for both primary and excess medical malpractice insurance policies issued on and after July 1, 1985 have been established by the Superintendent, under the statutory directive that they be both “stabilized” and “restrained.” Future rates are subject to surcharges if deficiencies emerge which are attributable to the stabilization methodology. Generally, the surcharges follow physicians to a new insurer. Many actuaries who reviewed New York’s medical malpractice experience in the mid-1980’s believed that the stabilized rates so established were significantly inadequate and that substantial surcharges would be needed until well into the 21st century before the perceived cumulative rate inadequacies of the mid-1980’s could be overcome.

In the mid-1980’s, the medical malpractice experience continued the deteriorating trends of the 1970’s and early 1980’s and was reflected in insurers’ primary level rate filings which, in 1985, requested substantial increases of 57% to 128%. However, in accordance with the legislative mandate to bring stability to the market, the Superintendent established stabilized and restrained primary level rate increases for physicians and surgeons of 14% in 1985, 9% in 1986 and 9% in 1987. These rate changes were substantially lower than those requested because the Superintendent had the benefit of being able to impose surcharges on future premiums if these stabilized rates proved inadequate in the future. He was also able to take advantage of any benefits which would be derived from the tort reform measures enacted at that time.

The Superintendent also established rate levels for the first- and second-layer physicians and surgeons excess coverage in 1985. These premiums, which are expressed as a percentage of the primary premium, were developed from actuarial models, which extrapolate the primary experience to excess layers, because of the lack of credible historical loss experience for this type of excess coverage in New York. In 1988, the Superintendent established two premium charges for the first layer excess coverage; the first for when the insurance was purchased directly by the physician, and the second, higher charge for when the coverage was purchased by a hospital on behalf of its attending physician. The higher premium for the hospital-purchased excess coverage was necessary because of the lengthy delay in payment to insurers for this coverage.

As actual experience emerged in the 1990’s, it became increasingly evident, with the benefit of hindsight, that the actual New York medical malpractice experience was developing considerably more favorably than had been estimated in the 1980’s. To some extent, this was again reflected in insurers’ rate submissions which requested relatively modest rate changes, no changes, or decreases in rates, especially in the excess insurance layers.

C. Surplus Derived from Excess Coverage

The favorable loss experience described above was the impetus for several laws enacted to transfer what was believed to be redundant surplus accumulated by the MMIA and HANYS Insurance Company (HIC).

In summary, HIC has expended from its surplus, which was solely derived from excess medical malpractice coverage, approximately \$162 million (the sum of a \$9.6 million voluntary transfer in 1991, a \$55 million statutory transfer in 1991-92 and \$97 million to pay for the State’s Medicaid share in policy years 1992 through 1994). The MMIA has been divested of some \$846 million that was derived from the writing of excess policies (the sum of a \$155 million statutory transfer in 1991-92, a \$60 million transfer in September 1992, a \$150 million transfer in February

1993, and a \$481 million transfer completed in January 1997, the latter three transfers replaced by dry appropriations). The aggregate cash withdrawal from the funds of the two excess medical malpractice carriers has thus reached a total of approximately \$1 billion.

1. Litigation Involving the Excess Medical Malpractice Program

In 1991, an action, Preferred Physician Risk Retention Group v. Cuomo, was commenced by two Missouri domiciled risk retention groups against the Department and several medical malpractice insurers alleging, inter alia, that the Department's interpretation of a section within the statute establishing the excess medical malpractice program (§18 of Chapter 266 of the Laws of 1986), that physicians and dentists with underlying primary coverage with a risk retention group were ineligible for the statutory excess coverage because the primary coverage was not with a licensed insurer, was erroneous and violative of the federal Risk Retention Act. After commencement of the action, one of the Plaintiffs became insolvent and was dropped from the action.

Both parties moved for summary judgment and the District Court granted Plaintiff's motion. The Court's determination included a preliminary injunction forbidding the Department from enforcement of the restriction on underlying primary coverage. Therefore, while the injunction was in effect, physicians and dentists with underlying coverage from a risk retention group were eligible for the statutory excess coverage.

All Defendants appealed the determination of the District Court and, in July 1996, the United States Court of Appeals for the Second Circuit reversed the District Court, dissolved the preliminary injunction and remanded the matter back to the District Court. The District Court is, through a Magistrate Judge, supervising discovery. Accordingly, commencing with the policy year July 1, 1997 through June 30, 1998, physicians and dentists with underlying coverage from a risk retention group are no longer eligible for statutory excess medical malpractice coverage.

In 1995, an action, New York State Conference of Blue Cross Blue Shield Plans v. Muhl, (Blue Cross I), was commenced in Supreme Court, Albany County, against the Superintendent, Commissioner of Health, Pool Administrator and several malpractice carriers alleging that the rates charged for the statutory excess medical malpractice program for a number of years were excessive and otherwise contrary to statutory standards. The New York State Health Maintenance Organization Conference, and its constituent members, and Group Health Incorporated (GHI) moved to intervene.

