STATE OF NEW HAMPSHIRE

INSURANCE DEPARTMENT

REPORT on AVAILABILITY of MEDICAL MALPRACTICE INSURANCE

New Hampshire Medical

Malpractice Joint Underwriting Association (JUA)

February 19, 2015

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1. EXECUTIVE SUMMARY

The New Hampshire Insurance Department submits this report to the Legislature pursuant to recommendations contained in a final Report of the Commission to Study the New Hampshire Medical Malpractice Joint Underwriting Association, 404-I:1 (HB 489, Chapter 293:1, Laws of 2014). In its report, the Commission requested that the New Hampshire Insurance Department conduct a public hearing, inviting insurance companies and interested parties to present testimony and evidence as to the availability of medical malpractice insurance and whether the public interest supports the continued operation of the state's Joint Underwriting Association or some other form of risk-sharing plan. The Commission recommended the public hearing be focused on two key questions:

> (1) Is medical malpractice insurance readily available to health care providers in New Hampshire?
>
> (2) If such coverage is not readily available in the voluntary market, what form of risk-sharing plan to make coverage available on a guaranteed-issue basis is supported by the public interest?

The public hearing was conducted by the Department on December 4, 2014. The Department, through information gathered at the hearing and through additional research, testimony and surveys, finds that medical malpractice insurance is readily available in New Hampshire. Therefore, in accordance with instructions from the legislative commission that requested this report, the Department has prepared proposed legislation to wind down the JUA. This draft of proposed legislation is attached.

The Department also prepared an Addendum to this report to address other issues raised in the public hearing, anticipating these issues will be of interest to the Legislature and interested parties. The Addendum includes: discussions regarding the affordability of insurance; options for providing for a residual market plan despite the current availability of coverage, including continuation of the JUA; and, finally, comments concerning the impacts of JUA closure on JUA insureds who wish to retire or who are approaching retirement age.

2. BACKGROUND

A. Creation of the New Hampshire Medical Malpractice Joint Underwriting Association (JUA)

In 1975, many New Hampshire doctors were unable to obtain medical malpractice insurance because insurers were cancelling or not issuing coverage. This caused fewer doctors to practice in the state, which meant that residents were potentially losing access to needed medical care. [See "Background" Medical Liability Report of 1986, Attachment 1, page 006 and 013] The Insurance Commissioner sought to remedy this by drafting a bill, SB 92, to amend RSA 404-C to permit the Commissioner to establish a plan by administrative rule to address the medical malpractice crisis. [Attachment 2, page 058]

The Legislature accepted the Commissioner's plan and enacted SB 92, which took effect August 2, 1975, as Chapter 218, Laws of 1975. Under the new law, the Commissioner had authority to create a "residual market plan" or insurance industry "risk sharing plan" for medical malpractice insurance when the insurance market had failed. After holding a public hearing to gather information, the Commissioner determined that: (1) medical malpractice insurance is "not readily available in the voluntary market," and (2) "the public interest requires such availability."[1] [Attachment 3, page 72]

In accordance with RSA 404-C:1, the Commissioner adopted an administrative rule to establish a Joint Underwriting Association, which would guarantee medical malpractice coverage to all eligible medical providers who otherwise were unable to obtain it.[2] This rule, currently Ins 1700, established the New Hampshire Medical Malpractice Joint Underwriting Association (JUA) and controlled its operation. Since 1975, the rule has been amended and readopted dozens of times by successive Commissioners. The rule, in accordance with state law,[3] expires on January 30, 2017, and must be readopted in order for the JUA to continue operations.

However, the Joint Legislative Committee on Administrative Rules has raised questions as to the Commissioner's authority to re-establish and control the operation of the JUA by administrative rule. The Committee has determined that the Commissioner's control or management of the JUA by rulemaking is beyond the duties of the Commissioner under RSA 400-A:15 and RSA 404-C and is in conflict with RSA 400-A:12 and RSA 402:11-a.

B. Commission to Study the JUA

Questions have been raised in recent years concerning not just the proper role of the Commissioner but also the role of the JUA in the insurance market and whether it actively competes with private insurers by offering coverage at discounted or below-market rates, which would be inconsistent with the principles articulated in RSA 404-C:2,II.

The JUA's continuation is further complicated by the enactment of SB 170 and distribution of excess surplus to policyholders, which has resulted in the loss of the JUA's federal exemption from taxation. Effective January 1, 2013, as part of a Closing Agreement with the IRS, the JUA

[1] The enabling statute states as follows: "**404-C:1 Establishment of Plans. –** If the commissioner of insurance finds after a hearing that, in any part of this state, automobile insurance, aviation insurance, property insurance, workers' compensation, accident and health insurance or any form of liability insurance is not readily available in the voluntary market and that the public interest requires such availability, he may, by rule, either adopt plans to provide such insurance coverage for any risks in this state which are equitably entitled to but otherwise unable to obtain such coverage, or he may call upon industry to prepare plans for his approval."

[2] Under the standard in RSA 404-C, the Commissioner in creating a plan must "[g]ive consideration to… alternative methods of improving the market affected." In other words, the Commissioner must determine what form of plan would improve the private market. See RSA 404-C:2,I(b). The Commissioner also must consider which form of plan would cause "minimal interference" with the private market. See RSA 404-C:2,II. These statutory requirements help ensure that any plan created helps to strengthen, not further weaken, the private market. Therefore, under the law, the Commissioner cannot create a plan that provides insurance at below-market prices, as this would discourage growth in the private market.

[3] See RSA 541-A:16, III.

forfeited its federal tax exemption and became subject to federal and state taxation. In addition, because of the nature of the JUA's agreement with the IRS on its tax status, any legislative reauthorization of the JUA must be conducted carefully to avoid adverse state and federal tax treatment of the assets it holds. The Supreme Court's ruling in Tuttle v. State of New Hampshire also may constrain the manner in which the JUA uses or allocates excess surplus funds, which further complicates any restructuring. All these developments have brought attention to the JUA and the Legislature's interest in determining the JUA's role in the insurance market and what will be the proper mechanism for control and oversight over the JUA.

In 2014, the Legislature in HB 489 (Chapter 293:2, Laws of 2014) established a commission to study the JUA. This was the second Commission in three years to undertake this task. As with the prior Commission (enacted by SB 170, Chapter 201:2, Laws of 2011), the most recent Commission to Study the JUA was charged with making recommendations for proposed legislation concerning the JUA's future, form, and function.

The most recent Commission issued a report in November 2014 [Attachment 4, page 074]. The Commission found that the JUA exists only by virtue of an administrative rule (Ins 1700), which will expire in January 2017. The Commission also found that the Insurance Commissioner cannot act without legislative direction to reauthorize the JUA when Ins 1700 expires in two years. The Commission notes that if no legislative direction is provided in 2015, the Commissioner must begin to wind down JUA business under court supervision.

The Commission does not include any recommendation as to the JUA's future, form, or function. Instead, the report concludes that necessary legislation cannot be prepared unless there is a determination on whether medical malpractice coverage is readily available in the voluntary market. If medical malpractice coverage is not readily available, the report states, a further determination as to what form of risk-sharing plan, supported by the public interest, is required.

Because the Commission did not have sufficient time to address these two questions, it recommended that the Insurance Commissioner conduct a public hearing, inviting insurance companies and interested parties to present testimony and evidence as to the availability of medical malpractice insurance and whether the public interest supports the continued operation of the JUA or some other form of risk-sharing plan. The Commission's report asks the Insurance Commissioner to submit a report detailing these findings to the leadership of the House of Representatives and Senate.

C. Department Public Hearing

In accordance with the Commission's November 2014 recommendation, the Department issued a public notice of hearing. [Attachment 5, page 090] The Department published the public notice in all New Hampshire daily newspapers and posted it on the Department's website. [Attachment 6, page 092] The JUA also sent notice of the hearing by direct mail to all current JUA policyholders. In addition, the Department invited the top five writers of medical malpractice insurance and the two insurance producer associations to present testimony at the hearing. [Attachment 7, page 095-096] The Department also sent the notice to legislative leaders.

The JUA issued survey questions to its members to solicit additional information to supplement testimony presented at the hearing. [Attachment 8, page 098] The results of this survey are attached. [Attachment 9, page 100-101] When the Department was contacted by medical providers, the Department transmitted similar survey questions, and those results are also attached (in aggregate, as this data is confidential commercial or financial information under RSA 91-A:5, IV) [Attachment 10, page 103-104]. The Department also submitted a data request to the top five insurers offering medical malpractice coverage. [Attachment 11, page 107]. Data obtained from insurers constitutes confidential commercial or financial information under RSA 91-A:5, IV, and results are provided in aggregate. [Attachment 12, page 109-110] A data request also was sent to the JUA [Attachment 14, page 112-115] The JUA presented a response to the data request in both public and written testimony. [Attachment 14, page 131-134 and Attachment 15, page 170-172]

The public hearing was conducted on December 4, 2014, in the hearing room at the NH Public Utilities Commission. Approximately 50 people attended [Attachment 16, page 194-196]. The Department also accepted written testimony, and it solicited additional testimony to supplement testimony provided at the hearing. [Attachment 17, page 118-159] The transcript of the hearing is attached. [Attachment 15, page 161]

At the hearing, the Insurance Commissioner asked those testifying to address the two questions presented in the Commission Report:

(1) Is medical malpractice coverage readily available in the voluntary market?

