

ATTACHMENT 15

VOLUME: I
PAGES: 1-69

STATE OF NEW HAMPSHIRE
INSURANCE DEPARTMENT
INS NO. 14-034-IN

HEARING RE:)
NEW HAMPSHIRE MEDICAL MALPRACTICE)
JOINT UNDERWRITING ASSOCIATION)

BEFORE:

- ROGER SEVIGNY, Commissioner
- ALEX FELDVEBEL, Deputy Commissioner
- CHIARA DOLCINO, General Counsel
- CHRISTIAN CITARELLA, Assistant Actuary
- JAMES FOX, NHID Attorney

Public Utilities Commission
21 South Fruit Street
Concord, NH
Thursday, 4 December, 2014
10:03 a.m.

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1 P R O C E E D I N G S
2 COMMISSIONER SEVIGNY: Good morning,
3 everyone. My name is Roger Sevigny. I'm the
4 Insurance Commissioner in New Hampshire. With me
5 is our Deputy Commissioner, Alex Feldvebel, and
6 our General Counsel, Chiara Dolcino.
7 Welcome, and thanks to everybody for
8 taking the time in your day to come to the
9 Insurance Department and share your thoughts with
10 us.
11 As I think you know, the Insurance
12 Department has been asked to conduct a public
13 hearing in order to determine whether there is a
14 need for a risk-sharing plan to provide guaranteed
15 issue medical malpractice insurance in New
16 Hampshire; and if so, what is the most appropriate
17 form it should take?
18 Now, we look forward to hearing from you
19 today. The Insurance Department's role is to
20 inform the legislature; and we want to make sure
21 that all voices are heard. Let me take just a
22 moment to describe the bigger picture.
23 The New Hampshire Medical Malpractice

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1 Joint Underwriting Association -- or JUA -- is our
2 state's risk-sharing plan for medical malpractice
3 insurance.
4 It was established by the New Hampshire
5 Insurance Commissioner in 1976 by administrative
6 rule. It was established to make medical
7 malpractice insurance available so that New
8 Hampshire residents can have access to needed
9 care.
10 The JUA is not a corporation. It's not
11 a private insurance company. It is a
12 government-created entity; and it exists only by
13 virtue of the administrative rule that created
14 it -- INS 1700.
15 This administrative rule will expire in
16 January of 2017. In the coming year, the
17 legislature will determine the future of the JUA.
18 The department's role is to inform the
19 legislature, which will ultimately make the final
20 decisions regarding the future of the JUA.
21 The legislative commission established
22 to study the JUA this past year has issued a
23 report, which is available to you as a handout.

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1 If you need copies of any of the handouts -- they
2 were available as you came in -- please raise your
3 hand, and we'll see that you get them if anybody
4 didn't get any of the handouts that we have this
5 morning.
6 In that report, the commission requested
7 that I conduct a hearing to gather evidence and
8 testimony in order to determine whether there is
9 still a need for a medical malpractice
10 risk-sharing plan; and if so, what form it should
11 take.
12 I'm here to listen and to include all of
13 your comments in a report that I will submit for
14 the legislative leadership.
15 This report also will contain my
16 recommendations. These recommendations are going
17 to be based on your testimony and other evidence
18 or data that's available to help inform the
19 legislature on these important issues.
20 To be clear, I'm tasked with asking two
21 questions today.
22 The first: Is there a need for a
23 risk-sharing plan to provide guaranteed issue

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1 medical malpractice insurance in New Hampshire?
2 The second: If the answer is yes; if
3 so, what form should it take?
4 I would ask that you focus your
5 testimony on these two questions. You have them
6 laid out for you in the public notice of the -- of
7 this hearing and in the commission report --
8 again, both available as handouts.
9 For those of you who are medical
10 providers, I ask you that you include in your
11 testimony responses to some survey questions if
12 you've not already responded.
13 Those survey questions also are
14 available as one of the handouts; and I would ask
15 that you keep your testimony to the issues at
16 hand; and, again, be respectful of everyone's time
17 here this morning.
18 You'll also see that we're having a
19 transcript of this hearing prepared; and that
20 transcript is going to be posted on the
21 department's website just as soon as it is
22 available. We will also post testimony received.
23 A handout with contact information provides you

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1 with links to where this information can be found,
2 including where you can find the administrative
3 rule, INS 1700.
4 I'll be happy to accept any additional
5 -- and we've already received some -- written
6 testimony -- any additional written testimony you
7 may wish to submit after today's hearing.
8 Because it is critical that the
9 legislature act in this upcoming 2015 legislative
10 session, I have less than a month to prepare my
11 report and deliver it before the session starts.
12 Therefore, I'm going to need the
13 additional written testimony submitted no later
14 than next Thursday, December 11th. Addresses for
15 submission of written testimony can be found on
16 the contacts.
17 Now, please remember: There's going to
18 be plenty of opportunity for you to testify at
19 additional hearings before the legislature on any
20 proposal that our state House or Senate may
21 ultimately decide to put forward. I remind you
22 that this is only the beginning of the process.
23 With that, we want to hear from you; and

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1 we are here to listen. I have a list of those
2 that have signed up to provide oral testimony this
3 morning; and I will take it right from the list
4 that you signed up on.
5 The first is Henry D. Lipman -- last
6 name L-i-p-m-a-n.
7 MR. LIPMAN: Can I speak from here?
8 COMMISSIONER SEVIGNY: If you have a
9 mic -- there's no need to come forward if you've
10 got a mic available to you.
11 MR. LIPMAN: For the record, my name is
12 Henry D. Lipman from LRG Healthcare, which is
13 located in Laconia, New Hampshire, and operates
14 two hospitals: Franklin Regional Hospital and
15 Lakes Region General Hospital -- also has a large
16 medical community.
17 In terms of the two questions that we're
18 asked to address in terms of the ready --
19 readily-available commercial market, you know, I
20 think that the purpose of creating the JUA to
21 begin with is when the market failed. And at the
22 moment, the market isn't in a failure position.
23 It's in a pretty good position, from what I can

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1 size up as a -- as a provider.
2 And from my perspective, I think it's in
3 the best interests of the state and -- and the
4 policyholders that potentially might have to come
5 back to the JUA not to -- to wind down its
6 operations in the event that the market hardens
7 and -- and fails again. I mean, the consequences
8 of having to recapitalize something and start from
9 scratch in a crisis situation, I think, is
10 something that I think the legislature and
11 department need to consider.
12 And on the other hand, if the interest
13 is to unwind it despite that caution, I think that
14 the interests of the policyholders who built up
15 any excess surplus also have to be considered in
16 the unwinding process.
17 I do think that it would also be
18 important for the department to not just look at
19 the current market conditions, but to -- to model
20 out our stress test, as they have done in -- kind
21 of -- the banking sector, where they do a
22 stress-test type of situation: What -- what
23 happens to access to medical care for our state if

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1 we have that kind of crisis occur?
2 Thank you.
3 COMMISSIONER SEVIGNY: Good. Thank you
4 very much, Henry. We really appreciate your
5 testimony this morning.
6 And if I -- just to make sure that I
7 have captured it in my mind, you -- you believe
8 that there should be a continuation of some form
9 of risk-sharing mechanism that the JUA -- in its
10 current form is the one that we have now; and if
11 -- if there's any thought of doing anything
12 different that you would look to some kind of
13 stress test; and you indicated like what the bank
14 -- what banking did.
15 And I can relate to that. Back in 2009,
16 at the National Association of Insurance
17 Commissioners, we did significant stress-testing
18 with the life companies at that time. So I know
19 what you're talking about. And thank you for your
20 testimony.
21 Next on the list to testify is Dr.
22 Georgia Tuttle.
23 DOCTOR TUTTLE: Thank you. I had hoped

