FUNDING THE N.J. MEDICAL MALPRACTICE REINSURANCE ASSOCIATION DEFICIT

The Commissioner's Task Force
on Medical Malpractice

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Executive Summary

The New Jersey Medical Malpractice Reinsurance Association was created by the Legislature in 1976 to solve a crisis in the market for hospital malpractice insurance. Although its primary intent was to stabilize the hospital market by making 100 percent reinsurance available to companies, the Act also allowed use of the Association to back other kinds of medical malpractice insurance. In 1979, the Act was amended to allow the Association to write malpractice insurance directly, which it did. Between 1977 and 1982, the Association either insured or reinsured about 3,500 physicians, 450 Podiatrists and 68 hospitals.

In 1982, the Commissioner of Insurance deactivated the Association after a survey indicated that a commercial market again existed for all three groups -- physicians, podiatrists and hospitals.

Although the Association was deactivated, it is still paying claims against the five years it was active. Last year, the Association, whose members are the state's property-liability insurance companies, notified the commissioner that its actuaries do not believe the $89 million in reserves as of Dec. 31, 1983 will be sufficient to pay all claims.

The actuaries estimate that the deficit will reach at least $42.1 million and could prove to be as high as $68 million. They expect it will take until about 1993 to close all the claims.

The Association estimates that the physicians' fund, which has a projected $34 million deficit, will last until 1988. However, the podiatrists' fund, which has a projected deficit of $7.1 million, may already be over-committed and will probably need a temporary loan from the physicians' fund to get it through the year.

The Act which created the Association vests the Commissioner of Insurance with broad authority for overseeing the Association, including the power to set up a recovery fund and to levy surcharges on insureds to cover losses.

But the statute does not define "insureds." Nor does it specifically address the current situation, in which the losses were discovered after deactivation.

In October, 1984, then-Commissioner Kenneth D. Merin appointed a special task force of physicians, insurers and attorneys. The panel was given two charges: 1) to explore the options for funding the deficit and recommend an equitable solution, and 2) to recommend changes to bring down the cost of medical malpractice in the state.

During the 10 months of the panel's existence, leadership at the Insurance Department changed, and Commissioner Hazel Frank Gluck saw the WORK through to its conclusion. This report fulfills the first charge to the task force. The proposals for cost containment will appear in a second report.

The task force focused on four options for funding. Attorneys for the Medical Inter-Insurance Exchange, the state's largest physician insurer and a former competitor of the Association's, suggested that surcharges should be paid only by Association doctors and that they should vary by specialty. The estimated assessment would range from $460 to $11,120 a year per doctor for about eight years.

The Podiatry Society argued that the surcharge should be spread across the broadest possible base -- all physicians, surgeons and podiatrists -- so as to minimize the financial pain to any one doctor. This school of thought also holds that all the state's approximately 11,000 physicians benefitted from the existence of the Reinsurance Association (which insured some doctors that the Medical Inter-Insurance Exchange had rejected) and that MIX could someday benefit directly by seeking reinsurance from a reactivated Association.

The spreading would result in an estimated one-time payment of $4,695 per physician or eight annual payments of $870.

The Health Care Insurance Exchange/Princeton Insurance Company, which now insures most of the Association's former clients, suggests that since the Reinsurance Association paid about $170,000 in surcharges to the Property-Liability Guaranty Fund, it should be treated like any other insolvent insurer.

That scenario envisions the transfer of the Association's remaining assets to the Guaranty Fund, which would administer claims up to its payment ceiling of $300,000. If, as projected, the Association's assets proved insufficient to cover losses, the shortfall would be made up through a surcharge on all property-liability policies in the state, including automobile and homeowners policies.

A fourth approach involves a combination state bail-out and assessment in which the state would pay for a portion of the deficit from state appropriations and the Reinsurance Association doctors would pay the rest through surcharges.

The Task Force recommends the fourth approach, although not unanimously. First, the group believes that fairness dictates the full funding of the deficit, so that plaintiffs are paid in full and physicians are not left personally liable as a result of fund insolvency.

The majority of group members hold that the Reinsurance Association doctors are, by definition, responsible for a good portion of the deficit, because theirs are the claims which must be paid. In addition, most Association doctors had a choice between an insurance policy from the Association and one from the Medical Inter-Insurance Exchange, which had higher rates for most of the time the two competed. The task force believes the choice of the Association policy was a business decision based on lower rates, rates which, it turns out, were too low to cover the claims.

The group also recommends that the surcharge vary by specialty, just as the price of the original insurance policies did, and that it be spread over a number of years, since much of the deficit will occur in the future. This will also allow for careful monitoring by the Insurance Department and the Association board.

In view of the dire situation in the podiatrists' fund and the special burden a $3,720 surcharge would represent for podiatrists, the task force also recommends that the podiatrists' immediate cash flow needs be handled through an inter-fund loan from the physicians' account repayable over 12 years at eight percent interest

Calculations based on the Association's experience indicate the annual surcharge on Reinsurance Association doctors would then range from about $460 a year for retired doctors to $2,485 for podiatrists to $11,120 for orthopedists and neurosurgeons. Podiatrists would pay over 12 years; other physicians over eight.

Because the size of the surcharge is large, and also because a majority of task force members believe the state's extensive power over the Association's rates and administration creates an obligation on the state's part, the task force also recommends that the state take responsibility for part of the deficit. One suggestion for doing this calls for limiting payments by the Association doctors for the next five years to an amount equal to the expenses and claims for those years. After that, the deficit would become the state's responsiblity.

Creation and Amendment of the Medical Malpractice Liability Act

The early 1970s were turbulent times in the world of medical malpractice liability insurance. All across the nation, both suits and paid claims were rising rapidly, and commercial carriers were quitting the field.

It had long been common for particular insurance companies to have agreements with special segments of the medical community. By the mid-1970s in New Jersey, the hospitals, the podiatrists and the physicians all were encountering problems with their agreements.

