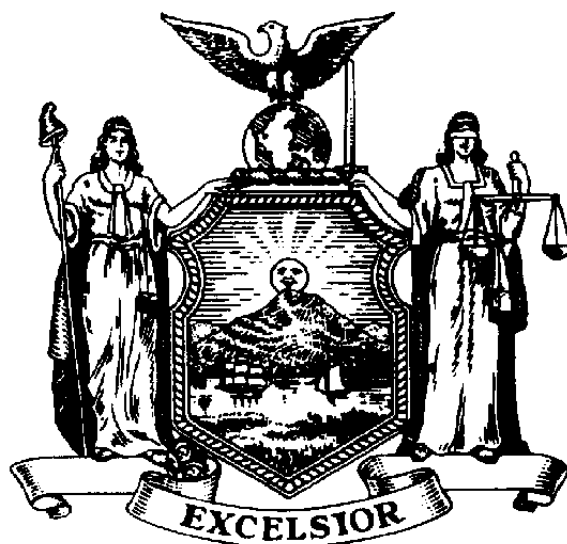


## REPORT ON THE HOSPITAL EXCESS LIABILITY POOL

A Report to the Governor and the Legislature  
by the Superintendent of Financial Services  
and the Commissioner of Health  
of the State of New York



Benjamin M. Lawsky  
Superintendent of Financial Services

Nirav R. Shah, M.D., M.P.H.  
Commissioner of Health

December 2012



STATE OF NEW YORK

December 2012

To the Governor and the Legislature:

Pursuant to Chapter 56 of the Laws of 2012, we are pleased to present the attached joint report on the Hospital Excess Liability Pool. The report identifies the problems confronting the Hospital Excess Liability Pool and proposes both immediate and longer-term options to ensure that the Hospital Excess Liability Pool functions as a public asset that enhances the viability of New York State's medical malpractice and health care systems.

In transmitting this report, we gratefully acknowledge the contributions of those persons and organizations that met with our Departments on this important topic, as well as the work of our staff members and actuarial consultants.

Respectfully submitted,

Benjamin M. Lawskey  
Superintendent of Financial Services

Nirav R. Shah, M.D., M.P.H.  
Commissioner of Health

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## **Executive Summary**

Section 18 (“Section 18”) of Chapter 266 of the Laws of 1986 created a medical malpractice insurance funding mechanism called the Hospital Excess Liability Pool (the “Excess Pool”). The Excess Pool was intended to help solve a medical malpractice insurance affordability crisis – a crisis that the Legislature characterized as a danger to public health because it discouraged doctors from practicing in New York State and contributed to the high cost of health care for consumers. Section 18 sought to contain these costs and keep doctors practicing in New York State, in part by providing a way to fund a secondary layer of medical malpractice insurance, known as “excess coverage,” for eligible doctors at no cost to them.

The law requires the Superintendent of Insurance (now the Superintendent of Financial Services) (the “Superintendent”), in conjunction with the Commissioner of Health (the “Commissioner”), to purchase medical malpractice policies for physicians and dentists (collectively, “doctors”) to cover liabilities in excess of their usual policy limits (known as their “primary” layer of insurance) of \$1.3 million for each incident and \$3.9 million for all incidents in a year. While the Excess Pool was originally funded by hospitals, in 2002 the State began funding the Excess Pool from tobacco settlement funds. This model continues today; the current 2012-13 budget appropriation for the Excess Pool is \$127.4 million. The purchase of policies is conditioned on doctors’ maintaining the underlying policy limits and from time to time providing emergency services at the hospitals that provide them admitting privileges and certify their eligibility for the Excess Pool program (“Excess Program”).

Changes in health care delivery, growth in Excess Pool participation, and certain insurance market stakeholder decisions have stressed the Excess Pool effectively to insolvency. In light of this problem, the Legislature in the spring of 2012 mandated that the Superintendent and the Commissioner prepare a report that includes, but is not limited to: (1) a review of the nature and extent of affiliations between physicians, dentists, general hospitals, private practices, and universities; (2) an analysis of the adequacy of premiums paid by the Excess Pool; and (3) recommendations to support the sustainability of the Excess Pool. *See* L. 2012, ch. 56. This report addresses the three mandated topics, and examines the relationship between the Excess Pool and the Medical Malpractice Insurance Pool (“MMIP”).

The report finds that, as the costs of maintaining solo practices rise, doctors have increasingly shifted to working for hospitals or large group practices. These changing relationships create varying degrees of alignment between hospitals’ liability interests and those of their doctors. The issue of a hospital’s liability for its physicians, especially with respect to doctors that are employed by hospital-affiliated universities, raises questions about the necessity of State-funded coverage for certain doctors’ individual risks.

A review of loss experience data provided by insurers reinforces the urgent need to answer these questions. The premiums paid for Excess Pool coverage have been diluted by participation increases. Pinnacle Actuarial Resources, Inc., consulting actuary to the Department of Financial Services (“DFS”), found that the appropriate aggregate premium for the 2012-13 policy year would be \$151 million; the MMIP’s consulting actuary Milliman put the number at \$156 million. The current appropriation for Excess Program premiums is \$127.4 million.

Premium dilution negatively impacts the MMIP, which writes policies for a disproportionately high number of high risk doctors. Unlike other carriers, the MMIP cannot refuse to write policies. Also, the MMIP’s unfunded liabilities are statutorily allocated among all authorized medical malpractice insurers proportional to their market share. Therefore, when one carrier recently dropped its highest risks, it effectively spread those risks among all carriers. As of June 30, 2012, the MMIP reports insufficient funds to match its claims liability, which equals \$418 million on an undiscounted basis (\$349 million on a discounted basis).

Some carriers also profit under the current framework. Profit and risk spreading, however, are not the purposes the Legislature intended for the Excess Pool.