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1 to speak later and listen, but I'll go now. My
2 name is Georgia Tuttle. I'm a solo private
3 practicing dermatologist. I'm also a member of
4 the AMA Board of Trustees, where I work on
5 national issues of medical liability reform; and
6 so some of my remarks will be directed there as
7 well.
8 And for full disclosure, I am the
9 "Tuttle" of Tuttle versus the New Hampshire
10 Medical Malpractice JUA case that was settled in
11 the Supreme Court in 2010.
12 So my concerns are, I think this
13 discussion is premature. We have a national
14 crisis in medical liability that the -- our
15 congress and our state legislatures have not yet
16 managed to resolve. With the ACA in place, I
17 don't know that we know where medicine is going to
18 go.
19 We have physicians moving from private
20 practice into -- into other types of practice --
21 employed practice; and we may swing the other way.
22 Right now I think the healthcare system is in such
23 flux, it's very hard to predict where any

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1 physician will be -- or any healthcare provider
2 covered under JUA policies will be five or 10
3 years from today.
4 So I think we need a lot more
5 information before trying to make a decision in
6 this situation. Perhaps the JUA should be closed;
7 and perhaps it shouldn't. But I don't think there
8 -- we'll have any -- enough information within the
9 next month to instruct the legislature for
10 long-term planning. So I hope that we will
11 proceed slowly, and carefully, and cautiously in
12 this arena.
13 Speaking as an individual who has had
14 occurrence insurance with the JUA for 29 and a
15 half years, I paid up front for my policy, and can
16 lock my office door any day I wish, walk away,
17 protected forever from malpractice claims that may
18 be made against me.
19 If the JUA is closed, physicians like me
20 who are late in our practice will have to go find
21 other insurance. I have called other companies,
22 and small individual practices and solo physicians
23 like myself cannot get insurance -- we will have

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1 to practice five years to have our tail covered.
2 And so one of my concerns is, if you
3 close the JUA in 2017, you're taking physicians
4 who are near retirement and are a vital part of
5 the healthcare system, and you are -- sort of --
6 forcing them to either make the choice to retire,
7 or to work beyond the years that they had planned
8 to. 55 percent of physicians in this country are
9 over 55 and looking to retire; and I think this
10 could push many over the edge.
11 So, again, I hope that -- you know, we
12 could lose good physicians, because they don't
13 want to work five years to have their tail covered
14 under an any carrier.
15 So if you do decide to wind down the
16 JUA, I think you have to make some concessions to
17 those physicians who -- who may have to go to
18 another company, might want to work three years or
19 four years, and have some of the reserves of the
20 JUA cover their tail so that they're not having to
21 put 60, 70, \$80,000 in cash out of their pocket
22 just to continue to provide care to New Hampshire
23 physicians [verbatim].

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1 And then I -- I do want to raise the
2 issue that was settled in the -- in the Tuttle
3 case: As I understand it, the legislature cannot
4 take the money -- the excess surplus reserve from
5 the JUA.
6 That money is now designated for another
7 purpose. And so I want to -- I hope that any
8 decisions along this route are not being made by
9 the legislature with the incorrect assumption that
10 they can take this money and put it into the
11 general fund. I think there's still some
12 confusion about what that money represents and who
13 it belongs to; and it does not belong to State of
14 New Hampshire.
15 And so I want to be very clear that, if
16 that's the purpose of a legislator bringing
17 forward this -- this idea that perhaps this can be
18 closed and that money can be transferred, they'll
19 need to look at that final court decision and --
20 and take that into consideration.
21 Thank you.
22 COMMISSIONER SEVIGNY: We thank you very
23 much, Doctor Tuttle, for providing us with your

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1 thoughts and testimony this morning.
2 Next on the list is Autumn Vergo,
3 V-e-r-g-o.
4 MS. VERGO: Good morning. I'm Autumn
5 Vergo from the New Hampshire Midwives Association.
6 I'm representing the state licensed midwives in
7 New Hampshire.
8 We are a unique group, because there --
9 about half of our membership is insured through
10 the JUA right now; and there is not really another
11 option for us. We have looked on the federal
12 market, and several of our members have been
13 provided quotes in the research phase leading up
14 to this meeting; and those quotes represent about
15 a 400 percent increase in cost for us, compared to
16 what we're paying now.
17 So this -- this has impact in several
18 areas that I hope everyone will consider in making
19 decisions: One is that New Hampshire midwives are
20 the owners of all four of the free-standing birth
21 centers in New Hampshire; and if we can't find
22 affordable coverage, we won't be able to operate
23 those birth centers.

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1 Right now we're required -- anyone who
2 works in a birth center or who has women in their
3 care who are funded by Medicaid needs to have
4 professional liability insurance; and so if we're
5 not able to have that, then that population of
6 women no longer has birth center services; and
7 Medicaid-dependent women don't have midwifery
8 services in their community.
9 It's, I think, interesting to note that
10 about 2.8 percent of the births in New Hampshire
11 occur in birth centers or at home, which is higher
12 than the rate -- the national average. And so
13 this affects hundreds of women annually and has
14 the potential to increase costs overall.
15 When women give birth in birth centers
16 or at home, for everyone who does so, there is
17 about a \$4,000 savings to the healthcare system;
18 and so removing that option, it has some
19 implications for cost.
20 So we hope that you consider our
21 options -- women's access to care, and a potential
22 increase in cost of healthcare -- as you make your
23 decisions. Thank you.

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1 COMMISSIONER SEVIGNY: Good. Thank you,
2 Autumn.
3 So if -- again, just to make sure that I
4 understand you, coverage could be available, but
5 it could -- it is not -- what is available, in
6 your view, is not affordable.
7 MS. VERGO: Right. What is available --
8 there are two programs we were able to find that
9 might have coverage available: The one that was
10 able to give us quotes was so prohibitively
11 expensive that it's not really an option.
12 The second said maybe they could put
13 something together, but they've gone to their
14 underwriters, and we don't have anything solid
15 from them.
16 So right now we don't have another
17 viable option.
18 COMMISSIONER SEVIGNY: So what -- what
19 you're asking -- what you would be asking the
20 legislature to consider is what -- what happens
21 with regard to the fact that coverage in your
22 specialty would -- might be available, but would
23 likely not be affordable.

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1 MS. VERGO: That's right.
2 COMMISSIONER SEVIGNY: Good. Thank you.
3 Next I'd like to invite Bob Nash to come
4 and provide us with testimony.
5 MR. NASH: Thank you, Commissioner;
6 appreciate the opportunity to speak.
7 For the record, I'm Bob Nash. I'm the
8 president of the New Hampshire Association of
9 Insurance Agents. At the request of the
10 Department of Insurance, we have surveyed our
11 members over the course of the past two to three
12 weeks. I requested information on any of those
13 agencies that may be involved in medical
14 malpractice insurance.
15 Looking at the statistics, Commissioner,
16 that we see of JUA currently is fourth in market
17 share in the State of New Hampshire, with
18 approximately 7.2 percent at about \$3 million of
19 direct written premium.
20 The members that we have surveyed
21 account for over 2 million of that 2.9 direct
22 written premium that are members of our
23 association.

