Wyoming Healthcare Commission
Oct. 27, 2003
Meeting Minutes

Attendance:
Commissioners: Chris Muirhead, Chairman, John Vandel, Reform Subcommittee Chair, Carol Jenkins, Healthcare Access Subcommittee Chair, Dr. Stacy Childs, Dr. Robert Volz, Ford Bussart, George Bryce, Dixie Roberts, Paul Lang. Ex-officio: Deborah Fleming, Wyoming Department of Health Director, Ken Vines, Wyoming Insurance Commissioner. Staff: Director Diane Harrop, Assistant Emily Genoff.

Meeting called to order, 8 a.m.

T. Chris Muirhead, Chairman – Welcome and Introductions
Chairman Muirhead introduced the Commission and reviewed the Commission's agenda. The Commission now has a website, www.wyominghealthcarecommission.org. He reported that the Wyoming State Planning Grant task force, studying the issue of the uninsured, is culminating its work. A detailed study of the demographics of the uninsured has been completed; the report will be on the Commission web site.

Ken Vines, Wyoming Insurance Commissioner
Report on findings from Merlinos and Associates
Review of process used in draft JUA report
The third draft of the Joint Underwriting Study report from Mr. Vines, Insurance Commissioner was distributed (available on the Commission web site), along with a letter of the Merlinos and Associates recommendations for operation of a JUA in Wyoming. He reviewed the statute (Enrolled Act 90) that mandated the study and the parameters it set. Merlinos' letter provides rate projections. He reviewed the rate filings that the other companies in the market in Wyoming had made in recent years (OHIC, The Doctor's Co.). He also looked at other industry information available to him as an actuary. The rate recommendations he makes are tied to the market rate and two types of JUAs – one that is competitive in the market and one that is a last resort should other insurers pull out of the state or be unavailable to physicians due to claims histories. In order for a JUA to be self-supporting, the rate would have to be 30 percent above current market. As a last resort, the rate would have to be 75 percent plus market in order to be self-supporting. When I first saw these rate indications, I asked why these have to be so high. This particular actuary still feels our market rates in Wyoming are below where they need to be from an actuarial standpoint. Over the past few years, the companies have selected a rate lower than they could have selected.

He also looked at JUAs in other states and how they compared. He looked at the industry loss experience, loss cost trends and rate charges. With regard to the last resort JUA, you're going to have risks that aren't very good as opposed to the competitive JUA where you're going to take all comers. The Wyoming premium:claims ratio is $1:$1.25, compared to $1:$1.20 nationally. One Wyoming medical malpractice insurer just filed

successfully for a rate increase and should the other insurer providing that coverage in the state, the actuary said he would lower the potential above-market cost of a JUA in Wyoming. Merlinos did similar work for the Mississippi Insurance Department. He says the same recommendations would apply in the case of Wyoming – including that any JUA should be able to underwrite and turn down certain risks if it is competitive. He suggests with both JUAs is that there be some kind of assessment mechanisms to pay claims for which inadequate premiums were collected. You're either going to assess the casualties insurers or the policyholders in order to cover those claims.

The medical liability compensation law on the books now allows assessment of doctors up to 150% of what they pay for their primary policy. If you got one of the current companies – The Doctor's Co. or OHIC – to operate the JUA, a smaller number of participants than the 50 to 100 otherwise necessary. He compared the JUA in that situation to the state high-risk insurance pool, run by the state employees' insurance provider. As a regulator one of the goals is to preserve the market that you have and encourage more competition. You don't know for sure what's going to happen when you inject a state-sponsored or state-imposed insurance company into the market. The Doctor's Co. and OHIC and anyone else offering medical malpractice insurance in the state will then have to decide whether to compete with the state's JUA. But with the rates recommended, that probably won't be an issue. What the JUA triggering mechanism would be hasn't been determined by the Insurance Commissioner, but the statute that defines what a noncompetitive market is might be used to set criteria. It would have to be triggered with some significant hit to the market, such as insolvency and/or withdrawal of either of the companies now covering Wyoming physicians.