(2) If such coverage is not readily available in the voluntary market, what form of risk-sharing plan to make coverage available on a guaranteed-issue basis is supported by the public interest?

3. AVAILABILITY of MEDICAL MALPRACTICE INSURANCE

A. Determining Availability

In evaluating the first question presented, of whether medical malpractice insurance is readily available, the Department must be guided by existing law. The JUA Commission, in its report, notes that the question of availability "is rooted in RSA 404-C, which sets out the conditions under which a government-sponsored market facility, that relies on financial support from assessments on the insurance industry, can be created in order to ensure access to coverage."

Since the enactment of RSA 404-C in 1971, the Department has applied RSA 404-C and analyzed the availability of insurance in the creation and maintenance of residual market plans established for automobile insurance, health insurance, and workers' compensation insurance, as well as for medical malpractice insurance. Under RSA 404-C, The Department has been guided by the following principles in the evaluation of availability:

- Insurance may be considered readily available even if some individual medical providers cannot secure coverage. Insurers may refuse to insure some health care providers without triggering a finding of "lack of ready availability." For example, insurers may refuse to insure those who are providing care without adequate training, who have been subject to disciplinary action, who have lost their license to practice, or who have been convicted of falsifying medical records – and the Department may still consider medical malpractice insurance to be readily available. The Department does not regard it as a market failure when insurers refuse to insure health care providers who have demonstrated they cannot practice consistently with the medical standard of care, to the detriment of their patients.

- Insurance may be expensive, even unaffordable, but still considered readily available under RSA 404-C. The cost of insurance is not a factor to be considered in a determination of availability under RSA 404-C. The statute authorizes the Commissioner to find that insurance is not available and then to require insurers to participate in a plan in order to make insurance available. But under the law, the Commissioner cannot create a plan to make insurance available at a discount to policyholders or require insurers participating in the plan to subsidize the cost of insurance for policyholders.[4] RSA 404-C:2, II, requires state-sponsored plans to minimally interfere in the private market. Therefore, a state plan cannot offer discounted insurance, competing for policyholders and drawing policyholders away from private insurers. This would impermissibly interfere with the private market and exacerbate a failed market condition. Furthermore, the Department does not have the authority to create a mechanism to subsidize the cost of medical malpractice insurance for policyholders who cannot afford to purchase insurance. Therefore, under RSA 404-C, the cost of insurance is not a factor in determining availability.

- Insurance carriers may limit the manner in which health care providers practice, and insurance still may be considered readily available. Proper risk management practice may dictate what medical procedures the provider can perform or how those procedures should be performed (e.g. in an office setting versus hospital setting). This, on its own, would not cause the Department to find that malpractice insurance is unavailable. "Ready availability" does not require that insurance be available without regard to appropriate risk management constraints, so as to permit any health care provider's preferred manner of practice or approach to practice.

- The Department's availability standards do not require that policies provide "occurrence coverage" in order for insurance to be readily available. An occurrence policy provides coverage for any claim arising out of treatment provided while the policy is in effect,

[4] See State Farm Mutual Automobile Insurance Company v. Whaland, 121 N.H. 400 (1981), in which the court discusses the plan established by the Commissioner under RSA 404-C to address unavailability of automobile insurance. This plan required that the premium charged to plan policyholders be based upon actual loss experience and classifications. The plan however, prohibited insurers from charging a higher premium based solely upon the fact that the policyholder was insured through the plan. The Supreme Court found that the plan did not impermissibly interfere in the private market because insurers were "free to seek additional or increased rates, providing they are based on tangible factors that justify the levy of a higher premium."

regardless of when the claim is actually filed.[5] Whereas "claims-made" coverage provides coverage only for claims filed while the policy is in force.[6] While a medical provider may prefer to purchase an occurrence policy, but if the insurance market offers only claims-made coverage, the Department may nonetheless consider medical malpractice coverage to be readily available.

- Medical malpractice insurance may be offered by relatively few insurers and still be found to be readily available. Medical malpractice is a specialty coverage, and, as a result, relatively few insurers may sell this coverage. As long as those insurers offer sufficient coverage to protect against liability claims, the Department will consider medical malpractice insurance to be readily available.

- The medical malpractice market may be declared "noncompetitive" in accordance with RSA 412:13, and medical malpractice insurance nevertheless may be considered readily available. A finding of a noncompetitive market has a direct impact on the regulation of the rates filed by companies selling medical malpractice,[7] but a noncompetitive market may still offer what the Department considers to be readily available insurance to the medical community.

To determine whether medical malpractice insurance is readily available to medical providers in New Hampshire, the Department looked for evidence that health care providers are unable to obtain medical malpractice insurance. Any of the following circumstances would indicate that medical malpractice is not readily available: (a) active residual market plans in all neighboring New England states; (b) consistent guidelines for the major medical malpractice insurance writers indicating an unwillingness to insure a class or classes of health care providers; (c) indications that a significant number of health care providers each year are denied coverage and have turned to the JUA for coverage; (d) evidence that a significant number of health care providers have had their coverage in the voluntary market cancelled/nonrenewed; or (e) indications that the JUA is the sole source of insurance for any given class of health care provider.

[5] If a medical provider has had claims-made coverage at any time during his or her career, that provider must purchase "tail" or extended reporting coverage upon retirement to protect against claims filed after the last claims-made policy expires. This additional coverage will extend protection for subsequently reported claims-- even claims reported years after the claims-made policy was in force. For this reason, many health care providers prefer to purchase only occurrence coverage, which provides coverage for claims regardless of when they are reported. Purchasing occurrence coverage avoids the additional cost (upon retirement) of purchasing a "tail" policy.

[6] It is difficult for insurers to forecast whether the premium collected when an occurrence policy is sold will be sufficient to cover losses that might be reported many years in the future. For this reason, many insurers now offer only claims-made policies.

[7] See discussion in the Addendum to this report concerning the Department's review of medical malpractice rates in a noncompetitive market.

B. Residual Market Plans - New England Region

The Department looked to other New England states to see which had state-sponsored residual market plans. The presence or absence of such plans in other states may indicate whether medical malpractice is readily available in New Hampshire. The adoption of residual market plans in nearby states may indicate that medical malpractice insurance is not readily available in the region, unless there is some circumstance in New Hampshire that is unique and impacts the availability of insurance. Conversely, the absence of residual market plans in neighboring states would indicate that medical malpractice likely is available to health care providers in the region.

Massachusetts and Rhode Island have adopted residual market plans for medical malpractice insurance. Massachusetts mandates that all insurers "take all comers." This means medical malpractice insurers may not refuse to issue a policy to a health care provider seeking medical malpractice coverage. However, Massachusetts also has in place a reinsurance pool, and insurers can transfer ("cede") high-risk policyholders into this pool, where the losses or profits of each ceded risk will be shared by all insurers. Those health care providers who are issued coverage that is ceded to the reinsurance pool are charged at market rates or even above-market rates for coverage. There is no subsidizing of policyholder premium.

Rhode Island maintains a joint underwriting association that was created at the same time New Hampshire created its JUA. The Rhode Island JUA, like New Hampshire's, has seen a significant reduction in policyholders.

There are no residual market plans for medical malpractice insurance in Maine, Vermont, or Connecticut.

The absence of a JUA in Maine, Vermont, and Connecticut indicates that medical malpractice insurance is readily available to health care providers in those states and that insurance is readily available in New Hampshire as well. The Department notes no unique law or circumstance that would cause NH health care providers to be differently situated for purposes of insurability.

C. Analysis of Evidence Presented

Survey Results on Availability

The JUA sent a survey consisting of six questions to 450 current policyholders. The JUA received 123 responses, approximately a 27% response rate. Not all those responding replied to all questions. A compilation of the survey results was made by the JUA and provided to the Department; this survey is attached. [Attachment 8, page 98 and Attachment 9, page 100-101]

After posting the hearing notice, the Department received inquiries from health care providers by phone and in writing. The Department asked providers to respond to survey questions that were similar to those sent by the JUA to its policyholders. The Department compiled the responses, rejecting responses from JUA policyholders who had already responded to the JUA survey, and those responses are aggregated and attached. [Attachment 10, page 103-104].

The survey responses indicate that health care providers are not being denied coverage to any significant extent. In response to the question "Have you ever been denied coverage?" just six providers out of the 129 responding[8] reported that they had been denied coverage. Those denials occurred in 2000, 2003, 2006, 2008, and 2013. One respondent did not specify the year of denial. The single coverage denial in 2013 was the result of the applicant having been subject to disciplinary action by the applicant's state licensing board.

Hearing - Testimony on Availability

On December 4, 2014, the Insurance Department heard testimony that the medical malpractice market is currently functioning and medical malpractice insurance is readily available to health care providers. Dr. Henry Lipman, representing LRG Healthcare (Franklin Regional Hospital and Lakes Region General Hospital), testified: "At the moment, the market isn't in failure position. It's in a pretty good position, from what I can size up as a provider." [Attachment 15, page 163]. Scott Colby, representing the New Hampshire Medical Society, also testified: "We are currently not in a crisis mode in New Hampshire." [Attachment 15, page 172] David Luca, representing Coverys Insurance (Pro Select), similarly testified: "As to your first question, whether medical malpractice coverage is readily available, we believe it is." [Attachment 15, page 174] Joel Whitcraft, an actuary representing Medical Protective Company, testified that his company is a national carrier that has been writing in New Hampshire for a number of years. He stated: "We've seen our market share and policyholder distribution grow over the last few years, and we write across a broad spectrum of the healthcare provider segments -- physicians and surgeons, dentists, other healthcare providers, hospitals, other facilities -- and we have policyholders in all of those segments." [Attachment 15, page 167] Just one individual testified as to a current crisis,[9] but otherwise, no one testified that the medical malpractice market was in crisis, as it was in 1975 when the Department created the JUA. No health care provider testified that he or she had been denied insurance.