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1 The results came in twofold: No. 1,
2 there is no question that our members who deal
3 directly with the insureds think that it is
4 necessary that some form of a JUA continue in
5 existence. We're certainly not hung up on the JUA
6 as it's currently structured, taking in mind it
7 was structured in 1976; and there is certainly no
8 reason to think that there may not be a better way
9 of doing things in this day and age.
10 At the same time, we want to stress and
11 support Doctor Tuttle's comments to suggest to you
12 that the state of healthcare in New Hampshire and
13 this country is in such flux that to take any
14 steps whatsoever that may endanger medical
15 malpractice insurance for our doctors would be
16 folly -- at best -- at this stage of the game.
17 We're taking a look at the concentration
18 level here in New Hampshire. And without the JUA,
19 you are in a highly concentrated area for medical
20 malpractice. With the JUA, it lessens it
21 slightly. As you continue to go down the track,
22 you never get to the point where there is anything
23 but moderate to high concentration in New

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1 Hampshire at the moment for medical malpractice
2 insurance.
3 But with the JUA in that formula, you
4 do, indeed, reduce that concentration
5 substantially.
6 We're going to suggest to you that -- I
7 think Doctor Tuttle's comment about treading
8 slowly, taking a good look at this, and dealing
9 with our legislative committees in the next two
10 years bodes well to developing a process that's
11 going to ensure guaranteed issue, not mettle with
12 medical malpractice, which is absolutely essential
13 to make sure that we maintain a strong medical
14 community, but at the same time, to keep in mind
15 that, with the high concentration currently in New
16 Hampshire, the fact that we have midwifery,
17 radiologists, and dentists -- particularly --
18 taking advantage of the JUA option, we think it's
19 essential that this type of process continue.
20 We would certainly want to work with the
21 department and the legislature in that vein, but
22 we strongly feel, Commissioner, that there should
23 be some form of JUA mechanism in New Hampshire.

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1 COMMISSIONER SEVIGNY: Good. Thank you
2 very much, Bob.
3 The -- the crux of the recommendation
4 then is that some form of risk-sharing mechanism
5 be maintained in the State of New Hampshire; that
6 the JUA in its current form is not necessarily
7 the magical answer, but that there be something
8 that provides for a guaranteed issue to those that
9 have difficulty with finding coverage.
10 MR. NASH: Yes, sir.
11 COMMISSIONER SEVIGNY: Next I'd like to
12 invite -- I can't tell if it's a yes or no.
13 David Johnson, was that a yes or a no?
14 MR. JOHNSON: No. I submitted written
15 testimony.
16 COMMISSIONER SEVIGNY: Okay. Thank you
17 very much.
18 MR. JOHNSON: No problem.
19 COMMISSIONER SEVIGNY: Next is Brad -- I
20 hope I'm pronouncing it right -- Lachut?
21 MR. LACHUT: Lachut. You're close.
22 That's good. I've been called worse.
23 COMMISSIONER SEVIGNY: L-a-c-h-u-t.

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1 Yes. I know. Do you see my last name?
2 MR. LACHUT: Good morning. My name is
3 Brad Lachut. I am counsel for Professional
4 Insurance Agents of New Hampshire -- association
5 of independent insurance agents in the state and
6 their employees.
7 To answer the two questions presented to
8 us, the PIA believes that JUA is a necessary
9 entity in the state currently still; and -- but it
10 should be in a different form than it is now.
11 When the JUA was created in the '70s,
12 there was obviously a need in the marketplace; and
13 there was a dearth of available medical
14 malpractice; and it was established as a residual
15 market.
16 PIA now believes that the JUA is perhaps
17 not the residual market it was intended to be;
18 that -- that the coverages and rates may be too
19 competitive with the voluntary market.
20 The coverage has certainly improved --
21 our coverage options have certainly improved since
22 the '70s, and insureds should be directed towards
23 those voluntary markets and not to the JUA; and if

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1 the coverage and affordability of the JUA is so
2 good, there's no incentive for them to go to
3 voluntary market.
4 So you're essentially -- you're creating
5 a safe haven for those you want to kind of send
6 out into the world, so-to-speak.
7 You know, it -- again, the JUA is
8 necessary; and it is a valuable medical source of
9 insurance for many healthcare professionals that
10 may be high risk and may not be able to find
11 coverage elsewhere. But to be in the JUA, they
12 should feel a little bit of pain -- for lack of a
13 better term -- to improve the risk; you know, to
14 lower their -- their hazard, if you will; to try
15 to find coverage in a more, you know, conventional
16 market.
17 And that is the belief of the PIA.
18 Again, necessary? Without a doubt. But certain
19 modifications should be taken into consideration
20 in going forward.
21 COMMISSIONER SEVIGNY: Great. Thank you
22 very much, Brad.
23 Your comments indicated that, in your

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1 view -- or your association's view, rates are more
2 competitive than PIA believes they should be; and
3 that has an impact or an effect on the market
4 itself; that there is need for some risk-sharing
5 mechanism to be continued; and if that is to be
6 the case, then defining participation or -- needs
7 to be explored carefully.
8 MR. LACHUT: Yes. Correct.
9 COMMISSIONER SEVIGNY: Thank you.
10 MR. LACHUT: Thank you.
11 COMMISSIONER SEVIGNY: Next up is Joel
12 Whitcraft, W-h-i-t-c-r-a-f-t.
13 MR. WHITCRAFT: Good morning. My name's
14 Joel Whitcraft. I'm vice president and actuary
15 for the Medical Protective Company; and I
16 appreciate the opportunity to share our thoughts
17 with you this morning.
18 I'm not going to touch on everything
19 that we're going to provide to you in written
20 form, but just hit a few highlights of our
21 comments -- and specifically to the two questions
22 that you posed this morning.
23 We have provided information in a

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1 written document -- or we will -- that address the
2 questions that the Insurance Department has posed
3 to us. So we'll address all of those.
4 I would point out that Medical
5 Protective is a national carrier; and we write in
6 virtually every state in the country. We have
7 been actively writing in New Hampshire for a
8 number of years.
9 We've seen our market share and
10 policyholder distribution grow over the last few
11 years; and we write across a broad spectrum of the
12 healthcare provider segments -- physicians and
13 surgeons, dentists, other healthcare providers,
14 hospitals, other facilities; and we have
15 policyholders in all of those segments.
16 In regards to the question as to whether
17 we believe that a JUA or some kind of a residual
18 market mechanism is necessary, as a -- as a
19 company that believes in an open, competitive
20 market, we believe that in a competitive
21 marketplace the commercial carriers can address
22 the needs of the market, but we also recognize and
23 concede that there are unique situations that can

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1 arise that will give need to some kind of a
2 residual mechanism that might need to meet unique
3 circumstances.
4 And so we would recommend that there
5 would be some type of residual market mechanism
6 that would serve those situations that might
7 arise.
8 Often carriers will view a marketplace
9 from the respect that -- what type of provider
10 segments they're interested in writing. Some of
11 that may be influenced by the particular laws that
12 affect those types of providers -- if there's any
13 particular unique characteristics to the laws.
14 For example, some states have enacted
15 unique standards of care for such things as
16 emergency medicine and raising the -- the bar for
17 what represents negligence, because of the unique
18 characteristics of patients coming into an ER
19 situation.
20 So those types of things are additional
21 considerations around the whole idea of whether
22 the commercial market can respond to the needs of
23 all of the healthcare providers in a given

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1 jurisdiction.

2 There are examples of different types of

3 mechanisms that -- that have been used in

4 different states and that are actively successful,

5 if you will, in addressing the needs of the

6 markets.

7 One is in our home state of Indiana, in

8 which we have the Indiana Medical Malpractice

9 Residual Insurance Authority -- or it's called

10 IMMRIA; and that's been in place since the mid

11 '70s. But that -- the difference there between

12 IMMRIA and New Hampshire's JUA is that IMMRIA

13 operates as an insurer of last resort. It also

14 goes through a particular rating mechanism,

15 whereby its rates will always be a certain margin

16 above the voluntary market, such that it won't

17 compete with the voluntary market, but will be

18 that last resort for providers that are having

19 difficulty finding coverage.

20 Another option or potential alternative

21 is something like the reinsurance plan that exists

22 in Massachusetts, in which case providers are

23 ceded into a reinsurance plan after being

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1 essentially insured by a commercial carrier. That

2 carrier cedes that risk to the plan; they're

3 reimbursed via a ceding commission for operating

4 expenses; and then the carriers that participate

5 share in the -- the potential deficit or surplus

6 that might arise from their reinsurance plan's

7 operations.