The Department, as well as all other Respondents, moved for summary judgment on procedural grounds. The Court granted intervention by the HMO's and GHI and dismissed the action for all policy years prior to the period of July 1, 1995 through June 30, 1996. After all Respondents answered, the Department, as well as some other Respondents, again moved for summary judgment. In July 1997, the Court granted summary judgment to the Petitioners and held the Superintendent, in view of the substantial surplus amounts accumulated, primarily by the MMIA, had erred in establishing any rate at all for the 1995-1996 policy year. This determination has been appealed to the Appellate Division, Third Department.

While Blue Cross I was following its procedural path, the same Petitioners commenced another action in 1996, New York State Conference of Blue Cross Blue Shield Plans v. Muhl, (Blue Cross II), in Supreme Court, Albany County, making the same allegations for the policy year July 1, 1996 through June 30, 1997 as had been made in Blue Cross I. Again, all

Respondents moved for summary judgment on procedural grounds, which was denied. All papers have been filed, the matter argued and it is now sub judice.

IV. Medical Malpractice JUA's in Other States

1996 Medical Malpractice JUA Market Shares Direct Premiums Written (dollar amounts in millions)				
State	Private Market	JUA Market	Total Market	JUA Market Share
Florida	\$393.9	\$1.9	\$395.8	0.5%
Kansas	39.6	0.7	40.4	1.8%
Minnesota	45.1	0.2	45.3	0.4%

New Hampshire	20.2	5.1	25.3	20.3%
New York	783.4	38.7	822.1	4.7%
Pennsylvania	200.8	1.2	202.0	0.6%
Rhode Island	19.8	5.3	25.1	20.9%
South Carolina	10.7	12.3	23.0	53.4%
Texas	287.8	4.7	292.5	1.6%
Wisconsin	64.2	2.7	66.9	4.0%
Source: 1996 <i>Financial Condition of Medical Malpractice JUAs</i> , published by the National Coordinating Committee on Medical Malpractice Insurance, and included as Appendix 3. Minnesota data obtained through the Minnesota Medical Malpractice JUA.				

Overview

Medical malpractice insurance joint underwriting associations, (JUA's), are currently active in ten states, including New York.¹³ The following summarizes the experience of the nine medical malpractice JUAs operating outside of New York. Generally speaking, most of these JUA's have encountered similar market conditions since they began operations roughly twenty years ago: they were born in the tight market conditions of the mid-1970's; faced deficits in the early 1980's; saw those deficits transformed into surpluses by the early 1990's; and now, in 1997, confront soft markets and declining market shares.

These JUA's were typically established as "insurers of last resort" and helped provide coverage to physicians and other health care providers who had nowhere else to turn. In the early 1980's, escalating medical malpractice claims costs indicated that most medical malpractice JUA's had underestimated the reserves necessary to pay future claims. However, by the late 1980's, the situation had reversed itself. Because medical malpractice claims typically take many years to close, JUA's were able to adjust their early-year reserve estimates downward, thereby enhancing surplus. Thus, by year-end 1996, nearly every state could boast a positive surplus on a discounted basis for their medical malpractice JUA.

Except for South Carolina, most JUA's have seen sharp declines in market share in the 1990's as new insurers have gained entry into the marketplace and the influence of risk retention groups and captives has accelerated. Countrywide, the market for medical malpractice insurance is extremely soft, which means that there is no shortage of carriers vying for these risks in most states. In states without JUA's, substandard writers--companies that write high-risk physicians at rates commensurate with those risks--often fill the void.

In addition to summarizing the experience of states with existing JUA's, this section examines the experience of two other states—Massachusetts and Maine—that recently dissolved their medical malpractice JUA's.

Please note that references to primary and excess medical malpractice liability limits (*e.g.*, \$1 million/\$3 million) refer to limits for nonhospital health care providers; hospital limits are generally higher.

Florida

¹³ There is also a small, inactive medical malpractice JUA in Virginia which is not discussed herein.

The “Florida Medical Malpractice Joint Underwriting Association” began operations in 1975 and operates as a nonprofit. Florida’s JUA currently writes about 135 primary policies at limits of \$250,000 per occurrence/\$750,000 per year. Annual JUA premium in 1996 declined to \$1.9 million, less than 1% of Florida’s \$400 million medical malpractice insurance market (second only to New York among states with medical malpractice JUA’s). Most physicians in Florida’s voluntary market purchase policies with at least \$1 million/\$3 million limits. The JUA writes no excess coverage.

As a nonprofit, Florida’s JUA periodically refunds premium to policyholders of record. In 1997, the JUA refunded \$11.7 million in premium, which raised its total refunds since inception to \$26.7 million. The loss experience from a book of business must be properly evaluated prior to authorizing refunds, therefore, policyholders typically must wait at least five years before becoming eligible for refunds.