Many who testified did not address specifically whether medical malpractice insurance was <u>available</u> but instead spoke in broad terms in support of retaining the JUA (in its current form or some alternative) not because insurance is unavailable but because of the JUA's <u>value</u>. This testimony in favor of keeping the JUA in place was based on the value of the JUA as:

- **A source of affordable coverage as compared to the private market, especially for those providers with unique circumstances (nontraditional medicine, prior claims history, etc.).**

  For example, Autumn Vergo testified on behalf of New Hampshire Certified Professional Midwives, who provide services outside the hospital setting (birth centers/homebirths), many of whom are insured with the JUA: "We have looked on the federal market, and several of our members have been provided quotes in the research phase leading up to

[8] The 129 responses consist of 123 responding to the JUA survey and the additional 6 individuals responding to the Department.

[9] Dr. Georgia Tuttle testified that "We have a national crisis in medical liability that the – our congress and our state legislatures have not yet managed to resolve." [Attachment 15, page 164]

this meeting; and those quotes represent about a 400 percent increase in cost for us, compared to what we're paying now." [Attachment 15, page 165] Dr. Kathryn Cranford, a naturopathic physician and certified midwife, testified similarly: "Some of the larger policies are out there, but my small practice and what I am reimbursed by both Medicaid and by insurance for home birth doesn't begin to allow me to pay for a -- for a policy from the general market." [Attachment 15, page 178] Dr. Stanley Gorgol, a sole practitioner of podiatry, urged the JUA be continued. He testified that he could secure coverage outside the JUA, but the cost would be 35% higher, and "any discount, any help I can get, I'm very much in favor of." [Attachment 15, page 175]

- **A source of occurrence coverage and tail coverage, which is not always available in the private market.**

  Dr. Georgia Tuttle testified that she is approaching retirement and that if the JUA were to close and she wanted to continue to work, she would be unable to purchase occurrence coverage in the private market. She would have to settle for purchasing claims-made coverage instead, she said. As a result, Dr. Tuttle testified, she would have to work for an additional five years under this claims-made coverage in order to secure the "tail" coverage she would now need. If the JUA remained open, she testified, she could instead continue to be insured under an occurrence policy and would not need to worry about securing tail coverage. "If the JUA closes, I have occurrence insurance … I can lock my door today. If I go to a new company -- I've checked a few companies – I can buy insurance, but I'll have to work at least five years."[10] [Attachment 15, page 174]

- **A safety net providing stability in a volatile market and available insurance in the event the medical malpractice market fails again.**

  Henry Lipman of LRG Healthcare (Franklin Regional Hospital and Lakes Region General Hospital) testified: "From my perspective, I think it's in the best interests of the state and the policyholders that potentially might have to come back to the JUA not to wind down its operations in the event that the market hardens and fails again." [Attachment 15, page 163] Judy Howard, an insurance producer who works for clients to secure medical malpractice coverage, stated: "And the market seems to be very volatile for agencies where companies come and go. They come; they want the business; they get the business; and then the next thing you know, you've got to replace it in three years. And it just seems like the JUA provides a great deal of stability for us and for our clients." [Attachment 15, page 177]

- **An entity providing excellent service to its longstanding policyholders, who take comfort in this relationship.**

  Robert Lanney of the Medical Society testified: "There have been a lot of relationships that have been formed over the years with the physicians who have been with the JUA for

[10] See discussion on page 5 of this report, footnote 6, concerning tail coverage as well as the Addendum to this report which discusses the concerns of health care providers like Dr. Tuttle, who are insured by the JUA and are nearing retirement.

many years in terms of claims handling. That is an important part of what the JUA has done. There have been institutional people there, they have been there for many, many years; they form relationships with the physicians. And so in addition to the whole availability and affordability, there is also a relationship and a bonding that has gone on between the organization and its insureds." [Attachment 15, page 170] Dr. Mark Timmerman echoed this sentiment, testifying: "I have not recently researched the availability of coverage but want to emphasize my comfort in the State of New Hampshire – finding the JUA is of significant importance in an environment where I see so many other things in the environment changing…. And I feel the comfort of my own state providing that coverage to be a very important factor to me." [Attachment 15, page 176]

- **A positive force in the market as a state-sponsored competitor.**

  Scott Colby of the Medical Society testified: "If the JUA's existence can help create competition in what should be characterized as an oligopoly – high barrier to entry, few players in the market -- then it's doing its proper role in ensuring real competition -- to the benefit, ultimately, of New Hampshire citizens." [Attachment 15, page 172] Representative Peter Hansen noted this dynamic as well, stating: "I think if we reflect back on the industry of workmen's compensation, at one time, we found that aggressive claims [management practices] were not in place at the time; and the providers were using that as a mechanism to raise their rates. And I think it should be noted that, with something like the JUA remaining in position, that this will help us to at least caution the public companies that they need to tend to business." [Attachment 15, page 176]

Testimony from Insurers, the JUA and Insurance Producers

The Department analyzed the responses provided by the top five insurers (excluding the JUA) writing medical malpractice in New Hampshire to determine the number of times the insurer received an application for insurance but ultimately did not issue a policy (a declination). These insurers and the JUA together write 68.5% of the medical malpractice premium in this state. [Attachment 17, page 199-200] The Department requested additional information or clarification from these insurers as necessary to complete its analysis.

Two of the five insurers, Lexington and Essex, are surplus lines insurers and do not track declinations. The remaining three insurers (referred to as "standard" or "admitted" insurers) had, collectively, 49 declinations over this five-year period. From the information gathered from these insurers, we estimate that the companies declined, on average, over the last five years, less than 5% of applicants. These declinations were primarily due to poor claims history, but reasons also included withdrawal of application by the health care provider, duplicate requests from the same applicant or failure to provide necessary information. The relative lack of declinations in the last five years is evidence that medical malpractice insurance is available to health care providers in New Hampshire. These data from insurers are consistent with the Department's findings from the hearing—that is, the lack of any testimony that medical providers had been denied coverage. These data are also consistent with the survey responses from medical providers discussed above.

In analyzing availability, the Department also considered the willingness of private market insurers to cover certain insurance risks (insurer underwriting standards) and whether any insurer underwriting standards indicated they would refuse to insure certain professionals, thus limiting the availability of insurance. The Department did not find any underwriting standard that would affect availability. This would include the location of the medical practice – that is, practices in more remote locations.

There were, however, indications that insurance companies prefer to insure certain classes of medical professionals and develop programs aimed at certain groups or segments of the medical community (referred to as "underwriting risk selection"). Insurers may limit the types of practices or professionals to whom they will provide coverage, but the Department did not find a uniform refusal across all insurers to insure any particular health care provider by profession, nor did it find a refusal to insure based on any particular characteristic that would have indicated that medical malpractice insurance was not available. Certain factors or characteristics, such as claims experience, will affect premium and limits, and companies may refuse to insure health care providers who fall outside a range of acceptable risk (e.g. those who have been subject to disciplinary action), but the Department found no evidence of uniform refusal to insure. Thus, there are no indications that underwriting guidelines act as a barrier to availability of insurance at this time.

Testimony from the JUA administrator provides additional information that supports a finding of availability of medical malpractice insurance. Jim Vaccarino testified that the population of the JUA is declining: "During the period 2010 through the third quarter of this year, the JUA saw a decrease in the number of insured policyholders from 676 in 2010 to 550 in 2011; 504 in 2012; 469 in 2013; and 457 as of today." It is unclear how much of the decline in the JUA's population is related to physicians moving to hospital groups that insure in the private market or through self-insurance. However, it is clear that the decline is significant.

In addition, the JUA survey indicates that the majority of the 123 policyholders who responded to the survey have been with the JUA for over 10 years: 88 in total. Fifty-nine of those indicate they have been JUA policyholders for more than 20 years. Just 24 JUA policyholders have joined the JUA in the past five years. Cost was the most cited reason for insuring with the JUA (40 out of 71 respondents responded to the question). [Attachment 9, page 100].

The Department also compared, by geography and specialty, the medical professionals insured by the JUA with those insured by the private market. There is no indication that the JUA insures significant numbers of professionals in any given geographic areas. For example, the JUA does not appear to be the exclusive insurer of health care providers in more rural or remote locations. [Attachment 18, page 217-218] The Department also looked at the medical specialties insured by the JUA. If certain segments of medical professionals are exclusively insured with the JUA, this may indicate that the private market is unwilling to insure that specialty, which would support a finding of that insurance is not readily available for that specialty. With the exception of two such segments, the JUA does not appear to exclusively insure any single health care specialty/professional.[11] See Attachments 18, page 216 and Attachment 19, page 220-221]

[11] For example, Dr. Stanley Gorgol testified on behalf of the New Hampshire Podiatric Medical Association and indicated that of the 47 podiatrists in his association, 19 podiatrists have the JUA as their malpractice insurer.