With these factors in mind, as well as the Legislature’s mandate that this report assume no increase in appropriation, the Superintendent and Commissioner examined a series of options and their respective impacts on the Excess Pool. Some of these options were advanced by insurers, hospitals and physician representatives. The options include: (1) limiting the number of covered doctors; (2) eliminating the Excess Program altogether; (3) authorizing the MMIP to be the sole writer of Excess Program insurance; (4) reducing coverage limits; (5) introducing doctor assessments; (6) expressly eliminating the eligibility of faculty practice physicians (“FPPs”) for the Excess Program; and (7) adjusting premiums downward for doctors, including FPPs, that practice part-time because they also teach.

The discussion of these proposals considers their impact on doctor retention, cost containment, and, where applicable, their potential impact on the MMIP.

## **I. The Excess Pool**

Apart from an increase in the size of the required underlying policy limits, the eligibility criteria for Excess Pool coverage have remained largely unchanged since the Excess Pool’s creation. The law requires the Superintendent, in consultation with the Commissioner, to purchase excess layer medical malpractice policies from authorized insurers in New York State for doctors having professional privileges in hospitals. There are three caveats:

- (1) A single insurer may not write more than 50% of the total excess premium for a given policy year;

(2) Each eligible doctor must have an individual policy from an authorized insurer for \$1.3 million / \$3.9 million, or be endorsed as an additional insured under a hospital professional liability policy that is offered through a voluntary attending physician (“VAP”)<sup>1</sup> program previously permitted by the Superintendent during the period of such excess coverage for such occurrences; and

(3) Doctors must, from time to time, provide emergency medical or dental care in the hospital that certifies their eligibility for the Excess Program.

Chapter 56 of the Laws of 2012 further limited eligibility for the 2012-13 policy year to doctors for whom the Superintendent purchased policies in each of the three prior policy years. Table 1<sup>2</sup> details the number of policies written for every year of the Excess Pool.

## **II. Doctor Qualification: The Nature and Extent of Affiliations**

The clinical, financial and employment relationships between doctors, their private practices, hospitals and medical schools are in a period of rapid change. The nature of these arrangements directly relates to the function and sustainability of the Excess Pool.

### **A. Employment Trends**

Employment trends for doctors are affected by realigned financial incentives, payment reductions, workforce challenges, and a new generation of medical professionals seeking new practice models. As costs of maintaining solo practices rise, doctors have been moving toward working for hospitals or large group practices. Merritt Hawkins, a physician recruiting and consulting firm, concluded from a survey that by 2014, 66% of the nation’s doctors will be employed by hospitals. This is not a new trend – more than half of the doctors in the United States are employed by hospitals – but it represents a doubling from the last decade and an acceleration even since 2008. In 2004, 11% of Merritt Hawkins’ employment searches were for hospitals looking to hire doctors; by 2011 that number increased to 63%. Merritt Hawkins now concludes that 75% of newly hired doctors will be hospital-employed within the next two years.<sup>3</sup>

Merritt Hawkins’s findings comport with a survey by trade organization Healthcare Association of New York State (“HANYS”), which found that 65% of its members expect that between one-third and two-thirds of physicians will be employed by hospitals in the next three years. Another 15% of the membership thinks the figure will

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<sup>1</sup> The term “voluntary attending physician” is typically used to refer to an independent doctor who has admitting privileges in one or more hospitals.

<sup>2</sup> The Tables and Charts for this report are located in the Appendix.

<sup>3</sup> CNN Money, available at <http://money.cnn.com/2012/07/11>.

be higher.<sup>4</sup> Findings of the non-profit Center for Studying Health System Change support these conclusions. Informed by site visits to 12 nationally representative metropolitan communities, the report noted that since 2007, the trend of hospital employment of physicians has accelerated and widened to include not only primary care practitioners but specialists as well. This trend supports the development of integrated delivery networks and the Accountable Care Organizations that will manage future risk based on population health.<sup>5</sup>

## B. Nature of Employment

Hospital-related physicians fall generally into two categories: in one, the hospital includes the doctor's salary as a hospital expense in its cost report, with few, if any, separate billings for the doctor's services; in another, private doctors provide and bill for services separately from the hospital. The latter category includes: (1) doctors affiliated with a hospital or its affiliated medical school (i.e., FPPs); (2) doctors employed by a hospital, but whose salaries are not included in the hospital's reimbursement cost reports; (3) doctors belonging to professional corporations or partnerships that have admitting privileges at a hospital; and (4) employed doctors who bill for health services separately and report that salary as a non-reimbursable cost on the hospital's cost reports.

Generally, hospitals pay a base rate to doctors and add an adjusted year-end amount based on a number of factors including volume and revenue attributable to patient services at the hospital. This adjustment may be net of expenses for services the hospital provides the physician, such as office space and billing, or expenses for medical malpractice insurance.<sup>6</sup>

Faculty practice plans ("Plans") constitute employment arrangements specific to academic medical centers. Plans govern the manner in which FPPs provide patient services, bill for those services, and apply their income from providing services. Plans often consist of doctors who serve as the faculty of a medical school or a related teaching hospital, and thus are closely aligned with the medical school or teaching hospital; they often provide the school or hospital with some benefit from the Plans' revenue – either a payment or in-kind services.

FPPs derive compensation most commonly through salary from the medical school or hospital, salary with additional compensation from a Plan, or salary entirely from a Plan, with limits on the amount that a doctor may receive. Revenues collected by a Plan are also applied to cover the overhead costs of operating the practice plan (e.g., billing and administrative costs), including the cost of medical malpractice coverage. A

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<sup>4</sup> HANYS, *Help Wanted: New York's Physician Shortage Continues to Worsen*, January 2011, available at [http://www.hanys.org/communications/publications/2011/2011-01-10\\_physician\\_survey\\_results\\_2010\\_electronic.pdf](http://www.hanys.org/communications/publications/2011/2011-01-10_physician_survey_results_2010_electronic.pdf).