Kansas

The Kansas JUA (the Health Care Provider Insurance Availability Plan) provides primary policies with coverage limits of \$200,000 per occurrence/\$600,000 per year. The JUA wrote only \$746,000 in medical malpractice insurance premium in 1996, down from more than \$4.6 million in 1989. Like Florida, the association acts on a no-profit/no-loss basis. However, Kansas does not refund premium when surpluses arise. Instead, when premium and other income exceed losses and expenses, any statutory surplus is transferred to the Health Care Stabilization Fund, which is a state agency that provides excess coverage. If the JUA posts a statutory deficit in any year, then the Health Care Stabilization Fund is required to transfer funds to the JUA to eliminate the shortfall.

Physicians in Kansas are required to maintain a \$200,000/\$600,000 medical malpractice policy and must purchase excess coverage of at least \$100,000/\$300,000 from the Health Care Stabilization Fund. As an alternative for those physicians seeking more coverage, the Health Care Stabilization Fund offers excess policies with limits of \$300,000/\$900,000 and \$800,000/\$2.4 million. Thus, physicians are required to purchase the primary policy from either a voluntary insurer or the JUA. The next layer (\$100,000/\$300,000) must be purchased through the Health Care Stabilization Fund. Additional layers may be purchased either from the Fund or in the voluntary market.

The Health Care Stabilization Fund has roughly a \$40 million surplus and has transferred about \$11 million to the JUA since 1976. In 1996, the Fund wrote about \$15 million in direct premium for excess coverage.

Minnesota

Unlike other JUA’s, the “Minnesota Medical Malpractice Joint Underwriting Association” was not activated until 1986. Although it had been authorized by statute in 1975, Minnesota’s medical malpractice insurance market was being adequately served at that time. The JUA has never written more than 500 policies or generated more than \$700,000 in premium in any one year. Currently the JUA writes twenty-one medical malpractice policies with limits of \$1 million/\$3 million. Its premium writings totaled \$233,000 as of year-end 1996.

In 1995, the medical malpractice JUA was combined with Minnesota's JUA for commercial liability and liquor liability risks. Although the JUA's have merged, segregated data are maintained for the medical malpractice, commercial liability and liquor liability lines. Minnesota's medical malpractice JUA does not calculate its surplus on a discounted basis.

New Hampshire

Competition in the marketplace has reduced New Hampshire's JUA market share from just under 60% in 1992 to about 20% in 1996. The JUA, which wrote \$5.1 million in direct premium in 1996, provides only primary policies (no excess policies) to New Hampshire physicians and other health care providers. Primary coverage in New Hampshire typically is \$1 million per occurrence/\$3 million per year.

The discounted surplus of the New Hampshire JUA stood at \$54.7 million as of year-end 1996, up from a negative surplus of \$5 million in 1991. Many New Hampshire physicians are still attracted to the New Hampshire JUA because it offers occurrence policies; the voluntary market offers primarily claims-made policies.

Pennsylvania

The joint underwriting association in Pennsylvania is called the "Pennsylvania Professional Liability Joint Underwriting Association." The JUA provides primary policies with coverage limits of \$300,000 per occurrence/\$900,000 per year. Unlike New York, Pennsylvania requires its physicians to carry professional liability insurance as a condition of being licensed. The JUA has \$37.8 million in discounted surplus and annual writings are about \$1.2 million as of year-end 1996 (less than 1% of the market).

The "Pennsylvania Medical Professional Liability Catastrophe Loss Fund" writes excess layer policies (\$1 million) and its annual writings are about \$3 million a year; however, the fund is operated on a "pay as you go basis," so there is no prefunding of reserves.

Rhode Island

In the early 1990's, Rhode Island's JUA market share hovered around 70%. That percentage has shrunk to about 20% in 1996 with about 400 or 500 physicians and other health care providers insured through the JUA. The JUA writes primary policies in the amount of \$1 million per occurrence/\$3 million per year. Medical malpractice insurers such as Norcal, St. Paul and Medical Protective are currently marketing in the state. The former Massachusetts JUA, the Medical Professional Mutual Insurance Company (see discussion of Massachusetts below) is also developing a presence in the Rhode Island market.

Rhode Island's plan was the only state JUA to register a negative discounted surplus (\$9.9 million) at year-end 1996. The Plan's annual direct written premium writings were about \$5.3 million in 1996, down from \$32.2 million in 1989. There is no excess coverage fund.

South Carolina

In South Carolina, the state medical malpractice JUA still dominates the market with a 53.4% market share, primarily because its rates are highly competitive. It insures about 5,000 physicians, 1,300 dentists, 1,400 professional associations, 600 other health care providers, 12 hospitals and 49 clinics. The fund offers primary policies with a \$100,000/\$300,000 limit. The JUA's discounted surplus was \$5.3 million as of year-end 1996, with premium writings of \$12.3 million. It should be noted that South Carolina's second largest medical malpractice writer is the "Insurance Reserve Fund," which insures health professionals employed by the State of South Carolina.