Certified Professional Midwives

The only medical professionals who appear to be insured exclusively through the JUA are Certified Professional Midwives. The Department analyzed the data and testimony provided to determine whether the fact that this group appears to be exclusively insured through the JUA is evidence of the unavailability of insurance.

As a point of clarification, in New Hampshire, there are two categories of licensed midwives:

> **1. Certified Professional Midwives (or CPM):** In New Hampshire, there are approximately 30 CPMs, who are certified by both the state of New Hampshire and the North American Registry of Midwives. These midwives deliver babies outside of hospital settings (in the home or in one of four freestanding birthing centers in New Hampshire).
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> **2. Certified Nurse Midwives (CNMs):** These midwives are nurses, who typically work in larger medical practices and hospitals and appear to be insured through their employers rather than through individual coverage.

Availability of insurance for Certified Nurse Midwives does not appear to be an issue. Only the Certified Professional Midwives claim to have difficulty obtaining insurance.

Based on testimony provided, all the state's Certified Professional, or out-of-hospital, Midwives who have medical malpractice insurance are insured through the JUA (10 in total)[12], including all of the CPMs who attend births in the state's four birth centers. [Attachment 15, page 165] The other CPMs, according to the New Hampshire Midwives Association, choose not to carry insurance "for a variety of reasons, including financial ones, as the cost of insurance may represent a large proportion of their income in cases of midwives with small practices." [Attachment 14, page 154] Insurance is reported to be critical for those CPMs insured through the JUA because in order to be reimbursed by Medicaid or to receive reimbursement as an in-network provider by most private health insurers, CPMs must carry malpractice insurance. CPMs who attend births at the four freestanding birth centers in New Hampshire also must carry malpractice insurance. [Attachment 14, page 157]

CPMs testified as to the unavailability of affordable insurance: "It is difficult for independent, licensed midwives practicing in homes and freestanding birth centers to obtain medical malpractice insurance." [Attachment 14, page 158] For New Hampshire out-of-hospital midwives, the JUA "is currently the only affordable option for obtaining malpractice insurance." [Attachment 14, page 158] CPMs report that outside the JUA, just two programs are available to provide medical malpractice insurance to out-of-hospital midwives in New Hampshire: coverage developed by Contemporary Insurance Services, Inc. (annual premiums begin at $4,976 and reach $37,548 by year five); and a program developed by Southern Cross Insurance Solutions, LLC (annual premiums begin at $9,000 and are expected to reach $18,660 within five years). [Attachment 14, page 158] New Hampshire out-of-hospital midwives say their profession is a

[12] See Attachment 18, page 216.

low- to middle-income vocation; their annual income ranges from as low as $21,000 for individuals to up to $63,000, for birth center owners. [Attachment 14, page 148, 158] Based on this evidence, it would appear that medical malpractice insurance is available to CPMs in New Hampshire. However, this coverage may for many (if not all) CPMs be unaffordable. The cost of insurance in the private market appears to cause those CPMs who require insurance (in order to receive Medicaid or insurer reimbursement or in order to attend births in the state's birth centers) to insure exclusively through the JUA, and it likely causes other CPMs to forgo insurance altogether. As discussed above, insurance may be expensive, even prohibitively expensive, but still be considered "available" pursuant to RSA 404-C. The fact that CPMs insure exclusively in the JUA or not at all is not evidence that insurance is unavailable, given that insurance programs are offered in the private market. However, it does appear to demonstrate that medical malpractice insurance outside the JUA may be unaffordable for CPMs.

The Department was tasked with determining whether medical malpractice insurance is available in New Hampshire, not with determining whether such insurance is affordable. The Department is not authorized to address affordability in any plan created under RSA 404-C. Further discussion as to affordability of insurance can be found in the Addendum to this report.

Radiologists

A second specialty group, radiologists, also appears to be largely (although not exclusively) insured through the JUA. Radiologists (specialty code 80280), are the largest single group insured by the JUA. The JUA insures 72 radiologists, who constitute 16% of the JUA's current book of business. [Attachment 18, page 216] There are 93 licensed radiologists in New Hampshire. [Attachment 19, page 221] Therefore, the JUA insures approximately 78% of the radiologists licensed in NH. Some radiologists may be insured through the excess and surplus lines market or through a hospital employer or other self-insurance arrangements, but at least one major standard lines carrier has six active policies for radiologists.

David Stowe, an insurance agent with Eaton & Berube Insurance Agency in Nashua, provided written testimony on insurance of radiologists. He states that he writes on behalf of the 50 physicians he insures through the JUA. Of these, 33 are radiologists. [Attachment 14, page 127] He also says that he has access to a wide range of insurers and has attempted to find coverage outside the JUA for these 33 physicians, but "so far they have been unable to offer cover terms due to the poor claims experience and/or have indicated that they can't offer a competitive quote." [Attachment 14, page 127-128] He adds, "If it were not for the NHJUA these doctors would likely be forced to seek coverage from a surplus lines company where policy forms are not reviewed and approved and where premiums tend to be what the market will bear. I would argue that for these doctors, the NHJUA is their best option." [Attachment 14, page 128]

It is possible that some radiologists may face difficulty obtaining insurance due to claims history. Relevant to this issue is information obtained from the JUA discussing the number of JUA insureds who are "surcharged" -- charged an additional amount of premium because of their unfavorable claims histories. The JUA surcharges health care providers who have incurred two or more paid claims over $50,000 within the last 10 years. In January 2010, the JUA surcharged

37 policyholders. As of January 23, 2015, the JUA is currently surcharging 23 policyholders. These policyholders are not exclusively from any one specialty; however, radiologists are represented most strongly: six of the 23. [Attachment 20, page 223-225]

These six radiologists who are surcharged in the JUA may have difficulty obtaining coverage from standard lines insurers in the private market. In that event, they likely would need to secure coverage from excess and surplus insurers rather than standard lines companies and likely would pay more for coverage. It is likely that even some radiologists who are not surcharged in the JUA (e.g. those with a single claim or multiple smaller claims that do not trigger a JUA surcharge) also would need to turn to excess and surplus lines insurers for coverage.

Even radiologists who never had a claim could see increased insurance costs if the JUA were to close, because the JUA appears to offer insurance at a significant discount from private market rates. Attached to this report is an exhibit submitted by the Department in the recent public hearing to evaluate whether the medical malpractice insurance market is competitive. [Attachment 17, page 198-214] A table contained in this report indicates that the JUA's rates for radiologists are lower than rates charged by at least two private insurers. [Attachment 17, page 202] However, until an applicant submits a request for insurance and all available discounts are applied, it is impossible to know with certainty what the cost of insurance may be in the private market.

Nevertheless, the Department does believe that the primary factor contributing to the higher concentration of radiologists in the JUA is the fact that the JUA rates are lower than what is available from the private market. In addition, the JUA offers radiologists occurrence coverage, which would not be available to them in the private market. Of the 72 radiologists insured by the JUA, 40 have purchased occurrence coverage. The JUA survey indicates that radiologists do insure with the JUA for these reasons rather than because insurance is unavailable in the private market. See JUA Survey responses to questions 3 and 6 indicating that radiologists choose the JUA because it is less expensive. [Attachment 9, page 100 -101] The Department believes the disproportionate number of radiologists in the JUA is not due to unavailability of insurance. Furthermore, as noted above, at least one insurer has six active policies for radiologists. Radiologists in Connecticut, Vermont, and Maine (states without residual market plans) are able to obtain insurance in the private market. Based on the information reviewed, it would appear that coverage is available in the private market for radiologists, although it may be more expensive than JUA coverage.

Additional evidence in support of the availability of medical malpractice insurance, even for those health care providers engaged in high-risk activities, is the presence of active excess and surplus lines carriers in the medical malpractice market. Excess and surplus lines companies are not subject to the same levels of regulation that govern insurers writing standard coverage. As a result, the "non-admitted" insurers have more flexibility to take on risks that admitted or standard insurers are unwilling to accept. This does not mean that excess and surplus lines companies are themselves "substandard." Excess and surplus lines companies play an important role in the insurance market and, despite the fact that they are not subject to the same regulatory oversight, these companies can be a safe and reliable source of insurance.

Excess and surplus lines insurers account for four of the top 10 medical malpractice insurance writers in New Hampshire, with a combined market share of 16.3%. Overall, excess and surplus lines insurers make up 22.6% of medical malpractice insurance business written in the state. [Attachment 17, page 199-200] The extent of the involvement of excess and surplus lines insurers in the medical malpractice market provides evidence that there is a private market for the less desirable medical malpractice risks. These insurers act as a buffer against lapses in availability by satisfying the need for medical malpractice coverage that is not met by the admitted market. An active excess and surplus lines market is further evidence that medical malpractice insurance is readily available.

4. CONCLUSION

Based on the above, the Department finds that medical malpractice insurance is readily available, and therefore, in accordance with the instructions in the JUA Commission's report, the Department has prepared proposed legislation to wind down and dissolve the JUA. This proposed legislation is found at the end of this Report, beginning on page 35

Because the Department has concluded that medical malpractice is readily available, the Department did not address the second question posed by the JUA Commission: What form of risk-sharing plan to make medical malpractice coverage available on a guaranteed-issue basis is supported by the public interest?