In late 1974, Argonaut Insurance Company, which had an agreement with the N.J. Hospital Association, announced it was cancelling 29 hospitals. This was followed by an application for a controversial 410 percent rate increase, and, when the commissioner refused to approve it, the company's withdrawal from the market in 1975. The other major hospital insurer, St. Paul Fire & Marine, declined to write the cancelled hospitals. St. Paul sought permission to change its own policies over to a lesser form of coverage and warned that it, too, might withdraw.

Meanwhile All-Star Insurance Company, which had a multi-year contract with the N.J. Podiatry Society, notified the Society that it wanted to either renegotiate its rates upward or stop writing the coverage. The Society took the company to court and won a Chancery Division decision ordering All-Star to issue the coverage at the agreement rate through January, 1976.

When that period was up, the Podiatry Society again took All-Star to court. On the second round, the Chancery Division ordered renegotiation of the rates upward and extension of coverage into early 1977. All-Star eventually went into receivership, and the Podiatry Society approached 18 insurance companies without finding an insurer.

Physicians' coverage also was in rough waters. In 1974, Commercial Union Insurance Company, which had been marketing excess coverage (a policy for a large amount, sold as an addition to a basic policy) announced that it was withdrawing.

Then Federal Insurance Co., which through an agreement with the Medical Society of New Jersey was insuring about 6,300 of the approximately 9,300 active doctors in the state, began threatening to leave in the wake of a 49.5 percent overall rate increase it said was inadequate.

In 1975, the Legislature held hearings and considered legislation which would set up a reinsurance association. The original idea was to both force and foster competition.

The forcing was to be done by requiring any property-liability company which did business in New Jersey and wrote malpractice coverage somewhere in the United States to write it here, too, or stop doing any kind of business in New Jersey.

The sweetener was creation of the Reinsurance Association to back up the malpractice coverage.

Although the bill passed the Assembly in that form, it was amended substantially in the Senate. Federal had alleviated the crisis by stepping in and offering insurance to the 29 orphaned hospitals. With the pressure reduced, the Legislature was more amenable to changes suggested by the insurance industry.

The final version of the bill created an organization more akin to the automobile assigned risk plan. Membership in the Association was widened to include all property-liability companies; the forced writing requirement was removed, and the Commissioner of Insurance was empowered to activate the Association only upon a finding that insurance was unavailable for a particular group of health professionals. The statement attached to the bill by the Senate Labor, Industry and Professions Committee said that losses were to be reimbursed through surcharges on "all members of the class for which the reinsurance association was activated," but the bill itself was vague on the point.

The Association was activated for hospitals in 1976 and for physicians and podiatrists in 1977. The Health Care Insurance Exchange reinsured 90 percent of its business with the Association. Public Service Mutual, which insured podiatrists, and North River Insurance Company and Federal Insurance Company, which wrote osteopaths and medical doctors, reinsured 100 percent of their physicians' coverage with the Association.

But by 1978, pressure was building again. Federal and North River wanted to stop writing the coverage themselves, and new volunteers were scarce. So the Act was amended to allow the Association to write coverage directly and to make clear that the member companies were to derive no benefit or loss from the Association. The section on surcharges remained vague.

The Act, as it is now, says that its purpose is "to assure that medical malpractice liability insurance is readily available to licensed medical practitioners and health care facilities by establishing a reinsurance association, requiring the association to reinsure medical malpractice liability insurance policies ...", allowing it to write policies directly and permitting the recoupment of losses through "surcharges on insureds."

It also gives the commissioner the power to set up and operate the reinsurance association if insurance became unavailable for any class of licensed medical practitioners or health facilities.

The definition section of the act explains the meaning of the terms, "association," "commissioner," "licensed medical practioner," "medical malpractice liability insurance" "health care facility," "plan of operation," "net direct premium written" and "provider (an insurance company admitted and licensed to write general liability insurance)." It does not define either "insureds " or "surcharges on insureds."

The members of the Association are the approximately 280 companies writing personal injury and property damage liability in the state. The Association is governed by a board of 12 directors, nine elected by the companies and three producers (agents and brokers) named by the commissioner.

The 1984 board included United States Fire Insurance Co.; Lumberman's Mutual Casualty Co.; St. Paul Fire & Marine Co.; N.J. Manufacturers Co.; State Farm Mutual Automobile Insurance Co.; Allstate Insurance Co.; Continental Insurance Co., The Health Care Insurance Exchange; Chubb & Son (Federal); The Donald Bruce Agency, representing the independent agents; The Pike Agency, representing the brokers; and The Allen Stretch Agency, representing the professional agents.

In Section 17:30D-5 the Association was empowered, among other things, "to provide separate accounts for categories and subcategories of insureds reinsured or insured by the association;" to contract for claims handling and auditing services; and to establish "fair and reasonable procedures to assess members whenever the assets of the Association and the New Jersey Medical Malpractice Reinsurance Recovery Fund are insufficient to pay claimants as required by this Act...."

The Association was authorized to invite member companies to apply to become providers (an industry term for a company that writes a particular line of business, in this case, malpractice.) In conjunction with that authority, the Association was also given power "to establish procedures for reviewing claims procedures and practices of providers" and to charge providers when things went wrong. "...(I)n the event that the claims procedures or practices of any provider are considered inadequate to properly service the risk ceded by it to the association," the Act says, the Association may "establish a claims program that will undertake to adjust or assist in the adjustment of claims for the provider on risks ceded by it, and in such event shall charge such provider a reasonable fee for establishing and operating such claim program."

The Act also directs the Association to prepare a plan of operation for review by the commissioner. The commissioner "may review the plan of operation whenever he deems expedient, and shall review same at least once a year and may amend said plan after consultation with the directors and upon certification to the directors of such amendment."

Section 17:30D-10 of the Act says that for the purpose of providing moneys to establish the recovery fund, the commissioner "shall establish reasonable provisions through additional premium charges for policies of the various categories and subcategories of medical malpractice liability insurance" to provide money for the recovery fund. The recovery fund was never activated.

The Act goes on to say, "Such provisions may vary by category or subcategory of risk in reasonable relationship to the loss experience both past and prospective of the association and its members attributable to such category or subcategory."

The state treasurer is named as custodian of the fund with disbursements to be made by the treasurer upon vouchers signed by the commissioner.