South Carolina also has a patients compensation fund, which provides unlimited excess coverage and accepts all applicants. The fund is financed totally by health care providers and currently is in neither a deficit nor a surplus position. There is no cap on medical malpractice damages in South Carolina (except for government health care professionals).

Texas

A Texas health care provider must be turned down by two medical malpractice insurers in the private market before he or she can obtain a primary (\$1 million/\$3 million) or excess policy through the Texas JUA. The JUA writes primary and excess policies, but its \$4.7 million in 1996 premium represents less than 2% of the state's medical malpractice insurance market. The JUA wrote primary policies for only 183 individuals and four institutions in 1996 and 55 excess policies. It has not levied any additional assessments on insurers or providers since 1987. Its discounted surplus stood at \$15.9 million at year-end 1996.

In 1997, in an interesting legislative development, Texas became the first state to expand the number of parties that could be held liable for an adverse medical outcome. Traditionally, only physicians, hospitals and similar health care facilities would be considered liable in such cases. The Texas law expands the body of potentially liable parties to include HMO's, insurers and managed care entities. The law states that parties have a duty to exercise "ordinary care" when making health care treatment decisions and that they will be liable for damages in instances where harm is inflicted as a result of their failure to exercise such care. Such changes should open up a whole new market for medical malpractice insurance in Texas and other states which enact similar laws.

Wisconsin

In Wisconsin, the residual medical malpractice joint underwriting association, "The Wisconsin Health Care Liability Insurance Plan" (WHCLIP), now writes far fewer physicians than it did in the early 1990's due to enhanced competition among the state's voluntary medical malpractice insurance writers. Policyholder premium attributable to WHCLIP has declined precipitously from \$11.7 million in 1992 to \$2.7 million in 1996. Currently, fewer than 500 physicians and other health care professionals are insured through the Plan, which constitutes about 4% of the market.

The Plan, which is administered by the Wausau Insurance Company, posted discounted surpluses of \$69.8 million in 1996, down from \$72.6 million in 1995, but up from \$63.5 million in 1994. In 1997, the Plan returned \$17.6 million to its policyholders of record between 1992

and 1996. Wisconsin physicians are required to carry primary policies with coverage limits of \$1 million/\$3 million.

Physicians in Wisconsin are also required to purchase excess policies with unlimited limits through the “Patients Compensation Fund,” which is administered by the Wisconsin Insurance Department. (Wisconsin Law caps noneconomic damages at \$350,000.)

States with Dissolved Medical Malpractice JUA’s

Maine

Maine’s medical malpractice JUA began in the 1970’s, at about the same time as other JUA’s throughout the country were getting off the ground. The JUA acted as an insurer of last resort and required policyholders to participate in a Stabilization Reserve Fund. In the early 1980’s, Maine physicians formed the “Medical Mutual Insurance Company of Maine,” which captured about two-thirds of all Maine doctors and health care providers; St. Paul wrote most of the remaining eligible policyholders. With the vast majority of Maine physicians covered at that point, the state enacted legislation, effective July 1982, that halted all new JUA writings, but permitted the company to continue to pay claims for policies in effect prior to that time.

In the mid-1980’s, the JUA distributed money from its Stabilization Reserve Fund to as many original policyholders (including hospitals) as it could locate. Distributions were based on each policyholder’s contribution to the Fund.

By 1996, the JUA had settled all outstanding claims and the state was moving to dissolve the insurer. Hearings were held to help estimate the likelihood of any future claims and to assess the impact of dissolution. Following the hearings, Maine put the JUA’s tail coverage out for bid, which was won by The Healthcare Underwriters Mutual Insurance Company (HUM). Thus HUM, in exchange for a portion of the JUA’s surplus, assumed responsibility for all future claims against the JUA. To date, no claims have been filed.

The Medical Mutual Insurance Company of Maine currently accounts for about 50% of Maine’s \$25 million medical malpractice insurance market. St. Paul (22%) and Phico (10%) are the state’s other major writers.

Massachusetts

The Medical Professional Mutual Insurance Company (ProMutual) is now a Massachusetts mutual medical malpractice insurance writer, but prior to 1996, the company operated as the Massachusetts JUA. As the JUA, ProMutual dominated the Massachusetts marketplace. (As a mutual, the company still accounts for about 85% of the Massachusetts medical malpractice insurance market.)

In 1992, the Massachusetts Insurance Law was amended, and as a result, the composition of ProMutual’s Board of Directors changed dramatically. Health care providers replaced the insurance company representatives who had previously comprised the Board. At the same time, in a *quid pro quo*, the property/casualty liability insurance industry was relieved of its obligation to fund any future JUA shortfall. That potential liability was shifted to hospitals, physicians and other health care providers. The fund’s surplus had grown considerably by the early 1990’s, so the risk of such a shortfall was considered minimal.