What we probably need is some emergency JUA that's in effect that could be activated if we had a real problem. Sen. Charlie Scott said he thinks there are two elements here. I think we wanted it explored as a possibility as a competitive JUA in the marketplace to increase competition or replace existing carriers. The other issue is, what do we do if we have a sudden crisis. Mr. Vines said physicians are likely to pay higher rates for insurance when receiving JUA coverage, even if it were the only insurer in the state. He said insurance companies make money through their underwriting, which we're talking about here, and they also make it through their investment income. If the market improves, rates may be positively impacted. I don't think that's a bad thing. When the market goes south, they're going to have to tighten up their underwriting. Medical malpractice is part of the property and casualty market and is rising along with home and auto insurance. In the 90s, companies were coming in for negative rate increases when the market was soft. I think the Doctor's Co. is in fairly good shape. OHIC maybe not in as good shape but they've put some things in place. They've both expressed to me that they want to be here in the market.

As Diane Harrop pointed out in her white paper (available on the Commission website), OHIC pulled out of Montana a few years ago because they thought there was too much of a regulatory burden. Wyoming is part of their heartland states, one of eight states in their core business. Several other companies are getting out of the medical malpractice business, like Farmer's, which recently announced it would not longer be providing

coverage to physicians in Wyoming. Dr. Stacy said he's concerned about OBs delivering babies that can't get coverage because OHIC and The Doctor's Co. won't write – the JUA should be in place for those physicians. George Bryce said there's going to be a handful of people whose rates are too high and will need state subsidy. He asked how the assessment system would work under a small JUA or a big one. Is the deficit passed to all people who write property and casualty? Mr. Vines said you have to decide that.

The way the statute reads that mandated the study said that the association would be of all casualty insurers so all 600+ casualty underwriters in the state would be subject to the assessment. I think you would want to do it on the basis of premium written. To make that assessment viable, you would have to have all the casualty insurance companies who hold a license assessed. Another quandary develops then – we have a lot of companies in the state that don't write a lot that will probably pull out if looking at an assessment. The other way is, the compensation account law says the providers can be assessed up to a certain level. There are 11 other states that have tried a JUA or have a JUA and you could look at those laws to see how those assessment works. Tax credit mechanisms were discussed to make a JUA more palatable to the companies. Mr. Vines said he was not aware of any lawsuits challenging the assessment of all carriers to fund a JUA, but there may be some.

Analysis of claims information reported by The Doctor's Co.

Mr. Vines said that Ms. Harrop shared with everyone the Oct. 7 letter from the Doctor's Co. that addressed the request for information I made to them (visit web site). I have not received the information from OHIC. In fact, I received a voice mail from OHIC on Oct. 7 saying we would have this information by the Oct. 13 deadline; I left numerous messages but still have not received that. I'm a little perplexed by it. I'm concerned about it. I intend to pursue that with them and see what's happening. Melissa Denison is my contact. She's always provided information and has been very cooperative so I'm a little at a loss on why we don't have this information. Ford Bussart said the Commission cannot make informed decisions without that information. We can't do our job thoroughly. I don't know what Ken's authority here is, but if for whatever reason Ken can't get them to be responsive I think we need to do whatever we need to as a Commission to get their attention. Chairman Muirhead said he was turning the matter over to the Insurance Commissioner but if a letter is needed, he will assist with getting one from the Legislature. He said at some point, decisions have to be made with what's available in the way of data. Mr. Vines said he will make finding out what's going on with OHIC a high priority.