<sup>5</sup> Laurie Felland et al., *Key Findings from HSC's 2010 Site Visits: Health Care Markets Weather Economic Downturn, Brace for Health Reform*, Issue Brief 135 (May 2011).

<sup>6</sup> Correspondence from Manatt, Phelps & Phillips, LLP to Department of Health, June 18, 2009.

Plan may even contribute towards the cost of the medical school or the teaching hospital, or, where a Plan's ability to cover its expenses is limited, the medical school or teaching hospital may help support a Plan.

When Section 18 was enacted, solo practitioners or small group practices predominated. Now, as the delivery paradigm shifts to population health management and healthcare costs increase, hospitals and doctors increasingly share financial interests. However, an alliance of financial interests does not necessarily align the legal interests of the doctors and hospitals in connection with a medical malpractice action. Whereas hospitals used to be solely responsible for their employees, in the case of FPPs, courts generally look at the facts of a case to determine whether a doctor is an employee or an attending physician.<sup>7</sup> In the case of the Plans, there is no objective measure by which to determine whether a doctor's and hospital's liabilities are aligned such that one insurance policy could and should cover both risks. The State, therefore, has no way to determine whether the money it expends on the Excess Pool really covers an FPP's individual risk, or a risk for which a hospital would be liable anyway.<sup>8</sup>

### **III. Adequacy of Excess Pool Premiums**

Under current law and absent an increase in appropriation, either the number of covered doctors, or the riskiness of the pool – which actuaries assess using the concept of base class equivalent exposures (“BCEEs”)<sup>9</sup> – must be reduced for premiums to be sufficient.

The risk profile of the Excess Program has remained largely constant through the years, as evidenced by the BCEEs remaining in line with the annual number of participating doctors (*see* Chart 1). Table 1 shows the relationship between BCEEs, premiums, the number of physicians, and the sufficiency of premiums for a given year. In the years where the estimated combined operating ratio (Table 1, Column 12) is less than 100%, the premium is sufficient to support the claims; where it exceeds 100%, the premium is insufficient.

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<sup>7</sup> *See, e.g., Nobel v. Ambrosio*, 502 N.Y.S2d 511 (1986), *Perez v. Mra*, 11 Misc. 3d 1062(A), Sup. Ct. N.Y. County (2006).

<sup>8</sup> Notably, one authorized medical malpractice insurer, Academic Health Professionals Insurance Association, only insures doctors in the State University of New York system. Those doctors are issued part-time policies that only cover the risk of the doctors when they actually practice, not when they teach or perform other non-clinical work.

<sup>9</sup> The actuarial concept of base class equivalent exposure (“BCEE”) is used to express in a uniform manner the varying levels of riskiness that different classes of physicians present. A hypothetical doctor, often one posing the lowest risk, serves as the “base class,” and all the other doctors’ potentials for loss are measured relative to the base class. For example, assuming the base class is a dermatologist, that dermatologist would be assigned a base class categorization of 1. An obstetrician may be found to be 10 times riskier than that dermatologist, so the obstetrician would be assigned a base class of 10. If these were the only insureds in a hypothetical insurance company, then the insurer would have a base class equivalent exposure of 11. That number could be compared to an insurer whose exposure included 11 dermatologists, producing a BCEE of 11. With large enough numbers and a long enough time period, both insurers share a similar risk profile.



Assuming consistency in the risk profile for 2011, it is reasonable to expect, based on the historical trends, that any increase in the number of covered doctors would dilute the premium to produce combined operating ratios exceeding 100%.

Table 2 shows an actuarial forecast of the estimated expected difference between the current budget allocation of \$127.4 million and the expected program results in the future. Row 8(a) of Table 2 shows the percentage of BCEEs (assuming that FPPs are included) that \$127.4 million can support into the future. Even under the most optimistic scenario assuming the lowest pure premium per BCEE, \$127.4 million would only cover 90% of the risks in the Excess Program for the 2012-13 policy year and just 71% in the 2016-17 policy year. Chart 2 shows the historical profitability of the Excess Program.

This trend not only projects long-term insolvency, but also provides an incentive for insurers to offload their high-risk excess coverage business to the MMIP.

#### **IV. Options to Reform the Excess Program**

The Superintendent and Commissioner examined the following options and their relationship to the public policy objectives for the Excess Pool, namely containing costs and ensuring that New Yorkers are able to have their health care needs met.

##### **A. Limit the Number of Covered Doctors**

There are a number of methods by which a reduction in the number of covered doctors could be applied, including restricting FPPs from participating (an option discussed later in greater detail), capping enrollment, or restricting enrollment to doctors of a certain level of risk based on specialty and region. The first two options are self-explanatory. The latter would entail assessing the extent to which having the coverage is necessary to ensure that doctors will practice in New York State.

Tying Excess Program participation to degrees of malpractice risk would allow the State to limit coverage to the highest risk doctors most likely to incur claims. By eliminating from the Excess Program doctors whose risk profiles show the Excess Pool coverage to be of little significance, the State would ensure that adequate premiums are available to the remaining pool of doctors most likely to incur claims. This measure would reduce the state dollars paying for unnecessary premiums.

Lower-risk doctors excluded from Excess Pool participation under this approach could still purchase primary policies with higher coverage limits to the extent they felt the need for additional insurance protection. Some stakeholders have suggested that modest increases in policy limits would come with minimal to no cost increases for the coverage.