The JUA, however, was still limited in the types of products it could offer in Massachusetts. Due to legislative restrictions, the JUA had estimated it would take approximately eighteen months to introduce products deemed essential to meet policyholders' needs. The provider-dominated Board determined that JUA policyholders would be better served if the association converted to mutual form without the rate and form restrictions that characterized the JUA approach. In June 1993, all stakeholders (*i.e.*, medical groups, dental groups, specialist groups, insurers, captives, etc.) were asked for comments.

Following such discussions, legislation was enacted that converted the JUA to a mutual insurer; deregulated the rate-setting process (rather than being set by the Commissioner, medical malpractice rates would now be introduced on a "file-and-use" basis), and required the new mutual to continue writing medical malpractice policies on both a claims-made and occurrence basis. In addition, Massachusetts became a "take-all-comers" state, but "The Massachusetts Reinsurance Plan" was established as a mechanism through which medical malpractice insurers could, in effect, cede unwanted business. The new legislation became effective in January 1995.

The Massachusetts Reinsurance Plan ("the Plan") began accepting business in January 1997 and has thus far taken in about \$1.2 million in premium. Policyholders are still serviced by the primary carrier and are largely unaware they have been placed in the Plan. Carriers forward their premium to the Plan and bill the Plan for all claims-related expenses. Medical malpractice writers are expected to treat Plan business like any other business, and the Plan periodically audits the claims operations of participating companies.

Medical malpractice insurers are obligated to fund any shortfall in the Plan. Captives, risk retention groups and surplus lines carriers are not permitted to cede risks to the Plan nor are they obligated to fund any shortfall.

Since the Massachusetts JUA converted to mutual form, several new players have entered the Massachusetts medical malpractice insurance marketplace and ProMutual has begun marketing in other states (see discussion of Rhode Island above). At year-end 1996, ProMutual had written \$121.8 million in medical malpractice insurance premium in Massachusetts.

V. Recommendations for the Improvement of the Markets Providing Primary and Excess Medical Malpractice Coverage in this State

As has been noted, the Department held meetings with the leading writers of medical malpractice insurance in New York for the types of coverages offered by the MMIA. A key element of these meetings was the solicitation of opinions with regard to the state of the marketplace, developing trends, emerging issues and products, and competitive forces. Other key components of such sessions were views expressed regarding the regulatory environment, its effectiveness, benefits and pitfalls in maintaining stability in the marketplace, fostering the growth of competition, product development and the ability of the industry to respond to emerging issues and the rapid changes in the healthcare industry.

Most insurers interviewed agreed that while there appears to be a generally rising trend in frequency and severity, competition seems to be driving rates downward. This has been less of a factor in New York with regard to physicians and surgeons rates because such rates are established by the Superintendent.

The following will summarize the comments, and categorize the major themes and recommendations, that emerged from these discussions.

A. The Healthcare Industry

The emergence of managed care programs has changed the manner in which the health care system is structured and health care services are provided. For example:

- The role of the individual practice healthcare provider has been diminished and the traditional insurance regulatory framework does not enable insurers to respond to these changes or compete with non-regulated entities for emerging products.
- Hospitals and physicians groups are reorganizing in order to be able to negotiate with managed care organizations. Significant discounts are a hallmark of these negotiations. In attempting to save costs, both the hospitals and their providers' groups seek to have the cost of insurance reflect reduced administrative expenses, improved risk management, and other controls installed to monitor the necessity, quality and type of healthcare furnished by provider groups. Some use risk managers who assert the right to negotiate terms of coverage, group limits of liability and premiums.
- Group health care practices also integrate several professional disciplines, and their managers seek to combine the various coverage needs in a single package policy that would also provide group property and commercial liability coverages. Managed care organizations also prefer to purchase insurance in this manner. Since these entities are often large conglomerates with multi-state operations, they seek to contain insurance costs through negotiation with the carrier.
- Guaranty fund protection, a distinctive characteristic of licensed carriers, is not a significant factor to hospitals when coverage is purchased directly from a surplus lines carrier that has a solid financial background. In addition to availing themselves of opportunities in the traditional surplus lines market, some managed care organizations and provider groups have developed risk retention groups or offshore captives to address their insurance needs.

The Insurance Department recommends changes to merit rating, risk management and group insurance regulations in order to address the effects of the issues discussed above.

B. Level Playing Field for Medical Malpractice Insurers in New York

The current regulatory environment, whereby the medical malpractice insurance rates for physicians and surgeons are established annually by the Superintendent, was first mandated by the Legislature in 1985. That process, intended to stabilize the marketplace, placed greater restrictions on insurers concerning rating criteria for acceptable rating of such risks. These measures included a tightening of standards for "channeling" and voluntary attending physician ("VAP") programs. A channeling program allows a hospital to provide coverage for itself and its physicians under a single policy. Physician services rendered to patients outside the hospital are also covered under such policies. The Voluntary Attending Physician Program, a similar program, permits separate policies that insure the hospital and its attending physician (physician services rendered outside the hospital are also covered). Under VAP, physicians and hospitals

agree to a joint defense for claims to which they are each a party. These programs reflect sizable premium savings attributable to intensive risk management programs and joint defense of claims.