Mr. Vines reviewed the claims paid and expenses accrued to defend physicians in Wyoming, range of amounts, the absence of a breakdown in economic and non-economic damages and reserves for claims payment. There are no jury awards in Wyoming, typically, only settlements. Mr. Bussart said one of the premises that underpins tort reform is that insurance companies are getting hammered by juries for non-economic damages. He said there's nothing indicative in The Doctor's Co. data of aberrant non-economic damage jury awards. Dr. Childs said that this is Wyoming and what we've got is insurance companies that are out there -- like COPIC -- that won't come into this

environment based on runaway jury experience across the country and therefore fear a similar situation will develop here. How do we convince insurance companies to come here? Mr. Bussart asked whether Congress is looking at whether insurance companies' exemption from anti-trust laws. There needs to be some federal regulation of what's an endemic national problem that we're getting caught up in. We need to send a letter to Congress. Mr. Vines said because of Wyoming's small numbers, the range in claims varies widely from year to year. In comparing Wyoming to other states, severity seems higher and frequency is lower.

He reviewed how loss ratios vary for physicians depending on their specialties and practices. Insurance carriers say they incur in excess in $1 million in expenses to provide loss management services countrywide to those they insure (no Wyoming specific cost figure is available). The Doctor's Co. uses their Wyoming data, their biggest competitor's data (OHIC) and no national or regional data when developing Wyoming indices. Whether that's good or bad, I don't know. If it's true that other states have lower rates, maybe it would be better if they didn't use Wyoming experience. I think we heard that typically there aren't enough Wyoming numbers to develop rates so they have to use blends with other states' data. The Doctor's Co. said a low doctor count and a lack of caps in Wyoming makes the state's market more volatile.

Diane Harrop and Emily Genoff
Report of findings from physician survey
Ms. Harrop reviewed the survey of 907 physicians (better than 40% response rate), "affordability and availability of medical malpractice insurance questionnaire" who mostly reported that they had not been cancelled or nonrenewed, unless their insurance carrier had pulled out of the state. Most reported no claims against them. No verdicts were reported and settlement amounts, when known. She read comments from physicians who reported escalating malpractice insurance costs impacting their ways of practicing or potential that they might leave the state. Nineteen percent say they are changing the services they offer, most commonly OB deliveries, high-risk procedures, VBACs, tubal ligations, vasectomies, and ER coverage. Dr. Childs said he is amazed at the consistency in frustration among doctors. I don't know what the answer is. The rates keep going up. Chairman Muirhead said in all the studies he's read, there's no way to quantify the cost of defensive medicine. When you read the result from the physician survey, there's no doubt it's pervasive. It is now an inborn operation. As to what that costs, it's hard to say but it's there.

Mr. Bryce said he doesn't think it's any particular to any industry. There's a general feeling in our culture of outside forces trapping us. It's happening with teachers. It's happening with nurses and doctors, insurance people, stockbrokers, bankers. This is just a little snapshot of part of our society where it's a very serious problem, an expensive problem for some people. Access is the biggest problem. Where you just can't have people providing care, that's our work. Chairman Muirhead said there are quite a few physicians who are limiting their practice. Those procedures are leaving the state to get done and those citizens are not being served. Ms. Fleming said the first groups of patients are dropped because they are likely to sue was an interesting finding – how to follow up

on that? Obviously you got that impression from the responses. Chairman Muirhead said the physician survey will be released.

Report of findings from hospital survey

The hospital survey, "current medical staff development plan listings," is incomplete. Emily Genoff reviewed the hospitals' responses, to date, including staffing shortages, impact on the communities, and anticipated future needs. She said that 55% of the vacancies were for nurses, followed by primary care physicians, technicians (rad techs, lab techs, and ultrasound techs), ER docs, and psychiatrists and other specialists. Communities are being impacted by the medical malpractice insurance availability situation in the state in some areas where services are being curtailed as specialists become harder to recruit and practices – like OB deliveries – become more expensive to insure.

Outline of methodology and conclusions from the white paper: "Medical Malpractice Insurance – Comparisons of Rates in Wyoming and Surrounding States."