Section 17:30D-12 says the commmissioner "may promulgate reasonable rules and regulations to carry out the purposes of this act...."

In 1981, Section 17:30D-16, a sunset provision, was repealed.

History of the Association

The Medical Malpractice Liability Act was born as a response to a crisis in the market for hospital insurance, and it was hospitals that took advantage of it first.

In 1975, the Hospital Association was keenly interested in forming a new, member-owned company but could not raise sufficient capital to meet the state's surplus requirements.

Activation of the Reinsurance Association in 1976 solved the problem. The Hospital Association created a new company, The Health Care Insurance Exchange. The Association loaned the company $1 million in seed money, and each hospital that became a subscriber put up a full year's premium or a capital contribution in addition to its first year's premium. The Health Care Exchange then reinsured 90 percent of its business with the Association.

St. Paul Fire & Marine also reinsured one hospital for a year, then dropped out.

Over time, the Reinsurance Association's participation in the Health Care Exchange dropped to 60 percent, then to 40, and finally, to zero in February, 1982. On Feb. 1, 1982, the Health Care Insurance Exchange and the Association rescinded their reinsurance agreement.

Under the terms of the agreement, the Health Care Insurance Exchange withdrew $26 million in premium and premium income from the Reinsurance Association. [The Association's accounting seperates insureds by company, with separate line items for HCIE, for Federal, for North River and Public Service Mutual. So HCIE's withdrawal amounted to closing out the line item for that company's reinsurance.] In return HCIE agreed to accept responsibility for all future claims arising against 1976-1982, the years its member hospitals' coverage had been reinsured by the Association.

At the same time the Hospital Association was trying to put together its new company, the Medical Society was exploring possibilities for terminating its relationship with Federal Insurance Company and starting its own member-owned company. But the Society's company, the Medical Inter-Insurance Exchange (MIX), took a different tack on meeting the state surplus requirement. The Society asked doctors to purchase subordinated loan certificates, at a price which varied by specialty. Payments ranged from about $1,300 to $7,800, with the average estimated by MIX to be in the neighborhood of $4,200.

The Society arranged for young doctors who could not afford the certificates to borrow the funds from the N.J. National Bank at one point above prime. The bank's older records are in storage, but in 1979, the bank reports, it had 720 loans out to young doctors.

Those who borrowed $2,500 had two years to repay; those who borrowed $5,000 had four years. The average annual rate for prime in the five-year period ranged from a low of 6.83 in 1977 to a high of 18.87 percent in 1981, according to the Federal Reserve.

The Medical Society's decision to start MIX was itself controversial. The Society contended that a doctor-owned company, which could avoid paying agents' commissions and experts' fees, could run more cheaply than either a commercial malpractice company or a state-created organization and could offer physicians a say in how things were done.

But some physicians thought the idea was impractical, and others, particularly specialists who would be required to purchase the largest certificates, objected to the expense of the subordinated loan certificates.

There was also the question of choice. Federal Insurance Company, which, as the Medical Society's insurer, had been the largest malpractice writer in the state, was warning that it did not want to compete with the doctor-owned company unless some kind of reinsurance was available to reduce the risk.

Both the Society and the dissenters lobbied fiercely with their fellow physicians and the Insurance Department. The Medical Society, which argued that there was no need to activate the Association for physicians, warned that the Association might eventually require added assessments. In one letter to Society members, the Medical Society's chairman characterized the Association program as "not insurance but an indemnity program ultimately supported by the physicians without risk to any insurance carrier."

The Society doctors who opposed formation of MIX spoke skeptically of "bedpan mutuals." Those who called the Insurance Department to lobby against MIX seemed to be mostly those from the classificiations which paid the highest premiums and would have to buy the largest certificates.

On December 24, 1977, then-Commissioner James Sheeran granted MIX a license to operate and declared the Reinsurance Association activated for podiatrists. Four days later, he declared that the expense of MIX's subordinated loan certificates created a lack of insurance availablility for some physicians, and he activated the Association for doctors, effective February 1, 1977. MIX's rating plan also was approved February 1.

Almost immediately, the Association qualified Federal, a Chubb & Sons subsidiary, as a company it would reinsure for primary physician's insurance -- in insurance parlance, a provider. In Federal's case, the Association agreed to reinsure 100 percent of Federal's physician coverage for policies of up to $1 million/$3 million ($1 million per claim, $3 million the maximum for any year.)

Public Service Mutual, which had not previously written podiatry insurance here, applied to become a provider for podiatrists, but the board refused to qualify it. The Act said that in such situations the commissioner was to designate a provider, and Sheeran named Public Service. The company wrote podiatrists' policies for coverage of up to $1 million/$3 million.

North River Insurance Company, a Crum and Forster subsidiary, was designated by the Association board as provider for excess coverage of limits up to $5 million/$5 million.

The activation of the Association gave some doctors a choice on basic insurance: They could spend several thousand dollars on joining MIX in the belief that MIX could deliver on its promise of lower rates through greater efficiencies. Or, they could buy an Association-backed policy from Federal avoiding the initial capital payment and hoping that the Reinsurance Association would charge premiums either equal to or less than MIX's.

By law, Federal, North River and Public Service, as Association companies, were required to take any doctor who wanted coverage, including those rejected by other companies, such as MIX, for having bad claims records.

MIX says its ability to reject physicians probably did not give it a serious advantage over Reinsurance Association companies because those physicians transferred to the Association did not constitute a large percentage of MIX's 6,000-plus members. MIX estimates that between 1977 and 1982, it ousted about 70 to 75 physicians and rejected applications from about two dozen more. MIX says, however, that there may have been physicians who bypassed MIX entirely, knowing their applications would be denied. MIX says it would have no record of them.

The February, 1977 rates for both MIX and Federal were identical and represented a 62.5 percent increase over Federal's from the previous year.

Federal's contract with the Association allowed the company to retain 7 percent of premiums for commissions, taxes and general expense. In December, 1977, Federal complained that it was being shortchanged, because the premiums were too low to cover the eventual costs.