The Department would note, however, that the overwhelming majority of those testifying at the hearing on December 4th were in favor of retaining the JUA or some other form of residual market mechanism. Midwives practicing outside of hospital settings raised concerns, as did health care providers who may be approaching retirement and unable to secure tail coverage. In the event the Legislature wishes to address these issues, the Department has attached an Addendum to this report providing further comment.

Addendum to Report

Introduction

The Department believes important issues were raised at the public hearing that require additional comment. Testimony uniformly supported maintaining a risk-sharing plan in New Hampshire: the JUA in its current form or in some other form. People also spoke about the need for insurance that is not only available but *affordable* for health care providers in New Hampshire. In addition, they raised concerns that closing the JUA would adversely impact older health care providers who are of retirement age. The Department wishes to provide additional comment on these issues in the event that this information is helpful to members of the Legislature in their deliberations.

Affordability of Medical Malpractice Coverage

Affordability of medical malpractice insurance was a topic of concern to many who testified at the public hearing on December 4, 2014. The regulation of medical malpractice rates is controlled in part by the Department's determination as to whether the medical malpractice insurance market is competitive. See RSA 412:13 and 14. In a competitive market, the Department can deny a rate for being inadequate but cannot deny a rate for being excessive. RSA 412:15, I, directs that a rate in a competitive market is, by law, not excessive. The Department regulates the adequacy of rates in a competitive market to ensure the rate is not so low that it could endanger the solvency of the insurer or have the tendency to create a monopoly market. RSA 412:15, I (c).

In a noncompetitive market, however, the Department has the authority to deny a rate if it is either inadequate or excessive. See RSA 412:15, I. A rate is considered excessive "if it is likely to produce a profit that is unreasonably high for the insurance provided or if expenses are unreasonably high in relation to services rendered." See RSA 412:15, I (b).

Since 2005, the Insurance Department has determined that the medical malpractice market in New Hampshire is noncompetitive. [Attachment 23, page 227-228]. The most recent order confirming this was issued in November 2014. [Attachment 23, page 230-232] The

Department reviews all medical malpractice insurance rates that will be charged by standard line insurers to ensure they are adequate but not excessive.

Despite the Department's regulation of rates, many of those who testified at the public hearing indicated concern about the cost of insurance in the private market and about whether they could afford to purchase insurance at market rates. Based on its review of testimony and data, the Department anticipates that some health care providers may pay more for coverage outside the JUA, especially those with multiple claims who may need to secure coverage in the excess and surplus lines market. It is difficult to determine just how much more some JUA policyholders will need to pay outside the JUA and equally difficult to compare premiums charged by the JUA with those charged in the private market. About half of JUA policyholders have been with the JUA for at least 20 years and may not have sought coverage from any private insurer. At the hearing, JUA policyholders offered largely anecdotal information on alternative options for coverage. Discounts and other adjustments to premium may affect the cost of insurance offered by private insurers, and these adjustments may be evaluated and applied only after a complete application for a quote has been submitted and processed by the insurer. Absent an actual application for coverage, it is difficult to determine with certainty what any given health care provider would pay for coverage outside the JUA.

However, the Department does not believe that the cost of insurance in the private market would act as a barrier to securing coverage for the vast majority of JUA policyholders. This includes radiologists, who appear to be insured primarily through the JUA. The Department's conclusion is based on the fact that in any given specialty, there are individuals currently insured outside the JUA by private companies, and on the fact that in Maine, Connecticut, and Vermont, health care providers appear to be securing insurance from private insurers, including surplus and excess insurers, at market rates. The rates charged by standard line insurers are not excessive, based on the Department's review under RSA 412:15. So, while some health care providers may pay more for private insurance outside the JUA, the Department does not believe that health care providers overall will find the cost of insurance in the private market to be prohibitively high.

Nevertheless, as discussed in the attached Department report, Certified Professional Midwives (CPMs) who operate outside of hospital settings may find the cost of private insurance to be unaffordable. It is difficult to determine what coverage may be available to CPMs delivering children and providing care in free-standing birth centers or in private homes until these midwives have engaged in the process of applying for coverage and receiving a firm quote from insurers.

In New Hampshire, legislative initiatives are in place to help control the costs associated with medical malpractice litigation -- and thus help to reduce insurance costs. These initiatives include the Medical Malpractice Screening Panel and Insurance Oversight Committee (RSA 519-B) and Early Offer process (RSA 519-C).

In addition to these or other initiatives to control the cost of medical malpractice insurance, interested parties have asked whether the Legislature could directly address the affordability of medical malpractice insurance by developing in law a mechanism that would directly subsidize the cost of insurance for certain medical professionals who demonstrate financial need. Health care providers with multiple claims also may face higher insurance costs, and they, too, may wish to have access to some form of subsidy to make insurance more affordable: This also is a question for the Legislature.

Interested parties have suggested that the Legislature could create a hardship fund to operate while the JUA is wound down, as policyholders transitioned from their current coverage with the JUA to private coverage. A hardship fund could help defray the cost of insurance for those providers showing financial need, but it is up to the Legislature to decide whether such a fund is in the public interest. The Department takes no position as to a hardship fund: The Legislature alone can address the complex policy issues underlying the subsidization of insurance for high-risk health care providers or those of modest income.

Others have recommended that the Legislature require the JUA to provide free extending reporting (tail) coverage to all JUA claims-made policyholders. Extended reporting coverage

protects against claims attributable to acts occurring while a policy was in force, but where the claim is filed subsequent to the expiration of that policy. If the JUA closes, this additional free coverage may help reduce the cost of insurance that would be purchased by JUA policyholders in the private market. With this tail coverage in place, JUA insureds will not need to have "nose" coverage provided in their new policies. Nose coverage is the coverage provided by a new insurer to cover the same claims that the prior insurer would cover with tail coverage—that is, claims associated with an injury that occurred while the policyholder was insured under a prior policy, but filed against the new policy. Therefore, if a policyholder has tail coverage from a prior insurer, the new insurer does not need to provide nose coverage. In this way, the cost of the new policy may be reduced. Providing free tail coverage will, however, place the cost of both providing this insurance and the financial obligations associated with such coverage, upon the JUA. Again, whether it is appropriate and in the public interest to provide this additional benefit to JUA policyholders is a decision for the Legislature.

Uncertainty and Volatility in the Medical Malpractice Market

At the public hearing, people testified in support of maintaining a residual market plan in the event of another medical malpractice market crisis. The last "hard" market in medical malpractice occurred in the late 1900s into the early 2000s. A hard market exists when fewer insurers are willing to offer coverage, underwriting criteria are more stringent, competition is low, and premiums are high. Medical malpractice may not be readily available in a hard market. Currently, however, the medical malpractice insurance market is "soft" as evidenced by lower premiums, more companies entering the market, greater competition, and greater flexibility in underwriting.

The medical malpractice insurance market is, as are other insurance markets, cyclical in nature. But the medical malpractice insurance market is more volatile than many other lines of insurance. Contributing to this volatility is the fact that it often takes years from the time a claim is reported until it is finally settled and paid. In addition, in the case of occurrence coverage, it can be years from the time the policy is issued and premium collected to the time a claim is filed.

This results in greater uncertainty for the insurer as to total expenses associated with any policy issued, and this affects the reserves that are set aside to cover anticipated losses. Insurers adjust these reserves, and changes made in reserves can affect both the amplitude (severity) and duration of a hard market.

In addition, insurers' uncertainty as to what total losses will be also has limited the number of companies that are willing to offer medical malpractice coverage. With fewer writers willing to sell medical malpractice, even in a soft market, the departure from the market of just one or two insurers may have a large impact on the supply of insurance.

The ebb and flow of interest rates also may have a large impact on the medical malpractice insurance cycle because premiums are based on the present value of anticipated future losses. If interest rates are high, the value of future losses goes down, and premiums decrease as well—which can lengthen a soft market. However, if interest rates are low, premiums may increase, and this can increase the cost of insurance, threaten availability, and aggravate hard market conditions.

As the Legislature discusses whether to continue the JUA (or some other form of residual market plan) it should consider the volatility of the medical malpractice market. Attached to this report is an extract of a U.S. Government Accounting Office report entitled "Medical Malpractice Insurance: Multiple Factors Have Contributed to Increased Premium Rates." [Attachment 23, pages 234-237] A full copy of this 74-page report can be reviewed online at this link: http://www.gao.gov/new.items/d03702.pdf. The GAO report discusses some of the factors affecting the medical malpractice market.

The Department suggests that the Legislature may also want to consider the following factors that may affect market conditions and the availability of medical malpractice insurance:

- An additional element of uncertainty for medical malpractice insurance is the Affordable Care Act (ACA) and the changes occurring in the practice of medicine. The ACA is enabling more patients to receive medical care, which may increase medical malpractice exposure.

- There is a currently a trend of hospitals purchasing medical practices, forming larger practice groups. Patients receiving treatment through hospital-affiliated groups are less likely to receive treatment from a single physician or health care provider, which may increase medical malpractice exposure and reinsurance costs. It is difficult to determine whether losses in large hospital groups (which are primarily self-insured) will have any effect on demand for, or availability of, medical malpractice insurance or upon the market as a whole.
- The aging baby boom population also could affect the availability of medical malpractice insurance. Baby boomers, with their increasing need for medical care, and at the same time the aging of the health care providers themselves, could also affect exposure and risk.