Ms. Harrop reported that Commission members almost from the beginning have said, "how do we compare malpractice rates in Wyoming to other states'"? We went to the Doctor's Co. and OHIC, which provide about 85% of the malpractice market in Wyoming and looked at neighboring states (Colorado, Idaho, Utah, Montana, North and South Dakota, Nebraska), which compete with Wyoming for physicians and compared base rates for family practice with and without OB, general surgery, emergency medicine, OB/GYN, general surgery, major surgery, orthopedic surgery and neurosurgery. Doctor's Co. provided side-by-side comparisons of base rates; OHIC was unable to provide that data but did compare several states they do cover. Mainly we looked at The Doctor's Co. – they were able to give information in all the areas we requested. Wyoming rates were the highest among all eight regional states in all but two instances (ER and general surgery). In Colorado, 80 percent to 90 percent of physicians are insured by COPIC. The Doctor's Co. rates are higher in Colorado but probably because that company is picking up higher risk doctors. Utah has just instituted recent reforms not reflected in insurance rates. Montana is considered an unfriendly market. South Dakota has a $500,000 cap on total damages. Nebraska's cap total damages at $1.75 million but individual physicians' payment is $200,000, with overages paid from a special fund set up for that. South Dakota and Idaho allow for periodic payment of damages.

Arbitration panels and expert testimony to establish negligence are other means of limiting malpractice costs. Statistically it seems Wyoming medical malpractice base rates are higher than surrounding states. Reform laws are at least partially responsible for some of the differences. Certain non-economic damage caps lessen rises in medical malpractice insurance premiums. While the scope of this inquiry does not quantify Wyoming patient's access to care, access to care must be considered when this issue is debated. Recently concern has arisen regarding COPIC-insured Colorado physicians traveling to Wyoming to provide care in Laramie. If these physicians and others from other surrounding states who routinely hold outpatient clinics here are required to pay more for coverage while seeing patients in Wyoming may limit or eliminate their availability and

reduce access to care. Chairman Muirhead said this survey is in discussion draft but has not been released pending approval by the Commission. Mr. Vandel said there are a lot of things Wyoming can do based on this survey to make this a more favorable climate to insurers. Chairman Muirhead said Wyoming's rates are significantly higher than surrounding states, particularly in comparison to South Dakota. Ms. Jenkins questioned how much weight could be assigned to caps. While tort reform may address a portion of the problem, it's not the whole problem. I think we need to couple that with a medical errors system that is supported by technology to get to the other portion of this problem.

Mr. Bryce asked for a definition of collateral source reform definition. Ms. Harrop said that allows for admission in a jury trial other sources of payment coming to that victim (hospital insurance, auto insurance). If his bills were taken care of already by some insurer. Periodic payments were discussed – it would not require constitutional remedy, most likely, to allow in the state. Sen. Charlie Scott said that the Joint Labor, Health and Social Services Committee introduced a number of bills last year to address reforms similar to other states. One was a collateral source rule, and the fear was that the Supreme Court would hold that as impinging on their ability to make rulings. Those bills got sent to the Senate Judiciary Committee on the theory that they would look at potential constitutional issues but they chose not to look at the bills at all.

Ms. Harrop said Barb Boyer in the Attorney General's Office is working to analyze the most common forms of tort reform in the U.S. listed in GAO reports to determine which if any would require constitutional amendments. Those will be ready by the November meeting. Ms. Fleming said that she spent time in South Dakota recently and their medical system differs from Wyoming – Sioux Falls has a large VA center, a new heart hospital with 40 cardiologists and Rapid City has a large medical center. They do have a system Community Health Centers. I'm just wondering if that contributes to a whole different medical system and approach and behavior of patients. Chairman Muirhead said the dollar amounts a South Dakota physician pays for medical malpractice coverage is startlingly different than what Wyoming physicians pay.