During discussion at the annual meeting of 1978, Federal argued that the 7 percent figure was just an oversight in the contract. The Association's board eventually agreed, and with Federal abstaining, voted to allow Federal a 4 percent boost, retroactively.

In October, 1978, the Association's enabling statute was amended. The new language gave the Association the power to write insurance directly, and it made the Association "a legal entity separate and distinct from its members." The term "provider" was added to the definition section, and the commissioner's power to designate a provider when no volunteers were deemed qualified -- no longer needed -- was dropped.

New sections also specified that "no part of the net earnings of the association shall inure to the benefit of any member insurer." However, other language, which specified that in deficit situations, surcharges would be applied on all medical malpractice policies, was changed to remove the word "all." Following deletion of the word, the Health Care Exchange and MIX withdrew their opposition to the bill. A July 27, 1978 explanatory statement attached by the Senate Labor, Industry and Professions committee specifies that the amendments "delete the provisions of the bill which would provide for the levying of surcharges on all medical malpractice policies if a deficit exists in the recovery fund." So the exact language on deficits remained vague.

There were several reasons to change the enabling statute. One was the fact that Federal Insurance Company, which thought rates were inadequate and feared it might be held responsible for future deficits on the policies it reinsured, wanted to stop writing malpractice insurance.

Another was the pressure on the Health Care Insurance Exchange. By late 1979, it had become apparent that the rates for 1976 and 1977 had been too high, so much so that the Exchange was facing the unhappy prospect of having to pay taxes on profits from the hospitals' premiums. To avoid that, the Exchange instituted a retrospective rating plan which in 1980, returned $17 million in unnecessary premiums to member hospitals. Since the Association was holding more than half the premiums for 1976 and 1977, the Association put up the largest piece of the repayment, about $11.4 million.

Meanwhile, the Association had its own tax worries. It had not secured tax-exempt status from the Internal Revenue Service.

During that period, medical underwriting associations nationwide were wrestling with tax problems. Although the IRS had generally ruled against them, one IRS region had held that malpractice organizations similar to the Association would be tax-exempt if, through a retrospective rating plan, all investment income and underwriting profit went into a special fund for eventual return to policyholders.

The retrospective rating plan, which was finally adopted in 1981 applied separately to each category of provider (physicians, podiatrists, etc.). The results were broken out by year, and the money returnable to an individual policyholder from a good year could be reduced to the extent there were deficits in other years. No money has ever been returned to doctors.

The second paragraph of the plan says, "This plan may not be used to assess the clients of NJMMRA (the Association) for any indicated premium deficiency."

With legislative passage of the amendments, and IRS approval of the retrospective rating plan, the Association accomplished its goals.

Following adoption of the 1978 amendments to its statute, the Association began writing both regular and excess coverage on its own. North River continues to handle excess claims from the 1977-78 period, and Federal the claims handling on its coverage from those two years. Federal also contracted to became the servicing carrier for the Association's own primary and excess policies in 1979 through 1982. Public Service continued to reinsure 100 percent of its podiatrists' coverage and do all the related claims handling.

The Association also engaged what it called "a contracting agent," the Britton Agency, to collect premiums and handle clients. Britton had been Federal's broker since the early 1970s and possessed a great deal of data on the doctors it had handled. The Maben Agency made a bid to become the agent, but the board felt that Britton offered special expertise.

The "contracting agent" agreement allowed other agents to place business with the Association, but it meant that they had to do it through Britton, which retained a portion of the commission.

For three years, (1977, 1978 and 1979) premiums for MIX and Association policies were the same. MIX's experience for 1977 and 1978 was better than initially expected, and in 1979, MIX dropped its rates by 8.3 percent. The Association followed suit.

In late 1979, the Association asked for a 29 percent rate increase (on $1 million - $3 million coverage). The filing was amended March 10, 1980 to mirror MIX's, but only MIX was granted approval for a rate increase of 7.9 percent in November. On November 10, 1980 the Association replaced its request with a new filing for a 29.5 percent overall increase, which languished until 1982. In early 1982, MIX was granted another 15 percent increase and the Association an increase in rates of 12.2 percent overall.

Across the five-year period, then, MIX's rates had increased about 15.4 percent, while the Association's rose only 4 percent. As a result, the Association's rates on a basic $100,000/$300,000 policy were about $73 to $250 a year lower than MIX's after 1980.

However, due to differences in the ways the two organizations structured their charges, MIX policies were cheaper than Association policies for $1 million/$3 million coverage after April 1, 1982. A general practioner, for instance, paid $2,967 at MIX and $3,249 at the Association. A neurosurgeon would have paid $21,347 at MIX and $24,008 at the Association.

The Britton Agency estimates that about 100 physicians remained with the Association for all or part of the 1982-83 year. Of that number, it estimates about 50 to 55 held $1 million/$3 million policies.

At its height in 1979, the Association insured or reinsured approximately 450 podiatrists, 3500 doctors, 60 partnerships, 218 professional associations, and 68 hospitals. It insured or reinsured about 560 excess policies. By comparison, MIX had about 6,000 members.

The insurance companies that comprised the membership of the Association were always reluctant participants. Many insurers did not support the 1975 Act, and when Federal she helped to shepherd the 1978 amendments through the Legislature, no move was made to change the sunset provision, which terminated the Association as of January 31, 1981.

As 1979 wore into 1980, and there was still only one major physician insurer and no obvious market for podiatrists, the insurers sought a temporary extension. Instead, the Legislature simply deleted the sunset, allowing the Association to remain in operation indefinately.

In 1980, the Health Care Insurance Exchange formed a subsidiary company, Princeton Insurance, to write physicians' coverage. Although it took about a year to become fully competitive, Princeton quickly became a force in the market.[1] The Association directors agreed in November, 1981 to proceed drafting a plan for deactivation of the organization.

Things also changed at MIX. The company raised its limits of available coverage, and began to seek permission to pay a dividend on its profitable, 1977 year.

Some MIX board members felt it was unfair to continue asking new members to pay contributions to surplus in the form of subordinated loan certificates while paying old members a dividend from the same surplus.