When properly targeted, this approach could help achieve premium adequacy and possibly even produce a modest surplus. Any such surplus could be targeted towards relieving the long-term liabilities confronting the MMIP, funding patient safety programs, or cost containment. These uses could have long-term benefits. Addressing the MMIP's

deficit would bring essential relief to New York State admitted carriers while also making the State more attractive to potential new carriers; targeting patient safety would contain costs by reducing adverse incidents; and providing financial relief to hospitals would enhance patient access to critical care.

Alternatively, any surplus funds could be used to develop a program to provide additional Medicaid reimbursement payments (“add-on” payments) to hospitals for each targeted Medicaid service provided, such as obstetrics. Obstetrical services currently drive high medical malpractice premiums in New York for both hospitals and doctors. Some estimates conclude that 35-50% of medical malpractice premiums are attributable to obstetrical services.<sup>10</sup> As a result, many hospitals have closed or have asked to discontinue services based in part on medical malpractice premiums. There are also shortages of obstetric and gynecologist physicians in some regions of the state in part due to the high cost of medical malpractice premiums. Furthermore, Medicaid covers almost 30% of all health care costs in the state and 50% of all deliveries (closer to 60% in Brooklyn and 70% in the Bronx). Hospitals have provided credible financial data demonstrating that each Medicaid delivery creates a loss of anywhere from \$1,000 to \$2,000.

An add-on for each obstetrical service would provide hospitals and their physicians with additional funds to offset the premium expense for both. An add-on for Medicaid-covered obstetrical services could be eligible for matching federal funds and in turn be used to focus State and federal resources on high-need regions of the State.

The most obvious downside to this change would be that doctors currently receiving the benefit of the Excess Program in lower risk areas would be left to purchase adequate coverage to meet their needs on their own in the private market, to look to their hospital affiliates for assistance, or to forgo excess liability coverage altogether.

## **B. Eliminate the Excess Program**

In some ways the simplest, but perhaps most controversial, solution for addressing the Excess Pool problem would be to dispense with the Excess Pool altogether. However, eliminating the Excess Pool would not be without difficulty.

Eliminating the Excess Program would have a negative impact on the MMIP in the short term by reducing its cash flow. In the longer term, however, discontinuing the Excess Program would likely have a positive effect on the MMIP, as the MMIP has

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<sup>10</sup> Medical malpractice lawsuits brought on behalf of infants with birth-related neurological injuries are among the costliest for insurers because the economic damages can be so high. The State recently has addressed the high cost of insuring obstetrical services by sponsoring legislation in 2011 that amended Article 29-D of the Public Health Law to establish the Medical Indemnity Fund (“MIF”). The MIF, which is administered by DFS, reimburses the future medical costs of a plaintiff in a medical malpractice action in which there is a court-approved settlement or judicial finding that the plaintiff sustained a birth-related neurological impairment. Effectively, New York ameliorates the impact of birth-related neurological impairments on the tort system by paying for those injuries through a segregated fund.

reported to DFS that, in policy year 2011-2012, more than 50% of its close to half billion undiscounted deficit was attributable to its Excess Pool writings.

As with the proposal set forth in Section IV.A. above, which would limit the number of covered doctors, funds from eliminating the MMIP could be used to create targeted relief for the MMIP and high-risk, high-cost medical services throughout the state.

Eliminating the Excess Program could aid risk retention groups (“RRGs”), thus having a negative effect on New York-authorized insurers. An RRG is a specialized type of insurance company formed under the federal Liability Risk Retention Act of 1986, 15 U.S.C. 3901, *et. seq.*, in which policy holders are also stockholders. By contrast, policyholders typically do not hold equity in their insurance companies (though they may). RRGs are limited to insuring businesses of a similar type and its members control both risk and litigation issues. RRGs have various advantages over traditional insurance companies, such as freedom from rate and form requirements, lower capital requirements, and the elimination of many filing and licensing fees. RRG members are not, however, backed by a guaranty fund in the event an RRG becomes impaired.

RRGs enjoy competitive advantages over traditional insurance companies; they do not share MMIP liability and generally are not held to the State’s regulatory requirements. Despite this, many RRGs argue that the Excess Program eligibility requirement that doctors hold primary policies issued by an admitted carrier disenfranchises them in New York’s insurance marketplace. Although states are prohibited by federal law from discriminating against RRGs, the United States Court of Appeals for the Second Circuit has found that the Excess Program does not burden RRGs any more severely than other foreign unlicensed insurers competing for New York business.<sup>11</sup>

### **C. Authorize the MMIP to be the Sole Writer of Excess Program Coverage**

Without any reform of the Excess Program, if the number of FPPs or other doctors entering the program were to increase and reimbursements were to decrease commensurately, then fewer insurers would be willing to provide the coverage. In fact, in 2008, the carrier with the greatest share of the primary policy marketplace stopped writing excess coverage altogether. While other insurers have filled the vacuum left by that carrier, like any insurers, they too could offload higher risk doctors to the MMIP, thereby forcing the MMIP to provide excess coverage for those less desirable risks.

Unlike the risks of its predecessor, the Medical Malpractice Insurance Association (“MMIA”), which were apportioned among all authorized property/casualty insurers, the risks of the MMIP are apportioned only among authorized medical malpractice insurers in New York. Furthermore, in contrast to the case of the MMIA, which was a joint underwriting mechanism, the obligations of the insurers comprising the MMIP are

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<sup>11</sup> *Preferred Physicians Mutual Risk Retention Group v. Pataki*, 85 F.3d 913 (2<sup>nd</sup> Cir. 1996).

several. Therefore, if any one insurer fails in its obligations to policyholders, none of the other insurers is obligated to step into the shoes of that insurer.