8 The one shortcoming in the existing plan

9 in Massachusetts -- or one of the shortcomings --

10 is that the plan itself doesn't properly address

11 all of its potential costs in the course of

12 accepting those risks. They receive a portion of

13 the premium that should cover loss and loss

14 adjustment expenses. They don't collect any

15 premium for their operating expenses.

16 Also, the -- the premiums that are ceded

17 to the plan are based on the voluntary market's

18 rates, such that those premiums don't really

19 reflect the potential adverse risk represented by

20 the individual being ceded to the plan -- the

21 assumption being that the reason they're being

22 ceded to the plan is because the insurance company

23 used them as a risk that exceeds what they can

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1 hope to collect in terms of their file premiums.

2 The expectation then is that the -- the plan will

3 ultimately run at a deficit and require

4 assessments over -- over a period of time.

5 A better structure would be one that

6 fully contemplates all of the funding necessary

7 for the plan to operate at an adequate level.

8 That may mean an additional load to the premiums

9 that are being ceded, such that a company doesn't

10 have to file some kind of a different rate, but if

11 they were going to cede business to a reinsurance

12 plan, the -- the mechanism would allow for some

13 kind of additional premium charge above and beyond

14 what the voluntary market premium would have been.

15 The -- the Medical Protective Company

16 obviously is supportive of a residual market

17 mechanism that would provide that safety net for

18 the healthcare providers in New Hampshire. As an

19 individual commercial carrier, it's our desire to

20 address the needs of as many different segments of

21 the market as we possibly can.

22 Up to this point, we're currently

23 writing insurance across a broad spectrum of those

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1 segments; and we hope to continue to expand our

2 market share and our coverage for those healthcare

3 providers. But as I said earlier, we do recognize

4 the fact that -- that there will be those unique

5 situations where the commercial market may not be

6 able to respond to the needs of every provider.

7 The remainder of our testimony will be

8 in our written documentation.

9 COMMISSIONER SEVIGNY: Good. Thank you

10 very much.

11 Just to make sure that I understand,

12 Medical Protective is a national player in the

13 medical malpractice marketplace and believes that

14 the free market can meet most needs, but that

15 there's still a need for some risk-sharing

16 mechanism to address any unique needs.

17 Did I --

18 MR. WHITCRAFT: Yes, sir. That's

19 correct.

20 COMMISSIONER SEVIGNY: And you gave two

21 examples: One was Indiana, where there's an

22 insurer of last resort that's been established and

23 the rates that they develop.

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1 And they're there to address these
2 unique needs; I take it?
3 MR. WHITCRAFT: That's correct.
4 COMMISSIONER SEVIGNY: And the rates
5 they develop are developed using market rates,
6 with some sort of consideration for the fact that
7 these are higher-risk --
8 MR. WHITCRAFT: Correct.
9 COMMISSIONER SEVIGNY: -- insureds.
10 The other plan that you mentioned is
11 what's used in Massachusetts, which is a
12 reinsurance plan. I'm familiar with these here in
13 New Hampshire, not in the med mal market, but in
14 the auto market, where a risk -- where a carrier
15 takes the risks; and it's -- may or may not cede
16 it; may keep the risk and insure it themselves
17 without ceding -- or could cede it to the --
18 what's called "the facility" here in New
19 Hampshire.
20 Does it work in that sort of fashion, in
21 other words?
22 MR. WHITCRAFT: Yeah, would be very
23 similar.

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1 COMMISSIONER SEVIGNY: Take the risk
2 once it comes to you -- guaranteed issue so you
3 take it. You may keep it if you choose to, or you
4 may cede it to this insurance mechanism.
5 MR. WHITCRAFT: Correct.
6 COMMISSIONER SEVIGNY: Okay. Thank you.
7 MR. WHITCRAFT: Thank you.
8 COMMISSIONER SEVIGNY: Next is Robert
9 Lanney, L-a-n-n-e-y.
10 MR. LANNEY: Thank you. Hi. I'm Rob
11 Lanney. I am here representing the New Hampshire
12 Medical Society. I'm a partner at Sulloway &
13 Hollis and have spent the last 30-plus years
14 defending physicians and hospitals in medical
15 malpractice cases. So I bring a little bit of a
16 practical perspective, having worked with many
17 physicians who have been insured through the JUA.
18 I think there's helpful information I
19 can provide to you -- just the information we have
20 received from the members of the medical society
21 and that I have received from my clients about
22 their relationship with the JUA and the
23 availability of insurance.

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1 Many of my clients and our members share
2 with us that they feel they would not be able to
3 retain and purchase affordable insurance coverage
4 without the JUA or a similar residual market
5 mechanism.
6 Many of those physicians had prior
7 claims, but not necessarily because they provided
8 substandard care, but, rather, they're very
9 skilled physicians who are taking on high-risk
10 patients. And high-risk patients -- typically
11 many will do well, but many will not. And the
12 high-risk patient leads to many claims. And the
13 feeling of physicians who are willing to take on
14 those high-risk patients is, in the absence of
15 having the JUA be available to provide affordable
16 coverage, they would not be able to take on that
17 population. And eliminating the JUA or a similar
18 mechanism would have likely a very chilling effect
19 on physicians' ability to take on that high-risk
20 population.
21 Secondly, with respect to the JUA
22 itself, in terms of their claims handling for the
23 physicians, they've done a very fine job. They're

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1 very professional in their adjusting of claims.
2 They've done a nice job resolving the claims that
3 should be resolved and trying the cases that need
4 to be tried.
5 So as a company, they've handled the
6 cases quite well, which is not directly to the
7 point you're looking at, but I think, as you look
8 at the JUA, it is important to know that the
9 service they've provided has been strong and
10 appreciated by the physicians who are insured with
11 them.
12 And I think, finally, the care providers
13 -- the New Hampshire physicians in particular --
14 want as many options as can be available, both in
15 the commercial marketplace and through systems
16 like the JUA.
17 And one of the questions that you've
18 obviously asked is to comment on the -- what is
19 the best way to make malpractice insurance
20 available on a guaranteed-issue basis? And many
21 of the physicians who I've talked to about this
22 issue who are insured with the JUA feel that we
23 have that system in place currently.

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1 So for those reasons, the medical
2 society and its member physicians support the
3 continuation of the JUA, although recognizing
4 there may need to be some modification to reflect
5 the time frame we're in now -- 2014 -- as opposed
6 to when the legislation or the regulations were
7 initially issued.
8 Thank you.
9 COMMISSIONER SEVIGNY: Good. Thank you
10 very much, Rob.
11 Again, just to capture a little bit of
12 what you said, the -- the JUA -- that a
13 risk-sharing mechanism addresses the need to
14 provide a way for providers that take on very
15 high-risk patients to be able to get coverage,
16 where they may not be able to get it in the open
17 market -- at least that's some sense -- that they
18 may not be able to get it in the open market if
19 they weren't using the JUA.
20 MR. LANNEY: Yes. I also think that
21 there have been a lot of relationships that have
22 been formed over the years with the physicians who
23 have been with the JUA for many years in terms of

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1 claims handling that is an important part of what
2 the JUA has done. There have been institutional
3 people there, have been there for many, many
4 years; they form relationships with the
5 physicians.
6 And so in addition to the whole
7 availability and affordability, there is also a
8 relationship and a bonding that has gone on
9 between the organization and its insureds.
10 COMMISSIONER SEVIGNY: So it's, in part,
11 the need; and it's, in part, the fact that it
12 provides a service to those that avail themselves
13 of it appreciate.
14 MR. LANNEY: Sure.
15 COMMISSIONER SEVIGNY: And if I heard
16 you right also, it provides another option in the
17 marketplace?
18 MR. LANNEY: Yes, sir.
19 COMMISSIONER SEVIGNY: Okay. Good.
20 Thank you.
21 Next, Jim Vaccarino.
22 MR. VACCARINO: Thank you, Commissioner.
23 My name is Jim Vaccarino,