In 1982, the commissioner approved the dropping of the certificates and the payment of the dividend for the 1977 policy year. The credit varied with the size of the original premium. MIX estimates that the credit or refund ranged from about $379.40 to $3,482.40 per policyholder with the average around $990.29.

Meanwhile, in late 1981 the Health Care Insurance Exchange had proposed a reinsurance agreement in which it would take over the reserves and the future expenses of the Association for physicians and podiatrists. The Exchange argued that it could earn so much money on higher-interest securities that it could both pay Association claims and expenses and still make a profit.

The proposal was the subject of public hearings, but the Association board delayed on a decision for a year. One reason for delay was the board's fear that it did not have authority to agree to the plan. Finally, the Exchange withdrew its offer.

In early 1982, the Association was proceeding with plans for deactivation. The 1982 rate increase was a part of that plan. Although the board had previously requested increases of 29 percent in 1979 and 1980, it elected in 1982 to seek to raise them 12.2 percent, a move approved by the commissioner. This had the effect of putting them above Princeton's but below MIX's on some policies.

As a practical matter, it also allowed the Britton Agency to automatically change over all the Reinsurance Association policies to Princeton on the grounds that the Princeton policy was cheaper.[2]

MIX questioned the Association's 12.2 percent rate request at the 1982 annual meeting at which it was announced, prompting The Health Care Exchange's representative to offer to withdraw from the Reinsurance Association's board.[3]

MIX also complained about the automatic changeover, and the rates for both Princeton and the Association in letters to the new commissioner, and wrote a letter to all doctors telling them to evaluate their policies carefully before selecting a company based on price alone. Some physicians did switch to MIX, but the bulk went to Princeton.

On March 1, 1982, then-Commissioner Joseph Murphy signed a declaration deactivating the Association for podiatrists. Similar action followed for primary physicians on September 30, 1982 and for excess physicians coverage on Dec. 31, 1982.

Murphy cited the presence of Princeton, MIX and St. Paul Fire & Marine (which currently insures about 50 physicians in New Jersey) as evidence that a competitive voluntary market was again available. Since it took time to change over all the policies, about 100 physicians remained with the Association through March, 1983.

The Association no longer insures or reinsures new policies. However, it continues to pay claims and expenses involving incidents which occurred in 1977 through 1982, the years it was active.

Following deactivation, Princeton Insurance outbid Federal and in January, 1983, took over claims handling for the Association for the years 1979 to 1982. Federal continues to handles claims from 1977 and 1978 for its primary physicians' insurance; North River the claims for its 1977 and 1978 excess physicians' policies and Public Service the claims against podiatrists.

The Association's March, 1982 annual meeting reported near break-even results for calender year 1981. In March, 1983, the Association's consulting actuaries, Tillinghast, Nelson & Warren, informed Association members that 1982 showed a serious increase in both the severity and frequency of claims and that the cumulative effect of the deterioration could mean an eventual shortfall of $31 million.

The board of directors decided to wait a year to see whether the 1982 numbers were an aberration or part of a trend. By March, 1984, Tillinghast felt the shortfall was likely to reach $42.1 million, $68 million if the money were not raised immediately.

So far, the deficit is not applicable to all years. In its May, 1984 updated report to the Association, Tillinghast indicated that the years 1977 and 1978 still showed an indicated profit of $5.8 million. However, the actuaries noted, "We estimate that approximately 93 percent of this profit is attributable to doctors who were also insured by the N.J.M.M.R.A. during the unprofitable (1979-1982) years."

So, under the terms of the retrospective rating plan, the per-doctor credits applicable to profitable years can be offset by per-doctor debits applicable to deficit years for most of the physicians in the Association.

Currently the physicians' fund, with some $89 million in earned premiums available, is believed to have sufficient reserves to last into 1987 or 1988. The podiatrists' fund was down to $1 million last fall and may already be over-committed.

Although the Association's board had intended to hold funds separately for lines written by company -- primary physicians, excess physicians, hospital and podiatrists insurance -- Princeton discovered when it took over the books that all claims were, in fact, being paid from the physicians' and surgeons' fund, with the accounts being settled at year end. As of April 30, 1984, the Association still held $234,765 in its hospital account, a protection against any future problem with final settlement of the accounts.

The physicians' excess fund has approximately $4.2 million in earned premiums and only one, relatively small claim outstanding. At the end of 1982, it had 791 policies. However, the Association's consulting actuary says that the excess account also may slide into deficit if it follows the trends in the primary physicians' account.

The Options for Funding the Deficit

In October, 1984, then-Commissioner Kenneth Merin appointed a special panel of insurers, attorneys and physicians to recommend an equitable method of funding the deficit and strategies to reduce the cost of medical malpractice in the state. Commissioner Hazel Frank Gluck, who assumed leadership of the Department in March, led the task force to completion of its work.

This is the first of two reports. A second, outlining the task force's recommendations on cost reduction options, will appear under separate cover.

The task force included five physicians insured by the Medical Inter-Insurance Exchange; a podiatrist and physician who held Reinsurance Association policies; one representative each from Princeton Insurance Company, MIX and the Association; a nurse/attorney, and four plaintiff attorneys.

As discussion began, it became apparent that the question of how to fund the deficit was really two questions: 1) Who should pay? and 2) How should payment be structured?

In considering the first issue -- who should pay -- the panel focused on three groups -- Reinsurance Association physicians, all doctors and the people of the state.

Four members of the Medical Inter-Insurance Exchange were the leading advocates for limiting the assessment to Reinsurance Association doctors.

They say that the heated controversy surrounding formation of MIX and the Association saw to it that all doctors had a reasonably good understanding of the choices facing them, and that those who opted for the Association did so in hopes it would be cheaper over the long run. (One Association doctor affirmed that his choice was based on economics.)

Further, they contend that a Reinsurance Association-based surcharge will result in a balancing of financial equities -- that the expense of the surcharge will be roughly equivalent to the value of the subordinated loan payments and higher premiums plus 10 percent interest per year to represent the loss of their money since 1977.