Mr. Bussart said he has no problem reporting various states' rates and other states' tort reforms but he has a problem drawing editorial conclusions from that data which he says are unsupported by the survey data. I can write a minority report if those goes out as a Commission document. Mr. Muirhead said that's why the survey hasn't been made public and why he demanded Commissioners' input. The question is do we want the conclusions modified or allow for minority reports, or release the report. Mr. Lang asked if there is any reason to submit a conclusion, or could the survey data be released without the conclusions? A vote was taken. One commissioner was in favor of releasing the report with conclusions. Three were opposed. The conclusions will be removed before the data is released.

Mr. Vines said the aspect of the report about the COPIC situation was presented to him differently as Insurance Commissioner. He said COPIC's main concern was that doctors coming to Wyoming periodically were not being regulated properly by the Wyoming Insurance Department. Mr. Vines said we didn't have a concern – it was what we

considered incidental. COPIC is licensed in Wyoming. They are going to review that and determine whether they are going to charge more for those doctors. The initial concern was regulatory. Dr. Volz asked if we were to delete a portion of the conclusions that Mr. Bussart objected to, would that make the conclusions less speculative and more acceptable then for release? I think there are other elements in there that represent fact. Mr. Bussart said to the extent this report states facts, I don't have a problem with that. I haven't satisfied myself that there aren't other conclusory passages in it. We need to get anything out that is in any way conclusory. Dr. Volz said he accepts that. Chairman Muirhead let the straw vote previously taken stand and asked the Commissioners to read the conclusion page and respond back to him within the next week comments to consider with an eye toward eventual release of the document as part of the JUA report without page five (although page five, the conclusions, may later be added).

Enrolled Act 90 – JUA study

Chairman Muirhead said there are eight specific elements that need to be addressed. Those eight items are to determine the feasibility of establishing a JUA comprising all property and casualty insurers, determine the impact of a JUA on the current Wyoming market, rates for JUA solvency, level of policy holder participation needed to sustain a JUA, feasibility of revising statute (medical compensation liability accounts), feasibility of provider owned medical malpractice mutual insurance program, feasibility of provider liability risk retention group, assess the ability of the state to respond to a crisis of any of those alternatives. Those are the things I believe this Commission is to report on. I'm going to use those as the drivers as go through the JUA report that we address. We've all been waiting to do some work and I think finally this is the work we are supposed to be doing. The Commission then began a page-by-page analysis of the JUA study report produced by Mr. Vines.

Mr. Vines said we need to be careful on the language on feasibility. You could set up a JUA. The problem is the rates that have to be charged and whether it's economical. A competitive JUA is likely to be economically impossible, in terms of whether it would be self sustaining (Commission conclusion). Mr. Vines said if you're going to have a JUA with an assessment, there are not enough companies selling just malpractice to make that feasible – all casualty companies would have to be included. There's question about whether that's legal. I honestly don't know the answer to that. I do know you have to have a broad pool of people in order to make it work.

Mr. Bryce asked whether the NAIC (National Association of Insurance Commissioners) tracks the assessment mechanism with JUAs that have evolved in 11 places. Mr. Vines said he thinks that could be determined via NAIC or another source. Mr. Bryce said it would be said if small firms pulled out and specialty areas in insurance markets couldn't then find coverage. We would certainly want to talk to the association that represents casualty insurance companies. Mr. Bussart said it would be sad to have the state sued if the assessments were be made because the state was in medical practice coverage crisis; we need to get some kind of threshold legal analysis regarding whether assessments are defensible.

Mr. Vandel asked about reinsurance and whether that makes the state more attractive to insurers, and what would that cost the state? Mr. Vines said if you have the availability to get reinsurance that's going to cut your liability and therefore you're less likely to have to go out and assess, but he doesn't know what that would cost. My guess is, it's pretty expensive. Chairman Muirhead asked whether in the case of a JUA created as an entity of coverage of last resort in a crisis, the Commission would agree that assessing only those providing medical malpractice would not be appropriate, making the only alternative seeing whether it can be done broad-based to all casualty carriers. Subject to that, is there reinsurance and/or can the state provide a subsidy? Dr. Volz asked that there be a provision that the Commission recommend that the state provide some level of reinsurance to protect the small insurer. Mr. Vines said if you're going to do an assessment, you're going to need that big pool but that doesn't preclude reinsurance or other options. Mr. Bryce said it could be a pool of people who write liability insurance as opposed to those people who write home and car insurance. The Commission agreed.