The unpredictability of these future impacts, together with existing unpredictability of loss activity, market participation, and interest rates all contribute to uncertainty as to the future availability of medical malpractice insurance. Therefore, although medical malpractice insurance may be available at the present time, the market could again harden, resulting in reduced availability of medical malpractice insurance. It is difficult, however, with all the uncertainties discussed above, to estimate when or even if a medical malpractice crisis might again occur.

Continuation of the JUA

Testimony at the public hearing on December 4, 2014, was in favor of keeping in place the JUA or another residual market plan despite the current soft market. However, as a result of information gathered through the public hearing process, the Department believes that the continued operation of the JUA as a residual market plan for medical malpractice insurance may not be economically feasible.

The Department has analyzed the most recent Statements of Income prepared by the JUA, specifically, the total premium dollars collected by the JUA and the administrative expenses incurred by the JUA. [Attachment 24, pages 239-297] The percentage of premium used to pay

the JUA's expenses related to writing medical malpractice insurance is the JUA's "expense ratio." An expense ratio is expressed in terms of a percentage; the higher the percentage, the lower the insurer's profitability. As the expense ratio increases, so does the concern that the insurer may not be able to remain solvent. The expenses that are considered do not include what the JUA actually paid out in claims, or the costs associated with investigating and adjusting these claims.[13]

The figures related to the JUA's earned premiums, expenses, and its expense ratio are provided in the table below. These figures show that the JUA's expense ratio has increased from 26% in 2008 to 100% in 2013. This means that in 2013, the expenses associated with JUA overhead consumed the entire premium received by the JUA.

Values in ($000)

	2013	2012	2011	2010	2009	2008
Earned Premium	2,852	3,834	4,207	6,949	7,837	9,213
Commissions	170	200	154	389	357	565
Management Expenses	1,430	1,300	1,574	1,496	1,423	1,348
Investment Expenses	225	228	250	256	253	245
Professional Fees	932	841	1,038	641	179	155
Other Administrative Expenses	103	90	51	121	125	58
Total Expenses	2,858	2,660	3,066	2,903	2,338	2,373
As Percent of Earned Premium	100%	69%	73%	42%	30%	26%

To provide some context for these figures, the Department obtained the 2013 expense ratios for three financially solvent insurance companies doing business in New Hampshire that offer, almost exclusively, medical malpractice insurance. All have expense ratios well below 50%:

Medical Protective Insurance Company: 39%;
Medical Mutual of Maine: 30%
Preferred Professional Insurance Company: 14%.

[13] The expenses related to the cost of investigating and adjusting claims, called the "loss adjustment expenses" or LAE, are not part of the expense ratio calculation but are considered in a separate industry measurement, which is discussed later in this section.

For further comparison, the Department looked at the expense ratios of other medical malpractice insurers in New Hampshire that also write other lines of insurance business. These, too, had expense ratios below 50%:

Continental Casualty Company: 43%
Lexington Insurance Company: 21%
Essex Insurance Company: 43%

Based on information received from the JUA, they have included in the management fees certain expenses (e.g. in-house claims adjusters) which would be considered "adjusting and other" expenses by private insurers. "Adjusting and other" expenses are considered losses related to claims so these are not usually included in the underwriting expense ratios for private insurers. Further investigation of the annual statements of the above six insurers shows that the ratio of adjusting and other expenses paid in 2013 to premium earned is no more than 10%. So, even if an allowance is made for the adjusting and other expenses included in the JUA expense ratio, this figure remains significantly greater than other medical malpractice writers in New Hampshire with higher market share over the last couple of years.

The Department would note, however, that certain professional fees paid by the JUA and associated with policyholder litigation, tax issues, and the work necessary to implement SB 170 are not typical administrative costs for the JUA. Therefore, with input from the JUA, the Department has identified these expenses, subtracted them from the total expenses, and recalculated the JUA's expense ratio. Even this adjusted expense ratio is concerning. Without consideration of professional fees related to litigation, tax, and issues related to implementation of SB 170, the JUA's adjusted expense ratio still shows a significant increase: from 26% in 2008 to 74% in 2013, as represented in the following table:

Values in ($000)

	2013	2012	2011	2010	2009	2008
Earned Premium	2,852	3,834	4,207	6,949	7,837	9,213
Total Expenses	2,858	2,660	3,066	2,903	2,338	2,373
Expenses Attributable to Litigation, Tax and SB170	758	730	908	508	0	0
Adjusted Expenses (Exclusive of Litigation, Tax and SB 170 Expenses)	2,100	1,930	2,158	2,395	2,338	2,373
Adjusted Expenses as a Percent of Earned Premium	74%	50%	51%	34%	30%	26%

In 2008, 2011, 2012, and 2013, the JUA paid out more in claims and claims-related expenses than it earned in premium:

Values in ($000)

	2013	2012	2011	2010	2009	2008
Earned Premium	2,852	3,834	4,207	6,949	7,837	9,213
Paid Loss and LAE[14]	3,798	4,133	9,031	5,289	4,632	9,358
Change in Loss and LAE Reserve[15]	(5,664)	(7,790)	(4,654)	(852)	(1,454)	417
Total Incurred Loss	(1,867)	(3,658)	4,376	4,438	3,177	9,775
As Percent of Earned Premium	-65%	-95%	104%	64%	41%	106%

[14] This line represents all paid losses (claims) and what was paid to investigate and adjust claims -- Loss Adjustment Expenses (LAE).

[15] The line represents the difference in the amount the JUA had previously placed in reserve to pay claims as well as the expenses related to payment of claims (LAE), and the amount the JUA actually needed to pay.

So why is the JUA not operating at a loss, given its high administrative cost relative to premium, and the fact that for the last several years it has paid out more in claims and claims-related expenses than it has earned in premium? The change in loss and loss adjustment reserves reflects lower-than-expected claims for several of the policy years going back to 2000. The JUA has, therefore, been able to reduce reserves by more than it has paid out to claimants. Because the reduction in the amount held for reserves has exceeded the amount paid out for losses, the JUA does not show an operating loss. This is not uncommon in the medical malpractice insurance market. However, if the JUA pays out even a few large claims, similar to those in 2011 (when large claims payments did exceed the reduction in reserves), then this, in combination with continued high expenses and decreasing premium, will certainly have adverse financial impacts.

The Department also would note that the JUA's increasing expense ratio is not a result of increased expenses but rather from the *significant decline in JUA premium*. While total JUA expenses grew from $2.4 million to $2.9 million, JUA premium fell from $9.2 million to $2.9 million. During this period, management and investment expenses remained relatively consistent. This decline in premium is the result of a steep decline in the number of policyholders insured in the JUA, not falling JUA rates. In 2010, the JUA had 676 policyholders; in 2011, 550; in 2012, 504; and in 2013, 469. By December 2014, just 457 policyholders were insured with the JUA. [Attachment 15, page 170 and Attachment 14, page 131] This decline appears to be due to a nationwide movement by hospitals to buy physician practices, including specialists, and then provide medical malpractice coverage though self-funded plans rather than from individual, stand-alone providers. The current soft market cycle also may contribute to dwindling numbers of health care providers insured by the JUA because more health care providers are able to obtain coverage with favorable terms from private insurers.

Because of the declining JUA policyholder population, the JUA's administrative costs are very high in proportion to the premium collected, and they appear to be increasing beyond sustainable levels. This dynamic may become even more acute in the future. More than half the policyholders in the JUA are 55 or older, and 38% are between 55 and 64 years old. [Attachment 18, page 216] Therefore, if the JUA were to continue to operate, it could see a further reduction in policyholders as these older policyholders retire.

At the public hearing, the JUA testified that its actuaries are recommending a rate increase of about 80% for this coming year; a substantial portion of which is attributable to expenses. [Attachment 15, page 171] Increasing the cost of JUA coverage likely would motivate more JUA policyholders to insure in the private market, leaving primarily higher-risk providers insured in the JUA. This would further drive up claims costs. Ultimately, these factors could send the JUA into what is commonly referred as a "death spiral," in which premiums would rise higher and higher to cover fixed expenses and increasing losses generated by higher-risk policyholders remaining in the JUA. Based on the data above, the Department believes it is not feasible to continue to operate the JUA in the long term.

JUA as a State Competitor

The Department is also concerned that continuing the JUA in its current form is inconsistent with state law. As discussed, residual market plans established under chapter 404-C are not authorized to act as a competitor to private insurers. However, the JUA does appear to compete with private insurers, with some JUA policyholders receiving coverage at below-market costs. In addition, as a result of SB 170, policyholders insured by the JUA from 1986 to 2012 received a distribution of JUA surplus, which acted as a further discount of between 37 and 40 percent. [Attachment 25, page 304] The Department would note that the public hearing featured testimony in support of the JUA as a market competitor and of the benefits of having a state plan in place to create competition in an oligopolistic insurance market. It is up to the Legislature to decide whether this is the role the JUA should play in the market.

If the Legislature were to enact legislation to continue the operation of the JUA, the Department would urge the Legislature to address whether the JUA should be a state-sponsored competitor and whether the JUA should distribute profits to its policyholders. If the Legislature were to continue the operation of the JUA as a state-sponsored competitor in the private market, the Department would recommend amending current law to clarify that this is the JUA's proper role.