They also contend that their capital remains at risk, since MIX may yet run into serious financial trouble requiring it to dip into surplus, and that, had the Association collected a similar average capital contribution of $4,200, the Association would today have a surplus of at least $14.7 million to fall back on.

On a legal basis, the Association-only argument draws on the existence of the retrospective rating plan and the language of the 1978 amendments.

This argument reasons that since the rating plan contemplated distributing refunds only to Association insureds and that credits to individuals for profitable years would be offset by deficits in other years, it is proper to charge the losses to Association policyholders now, even though no funds were ever returned.

Additionally, MIX members say that the deletion of the word "all" before the phrase "medical malpractice liability policies," in Section 17:30D-10 prior to passage of the 1978 amendments is evidence that the Legislature did not intend a broad-based surcharge.

Further, MIX's attorneys contend that a surcharge on all malpractice policies would represent an unfair business practice, since it would force MIX members to subsidize a state-created organization that used to compete with their company and may do so again in the future.

The Podiatry Society is the leading spokesman for those who believe that all medical malpractice policies should be surcharged. It points out that podiatrists had no choice, because there was no company willing to write insurance for them.

The Society also says that assessing podiatrists for the $7.1 million deficit predicted for their account would create a heavy financial burden on them, especially since the originally small pool of 450 podiatrists shrinks with every passing day as doctors retire, die and leave the state. The Association estimates that 348 podiatrists would be available to pay, and that payments might range from $26,870 paid in one lump sum down to $2,485 over 12 years.

Others who believe the surcharge should not be limited to Association physicians say that many doctors did not, in fact, make an informed choice.

The Health Care Exchange/Princeton Insurance Company (which now insures all podiatrists and most of the Association's former policyholders) contends that the use of the Britton Agency and Federal's paper served to confuse doctors who didn't know the difference between insurance offered by their old insurer, Federal, through its agents, and insurance offered by Federal reinsured by the Association and sold by the same agents.

Since MIX doesn't use independent agents or brokers, a decision to go to MIX may, for some doctors, have meant a violation of the personal trust between them and their agents, Princeton contends.

Others also argue that MIX benefitted from the existence of the Association since the existence of the mechanism allowed MIX to decline to insure known high-risk doctors. (MIX contends that the approximately 100 physicians it declined represented about one-sixtieth of its policyholders -- too small a group to make a difference), and that MIX could have sought reinsurance through the Association and might still in the future.

Moreover, in 1982 MIX paid a dividend of $379.40 to $3,482 per policy to an estimated 5,150 policyholders, has returned the full amount of the subordinated loan certificates to 1,119 doctors who have retired or left practice here and has not required subordinated loan certificates since 1982. Approximately 1,879 physicians or about 26 percent of MIX's insureds joined after the certificate requirement was dropped.

On the question of financial equity, the surcharge to Association doctors over eight years is larger than the amount of money MIX doctors lost by having to tie up their capital. If the Association-only surcharge is varied by specialty and smoothed for credibility, the one-time surcharge for the highest class (orthopedists and neurosurgeons) would come to $60,120. Spread over eight years, the surcharge would reach $88,960.[4]

As for the existence of the retrospective rating plan, those who oppose surcharging only Association doctors point out that the retro plan was intended solely for tax purposes, as evidenced by the section prohibiting use for surcharges.

On the legal points, some who argue for a broad-based surcharge say that while Section 17:30D-10 spells out that any recovery fund is to be funded through premium charges on medical malpractice insurance, it gives the commissioner discretion in deciding how to structure the surcharges, since it speaks of "reasonable provisions" for additional premium charges which "may vary in reasonable relationship" to loss experience of the Association and its members.

Others contend that the fact that the experience "of the association and its members" is to be used indicates that the Legislature meant the surcharges to be upon all malpractice policies in the state.

The Podiatry Society also points out that there is ample precedent for subsidization of state-created associations, the foremost example being the surcharge on all automobile policies to help fund the Joint Underwriting Association.

A variation on the broad-based surcharge argument is the suggestion that the approximately 280 companies which are members of the Association should be surcharged one year to pay the deficit, then repaid through an annual assessment on all medical malpractice policies paid to the recovery fund. This theory addresses the mechanism for initial collection but not the question of which doctors should be surcharged.

If, as Tillinghast estimates, about $10 million is needed the first year, the assessment would come to an average $37,714 per company. Actual assessments, however, would vary with the size of the company, as required by the Act.

That suggestion derives its legal grounding from Section 17:30D-9, which speaks of a recovery fund to reimburse the association for any deficit and of "reimbursements to members for any and all assessments levied as a result of their participation in the association...."; as well as 17:30D-10, which discusses ""additional premium charges for...medical malpractice liability insurance" based on the loss experience "...of the association and its members...."

The third major school of thought on who should pay the surcharge holds that the assessment should be spread in some way to the state, either through the Property-Guaranty Fund (as the Health Care Exchange/Princeton argues) or through direct subsidization from the state treasury (as one MIX physician suggests).

Those who advance that theory contend that the state bears some responsibility because the state created the Association and controlled it through the commissioner's sweeping powers over the plan of operation, the rates, designation of providers, as well as activation and deactivation for any particular group.

The Health Care Exchange/Princeton argues that the Association should be treated as an insolvent insurer. In that scenario, the remaining assets and liabilities would be transferred to the Property-Guaranty Fund, where the $300,000 limit on payments might eliminate the expected deficit.

The Exchange/Princeton points out that the Association has levied assessments on physicians in the past to pay the fund for other insurers' insolvencies. The Associaton paid $79,473.34 in 1979 and $90,514.61 in 1980. It debited a payment of $82,000 for 1982, but the Association recently discovered that the money was never turned over to the guaranty fund. The Association was making arrangements to pay the debt.

Those who object to both the Guaranty Fund and state surplus suggestions argue that the enabling act provides a mechanism for funding deficits, which is a surcharge on medical malpractice liability policies, and that the Association should never have been assessed for the fund, because it is not a licensed insurance company under the law.

Others point out that using the Guaranty Fund or the state Treasury would involve charging either taxpayers or homeowner and automobile policyholders who had nothing to do with the problem for difficulties related to doctors' insurance. Further, the $300,000 cap on payments from the Property-Guaranty Fund may work to save money at the expense of injured parties.