Chairman Muirhead said the impact on markets is recognized by the Commission, should a JUA be created. Dr. Childs said if in fact we have a JUA of last resort, is there going to be cherry-picking by the insurance carriers who then dump higher risk specialties. Dr. Volz said these concerns need to be included in the report to the Legislature, even though it's speculative regarding what the market will do in response to a last resort JUA. Mr. Vines was asked to address what the trigger elements would be that would bring JUA into effect. He said we're talking about three kinds of JUAs, the competitive one, a market of last resort (a JUA that would be there to pick up physicians and hospitals unable to get insurance from the regular competitive market), and an emergency JUA that would come into effect when you lost a significant portion of your market (which is back to the competitive market, if they're going to come in and offer policies to everyone). Last resort implies insurance for everyone who can't get insurance anywhere else, usually due to claims history.

Discussion followed regarding how to provide insurance coverage to prevent physicians from dropping services like OB, and for ER physicians for whom there is no coverage available from one of Wyoming's primary carriers. It was recommended that that issue be addressed with something besides a JUA of any of the types being discussed. Dr. Childs said there are some specialties that are routinely sued, like neurosurgeons. Because a person has a lot of claims, that doesn't mean that physician isn't desirable to have in the state. Chairman Muirhead said any JUA would have rate risk analysis capability. The Commission's attention was directed to the Merlinos and Associates letter to Mississippi's state government regarding JUA activation, including temporary use of that mechanism should the market open back up and rejection of some risk.

Discussion followed regarding the physicians and hospitals that are going through a specific process to obtain insurance from companies that are not licensed to do business in Wyoming (surplus lines, typically more expensive). Mr. Bryce said some combination of subsidy and reinsurance might be the best method to look at then something as convoluted as a JUA. When the governor calls a special session and says the Legislature has to address it, there's no way to know what kind of circumstances will exist to make

that call happen. Chairman Muirhead asked if the Commission is continuing to debate something that is not ever going to be realistic in Wyoming. Ms. Harrop said that states that have gotten into JUAs have a sunset option but none have figured out how to shut them down once in operation. Dr. Childs indicated that this may just be a bad idea that we're trying to make into a good idea. "You can't make a dog out of a cat." General consensus supported this conclusion. The JUA of last resort (cherry-picking model) will not be recommended.

The emergency approach (if insurers have left the state) was discussed. Mr. Bussart asked if this might negatively affect the market. Sen. Scott indicated that this kind of crisis would probably necessitate a special session to address. A set of feasible options will prepare the Legislature to respond to a spectrum of types of crises. This doesn't not have to be in the form of legislation that will be considered at this time, but in the form of options available to the Legislature when a crisis occurs. Passing something as a backup might in fact trigger a crisis. Mr. Bussart asked how many states created JUAs as a backup and how many actually implemented them? Mr. Vines said he would locate that information. Emulation is the highest form of flattery, Mr. Bussart said, and he'd like to see copies of other states' legislation and the results from passage of those bills. Ms. Harrop said most states' primary problem was not affordability but availability; insurers left the market so they created their own insurance and they were not competing against anybody in the market. Mr. Vines said he's not aware of states that have passed enabling legislation and that have not then set up a JUA.