The members of the MMIP have reported a \$418 million undiscounted (\$349 million discounted) cumulative deficit as of June 30, 2012. The New York Insurance Law, however, expressly prohibits the Superintendent from rehabilitating or liquidating a domestic insurer whose liability arises from the business of medical malpractice insurance for reasons of insolvency or failure to make good an impairment of its capital or minimum surplus.<sup>12</sup>

Because the MMIP is a risk pooling mechanism, its liabilities reside on the books of its member insurers. When carriers relegate high risk doctors to the MMIP, it not only increases every admitted carrier's share of the MMIP deficit, including that proportion borne by the carrier transferring risk, but also the increasing deficit discourages potential new entrants to the market.

Authorizing the MMIP to be the exclusive writer of Excess Pool coverage could substantially assist the MMIP by increasing cash flow and preventing adverse selection. By alone writing the Excess Pool coverage, the MMIP would receive additional funds from the Excess Pool and attain a better mix of risks. Moreover, the MMIP would receive the profit other carriers currently earn on relatively low-risk Excess policies.

Besides having a negative impact on the other insurers, limiting Excess Pool writings to the MMIP has other potential drawbacks. In particular, there likely would be some lost discount on premiums that otherwise exists when the insurer that writes the excess coverage also writes the primary coverage. More specifically, when one insurer writes both the primary and the excess coverage, the insured can pay a lower premium for the excess. This premium discount results from defense cost reduction due to the need for only one counsel in the case of a lawsuit, since only one insurer is involved. When two different insurers are involved, by contrast, each insurer would have to hire its own defense counsel to defend the risk and the discount on premium is lost.

Mandating that the MMIP exclusively write the Excess Pool coverage would not eradicate the MMIP's present deficit. Nor would the measure in and of itself remedy the deficiency in the Excess Program appropriation; rather, it simply would effect a redistribution of Excess Pool premiums from the other insurers to the MMIP.

#### **D. Reduce Coverage Limits**

Currently, the Excess Program provides coverage of \$1 million per occurrence in excess of a primary limit of \$1.3 million per occurrence and a \$3.9 million aggregate limit. One way to bring the current budget allocation and the expected program

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<sup>12</sup> N.Y. Ins. Law § 2343(c).

experience into harmony would be to reduce the losses covered by the program by reducing the amount of the excess coverage.

Table 3 shows the percentage of current Excess Program losses that could be eliminated by reducing the excess coverage limits. Bridging the gap between the budget allocation and the expected losses requires an elimination of 16.1% of losses, according to 8(b) of Table 3, assuming that the number of doctors in the Excess Program remains the same in the 2012-13 policy year as in the 2011-12 policy year. This could nearly be achieved by reducing the Section 18 coverage limit from \$1 million per occurrence to \$800,000 per occurrence. The main benefit of this approach is that it would match Excess Program costs to the Excess Pool appropriation. However, this may shift part of the burden of paying for extremely severe medical malpractice claims from the State back to the hospitals and, to some degree, the doctors (i.e., insureds) themselves.

#### **E. Introduce Doctor Assessments**

Section 18 sets forth a requirement to impose premium assessments on participating doctors when funds for the Excess Program are inadequate, similar to patient compensation funds in other states such as Wisconsin. In practice, the Excess Program has never assessed doctors for a shortfall in funding.

Based on currently available information, if all the doctors eligible for Excess Program coverage in the 2011-12 policy year remain eligible for coverage, assessments for 2012-13 would be approximately \$690 per BCEE and all the same class and territory relativities used in the program would apply in developing the required assessments. These assessments would increase to approximately \$1,820 per BCEE by 2016-17. Assessments could become quite high for doctors in riskier specialties, who may each be assigned multiple BCEEs to reflect their greater exposure to liability.

Some doctors would likely voluntarily opt out of the Excess Program if they were required to pay any assessment, particularly those who believe that the chance that their losses would extend into their excess coverage layer is remote. The departure of those doctors would lower the amount of the required assessment, and simultaneously help better to align the Excess Program appropriation with its cost.

#### **F. Eliminate the Eligibility of Faculty Practice Doctors**

Eliminating all faculty doctors from eligibility for the Excess Program would help reduce the financial strain on the Excess Program. The language of Section 18 indicates that its purpose was insuring independent doctors who have admitting privileges in hospitals (sometimes known as voluntary attending physicians or “VAPs”), not hospital-employed doctors who do not need excess coverage because they are covered under their hospitals’ own medical malpractice policies. While FPPs generally are not hospital-employed, they are typically doctors employed by a university affiliated with a hospital. In addition, unlike VAPs, FPPs do not always maintain practices that are wholly independent of hospitals or their affiliated universities. It is unlikely that at the time that

it was created, the Excess Pool was intended to insure such physicians, since that model was not prevalent in 1985-86.

FPPs may meet the requirements for eligibility, since they maintain individual policies from an authorized insurer and provide emergency room coverage for the hospitals in which they have professional privileges. Furthermore, there is no basis to conclude that FPPs are likely to have different experience in the Excess Program from that of VAPs, since there is no historical data that makes a distinction between VAPs and FPPs.

### **G. Add a Part-Time Rating Factor**

As previously noted, one insurance carrier in the marketplace primarily insures doctors who only practice on a part-time basis and pay part-time rates for their policies; their teaching responsibilities reduce their expected hours of practice. While most commercial insurers have a rating factor to adjust premiums for doctors working on a part-time basis, the Excess Program does not make such an adjustment. Introducing a part-time rating factor to the Excess Program would reduce significantly the premium allocated to doctors practicing on a part-time basis, thereby allowing more money to be allocated to other areas.

Adding a part-time rating factor would address a weakness in the current rating plan and improve the equity and efficiency of the program. Since these part-time doctors have been participating in the Excess Program from the time the aforementioned insurer began writing this coverage, however, their experience is already part of the existing loss experience of the Excess Program. Thus, adding a part-time rating factor for those doctors currently in the Excess Program would reduce neither expected losses nor exposure to claims.