Other Residual Market Options

Because the Department has concluded that medical malpractice insurance is readily available, the Department has not addressed, in this report, what form of risk-sharing plan is supported by the public interest. However, the Department provides the following comments concerning what form of risk plan is supported by the public interest in the event that, based on the testimony presented, the Legislature wishes to maintain a risk-sharing plan.

Three types of risk-sharing plans or residual market mechanisms are used to make insurance available:

- Joint underwriting associations
- Reinsurance facilities
- Assigned risk plans

Joint underwriting associations, like the New Hampshire Medical Malpractice JUA, are one form of risk-pooling mechanism used to make insurance available when the private market has failed. States form a joint underwriting association by requiring all insurers to participate as "members" in the association and then authorizing the association to offer insurance coverage. The association selects one or more "servicing carriers" to manage the association's insurance business. The servicing carrier is a private insurer or an administrator who, in exchange for a fee, has agreed to process association applications, pay claims, collect premium, and otherwise service the contracts of the association.

Rates paid by policyholders purchasing coverage from the joint underwriting association are generally higher than those that would be paid in the voluntary market. However, because joint underwriting associations tend to take only the riskiest business, often even these higher premiums are insufficient to cover losses. Therefore, if premium adjustments or assessments on policyholders cannot generate adequate funds, the insurance company members of the association are subject to assessment to raise additional funds for the association. Insurers can pass along these costs to their own policyholders through surcharges or increased rates. In this way, joint underwriting associations act as a state-sponsored insurer, with the added security of having the authority to assess private insurers to raise needed funds.

A reinsurance facility often operates by requiring private insurers to "take all comers" (the insurer cannot refuse to insure). The insurer provides coverage based on the insurer's filed rates. The insurer, however, can decide whether it wants to retain the risk as part of its normal business or instead "cede" the policy to the reinsurance facility. When a policy is ceded, a portion of the premium collected by the insurer is sent to the reinsurance facility. If there is a claim on a ceded policy, the insurer who ceded the policy manages the claim but bills the reinsurance facility for any amount paid out. Claims from ceded policies are paid by the facility using the premiums transferred by the ceding insurer. Generally, insurers will cede to the facility only those policies that it anticipates will not be profitable. For this reason, reinsurance facilities often operate at a loss. Therefore, like joint underwriting plans, reinsurance plans impose assessments on private insurers to fund any shortfall. Insurers, in turn, can recoup these assessments through higher rates or surcharges on their policyholders.

In an assigned risk plan, those who cannot obtain insurance in the voluntary market complete an application, which is then submitted to the assigned risk "pool" of insurers that are required to participate in the plan. These applications are distributed by the pool administrator to the participating insurance companies, in proportion to each company's volume of business in the state. Insurance companies must accept the risks assigned to them by the pool administrator, and they also are responsible for setting the premium that will be charged (which is higher than what is charged in the voluntary market). The insurer must treat the policyholder assigned to it as it treats its other policyholders. Rather than impose an assessment on all companies participating in the assigned risk pool to cover losses, the company that is assigned the risk is responsible for any loss associated with the assigned policy. Losses incurred by the company can, however, be recouped through higher premium charged (or surcharge imposed) on policyholders of the company.

There are a number of variations on these three types of residual market plans, and states have incorporated additional provisions or requirements to ensure these plans work effectively given the state's unique needs or situation.

Recommended Risk-Sharing Plan

If the Legislature determines a residual market plan should be created, the Department believes the most appropriate plan for New Hampshire would be a reinsurance facility. The Department would recommend a reinsurance facility that operates as an unincorporated, nonprofit entity, with mandatory participation in the facility by all liability insurers, providing for effective pooling of the risks of medical malpractice insurance. Medical malpractice insurers should be required to take all comers but would have the option to cede high-risk policyholders to the facility. All liability insurers would share in the profits and losses of those policies ceded to the facility.

If such a facility is established, standards should be set to limit the number of policyholders that may be ceded to the facility. There also should be requirements governing the amount paid to the reinsurance facility ("ceded premium"), which customarily is the insurer's approved rate for the coverage minus an expense fee retained by the insurer to manage the policy and claims. It would be important to structure the facility so as to incent insurers to minimize resort to the facility and to rely on the voluntary market, including surplus lines and excess insurers to the full extent possible. One possible way to accomplish this is to place limitations on the number or percent of an insurer's business that may be ceded to the facility, thus minimizing any possibility of inappropriate ceding or over-ceding of risks. This form of reinsurance facility could operate with a fluctuating level of policyholders and in both soft and hard markets. The Department would recommend the reinsurance facility be governed by a board composed primarily of insurance company representatives, which would help ensure that costs were minimized and claims effectively managed.

A reinsurance facility as described would have the added benefit of having modest startup costs. In fact, instead of creating a plan immediately, the Legislature could direct the Department to develop a plan for a reinsurance facility but not implement the plan. This plan could be on stand-by, ready to adopt by administrative rule in the event there are adverse developments in the medical malpractice market and insurance again becomes unavailable.

Closure of the JUA; Impact on JUA Policyholders

At the public hearing, people spoke about the difficulties older JUA policyholders may face if the JUA closes. As discussed in the Report, "tail" or "extended reporting protection offers coverage for claims filed after a policy has expired, for an injury that occurred during the policy term. Thus, tail coverage protects a retired policyholder from claims that may be filed after the policyholder is retired and is no longer purchasing claims-made coverage.

The JUA offers two types of claims-made policies: "modified" claims-made coverage that charges a small additional premium and provides this tail coverage and standard claims-made coverage that does not. A policyholder may choose which policy to purchase. The policyholder must pay the higher premium for the additional protection provided under a modified claims-made policy.

Under the terms of the modified claims-made policy, a policyholder can receive tail or extended reporting protection if the policyholder has been insured by the JUA for at least 10 years, is 55 or older, and retires, dies, or becomes disabled while the modified claims-made coverage is in force. This tail coverage is provided under the terms of the policy and the cost is included in the premium paid, so the policyholder will receive extended reporting coverage at no additional cost. However, if the policyholder leaves the JUA before retirement (e.g. moves to another state or insurers with a different insurer) the policyholder will not receive the extending reporting coverage or a refund of premium. Only if the policyholder retires (or dies or becomes disabled) while the policyholder is a JUA insured will the extended reporting coverage be provided.

Impact of JUA Closure on Retired JUA Policyholders

Former JUA policyholders that have already retired and are protected under tail policies issued by the JUA will not see any change in the protections provided under their policies, even if the JUA closes. During the liquidation of the JUA and thereafter, these policyholders will continue to be protected and the terms of the coverage issued to them by the JUA and their coverage will continue to be honored. They, as well as all other JUA policyholders, can rely on the promises made under policies issued by the JUA and, unless JUA assets are insufficient to pay all JUA

claims in the liquidation of the JUA (which is not anticipated) these retired policyholders will continue to receive full benefits as provided under their policies.

Impact of JUA Closure on Retiring JUA Policyholders

Currently, 72 JUA policyholders that have purchased modified claims-made coverage from the JUA are over age 55 and have been insured with the JUA at least 10 years. These 72 policyholders qualify for extended reporting coverage at no additional cost if they retire while still insured with the JUA. The approximate ages of these 72 policyholders are as follows:

Age	Number of Policyholders
85-89	1
80-84	2
75-79	2
70-74	4
65-69	13
60-64	27
55-59	23
TOTAL	72

Policyholders who are insured under an occurrence policy continue to be protected under their occurrence coverage even after they retire, so they do not need to purchase tail coverage. Policyholders who purchase standard claims-made policies that do not provide tail coverage would need to purchase tail coverage upon retirement if they wish to have protection from claims filed after they retire and their coverage has expired.

If the Legislature does act to wind down and close the JUA, all 72 JUA policyholders with modified claims-made policies who are over 55 and who have been with the JUA for at least 10 years still would be able to retire and elect tail coverage while their JUA coverage is in place. Similarly, if any JUA policyholder with occurrence coverage decided to retire before his or her JUA coverage expires, that policyholder would be protected under the terms of the occurrence policy. These policyholders would not need to purchase any additional protection from the JUA or from the private market. Retiring policyholders would have the protections they were promised. If the Legislature decided to close the JUA, retiring JUA policyholders would lose no right or entitlement to tail coverage.

Impact of JUA Closure on JUA Policyholders Who Continue to Practice

If the JUA were to close, any of the 72 JUA claims-made policyholders who are over 55 and qualify for tail coverage *but who choose to continue to work* would forgo the benefit of the tail coverage they would have received at no additional charge under the terms of their policy. These policyholders would have the option to purchase insurance from a private insurer and be protected from any claims filed under their *new* policies. They would not need tail coverage until they retired. If these policyholders remained with their new insurer the required number of years, they could again earn extending reporting coverage so they would be protected upon retirement.

Most private insurers, like the JUA, offer extended reporting protection, the cost of which is included in the policyholder's premium and this extended reporting coverage would be provided at no additional charge if the policyholder retires while the policy is in force. In fact, most private insurers require only that the policyholder remain with the insurer 3 to 5 years (rather than 10 years, as the JUA requires). In the private market, extended reporting/tail coverage benefits act as a loyalty incentive to encourage a policyholder to remain with the insurer.