Chairman Muirhead asked for consensus on an emergency JUA. The JUA of last resort has been nixed. The emergency model where no other carrier provides is workable, although the final results might not be optimal (they don't go away, may be expensive). Other states have put them in place. Sen. Scott said your legislation speaks of it being self sustaining. You would have to ask is that feasible, and if not, it would have to be subsidized by the state. You would have to address that (physician mutuals, risk retention and some of those other things that would take time, or revising the existing statute so that you can put out a policy that looks like what they put out on the market and then subsidizing that). If you will recall at one of your initial meetings I suggested that's an option you need to consider but you have to figure out how much has to be appropriated up front if you have any early claims. Chairman Muirhead said he believes there's a consensus that it would be difficult to make a JUA self sustaining and premiums would be so costly, physicians would leave the state. Dr. Volz and Rep. Osborne: If necessary, premiums should be subsidized by the state, and reinsurance be available purchased by the state at a certain percentage of participation. Then, Dr. Childs said, the Legislature should be advised that should a JUA be created in the case of emergency then it should follow Merlinos' letter to Mississippi and the criteria set out therein.

The Commission adjourned for lunch at noon and reconvened in regular session at 1:30 p.m.

Mr. Vines reported on the medical liability compensation account law adopted in 1977. If you want to participate in it and you're a physician, a $50,000 medical malpractice

insurance policy would have to be purchased and a surcharge of up to 150% of the $50,000 policy premium paid. If the doctor was found liable in a claim, the doctor's insurance would pay the first $50,000 and the compensation account would pay amount over $50,000 up to $1 million. The account is allowed to buy reinsurance for $250,000 up to $1 million. It provided for a board to be appointed. The Insurance Commissioner and State Treasurer were members and a doctor, lawyer, an agent and a consumer appointed by the Governor. In 1977, the Legislature appropriated $300,000 for startup. This was never implemented, no board was appointed and none of the money was apparently used that was appropriated. I assume at some point that money went back to the General Fund. The only thing we can surmise from that is either the market was adequate and apparently the doctors at that point were not interested in using that compensation account. There was a disincentive in having to pay a surcharge. I don't know the reasons for sure that it wasn't implemented but those are my guesses.

How can this law be updated? I added several more paragraphs to this section. I discussed some of the problems that I see with the current law. One of the things you'd have to decide as a policy matter is at what level do the doctors need to buy insurance to. I had some information from several other states that have patient compensation funds and they're all over the map. Some require $100,000, one (Wisconsin?) is $1 million/$3 million (standard malpractice issued today). Once you make that public policy decision, then I think you'd have to do an actuarial study to determine a fair surcharge to keep the account solvent. It's going to have to be actuarially sound just like a JUA. The current law is administratively complex. For example, the doctor pays his premium and surcharge to the insurance carrier which then remits the surcharge to the Insurance Commissioner. It leaves the administration of this fund to the Insurance Department which I don't think is very good. Most of these patient compensation funds are governed by boards that typically hire administrators to run these patient compensation accounts. Inherent conflict in that the Insurance Department has regulatory authority.

I know there was discussion about this being the emergency provision if you lost your medical malpractice market and maybe it could work if it was reworked. Historically it didn't work before and wasn't use. Maybe the circumstances have changed. Dr. Volz said switching would be financially prohibitive because physicians have to pay a "tail" when dropping coverage, and that combined with the surcharge would make switching cost prohibitive. Dr. Childs said the potential would exist for physicians in this fund to be sued for more. George Bryce said this might be an approach to take in a crisis. They do have the ability to reinsure. They may, not must, charge a surcharge. Fixing this might make some sense. I'd be interested in finding out what other states have done with this sort of mechanism.

Mr. Vines discussed whether companies would be willing to sell a policy at a low level of coverage if there were a medical malpractice crisis and the companies weren't offering standards ($1 million/$3 million coverage) in Wyoming. If you're using it as an emergency situation, you're not going to have companies so I don't know where you get the initial policy. Discussion followed about the legislative history of the existing law. Chairman Muirhead asked for consensus on telling the Legislature that the law merits

more study; as written it is not relevant but it has features worth exploring. What's the availability of the small premium market? Chairman Muirhead asked that this be considered further in the Nov. 17 meeting and to be part of the recommendations due to the Legislature in December.