### **Conclusion**

The evolving nature of employment and practice relationships between doctors and hospitals raises questions about how the coverage of medical malpractice risk should be paid for. The changes in these relationships have led to increases in the number of doctors covered by, and for whom coverage is being sought from, the Excess Pool. This trend is unsustainable; the Excess Pool is currently oversubscribed such that premiums are diluted by at least \$23 million for the 2012-13 policy year.

From its inception, the objectives of the Excess Pool have been to contain costs and encourage doctors to locate and continue practicing in New York. However, the existing framework governing the medical malpractice insurance market allows risk spreading and profit taking in the excess market, neither of which contributes to the Excess Program's purpose. This behavior can be viewed not only as causing an improvident use of State resources, but also as a contributing factor to the deterioration of the MMIP, a detriment that inures to every insurer. This too is unsustainable.

This report evaluates a number of policy options for their impacts on the system. Each comes with potentially detrimental consequences for one or more constituencies – doctors, hospitals, or insurers. Both Departments agree, however, that the best interests of patients should remain at the fore of any policy decision, and the State’s limited resources must be targeted to maximize their impact toward those ends – containing costs and protecting access to quality doctors.

## APPENDIX



**Department of Financial Services**  
**Direct Section 18 Hospital Excess Program Experience (in 000's)**  
 All Companies Combined

Chart 1

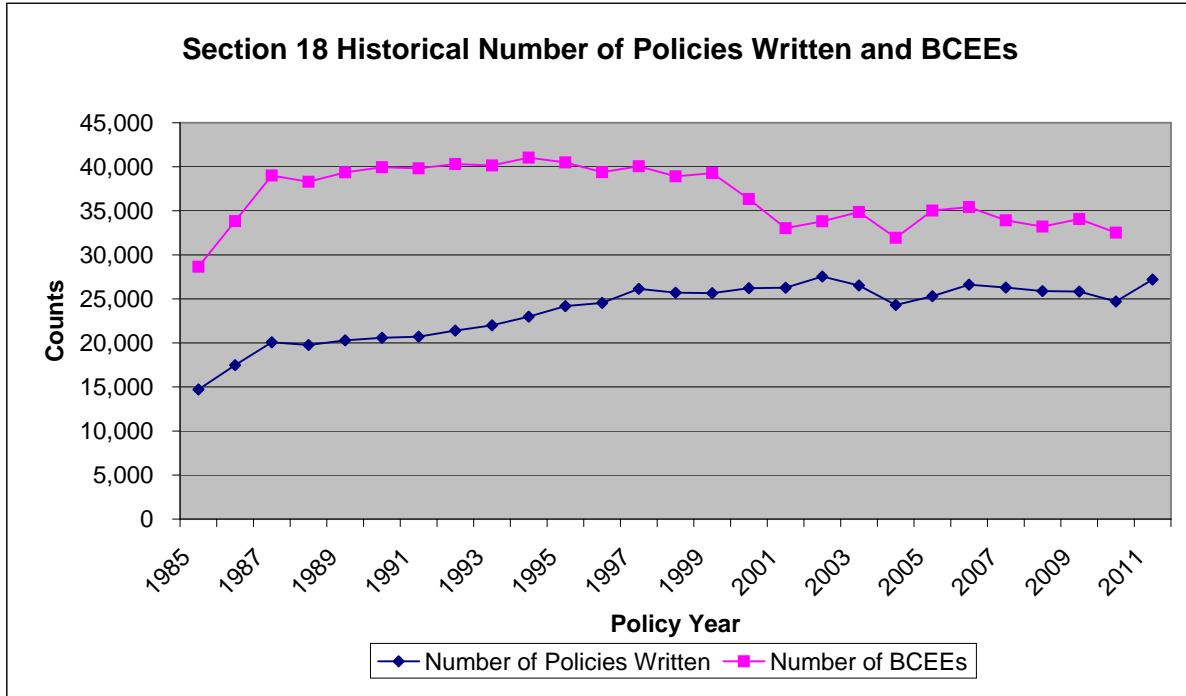
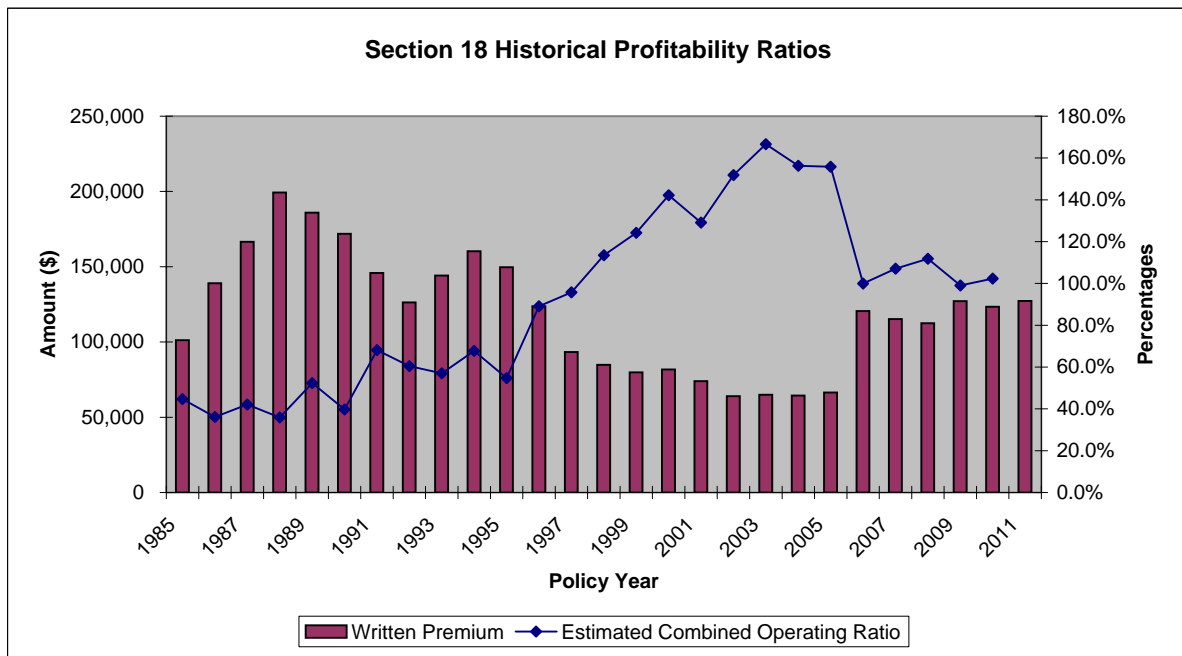