Similarly, if the JUA were to close, JUA *occurrence* policyholders who are of retirement age *but who choose to continue to work* could purchase a new medical malpractice policy from a private insurer. If these policyholders purchased occurrence policies, they would continue to be protected. Upon retirement, they would not need to purchase tail protection. Only if a JUA occurrence policyholder switched to claims-made coverage after the JUA closed would this policyholder (like his or her claims-made counterpart) need to work and be insured the required 3 to 5 years in order to secure the benefit of tail protection upon retirement.

It is not uncommon for an insured to purchase tail coverage upon retirement. Each year, the JUA has collected premium of $200,000 to $300,000 for tail coverage for its own policyholders. Whenever a policyholder is forced to change insurers for whatever reason (e.g. the current insurer will not renew a policy, no longer wishes to write coverage in this state, is placed into liquidation, etc.) that policyholder faces the same decision a JUA policyholder would, should the

JUA close. Policyholders in these situations must decide whether to retire (and receive tail protection) or continue to work (planning to again qualify for tail coverage under a new insurer).

Hardship Fund for JUA Policyholders Who Continue to Practice

The Department cannot determine how many of the 72 JUA policyholders with modified claims-made coverage who qualify for tail coverage at no additional cost, might choose to continue to work if the JUA were to close and, of those, how many would be unable to secure tail coverage from their new insurers. Nor can the Department determine how many current occurrence policyholders of retirement age would be unable to secure tail coverage from their new insurers should they continue to work and switch to claims-made coverage.

Some JUA policyholders may accelerate their retirement plans due to concerns over tail protection. The Department does not believe New Hampshire residents would be, in general, adversely impacted by the JUA policyholders that may retire earlier than expected. The Department anticipates that policyholders who are fewer than 3 years from retirement are the most likely to accelerate retirement plans to avoid the possibility of having to pay for tail coverage, and this would not result in a significant number of health care providers retiring in any given profession.

Providing additional tail protection over and above that which is provided for in a policy is not something that normally occurs in the wind down of an insurance entity. It is also impossible for the JUA or any insurer, to issue tail coverage to a policyholder in anticipation of retirement in the future. As discussed earlier in this Addendum[16] the Legislature could, as a transition measure, mandate that the JUA give free tail coverage to all JUA policyholders in order to help reduce the cost of the policy purchased in the private market after the JUA closes. But this coverage would only protect the policyholder from claims related to acts *that have already occurred.* It is not possible for the JUA or any insurer to issue a tail policy today, that would not take effect until the policyholder needs tail protection upon retirement--two, three or more years into the future. The free tail coverage discussed earlier in this Addendum would only serve to reduce the cost of

[16] See Addendum page 18-19

insurance purchased after the JUA closes, it would not provide the tail coverage needed at retirement.

As mentioned above, inquiries have been made to the Department concerning the possible creation by the Legislature of a hardship fund – one that would be available during the course of the wind down and liquidation of the JUA to provide for the some relief to policyholders. If the Legislature determines that a hardship fund should be established, it could help defray or pay for the future purchase of tail coverage for those JUA policyholders. JUA policyholders with modified claims-made policies, who choose to continue to work and then unexpectedly need to retire before they are able to secure tail coverage from a private insurer, could apply to a hardship fund for relief. A hardship fund also could pay for tail coverage for those JUA policyholders who are currently insured under an occurrence policy with the JUA, and are of retirement age (and therefore could retire without purchasing tail coverage) but who decide to continue to work. If these JUA occurrence policyholders purchase claims-made coverage in the private market after the JUA closes and then unexpectedly need to retire before they are able to secure tail coverage from their private insurer, a hardship fund established by the Legislature could be available to assist them in subsidizing or paying the cost of tail insurance.

Interested parties also have suggested a mandate on the private insurance market to provide tail coverage to JUA policyholders that are transitioning to the private market, either by requiring that insurers waive the requirement that former JUA policyholders be insured for 3-5 years before qualifying for tail coverage, or by giving former JUA policyholders credit for the years the policyholder was insured with the JUA (and this credit would apply toward eligibility for extending reporting coverage offer by the new insurer).

The Department is providing the above discussion, concerning possible hardship funds or mandates on private insurers, anticipating these suggestions will be raised in legislative hearings and this information may be helpful to the Legislature in their deliberations. It is within the Legislature's purview, not the Department's, to consider JUA policyholder requests for financial relief and how best to balance the costs and the public interest associated with these requests, ultimately determining the most appropriate resolution.

PROPOSED LEGISLATION TO WIND DOWN THE JUA

1. Statement of Purpose. The purpose of this act is to provide a mechanism for the orderly resolution of the obligations of the New Hampshire medical malpractice joint underwriting association. The general court finds and determines that medical malpractice coverage is readily available in the voluntary market and that it is no longer in the public interest to provide a state plan to provide medical malpractice coverage.

2. New Sections; Dissolution of the New Hampshire Medical Malpractice Joint Underwriting Association. Amend RSA 404-C by inserting after section 14 the following new sections:

404-C:15 Conclusion of the New Hampshire Medical Malpractice Joint Underwriting Association's Business; Issuance of Policies.

I. Upon the effective date of this section, the insurance commissioner shall bring a petition for the receivership of the New Hampshire medical malpractice joint underwriting association (NHMMJUA) pursuant to RSA 402-C. The receivership of the NHMMJUA shall include the stabilization reserve fund trust established in 1986 to pay deficits of the association incurred as a result of policies issued prior to January 1, 1986. Subject to such receivership, the NHMMJUA shall be a continuation of the same unincorporated association in existence immediately before the effective date of this section. The NHMMJUA shall be an insurer organized in this state for purposes of RSA 402-C.

II. To facilitate the orderly resolution of the obligations of the NHMMJUA and transition of policyholders to coverage in the private market, the commissioner, as receiver shall:

(a) Not cancel a NHMMJUA policy in effect upon his or her appointment as receiver unless the policyholder fails to comply with the terms of the policy, including the payment of premium.

(b) Not accept new applications for insurance for new policyholders after the effective date of this section.

(c) Renew any association policy in effect as of the effective date of this section, but shall not issue any NHMMJUA policy with an effective date after December 31, 2015, except that until December 31, 2016, the receiver may issue extended reporting coverage on policies issued before December 31, 2015.

(d) Issue notice of non-renewal in compliance with RSA 417-C to policyholders with renewal dates on or after January 1, 2016.

III. The NHMMJUA shall have no in-force insurance business after December 31, 2016, other than extended reporting coverage elected under policies issued on or before December 31, 2015.

IV. This section shall constitute a plan of complete liquidation for the NHMMJUA pursuant to section 331 of the Internal Revenue Code of 1986, as amended, for federal income tax purposes effective on the effective date of this section.

404-C:16 Receivership of the Association.

I. The insurance commissioner, as receiver of the NHMMJUA, shall, consistent with this section, RSA 404-C:15, RSA 404-C:17, and the provisions of chapter 402-C, wind-down its business, seeking to facilitate the payment of all policyholder coverage obligations in full and in the normal course of business.

II. After the effective date of this section, the commissioner, as receiver, shall explore and identify options to have any or all of the risks under policies issued by the NHMMJUA assumed by an insurer or insurers. Subject to the approval of the supervising court, the receiver may enter an agreement or agreements with an insurer or insurers to provide for the assumption of any or all of the risks under policies issued by the NHMMJUA. Any such agreement shall be on commercially reasonable terms and provide for continued protection for the NHMMJUA's policyholders against liability and expense in accordance with the coverage terms of their policies, as well as providing for established obligations to claimants under such policies.

III. Upon appointment of the commissioner as receiver of the association, no assessments of any kind shall thereafter be made by the receiver or ordered by the court.

IV. Until liquidated, the NHMMJUA shall continue as a legally cognizable unincorporated association solely for the purpose of winding down the NHMMJUA, consistent with this chapter, and the receiver, liquidator, board members and officers of the NHMMJUA shall continue to be officers, trustees, officials, or employees of the state subject to RSA 99-D during the period of receivership and liquidation. The provisions of this section and RSA 402-C shall control the management of claims and obligations of the association and shall supersede the provisions of administrative rules governing the operation of the NHMMJUA.

404-C:17 Closure of the NHMMJUA.

I. Subject to the provisions of RSA 404-C:15 and RSA 404-C:16, the NHMMJUA's obligations shall be wound up under chapter 402-C.

II. Upon the resolution of all the association's obligations, and upon the approval of the supervising court, the association shall thereupon be liquidated and the receiver discharged.

3. Applicability of Act. This act shall be liberally construed to effect its stated purpose which shall constitute an aid and guide to interpretation. This act is intended to provide authority for the performance of all duties authorized under this act, and all powers granted under this act shall be broadly interpreted to effectuate such intent and purposes and not as a limitation of powers.

4. Repeal. The following are repealed:

I. RSA 404-C:14, relative to the New Hampshire medical malpractice joint underwriting association.

II. RSA 404-C:15 - RSA 404-C:17, relative to the dissolution of the New Hampshire medical malpractice joint underwriting association.

5. Applicability; Effective Date of Repeal. Section 4, II of this act shall take effect upon the date of dissolution and the end of the receivership and liquidation of the New Hampshire medical malpractice joint underwriting association as certified by the insurance commissioner to the director of the office of legislative services and the secretary of state.

6. Effective Date.

I. Section 4, II of this act shall take effect as provided in section 5 of this act.

II. The remainder of this act shall take effect upon its passage.