The Exchange/Princeton points out, however, that the average claim payment from years 1980-82 is currently around $21,800, and that if the $300,000 maximum payment from the Property-Guaranty Fund were used for a structured settlement, it would produce a return to the plaintiff of more than $1 million.

The Exchange/Princeton also contends that the argument about burdening homeowners, auto policyholders and others through the Guaranty Fund is specious, because doctors pass higher malpractice premiums through to the public anyway in the form of higher health care bills.

Beyond the question of who should pay, there is the underlying issue of how to structure a surcharge. Should physicians and podiatrists, for instance, be treated separately? Should the surcharge be paid in a lump sum? Should doctors pay the same amount or should it vary with specialty?

The first question was whether the deficit should be funded immediately through a lump-sum surcharge or funded over time.

The one-time approach is attractive because it allows for investment income, lowering the amount of money which would have to come directly through the surcharge.

If the podiatrists' and primary physicians' funds were co-mingled and the deficit was spread among 11,500 doctors statewide, the one-time payment could come to about $4,695.

Limited to Association doctors only, it would reach $14,025 if funds were co-mingled, $12,755 for physicians and $26,715 for podiatrists if they were not. Broken out by class and experience for Association doctors alone, the charge would range from $2,470 for retired doctors to $20,097 for podiatrists to $60,120 for orthopedists and neurosurgeons. The largest group of doctors, those who perform only minor surgery, would pay $7,300.

The numbers demonstrate one major problem with immediate funding -- in most cases, the shock would be severe.

The other problem is that the size of the final deficit is still a matter of considerable uncertainty. In its report to the Reinsurance Malpractice Association dated Dec. 13, 1984, the consulting actuaries, Tillinghast, Nelson & Warren, warned that "indicated surcharges...are dependent on estimates of the future settlement values of claims which are either currently unreported or reported but not yet settled. The actual future settlement values can be expected to vary, perhaps significantly, from our estimates."

Thus, the Association could eventually have to return unnecessary funds or impose an additional surcharge.

A multi-year approach would lessen the immediate financial pain to any group, while allowing the commissioner and Association to monitor experience so that there are no over-payments. However, it may work to drive up the ultimate payment since it deprives the Association of investment income.

The next scenario considered was a surcharge spread over about eight years, the time it will probably take to settle the bulk of the claims. If the two funds are commingled and charges spread over all doctors for eight years, the assessment is estimated at about $870 per physician. Limited to Association doctors, the surcharge would come to $2,595 a year if the funds were commingled, $2,365 for doctors and $4,945 for podiatrists if they were not.

The sub-issue here is whether commingling is appropriate. The insurers say commingling of funds is improper under Section 17:30D-5 of the Act. That section says the Association "shall...have the power...to provide separate accounts for categories and subcategories of insureds...."

They also point to Section 17:30D-10, which says that in order to fund the recovery fund, the commissioner shall establish "reasonable provisions through additional premium charges for policies of the various categories and subcategories of medical malpractice liability insurance." In their view, the physicians and surgeons are one category; the podiatrists another. They say commingling would force doctors to subsidize podiatrists, with no hope of return, and that commingling opens up the possibility that hospitals also should be surcharged. As of April 30, 1984, the Association still held $233,875 in a separate account due to the hospitals as part of the buy-out.

The Podiatry Society alone argued for a flat surcharge and commingling of funds. The podiatrists argued that the actuarial projections used in estimating the podiatrists' future experience were influenced heavily by doctors' experience and therefore exaggerated. They also argued that a projected surcharge of $4,945 was simply too onerous, particularly in light of the fact that many physicians statewide have agreed to freeze their rates for a year in cooperation with the federal government's effort to bring down Medicare costs. Moreover, as a group, podiatrists tend to earn less than physicians. The median gross income for podiatrists in 1984 nationwide was $95,000, a sum roughly equivalent to the median net for physicians in 1983.

The commingling issue also raises the question of the excess physicians and surgeons' account. The Association is currently treating that as a separate, profitable account, although it is so small, the consulting actuary believes it, too, is likely to slide into deficit. While it currently has only one claim against its approximately $4.2 million in reserves, the actuaries point out it would not take many $1 million claims to wipe it out.

The third question was whether the surcharge should be varied by specialty. Traditionally, medical malpractice premiums have been stratified by specialty-class, with general practice rates being much lower than those for high-risk occupations such as neurosurgery.

Those who contend that the surcharges should also vary by specialty class again point to Section 17:30D-10 as justification. That section, which describes the recovery fund says that charges "may vary by category or subcategory of risk in reasonable relationship to the loss experience...."

At the request of the panel, the actuary prepared an estimate of surcharges varied by class and year, using the Reinsurance Association experience alone.

Since some classes -- most notably the podiatrists -- are too small to generate any pattern considered reliable by standard actuarial practice, the actuary adjusted the various classes for credibility. This works to reduce the assessment on some groups (like podiatrists) and raise the charge to others, primarily the major surgery and specialty surgery classes (such as opthalmologists, cardiac surgeons, urologists and gynecologists). Spread over eight years, the surcharges would range from $460 a year for retired physicians to $3,720 for podiatrists to $11,120 for orthopedists and neurosurgeons, with the largest number (g.p.'s) paying about $1,350.

For podiatrists, however, $3,720 a year still would represent an increase of about 90 percent above the 1985 rate of $3,988 a year. The 1985 rate already reflected a rate increase of 59 percent over 1984.

For a doctor in the general practioner-no surgery class paying Princeton's rate for $1 million/$3 million coverage of $1,486 in 1984, the surcharge would represent an increase of about 90 percent. For a neurosurgeon paying MIX's 1985 base $1 million/$3 million rate of $30,122, the increase would be 37 percent.

Two further possibilities were developed. The first, which envisions immediate borrowing from the physicians' and surgeons' account to meet the podiatrists' cash flow needs, involves 12 annual payments of $2,485 by each posiatrist. The second, which would be spread over eight years, would start with a surcharge of $2,485 this year and increase every year at a rate of 8.3 percent.