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1 V-a-c-c-a-r-i-n-o.
2 COMMISSIONER SEVIGNY: I'm sorry. I was
3 supposed to spell it.
4 MR. VACCARINO: I'm happy to do it.
5 I've been involved with the New
6 Hampshire JUA since 1984 -- administering the
7 program since that time.
8 And I thought I'd just give a brief
9 five-year history of some of the salient points of
10 operation for your benefit -- obviously you know a
11 lot of this, but also for the benefit of those
12 attending the hearing -- from an underwriting
13 perspective, a claims perspective, and just an
14 operational perspective.
15 During the period 2010 through the third
16 quarter of this year, the JUA saw a decrease in
17 the number of insured policyholders from 676 in
18 2010 to 550 in 2011; 504 in 2012; 469 in 2013; and
19 457 as of today.
20 The split between those purchasing
21 claims made and a coverage [verbatim] has remained
22 relatively constant at 65 percent claims made and
23 about 35 percent occurrence; and the written

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1 premium, as of January 1st, 2010, was 6.02
2 million, and at the end of the third quarter of
3 this year was 2.07 million. So you can see the
4 dramatic decline.
5 The JUA has also funded \$3.4 million to
6 cover the cost of so-called "tail premium," which
7 are the reporting endorsements of those claims
8 made policyholders who retire under the modified
9 claims made program, which affords them
10 essentially prepaid tail.
11 According to that plan, any insured with
12 a claims made policy who holds that policy for at
13 least 10 years and retires from the practice of
14 medicine at age 55 or later will receive a
15 reporting endorsement at no cost.
16 As of January 1st, 2010, there were a
17 total of 37 policyholders that were experience
18 rated for excessive indemnity paid. The number of
19 experience-rated policyholders as of today is down
20 to 27; and they account for \$49,800 in surcharges
21 on their premiums.
22 During the summary period, the five-year
23 period, the JUA has each year offered a 15 percent

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1 premium credit to any policyholder taking
2 advantage of a risk management home study course.
3 The courses have mirrored issues which reflect
4 what we believe to be areas of concern for the
5 JUA, such as poorly-written medical records or
6 misdiagnosis. We carry a large number of
7 radiologists, and misdiagnosis is a fairly common
8 claim.
9 Interestingly enough, for 2014, of 419
10 eligible policyholders to take this credit, only
11 182 took the course, which I thought was very
12 interesting.
13 On a claim -- from a claims perspective,
14 we've seen a fairly constant payout of claims in
15 total paid indemnity. In 2010, we paid 3.4
16 million; 2011 was a heavy year at 6.9 million
17 paid; but 2012 was 2.8; 2013, 2.9; and thus far --
18 and I'm pretty sure this is it for the year -- 3.1
19 for 2014.
20 Outstanding case reserves have come
21 down. In 2010, the outstanding reserves for
22 indemnity were 11.3 million; 2011, 8.8; 2012, 5.6;
23 2013, 5.5; and this year, 6.4 million for

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1 outstanding case reserves.
2 Actually, I'm -- I'm pretty pleased with
3 the comments that Mr. Lanney made about the
4 claims, because our posture in claims management
5 has led to the surpluses that we've experienced by
6 being fairly tight with the JUA funds and not
7 paying claims unless the demands are reasonable
8 and the claim is legitimate.
9 For the period 2010 through 2014, save
10 for the distribution of the \$110 million, the
11 investment portfolio has grown. While it was
12 164.5 million in 2010, then it dropped to 62.3
13 with a payment of the 110. But in 2012, it went
14 from 62 to 76 million; 2013, to now 81.9; and this
15 year it's at -- at the end of the third quarter --
16 82.9.
17 Lastly, with respect to actuarial
18 activity, no rate change was effected in either
19 2010 or 2011. But in 2012, the JUA increased
20 rates by 12 percent; 3.5 percent in 2013; and 4
21 percent in 2014.
22 In 2013 the JUA board established a
23 premium deficiency reserve of \$600,000 as security

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1 in the event that premiums collected were
2 insufficient against projected liabilities and
3 expenses.
4 The JUA actuaries have recommended an 80
5 percent rate increase overall for both claims made
6 and occurrence for the coming year, 2015; and the
7 board has yet to act on that recommendation.
8 In 2010 the New Hampshire legislature
9 passed Senate Bill 170, obligating the JUA to
10 distribute a surplus of \$110 million to
11 policyholders of record from 1986. The result of
12 the senate action has seen a number of material
13 changes to the JUA structure. The most
14 significant is the elimination of the JUA's
15 exemption from federal tax, and the formation of
16 this legislative study commission which has
17 resulted in this hearing.
18 To get directly to the points that
19 you've raised, the one thing that I've learned
20 over the period -- '84 to today, looking back, is
21 that there is definitely a need for a residual
22 market mechanism in a state with a thin market for
23 medical professional liability.

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1 And in reflection, it's interesting to
2 hear the testimony. Everybody touches on a
3 different perspective or a different aspect of the
4 need for that residual market, from the four --
5 what I've come to believe are of the four basic
6 constituencies: There are the providers; and
7 clearly the providers are interested to make sure
8 that there is coverage available so they can go on
9 and continue their practices.
10 But from the regulator's perspective as
11 well, so that, in the event that there's a
12 crisis -- as there was back in '76 -- that there's
13 a mechanism in place that's able to absorb the
14 problem.
15 The industry perspective: We see the
16 industry as being competitive, but the industry --
17 the residual market mechanism permits the industry
18 -- the med mal industry -- the luxury of deciding
19 to write or not write a certain piece of business.
20 If they decide to decline somebody, there is a
21 market that that person can go to.
22 If they decide that they want to drop
23 somebody because they're of a greater risk, there

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1 is a mechanism they can use to keep their book
2 more profitable than it would be if they were
3 forced to keep that person.
4 And then, lastly, the most important
5 constituency is the public. The public is assured
6 that they will have access to healthcare
7 providers, because those providers are required to
8 carry malpractice insurance if they want to have
9 any privileges at any facility in the state -- or
10 hospital.
11 So as I look at it, yes, I think there's
12 definitely a need for a residual market mechanism.
13 The format -- there are a variety of different
14 ways of approaching it. And whatever the
15 department and the legislature decides to
16 approach, the JUA will be happy to -- I'm sure the
17 board will be happy to cooperate with.
18 Thank you.
19 COMMISSIONER SEVIGNY: Good. Thank you
20 very much, Jim.
21 Just to give a brief recap: The JUA's
22 been well run for a number of years.
23 And No. 2, the JUA and its board

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1 believes that there is continued need for some
2 form of risk-sharing mechanism so that the
3 providers can access coverage outside of the
4 commercial market if they need to; and consumers
5 or patients are protected because their providers
6 have the coverage.
7 MR. VACCARINO: Right.
8 COMMISSIONER SEVIGNY: Thank you.
9 MR. VACCARINO: Thank you.
10 COMMISSIONER SEVIGNY: Next, if Scott
11 Colby could provide us with comments, please?
12 MR. COLBY: Thank you, Commissioner.
13 I'm Scott Colby from New Hampshire Medical
14 Society; and the medical society does support the
15 existence and continuation of the JUA. And
16 whether or not that needs to take a slightly
17 different form, we believe that the legislature
18 would be well serving -- would be serving the
19 public well by studying the issue further and
20 determining whether the current structure is, in
21 fact, the appropriate structure.
22 We would suggest that the current
23 structure does operate properly in the market; and

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1 that, to Mr. Lipman's point, that we are currently
2 not in a crisis mode in New Hampshire; and we
3 would offer that we're not in a crisis mode in
4 large part due to the mere existence of the JUA;
5 that the JUA itself acts as a very stabilizing
6 force.
7 We've heard some suggestion that in
8 certain instances the JUA may compete more
9 aggressively than the private market because they
10 have the luxury to do so.
11 That was my belief. And in the spirit
12 of full disclosure, I am a licensed producer and
13 the medical society has a wholly-owned subsidiary
14 that offers property and casualty products to
15 healthcare providers in the State of New
16 Hampshire.
17 And what I'm about to say may go a
18 little bit contrary to some of our insuring
19 partners, but I'll continue.
20 Up until Monday, I was under the
21 distinct belief that the private market couldn't
22 compete on premium relative to a specific
23 specialty -- in this instance, radiology.