Chart 2



**Department of Financial Services**  
**Direct Section 18 Hospital Excess Program Experience (in 000's)**  
**All Companies Combined**

**Table 1**

	Written		Number of				Company							
Policy	Premium	Number of	Base Class		Reported	Company	Ultimate	Underwriting	Unallocated	Estimated	Estimated	Estimated	Estimated	Estimated
Year	(Fund)	Policies	Equivalent	Paid	Incurred	Ultimate	Loss & ALAE	Expenses	Loss Adj.	Underwriting	Combined	Investment	Operating	Net
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)
Year	Appropriations	Written	Exposures	Losses & ALAE	Losses & ALAE	Loss & ALAE	Ratio	& TLF	Expense	Profit/(Loss)	Oper. Ratio	Income	Profit/(Loss)	Oper. Ratio
1985	101,233	14,718	28,653	0	38,027	30,001	29.6%	13,869	1,350	56,013	44.7%	7,140	63,153	37.6%
1986	139,013	17,486	33,826	38,047	36,084	29,869	21.5%	19,045	1,344	88,755	36.2%	7,109	95,864	31.0%
1987	166,597	20,076	39,012	36,084	44,477	45,316	27.2%	22,824	2,039	96,418	42.1%	10,785	107,203	35.7%
1988	199,252	19,764	38,304	43,477	44,191	42,248	21.2%	27,297	1,901	127,805	35.9%	10,055	137,860	30.8%
1989	185,916	20,287	39,371	44,191	63,486	68,799	37.0%	25,470	3,096	88,551	52.4%	16,374	104,925	43.6%
1990	171,881	20,580	39,952	63,279	47,871	42,834	24.9%	23,548	1,928	103,572	39.7%	10,194	113,767	33.8%
1991	145,806	20,715	39,823	45,812	71,416	75,880	52.0%	19,975	3,415	46,536	68.1%	18,060	64,595	55.7%
1992	126,303	21,398	40,311	69,891	56,498	56,481	44.7%	17,304	2,542	49,977	60.4%	13,443	63,419	49.8%
1993	144,125	22,006	40,157	55,975	70,232	59,777	41.5%	19,745	2,690	61,913	57.0%	14,227	76,140	47.2%
1994	160,251	22,989	41,039	66,083	83,343	82,874	51.7%	21,954	3,729	51,693	67.7%	19,724	71,417	55.4%
1995	149,666	24,187	40,502	68,834	71,868	58,740	39.2%	20,504	2,643	67,779	54.7%	13,980	81,759	45.4%
1996	123,722	24,553	39,390	62,618	94,358	89,286	72.2%	16,950	4,018	13,469	89.1%	21,250	34,719	71.9%
1997	93,300	26,144	40,060	84,108	87,602	73,252	78.5%	12,782	3,296	3,969	95.7%	17,434	21,403	77.1%
1998	84,829	25,715	38,912	77,327	105,618	80,984	95.5%	11,622	3,644	(11,421)	113.5%	19,274	7,853	90.7%
1999	79,778	25,659	39,277	85,881	101,556	84,350	105.7%	10,930	3,796	(19,297)	124.2%	20,075	778	99.0%
2000	81,740	26,207	36,326	82,054	114,282	100,531	123.0%	11,198	4,524	(34,513)	142.2%	23,926	(10,587)	113.0%
2001	73,965	26,273	33,037	98,893	96,474	81,664	110.4%	10,133	3,675	(21,507)	129.1%	19,436	(2,071)	102.8%
2002	64,032	27,545	33,811	67,629	96,841	84,665	132.2%	8,772	3,810	(33,215)	151.9%	20,150	(13,065)	120.4%
2003	64,904	26,531	34,858	58,629	116,453	94,964	146.3%	8,892	4,273	(43,225)	166.6%	22,601	(20,623)	131.8%
2004	64,432	24,301	31,935	53,409	91,368	87,912	136.4%	8,827	3,956	(36,263)	156.3%	20,923	(15,340)	123.8%
2005	66,475	25,307	35,019	44,055	80,685	90,406	136.0%	9,107	4,068	(37,107)	155.8%	21,517	(15,590)	123.5%
2006	120,567	26,612	35,421	23,002	68,760	99,537	82.6%	16,518	4,479	33	100.0%	23,690	23,723	80.3%
2007	115,231	26,283	33,914	16,475	45,033	102,948	89.3%	15,787	4,633	(8,136)	107.1%	24,502	16,366	85.8%
2008	112,410	25,880	33,203	5,859	19,918	105,510	93.9%	15,400	4,748	(13,248)	111.8%	25,111	11,864	89.4%
2009	127,081	25,832	34,061	951	2,571	103,730	81.6%	17,410	4,668	1,272	99.0%	24,688	25,960	79.6%
2010	123,420	24,715	32,517	0	1,161	104,700	84.8%	16,908	4,712	(2,901)	102.4%	24,919	22,018	82.2%
2011	127,181	27,205												
Through 2010	3,085,928	611,762	952,690	1,292,563	1,750,173	1,977,258	64.1%	422,772	88,977	596,921	80.7%	470,587	1,067,508	65.4%
1999-2008	843,533	260,598	346,801	535,886	831,370	932,486	110.5%	115,564	41,962	(246,479)	129.2%	221,932	(24,547)	102.9%
Through 2005	2,487,219	482,439	783,575	1,246,277	1,612,730	1,460,833	58.7%	340,749	65,737	619,900	75.1%	347,678	967,578	61.1%