Both possibilities call for the podiatrists to repay 8 percent interest on the loan from the physicians' and surgeons' fund. The rate is above the 6.8 percent average prime rate in 1977 but below prime for all other years of the Association's existence (Under the Medical Society's program, some doctors borrowed subordinated loan payments at one point above prime). As of Feb. 23, 1985, prime stood at 10.50 percent.

A further complication is introduced by the fact that the Association's actuary developed projections based on Association experience. The Act, however, says that surcharges must be calculated based on the experience of the Association's members, which include MIX, Federal and the Health Care Insurance Exchange. The final surcharge amounts would depend on an analysis of the combined experience of the three groups.

The Recommendation of the Task Force

Following months of research and debate, the task force has concluded, although not unanimously, that the surcharge should be restricted to doctors and podiatrists who were members of the Association between 1977 and 1982, since it was they who benefitted from the lower rates and fees charged by the Association and they who generated the claims involved in the deficit. Further, most of them had the opportunity to choose between the Association and MIX.

For the sake of exploring options for reducing future expenses and diluting the financial impact on individuals, the surcharge should be spread across a period of years -- a strategy that also recognizes the fact that most of the claim payments will, in fact, be made in the future. Additionally, the surcharge should vary by class and by specialty as determined after review of experience statewide for the period.

For podiatrists, the task force recommends the immediate borrowing with pay-back to the physicians' fund over 12 years at 8 percent, and that the podiatrists' experience be adjusted for credibility.

Further, a majority of members also believe the state should help to fund the deficit, because the state had extensive oversight power over the Association's rates and administration.

Although the task force has not settled on a figure for the state's participation, one possibility would be a surcharge on Association doctors for perhaps five years, after which the state would take responsiblity for the deficit.

There is also substantial but not unanimous agreement on the Association's obligation to pay all claims. The plaintiff attorneys in particular felt that claimants had a right to full payment for either settlements or awards, and that physicians had a right to insurance up to the limits of the policy they originally purchased.

The second best option would be an assessment on the property-casualty liability companies. Although this plan has a limited potential for hurting consumers who had nothing to do with the Association's problems, the assessment on the approximately 280 individual companies would probably come to only a few cents on any homeowner or auto policy.

The other option, transferring the assets and liabilities of the Association to the N.J. Property-Guaranty Fund is the least favorable. First, the $300,000 payment cap could leave at least a few injured people uncompensated. Second, more than half the money contributed to the Guaranty Fund came from automobile policyholders, who have no connection with the malpractice problem.

Moreover, the Property-Guaranty Fund is already overburdened. It currently is paying claims for 20 insolvent companies. With 1984 the worst year in recent memory for property-casualty companies and no dramatic improvement expected for several years, it may prove imprudent to add the Association to the list when other options are available.

FOOTNOTES:

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1. MIX and Princeton sell different products, and the choice between the two requires physicians to make a judgment about future risk. MIX sells the traditional occurrence policy, which pays all claims against the year of the policy, no matter when they arise. The physician, then, gambles on whether the coverage purchased for any particular year will prove adequate to withstand all claims ever to arise against that year. Say for instance, a physician bought a 1974 policy with limits of $100,000/$300,000. In 1984, a suit is filed over a 1974 incident. If a court awards the plaintiff $50,000, the doctor is covered completely. But if the court awards the plaintiff $150,000, the policy will pay only $100,000, and the physician becomes liable for the other $50,000. Similarly, if between 1974 and 1994, eight awards for $50,000 each are awarded to plaintiffs for incidents occurring in 1974, the physician will be liable for $100,000 of the $400,000, because the coverage had a maximum of $300,000.

   Princeton's occurrence-plus policy is a little different. The limits for any claim against the physician are the limits of the policy in effect at the time of the claim. Say, for instance, a physician bought a policy for $200,000/$600,000 in 1982 and now in 1985 has a $1 million/$3 million policy. A jury delivers an award to a plaintiff of $1 million for an incident occurring in 1982. The policy will pay the entire award. When the physician leaves Princeton for any reason, there is no extra premium to pay. The coverage for the years he or she was insured automatically becomes the aggregate of the past three years' coverage (unlike a claims-made policy, the physician does not have to pay anything extra for the future coverage.). So if the physician had been carrying a $1 million/$3 million policy for each of three years, the lifetime policy becomes $3 million/$9 million. The gamble is on the lifetime aggregate. If, over the next 20-plus years, the physician ends up with a total of 10 $1-million claims, the policy would stop paying after $9 million.

2. Different members of the insurance community hold sharply different views on the advantages and disadvantages of using independent agents and brokers. MIX handles its sales work in-house. Princeton contracts with agents, including the Britton Agency.

3. The Association's leadership has not changed often. Federal left the board in 1979 when it became servicing contractor for the Association, but it returned in 1982 when Princeton won the service contract. Travelers and Insurance Company of North America were replaced by N.J.M. and Continental. Although the Health Care Insurance Exchange always has held a directorship, MIX never has.

FOOTNOTES (continued)

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4. If the most expensive MIX loan certificate cost $7,800, and the $7,800 had been invested at an average 10 percent interest from 1977 (the first year of MIX's existence) through 1993 (the last year for which the eight-year surcharge is contemplated) the result would have been $39,080. ($7,800 + $31,280 (17 years' interest) = $39,080.

   If the most expensive certificate brought the largest dividend of $3,482, then an individual doctor's loss would have been $35,598, plus the difference between MIX premiums and Association premiums between 1980 and 1982 for whatever coverage that doctor chose.

   For example, the rate for a cardiovascular surgeon with a $100,00/$300,000 policy would have been $6,860 at MIX in 1980 and 1981, versus $6,434 at the Association. Figured at the same 10 percent interest rate over the 14 years between 1993 and 1980, the lost money would come to about $2,941 ($854 + $2,087). So the individual doctor's loss on premiums and the subordinated loan certificate would eventually come to about $38,539 -- assuming the principal remained inaccessible. Neither this calculation nor the value of the potential Reinsurance Association surcharge has been adjusted for inflation.