In order to avoid market displacement, existing channeling programs were allowed to continue and only one VAP program has been approved since 1985. Several insurers indicated that this has hampered the competitive environment in New York State. Insurers not able to offer such programs suggest that these programs be made available to all insurers. This suggestion was also made with respect to “slotting programs,” which are unique to claims-made coverage. Policies with slotting programs cover a physician’s position (or “slot”) within a group rather than the specific individual.

The Insurance Department recommends liberalizing the standards set forth for merit rating and risk management programs in order to provide insurers with more flexibility in pricing such programs.

C. Tort Reform

The issue of tort reform was discussed and most insurers recognized the difficulties inherent in obtaining significant tort reform in this State. While the matter of capping noneconomic awards was popular, there were varying opinions as to the amount of premium savings or other benefits that would be generated.

Since a consensus could not be reached with regard to tort reform, the Insurance Department will not make a recommendation with respect to this issue.

D. Regulatory Environment in New York

All carriers agreed that there is a significant amount of medical malpractice insurance regulation in New York as compared with other states. While some felt that this regulation had stabilized the marketplace over the last ten years, others felt that it has also prevented carriers from responding to marketplace demands for innovative insurance programs. Several carriers advised that they had been approached by managed care entities for insurance, but because of the Insurance Department’s restrictions on premiums, limits of liability, and coverage, they were unable to prevent the loss of that business to the surplus lines market.

They felt that the Insurance Department should be more responsive to new insurance products and should give more weight to an insurer’s underwriting judgment in setting rates for these products.

The Insurance Department will undertake a review of its procedures with regard to this issue.

VI. An Assessment of the Future Need for the Medical Malpractice Insurance Association to Provide a Market for Medical Malpractice Insurance Pursuant to Article 55 of the Insurance Law

From the numerous meetings conducted by the Department with the insurance companies that are currently competing in the medical malpractice insurance market in New York State, one may draw the conclusion that competition has grown significantly since the availability crisis of the mid 1970's. Perhaps as a result of tort reform laws passed in the mid-1980's, medical malpractice loss development has improved considerably. Consequently, the mass exodus of insurers from the medical malpractice insurance market has not repeated itself and, to the contrary, there has been an increase in the number of insurers that are writing in this market.

Originally, in the mid-1970's, the MMIA and the Medical Liability Mutual Insurance Company were the only members of the medical malpractice market. As of the date of this report, there are now at least six writers competing in this market. In addition, as noted earlier in this Report, there are also a number of risk retention groups which are competing in this market. Thus, there are presently more competitors in the market than there were when the MMIA was formed.

An issue which arose during the interviews with the medical malpractice insurers and which relates to potential competition among insurers is whether those especially adverse primary market risks written by the MMIA would be voluntarily written by other insurers in the primary market. Generally speaking, the majority opinion of those insurers interviewed was that they would be willing to write such risks, but only on the condition that they could charge an adequate rate and underwrite the risk accordingly. Several insurers also opined that certain regulatory changes might be necessary to provide them with the underwriting and pricing flexibility required to write such risks. The Department was surprised at the overall willingness of the insurers to entertain such risks; the opinion was voiced several times that most of even the most adverse risks would be insurable. Thus, while there is a possibility that some physicians with truly disastrous loss histories would be uninsurable, the Department is of the impression that there may be no need for either a continuation of the MMIA or the formation of a residual market mechanism to address a significant number of uninsurable physicians.

While analyzing the breadth and depth of the medical malpractice insurance market in New York, it also became apparent to the Department that there is an issue as to how the surplus lines market would react to an opening of the medical malpractice insurance market. Presently, a surplus lines broker must apply to the MMIA for a declination before he/she can shop the risk in the surplus lines market. Since the MMIA must accept all risks, this declination requirement effectively precludes the surplus lines market from entertaining these risks. If this requirement were eliminated, and a surplus lines broker could immediately bring the risk to the surplus lines market, the question arises whether there would be an interest in the writing of these risks. Based on comments made during the interviews with insurers, it appears that surplus lines insurers do insure medical malpractice risks in other states, particularly in the sub-standard arena. Thus, there is reason to believe that surplus lines writers would enter the market. However, the resulting question is whether the pricing for such policies would be prohibitively expensive, merely high, or affordable.

Similarly, as respects the issue of whether there would be an interest on the part of the insurers currently writing medical malpractice insurance in New York to cover the excess insurance risks written by the MMIA, the Department heard repeated assurances that many of the insurers currently in the primary medical malpractice insurance market would be interested in writing such excess risks if they were given the opportunity to do so. The present excess medical malpractice insurance market -- characterized by the dominance of the MMIA and HANYS Insurance Company -- appears to be one which would appeal to many insurers. As with the above-described issue of how surplus lines insurers would react to an opening of the medical malpractice insurance market, it is unclear as to the extent to which insurers would be receptive to writing excess risks. However, the majority of the insurers interviewed during the course of the preparation of this Report did indicate an interest in entering this market. Most were particularly interested in writing excess over their own primary policies, which would facilitate the underwriting of such coverage and eliminate problems which have been encountered in the coordination of defense and settlement of claims.