Footnotes:

- (2)-(7): data was provided by the insurers for the 308 Data Call for policy year 2010
- (8): (7)/(2)
- (9) 13.7% of premium based on most recent Pinnacle Section 18 review report dated April 18, 2012.
- (10) 4.5% of Ultimate L&LAE based on most recent Pinnacle Section 18 rate review report dated April 18, 2012.
- (11): (2)-(7) -(9)-(10)
- (12): 1-(11)/(2)
- (13): 23.8% of the ultimate loss based on most recent Pinnacle Section 18 rate review report dated April 18, 2012.
- (14): (11)+(13)
- (15): 1-(14)/(2)

		Policy Period					Total
		2012-13	2013-14	2014-15	2015-16	2016-17	
(1) Budget Allocation		127,400	127,400	127,400	127,400	127,400	637,000
(2) Provision for Underwriting Expenses		17,454	17,454	17,454	17,454	17,454	87,269
(3) Provision for Unallocated Loss Adj. Expenses		5,181	5,181	5,181	5,181	5,181	25,904
(4) Provision for Discounted Losses		104,765	104,765	104,765	104,765	104,765	523,827
(5) Indicated Undiscounted Losses		137,560	137,560	137,560	137,560	137,560	687,799
(6) Indicated Pure Premium per BCEE	Low	4.00	4.24	4.49	4.76	5.05	
	Central	4.30	4.56	4.83	5.12	5.43	
	High	4.60	4.88	5.17	5.48	5.81	
(7) Indicated Number of Insurable BCEEs at Current Allocation	High	34,390	32,443	30,637	28,899	27,240	153,609
	Central	31,991	30,167	28,480	26,867	25,333	142,838
	Low	29,904	28,188	26,607	25,102	23,676	133,477
(8a) Percentage of Current BCEEs Insurable at Current Allocation (including FPPs)	High	90%	85%	80%	76%	71%	
	Central	84%	79%	75%	71%	67%	
	Low	78%	74%	70%	66%	62%	
(8b) Expected Shortfall at Current Budget Allocation (including FPPs)	\$	26,490	36,409	46,710	57,773	69,600	
	# of BCEEs	6,160	7,984	9,671	11,284	12,818	
	% of Expected Losses	16.1%	20.9%	25.3%	29.6%	33.6%	
	Required Physician Assessment per BCEE (000)	0.69	0.95	1.22	1.51	1.82	
(8c) Percentage of Current BCEEs Insurable at Current Allocation (excluding FPPs)	High	105%	99%	93%	88%	83%	
	Central	98%	92%	87%	82%	78%	
	Low	91%	86%	81%	76%	72%	
(8d) Expected Shortfall at Current Budget Allocation (excluding FPPs)	\$	3,558	12,090	20,951	30,468	40,642	
	# of BCEEs	780	2,909	4,878	6,763	8,556	
	% of Expected Losses	2.5%	8.1%	13.2%	18.1%	22.8%	
	Required Physician Assessment per BCEE (000)	0.11	0.37	0.64	0.93	1.24	
(9) Average Class/Territory Factor per Physician		1.34	1.34	1.34	1.34	1.34	
(10) Indicated Number of Insurable Physicians	High	25,611	24,161	22,816	21,522	20,286	114,395
	Central	23,940	22,576	21,315	20,108	18,959	106,899
	(Currently 24,417) Low	22,270	20,992	19,815	18,694	17,632	99,402

**Footnotes:**

All dollar amounts in \$(000).

(1) Assumed to be fixed for five year period.

(2) 13.7% of premium based on most recent Pinnacle Section 18 rate review report dated April 18, 2012.

(3) 4.5% of loss and allocated loss expense based on most recent Pinnacle Section 18 rate review report dated April 18, 2012.

(4) = (1) - (2) - (3)

(5) = (4) / 76.16%, based on most recent Pinnacle Section 18 rate review report dated April 18, 2012.

(6) Pure premium based on most recent Pinnacle Section 18 rate review report dated April 18, 2012, trended forward at 6.0%

(7) = (5) / (6)

(8a) = (7) / 38,151 from most recent Pinnacle Section 18 Funding Report.

(8b) = (6 - Central) \* 38,151 - (1), then converted to # of BCEEs and divided by (5)

(8c) = (7) / 32,818 from most recent Pinnacle Section 18 Funding Report.

(8d) = (6 - Central) \* 32,818 - (1), then converted to # of BCEEs and divided by (5)

(9) from most recent MMIP Section 18 rate study.

(10) = (7) / (9)

New York State Department of Financial Services

Revised Section 18 Limit Percentage of Losses Eliminated

Table 3

\$950K over \$1.3 million	3.60%
\$900K over \$1.3 million	7.20%
\$850K over \$1.3 million	11.00%
\$800K over \$1.3 million	14.90%
\$750K over \$1.3 million	18.90%
\$700K over \$1.3 million	23.00%
\$600K over \$1.3 million	31.70%
\$500K over \$1.3 million	41.00%