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1 Monday our business partner who works
2 with us on the agency was able to provide a couple
3 of quotes -- one for an admitted carrier; one from
4 a nonadmitted carrier -- that actually was very
5 competitive relative to radiology specialty.
6 So my point is that, if the JUA's
7 existence can help create competition in what
8 should be characterized as an oligopoly -- high
9 barrier to entry, few players in the market --
10 then it's doing its proper role in ensuring real
11 competition -- to the benefit, ultimately, of New
12 Hampshire citizens.
13 So in closing, I think Attorney Lanney
14 definitely touched on some really good issues
15 relative to bad outcomes don't always mean medical
16 malpractice, yet providers realize higher premiums
17 as a result of bad outcomes.
18 And, in short, we would support a study
19 looking at this issue to see exactly what the
20 impact of the JUA is and what the proper structure
21 of the JUA should be moving forward. Thank you.
22 COMMISSIONER SEVIGNY: Thank you very
23 much, Scott.

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1 Again, to recap just a little bit: The
2 New Hampshire Medical Society supports some sort
3 of risk-sharing mechanism. The current form is
4 working well, as far as you're concerned, but not
5 to the exclusion of having the legislature
6 consider what other forms could be available.
7 MR. COLBY: Correct.
8 COMMISSIONER SEVIGNY: -- or could be
9 used.
10 And in addition to that, I think one of
11 the final points you made is that in -- in your
12 mind -- at least most recently -- you see it as
13 helping create competition.
14 MR. COLBY: Yes, sir.
15 COMMISSIONER SEVIGNY: Okay. Good.
16 Thank you.
17 Next, if I could call on Dr. David
18 Strang, S-t-r-a-n-g; please.
19 DOCTOR STRANG: Thank you for getting
20 the spelling correct, Commissioner.
21 My name is Dr. David Strang. I am a
22 partner and officer with Central New Hampshire
23 Emergency -- I'm sorry -- Central New Hampshire ER

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1 Associates, which is a large emergency medical
2 group that provides emergency medical care to the
3 citizens of the Lakes Region of New Hampshire.
4 And a couple of weeks ago when I learned
5 of this hearing, there were a couple of questions
6 that immediately came to mind, which is, one, how
7 many malpractice carriers are needed in New
8 Hampshire to insure a competitive marketplace?
9 Two, what body determined that New Hampshire is
10 adequately supplied with such malpractice carriers
11 such that the JUA can or should be dissolved; and,
12 three, how was that determination made?
13 Furthermore, what has changed in the New
14 Hampshire insurance climate that has welcomed this
15 new adequate amount of carriers? I'm not aware of
16 any legislation that's been filed that makes it
17 easier for carriers to enter New Hampshire and
18 offer policies to our medical providers.
19 And how can we be sure that the climate
20 will not reverse in three years, five years, or
21 longer to drive away these carriers, leaving us
22 with just one or two carriers, at which point we
23 do not have a competitive marketplace?

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1 In reading paragraph 2 of the final
2 report that was handed to all of us as we came
3 through the door here, it's very clear to me that
4 we don't know the answers to these questions.
5 But what troubles me more is the
6 conclusion reached in paragraph 3, which states;
7 and I quote, "Until there is a finding that
8 medical malpractice insurance is not readily
9 available in the voluntary market, then further
10 legislative action is premature."
11 That legislative action would continue
12 the functioning of the JUA. I think until we
13 answer these questions, then, we ought to reach
14 the exact opposite conclusion, which is, that,
15 until there is a finding that medical malpractice
16 insurance is readily available in the voluntary
17 market, then we should welcome further legislative
18 action to keep the JUA functioning and make sure
19 that we have a fair and competitive marketplace
20 for malpractice insurance in the State of New
21 Hampshire. Thank you.
22 COMMISSIONER SEVIGNY: Good. Thank you
23 very much, Doctor Strang.

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1 So if I hear you correctly -- just to
2 summarize the point that you made to address the
3 two questions: You believe that there is
4 continued need for some form of risk-sharing
5 mechanism.
6 DOCTOR STRANG: Yes, I do.
7 COMMISSIONER SEVIGNY: Good. Thank you.
8 That's it for those that have said they
9 would speak.
10 I do have one question, though, that I'd
11 like to get a little more clarity on if I could;
12 and the question is for Doctor Tuttle.
13 DOCTOR TUTTLE: Yes.
14 COMMISSIONER SEVIGNY: You spoke earlier
15 -- and I meant to ask you, but I went on to the
16 next speaker -- you mentioned something about the
17 tail coverage; and that, whatever happens, you
18 would want there to be consideration in some
19 fashion by the JUA by -- somewhere about the tail
20 coverage for those number of providers that could
21 be impacted if the JUA were to be unwound; am I
22 right in that?
23 DOCTOR TUTTLE: Yes, sir. Yes. That's

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1 correct, because whether you have claims made or
2 occurrence, if I -- I have occurrence insurance; I
3 don't think I told you that. I don't remember if
4 I did -- I can lock my door today. If I go to a
5 new company -- I've checked a few companies -- I
6 can buy insurance, but I'll have to work at least
7 five years. And if I retire or close my practice
8 early, I would have to pay some fee -- anywhere
9 from 10,000 to \$60,000, depending on my risk -- to
10 remain covered after that.
11 So I'm -- physicians like me would be
12 harmed; and, therefore, want to lock their door if
13 the JUA went away.
14 The only other thing I wanted to add, I
15 misinterpreted premature -- I was thankful for Mr.
16 Strang's comments. When I said I thought this was
17 premature, I thought -- I meant closing down the
18 JUA, but he interpreted it differently. So I just
19 want to clarify that.
20 I think it's premature to close it; and
21 I wanted to clarify that. Thank you.
22 COMMISSIONER SEVIGNY: Good. Thank you
23 very much.

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1 We do have another -- someone else that
2 has asked to speak.
3 David Luca, please.
4 MR. LUCA: Good morning, Commissioner.
5 Thanks for having us. I'm Dave Luca from Coverys;
6 and I have with me Mike Miller, our vice president
7 of underwriting, in case you have any questions.
8 One of our member companies, ProSelect
9 Insurance Company, is a main carrier here in New
10 Hampshire. And we did submit written comments, so
11 I'll just highlight a few notes, and you have the
12 written comments you can consider as well.
13 As to your first question, whether
14 medical malpractice coverage is readily available,
15 we believe it is. We'll point out that there are
16 16 commercial carriers writing business in New
17 Hampshire that have at least 1 percent of the
18 market share -- not including the JUA.
19 Speaking for ProSelect specifically, we
20 write all types of healthcare providers --
21 midwives, dentists -- in all geographic areas of
22 New Hampshire. We write both claims made and
23 occurrence.