VII. Possible Plans for Dissolution of the Medical Malpractice Insurance Association

A. Recommendations for the Equitable Reassignment to Other Approved Carriers of Primary and Excess Medical Malpractice Insurance of the Association's Primary and Excess Policies Providing Coverage to Physicians

In the course of the Department's research of the above-described topic and related interviews with insurers, it became apparent that there are several solutions to the potential availability problem which could result from the dissolution of the MMIA. One solution could be the reassignment to other insurers of the MMIA's primary and excess policies issued to physicians. However, as the Department conducted interviews with the insurers and obtained more information, it became clear not only that this was merely one possible solution to one potential problem which could result from the dissolution of the MMIA, but also that there are several other approaches which could be adopted to lead to a smooth and successful dissolution of the MMIA.

Due to the complex nature of the structure and operations of the MMIA, and the fact that it writes both primary policies and excess policies, it has been determined that there are actually several different means by which the MMIA could be partially or entirely dissolved.¹⁴ Thus, notwithstanding the above title to this Section of this Report (which has been quoted verbatim from Chapter 161 of the laws of 1997) the reassignment to other approved carriers is not the only means of dissolution and the following is a listing of all of the different permutations of approaches which could be employed in dissolving the MMIA:

1. Complete Dissolution of MMIA

- a. Establishment of a residual market mechanism for the primary and excess policies, or establishment of such a pool for either, or none, of these two classes of insureds; and
- b. Execution by MMIA of a loss portfolio transfer to a qualified insurer for the primary and excess policies, or the MMIA to handle run-off of both the primary and excess policies by itself, or a new or existing agency of New York State could handle the run-off of such policies.

2. Partial Dissolution of MMIA

a.(i) The MMIA continues to write the primary policies, but not the excess policies; the excess policies are written by the open market with a residual market mechanism established for them as a "back-up"; and the excess policies previously written by the MMIA are placed in a run-off mode, to be handled by the MMIA, a qualified insurer pursuant to a loss portfolio transfer, or a new or existing New York State agency.

(ii) Same scenario as described in a.(i) above, but no residual market mechanism is established for the excess policies.

¹⁴ In outlining the means of dissolution, one must also consider whether the MMIA should be completely dissolved by virtue of a statutory measure, or merely suspended so that stand-by authorization is continued for its reactivation at a future date.

b.(i) The MMIA continues to write the excess policies, but not the primary policies; the primary policies are written by the open market with a residual market mechanism established for them as a “back-up”; and the primary policies previously written by the MMIA are placed in a run-off mode, to be handled by the MMIA, a qualified insurer pursuant to a loss portfolio transfer, or a new or existing New York State agency.

(ii) Same scenario as described in b.(i) above, but no residual market mechanism is established for the primary policies.

3. Recommendations

Clearly, the variety and complexity of the foregoing arrangements compels a careful consideration of all of the above options.

After extensive internal analysis and discussion in the Department, and after a thorough evaluation of the interviews with the insurers, it is the recommendation of the Department that:

- *the MMIA should be allowed to dissolve at the conclusion of the statutory period. However, stand-by authorization should be maintained for its possible future reactivation.* The level of competition in the medical malpractice insurance market, for both primary and excess policies, appears to have increased sufficiently to warrant the dissolution of the MMIA. However, market volatility requires maintaining stand-by authority so that extensive statutes need not be enacted in the future should a residual market mechanism be necessary.
- *a residual market mechanism should be established among those insurers which are currently writing medical malpractice insurance policies in New York on an active basis, but only for those physicians who seek coverage in the primary market.* In view of the adverse loss experience of a very small number of physicians, and the potential danger these individuals could pose to the public in the event they were to practice medicine while uninsured, a residual market mechanism is necessary. In addition, the total number of physicians who would be unable to obtain coverage is estimated to be only between 100 and 200, so a large residual market mechanism is not envisioned at this time;
- *no such residual market should be established for the other classes of risks, e.g., dentists, podiatrists, etc., which are currently eligible to procure coverage from the MMIA.* As noted in the section of this Report entitled, “Scope of Report,” the Department has not been directed to study the other non-physician classes of insurance which the MMIA is authorized to write and, as such, these other classes fall outside the scope of this Report. However, judging from the MMIA’s overall writings of these classes, it would not appear that there is an availability problem presently affecting any of these lines of business;
- *the Legislature should recognize the likelihood that, if freed from regulatory controls, a voluntary excess market could improve and develop to the extent to which the voluntary primary market has improved and developed.* In view of the competitive and pricing changes

in the primary market, it is reasonable to anticipate equal stability in the excess market. Not only will the voluntary excess market change favorably, but perhaps even more importantly, there is also no longer a funding stream available for the New York State Hospital Excess Liability Pool. In the event that the Legislature decides to continue the “free excess insurance” program, the program should be opened up to all eligible insurers so that both the primary and excess layers for one physician can be written by the same insurer.