Mr. Vines was asked to check up on what the other seven states are doing, what is successful and what attributes we need to look at. Mr. Bussart suggested that it be designed as occurrence insurance to solve the problem of physicians have to buy a "tail." Another question would be whether the Doctor's Co. or OHIC would consider this an incentive or disincentive. It was decided to be considered a last resort model and not an emergency model – a market tool.

Next, the Commission discussed the provider-owned mutual insurance company statute. Mr. Vines said that anybody who wants to can go out right now and form a risk retention group or a mutual insurance company if they think it's in their best interests. It's there to be used if somebody feels like they can put it together to save money and issues policies at a lesser cost. I can run through the requirements: with a mutual insurance company, there are laws in every state for formation. You have that advantage – you can form in any other state and get licensed in Wyoming as a foreign company. In Wyoming, one thing I discovered in doing the research for this is that our statutes probably need to be revised. They are out of date and don't make a lot of sense for the current market. We have one domestic property and casualty company in Wyoming that is a mutual insurance company.

There are two ways to set up. One is to go out and recruit and take applications and accept premiums before you come in and get licensed which is something I don't look favorably upon and it says you have to be otherwise qualified under the insurance code. There's no provision for surplus requirements. To set up this kind of company you're looking at a minimum of $2 million to get it going. The second provision limits policies to $1,000 to $10,000 in coverage which is inapplicable to medical malpractice. Another requirement in current statute, it requires the mutual company to charge a rate not less than that charged by other insurers for comparable coverage. You could go to other states and form what's called a captive insurance company. Wyoming does not have a captive law.

A captive company is one that's owned by the people who are going to receive the insurance. You can have all kinds of captives, a single parent owner, a group of owners. An example of state where they have had captives for a long time is Vermont. The interesting thing is this is where the question arose about state assistance for starting a provider-owned mutual. The state could provide some initial capitalization, act as a reinsurer, you could also get into a situation again where you have some kind of assessment mechanism or the state could do some kind of loan used to get the company started that would then have to be paid back. The compensation account had a provision in there like that; there was a repayment plan of the money the Legislature had loaned the company. It's going to have to be able to charge rates that can keep the company going

and continue to pay claims. Can it be put together for less cost than your normal insurance company? You have to look at that.

Discussion followed about COPIC, the Doctor's Co. and OHIC being similar types of companies, at least originally, started by physicians and hospitals to cover hospitals and physicians. If you really felt it was feasible and you wanted to do it the mechanisms are there to do it already, Mr. Vines said. However, the Legislature will be advised – the Commission agreed – that the current statute impedes development because the mutual must charge the rates of existing carriers for similar coverage. The Wyoming Hospital Association reported 10 hospitals in Montana, six in Idaho, four in Wyoming and others exploring the idea paid some money for a feasibility study for a captive in response to the hard market and insurance companies that have left the state. It has gone live. It's currently for hospitals but discussion has been held about adding physicians. Provider liability risk retention groups were discussed; the hospital group is a risk retention group.

Mr. Vines said risk retention groups exist under federal law. These were basically adopted under the liability risk retention act of 1986 which amended an earlier act in response to a hard market at that time for liability insurance. What that act allows you to do is set up a risk retention group which is in effect an insurance company with a traditional license in one state according to that state's laws. Once you get licensed, you are then able to go out through the other 50 states by registering in those other states. There is very little regulatory authority by state insurance departments over that company other than the domestic home states so that the other states where it operates don't have a lot of authority to deal with it regulation wise. They're not covered by the guarantee association that acts as a safety net if a company were to become insolvent. There are no Wyoming domestic risk retention groups at the current time but, again, there could be. Like the mutual insurance companies, these can be captives, too. I believe there are a couple of other hospitals in the state using a risk retention group. I don't know if there's a need to change anything; it can be done already. Surplus lines companies are licensed in one state and act in other states as surplus lines; they tend not to get licensed in other states. They're more like regular insurance companies. Risk retention groups are more flexible, and have tax advantages, being under federal law.

Meeting adjourned at 2:30 p.m.