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1 We'll highlight that we don't feel that
2 the JUA is functioning as an option of last
3 resort; and they are functioning more as a market
4 competitor; and their -- the intention is that
5 they were an option of last resort.
6 As for question two, we do think that
7 some kind of -- if there were some kind of
8 residual market mechanism available, we'll echo
9 the earlier testimony that a reinsurance plan
10 could work. And we'll add to that testimony that
11 in Massachusetts, not only do they have a
12 reinsurance plan, but they also are a
13 take-all-comers state; and we think something like
14 that could work.
15 We don't think Massachusetts is
16 necessarily perfect. It might need tweaks, but
17 that, as the earlier testimony said, a reinsurance
18 plan where we could choose to cede insurance, as
19 you cede certain policies to the plan, and because
20 it's a take-all-comers state, everyone -- there is
21 a guaranteed mechanism for coverage for everyone.
22 So like I said, we -- I'll keep it
23 short, 'cause we're thrown on the end here, and we

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1 did submit written comments, but if you have any
2 questions, we'll be happy to try our best to
3 answer them.
4 COMMISSIONER SEVIGNY: Good. Thank you
5 very much.
6 If I were to sort of recap a little bit,
7 Coverys is an extensive writer of medical
8 malpractice coverage, and you've got both claims
9 made and occurrence policies available.
10 And it's your belief that there is
11 significant market availability. I believe you
12 then mentioned that if there is a risk-sharing
13 mechanism that is to be considered for the future;
14 that you believe that a system that -- that maybe
15 New Hampshire should look at what -- what's
16 happened elsewhere with regard to some form of
17 reinsurance mechanism.
18 MR. LUCA: That's right.
19 COMMISSIONER SEVIGNY: Okay. And Chiara
20 says that I forgot Stanley Gorgol, G-o-r-g-o-l.
21 DOCTOR GORGOL: Thank you, Mr. Chairman.
22 My name is Stanley A. Gorgol,
23 G-o-r-g-o-l. I'm a podiatrist; and I guess I'm

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1 one of the oldies, 'cause I got the JUA insurance
2 in November of '78. So I've been a long-time
3 member, so I'll speak to that. But I'm also the
4 executive director for New Hampshire Podiatric
5 Medical Association.
6 We're a small group. There's only 47 of
7 us here in the state. I come to find out that now
8 it's down to 19 of us that have the JUA as a
9 malpractice carrier.
10 Concerning your questions, as far as it
11 being needed, I would say yes. And the reason I'm
12 saying yes is because it has been strongly run,
13 well run, and has been an extreme help to my small
14 profession.
15 There was a crisis in podiatry in the
16 early '80s, where there was no carriers in the
17 country, period. And there was a company formed
18 call PICA, Podiatry Institute, that started
19 insuring. And they're licensed, I believe, now in
20 45 states. They are licensed here in New
21 Hampshire too.
22 However, if I was going to get similar
23 premiums with PICA, it would be 35 percent higher.

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1 There is no tail. As Doctor Tuttle, I have
2 occurrence. I'm old. I'm going to be retiring
3 some day; and if it there is no JUA to cover me in
4 the years that I retire, I don't know how I can
5 manage that, with coming up with -- she cited
6 50,000. I have no idea what the number would be.
7 So in that regard, I feel the JUA is a necessary
8 entity. It needs to continue.
9 Many of the other doctors in my state
10 are employed through either Matthew Thorn -- not
11 Matthew Thorn; I'm sorry - Dartmouth-Hitchcock,
12 you know, Core, and some other places or in large
13 group hospitals like Concord, where they can get a
14 large group, and the podiatrists get covered under
15 them.
16 So as far it maintaining and being
17 continued, I would strongly encourage your
18 committee to allow the JUA to continue. I don't
19 know -- I'm not an insurance person -- what is the
20 best mechanism risk-wise and so forth; that's for
21 you experts to come up with that decision.
22 But I believe it needs to be there. I
23 need to believe -- I believe it should continue

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1 and not cease to exist in 2017. There are
2 carriers out there. But at a significantly higher
3 premium.
4 So to address some of the other
5 speakers, they had made it competitive and
6 worthwhile to our members; and if you're looking
7 out for constituents in this state -- not just the
8 general public -- we're public also. We have to
9 pay these premiums.
10 I'm not employed. I'm a sole
11 practitioner. Therefore, any discount, any help I
12 can get, I'm very much in favor of; and I urge the
13 committee to continue.
14 COMMISSIONER SEVIGNY: Thank you very
15 much, Doctor.
16 If I were to, again, capture what --
17 what you've just testified to, you believe that
18 the -- that a risk-sharing mechanism is -- is
19 needed. The form of this risk-sharing mechanism
20 should allow for a guaranteed issue -- did I get
21 that out of there -- so the providers can get
22 courage.
23 DOCTOR GORGOL: Yes, sir.

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1 COMMISSIONER SEVIGNY: You believe the
2 JUA, in its current form, is well run.
3 DOCTOR GORGOL: Yes, sir.
4 COMMISSIONER SEVIGNY: You indicated
5 that coverage, although available for your
6 specialty, for example, the cost is significantly
7 greater than what you would -- than what you
8 currently pay in the -- as a JUA insured.
9 DOCTOR GORGOL: Yes -- with no tail.
10 COMMISSIONER SEVIGNY: And -- and that
11 tail coverage is a -- is a major concern of yours,
12 as it was with Doctor Tuttle -- and other
13 providers, I would imagine, in New Hampshire.
14 In addition to that, you mentioned that
15 JUA's existence -- you've seen it have an impact
16 on healthy competition in the state.
17 DOCTOR GORGOL: Yes, sir.
18 COMMISSIONER SEVIGNY: Did I essentially
19 capture what...
20 Next I'll ask Dr. Mark Timmerman,
21 T-i-m-m-e-r-m-a-n, please.
22 DOCTOR TIMMERMAN: I'm a sole family
23 practitioner from Merrimack, New Hampshire.

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1 I have not recently researched the
2 availability of coverage, but want to emphasize my
3 comfort in the State of New Hampshire -- finding
4 the JUA is of significant importance in an
5 environment where I see so many other things in
6 the environment changing, including large group
7 practices and the -- the abilities of factors we
8 may not able to predict to alter medical coverage.
9 And I feel the comfort of my own state providing
10 that coverage to be a very important factor to me.
11 I would propose that the most important
12 thing to me is the JUA be preserved. If the JUA
13 needs to be in some other format, that that be a
14 further-down-the-line and secondary determination.
15 That might make it easier to -- to meet the
16 continuing needs and -- and to do it at a
17 comfortable situation.
18 I'm not opposed to it being changed, but
19 I think that preservation is a first priority that
20 I would appreciate.
21 Thank you.
22 COMMISSIONER SEVIGNY: Okay. Thank you,
23 Doctor.

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1 If I've captured it right, you're -- one
2 of the priorities that -- first of all, you
3 indicated that having a risk-sharing mechanism
4 like the JUA in place provides the comfort that
5 you need, as a -- as a sole practitioner -- as a
6 provider, to be able to access coverage.
7 DOCTOR TIMMERMAN: Yeah.
8 COMMISSIONER SEVIGNY: But the future's
9 uncertain; and to simply not have a risk-sharing
10 mechanism -- whether it be in the form of the JUA
11 or some other form where there's guaranteed
12 coverage -- would be -- would be a mistake.
13 DOCTOR TIMMERMAN: I agree.
14 COMMISSIONER SEVIGNY: Okay. Thank you.
15 Is there anyone else that would like to
16 testify?
17 Yes, sir. Please state your name and
18 etcetera.
19 REP. HANSEN: Thank you, Commissioner.
20 My name is Representative Peter Hansen,
21 a member of the New Hampshire House and have -- I
22 would say -- somewhat extensive experience with
23 the JUA on some other issues.

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1 Having said that, I think it's important
2 for our notes today to reflect a number of things,
3 if you don't mind: One of them is -- is
4 aggressive claims resolution. It's -- it was
5 mentioned by, I think, the folks from the JUA that
6 one of the reasons their premiums are so low is
7 because they had aggressive claims resolution.
8 I think if we reflect back on the -- the
9 industry of Workmen's Compensation, at one time,
10 we found that aggressive claims were not -- were
11 not in place at the time; and -- and the -- and
12 the providers were using that as a -- as a
13 mechanism to raise their rates. And I think it
14 should be noted that, with someone -- something
15 like the JUA remaining in position, that this will
16 help us to at least caution the public companies
17 that they need to tend to business.
18 I also concur that competition is very,
19 very necessary in the state in this industry; and
20 particularly I think it should be noted that we
21 need to pay attention to issues about tail and
22 occurrence insurance.
23 Thank you.