- *all of the existing, outstanding liabilities of the primary and excess insurance policies of the MMIA should be transferred to a qualified insurer - in accordance with applicable state statutes governing the procurement of such services and transactions - so that an appropriate loss portfolio transfer or similar loss transfer mechanism can be effected and the liabilities of the MMIA can be run-off efficiently.* In view of the proposed dissolution of the MMIA and the economics of the run-off of a book of business, this method is most efficient and advantageous. However, the assuming insurer will have to recognize the numerous variables inherent in such a transaction, including but not limited to the extremely long term, high severity claims experience, the federal tax liabilities of MMIA, the outstanding obligations of New York State, and the orderly transfer of the premium payments supporting the claims-made “free tail coverage” to other insurers.

B. Return of All Remaining Association Assets

With respect to the issue of distributing the remaining assets of the MMIA, there are several complicating circumstances that the Department has identified as clouding any simplistic resolution of this issue.

First and foremost, as noted previously in this Report, there is a significant amount of money which has been borrowed by the State of New York from the MMIA. These funds are currently deemed statutory assets of the MMIA and the possibility that they may not be returned to the MMIA or that the obligation will be forgiven must be considered when evaluating and calculating the total assets of the MMIA eligible for distribution.

Second, as noted previously in this Report, the Blue Cross I and Blue Cross II lawsuits constitute legal actions commenced to recover allegedly excessive premiums paid to the New York State Hospital Excess Liability Pool for the 1995-1996 and 1996-1997 policy years. As with the funds borrowed from MMIA by the State of New York, the contingent liabilities at stake in these lawsuits could dramatically reduce the remaining assets of the MMIA.

Third, as noted previously in this Report, the MMIA’s Stabilization Reserve Fund has been fully funded and is presently earning investment income. According to the MMIA’s Plan of Operation, any amounts remaining in the Stabilization Reserve Fund - after the dissolution of the MMIA and the discharge of all of its liabilities - are to be paid to the MMIA policyholders. Thus, the Stabilization Reserve Fund represents a sizable amount of assets which will have to be distributed to one distinct class of “claimants” and will thereby reduce the total assets of the MMIA.

Fourth, prior to the statutory changes effected in 1997, the premiums for excess insurance policies issued through the New York State Hospital Excess Liability Pool were essentially paid by an eclectic amalgam of insurance companies, HMO’s and direct pay patients. Thus, from 1986 to 1997, a period of time during which the total premiums for the excess policies written by

the MMIA were cumulatively greater than the premiums for the primary policies, the latter entities paid the premiums for the excess policies. Simultaneously, during the same time period, physicians who purchased primary policies from the MMIA remitted their own funds to pay for these policies. In the interviews conducted with interested parties at the Department, all of the above-described entities and parties expressed an interest in receiving a distribution of any remaining assets of the MMIA. However, given the large numbers of unrelated parties who paid premiums, and the different time periods within which and for which these payments were made, it would appear to be virtually impossible to determine who is entitled to an allocation of these funds.

Fifth, the ongoing take-down of reserves by MMIA will, if it continues, result in both an increase in surplus and an increase in MMIA's federal tax liability. Since federal taxes will be payable out of MMIA's assets, this will result in a reduction in the MMIA's assets. Moreover, the Internal Revenue Service could adversely change its treatment of the reserve take-down process in the future.

In view of the foregoing factors, and the variety of means in which the MMIA can be dissolved, the Department recommends that the Legislature make a final valuation of the assets of the MMIA before addressing or attempting to resolve this issue. A final accounting of the assets of the MMIA will lead to a clearer understanding of who is entitled to such assets in the event that any assets remain after the dissolution of the MMIA.

Copies of these appendices are available in the hard copy version of this report. The hard-copy version is available by contacting the Department's Publications Unit at 1-800-342-3736.

APPENDICES

Appendix 1 - Insurer Responses to Department Inquiry for Medical Malpractice Data

Appendix 2 - Physician and Surgeons Premiums Written and Policies in Force for Primary, First Layer and Second Layer Excess Medical Malpractice Insurance - December 31, 1992 - December 31, 1996

Appendix 3 - 1996 Financial Condition of Medical Malpractice JUAs; Report by the National Coordinating Committee on Medical Malpractice JUAs

Appendix 4 - Medical Malpractice Insurance Association Discounted Surplus - December, 1990 - December, 1994

Appendix 5 - Statistical Summaries of the Rate Changes for the Primary and Excess Medical Malpractice Insurance Programs in New York, 1985 - 1997