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1 COMMISSIONER SEVIGNY: Good. Thank you
2 very much, Representative Hansen. Appreciate your
3 comments.
4 If I were to capture it, you -- you
5 mentioned the fact that it's -- that handling
6 claims -- and specifically now in medical
7 malpractice, but you also used an analogy to
8 Workers' Compensation -- in an aggressive,
9 effective fashion is a very important component of
10 success in the med mal business.
11 REP. HANSEN: As far as premiums are
12 concerned, that's very true; yes.
13 COMMISSIONER SEVIGNY: You also
14 indicated that, whatever the state does, we need
15 to be very mindful of both tail coverage and
16 occurrence.
17 REP. HANSEN: That's also correct.
18 And one final comment, if I might?
19 COMMISSIONER SEVIGNY: Please.
20 REP. HANSEN: There was talk about a
21 stress test on the industry itself. I think it's
22 important that we keep in mind that, just like
23 ourselves -- our bodies -- we can do a stress test

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1 today, and we'll be fine. If we do the same
2 stress test five years from now, it may be very,
3 very different.
4 And I think that to put a lot of
5 emphasis on today's stress test would be
6 unadvisable.
7 COMMISSIONER SEVIGNY: Thank you, sir.
8 If you would allow me to draw a
9 conclusion that, for the factors you mentioned,
10 that some sort of risk-sharing mechanism --
11 whether it be the JUA in its current form or some
12 other that provides guaranteed issue -- and that,
13 just in case something happens in the industry,
14 continue to be in place.
15 REP. HANSEN: That's correct.
16 COMMISSIONER SEVIGNY: Okay. Thank you.
17 REP. HANSEN: Thank you.
18 COMMISSIONER SEVIGNY: Is there anyone
19 else that -- yes. In the back of the room. Name.
20 And come to a speaker, please.
21 MS. HOWARD: My name is Judy Howard; and
22 I'm a -- H-o-w-a-r-d -- I'm a licensed producer in
23 the State of New Hampshire at People's United

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1 Insurance Agency; and I've been an agent for 30
2 years here.
3 And my concern about the JUA is that --
4 I think it's expertly run. I think that they do a
5 great job. And the market seems to be very
6 volatile for agencies where companies come and go.
7 They come; they want the business; they get the
8 business; and then, the next thing you know,
9 you've got to replace it in three years.
10 And it just seems like the JUA provides
11 a great deal of stability for us and for our
12 clients. And they offer affordable insurance.
13 They offer insurance for low-risk practices.
14 And some of the other companies that
15 we've looked into can't insure naturopathic
16 doctors, homeopathic doctors, and other
17 alternative medical -- nonmedical kinds of
18 practices.
19 And so I just think that the JUA, as it
20 currently operates, is excellent for those kinds
21 of businesses. And that's all.
22 COMMISSIONER SEVIGNY: Good. Thank you
23 very much.

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1 If I were to capture a little bit of
2 what you said here, you believe that the JUA is
3 very, very well run. And you believe that it
4 serves -- that it serves a function when there is
5 market turmoil; and that carriers could come and
6 go.
7 You also indicated that the JUA provides
8 a low-cost alternative to -- to insureds.
9 MS. HOWARD: Well -- and especially for
10 the businesses that never have claims. You go to
11 another carrier, and you ask about it, and they
12 can only offer claims made or they're charging,
13 you know, 50 percent more, 100 percent more, 400
14 percent more for, you know, businesses that you
15 can prove have never had a claim in 30 years.
16 And so it just seems, you know, some of
17 these companies should be thinking about -- maybe
18 if they really want to compete against the JUA --
19 should be thinking about alternative medicines
20 that -- or, you know, alternative therapies. They
21 don't really offer much for them.
22 And when I got the notice of the
23 hearing, I called around to a lot of these brokers

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1 that are looking for medical malpractice business
2 and other companies, and none of them could offer
3 me occurrence form policies.
4 Now, I may not have access to every one.
5 There are some that are -- have become direct
6 writers and taken business away; and so we don't
7 have access to those.
8 But I think the JUA is an excellent
9 resource for us, for our clients, and I've enjoyed
10 working with them.
11 COMMISSIONER SEVIGNY: Good. Thank you.
12 So, you know, again, part of your last
13 statement was -- although the coverage may be
14 available, it's not immediately available to you
15 because of some -- some of what's happened in the
16 marketplace with direct writers and things of that
17 name.
18 MS. HOWARD: Yeah. But we probably have
19 20 brokers that are asking us for med mal
20 business; and when you talk to them about
21 acupuncturists and physical therapists -- the
22 people who aren't MDs -- there really isn't a
23 great alternative from the JUA. So...

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1 COMMISSIONER SEVIGNY: Good. Thank you.
 2 Is there anyone else that would like to
 3 provide testimony this morning?
 4 Yes. Back of the room.
 5 DOCTOR CRANFORD: My name is Dr. Kathryn
 6 Cranford, and I'm a naturopathic physician
 7 licensed in New Hampshire; and I'm also a New
 8 Hampshire certified midwife.
 9 And I would just add to what's already
 10 been said about the necessity of the JUA to some
 11 of those of us who practice outside of MD
 12 medicine, that my experience is, as a naturopath,
 13 having had coverage with two other companies, that
 14 when they -- a year, two years down the line --
 15 decided that they didn't want to cover me because
 16 of my midwifery exposure, they would discontinue
 17 my policy as a naturopath as well.
 18 And to have local affordable coverage
 19 that covers me as a naturopath and as a home-birth
 20 midwife, where my population, according to my
 21 license and my law, has to be low risk, this is
 22 something that my small private practice -- solo
 23 practitioners can absorb.

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1 Some of the larger policies are out
 2 there, but my small practice and what I am
 3 reimbursed by both Medicaid and by insurance for
 4 home birth doesn't begin to allow me to pay for a
 5 -- for a policy from the general market.
 6 And so the fact that the JUA exists
 7 keeps open to the public some of these options
 8 when they are low risk and know exactly what
 9 they're looking for in the market, we're still
 10 available to them.
 11 But if this goes away, we very well may
 12 not be available to them.
 13 COMMISSIONER SEVIGNY: Good. Thank you,
 14 Doctor.
 15 So to sort of recap what you -- what you
 16 mentioned, in your specialty, you find that there
 17 -- there can be or has been in the past occasions
 18 of difficulty in both availability and
 19 affordability of coverage; that, if it's
 20 available, it may be beyond what you would be able
 21 to reasonably afford; and that the -- if I were to
 22 reach some sort of conclusion here, that
 23 risk-sharing mechanism needs to be continued.

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1 DOCTOR CRANFORD: Yes. Thank you.
 2 COMMISSIONER SEVIGNY: Thank you.
 3 Is there anyone else that would like to
 4 speak this morning?
 5 Thank you. Let me close this portion of
 6 the hearing. That is to say, we're going to leave
 7 open, as I mentioned, the opportunity to submit
 8 written comments. Please submit those written
 9 comments by next Thursday, December 11th, so that
 10 they can be included as part of the thought
 11 process that we need to go through here at the
 12 department in order to be able to provide the
 13 legislature with the best information we possibly
 14 can.
 15 And, again, thank you for joining us all
 16 this morning.
 17 (Whereupon the hearing recessed at
 18 11:18 a.m.)
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 21
 22
 23

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1 CERTIFICATE
 2
 3 I, P. Jodi Ohnemus, New Hampshire LCR #91,
 4 do hereby certify that the foregoing transcript
 5 pages 1 through 69 is a true, accurate and
 6 complete transcript of my stenotype notes taken to
 7 the best of my knowledge, skill and ability.
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 17
 18 P. Jodi Ohnemus, LCR #91
 19 RMR, RPR CRR
 20
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 22
 23

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