Medical Malpractice Premium Data Summary

New Jersey Department of Banking and Insurance
2002

INTRODUCTION

Every insurance product serves economic purposes beyond those sought by the policyholder. A variety of third parties are impacted by insurance coverage, whether directly through the receipt of claims payments or indirectly through the economic activity that such coverage actively generates or passively allows. But few insurance products compare with medical malpractice liability insurance when it comes to the potential for *non-economic* impacts. That is because med-mal coverage is about more than protecting policyholders, compensating third parties or keeping an industry humming; it is about the quality and availability of healthcare for everyone.

Healthcare availability problems related to medical malpractice insurance are held to a minimum when the coverage is easy to find and the premiums are relatively affordable, as was the case in the alternately stable or "soft" insurance markets prior to the mid 1970s, again during the first few years of the 1980s, and then again throughout most of the 1990s. In contrast, the "hard" markets of the late `70s (when there was no availability of coverage at all), mid and late `80s and early `00s have resulted in healthcare providers citing medical malpractice insurance as a reason for scaling back their practices, relocating or, increasingly, leaving their professions altogether.

Not surprisingly, potential healthcare availability problems related to med-mal are linked to problems in one of the few other forms of insurance with significant non-economic impacts for third parties: health insurance. The availability and affordability of health insurance also remains an ongoing national issue, despite legislative attempts to address the problem three decades ago

through the creation of managed care. Among other things, those attempts resulted in price controls that limit the ability of providers to recoup today's higher med-mal costs through higher fees. The irony, therefore, is that past attempts to make healthcare more accessible for average citizens have contributed to some of the accessibility issues that threaten us now.

BACKGROUND

The purpose of the insurance business is the transfer of risk. Purchasers pay a known, fixed amount, "the premium," to transfer the risk of unknown but presumably larger losses or expenditures, as set forth in a legal contract, "the policy." Governmental oversight of the insurance business was first instituted to assure that insurers maintained sufficient reserves and capital to fulfill the promise to pay claims as set forth in the policy. Insurers' capital provides a margin of safety in order to assure that future claims will be paid.

Since the policyholder pays the premium when the contract is initiated, while the insurer pays claims thereafter, the premium revenue is supplemented by investment income during the interim. Simplistically, premium plus investment income must equal the insurers' loss payments, plus the transaction costs and related expenditures, plus provide a competitive return on the insurers invested capital. The required return is affected by the perception of the risk assumed: the higher the risk, the higher the return required to attract and retain the capital necessary to underwrite the insurance business. Insurers are supplemented by re-insurers, by which a direct insurer (the one issuing the policy) transfers a portion of the risk to another insurer.

The ebb and flow of capital in and out of the insurance business has historically created cycles known as "hard" and "soft" markets. Hard markets are characterized by increasing prices, and decreased availability; soft markets are characterized by the opposite. Because the risks of certain lines or sub-lines of

insurance are perceived differently during different cycles, the cyclical nature of the business has historically resulted in hard markets for at least some policyholders at various times.

Today's "hard" market can be seen in the financial collapse or constriction of med-mal insurers and large premium increases for some providers in high-risk specialties. As in the past, today's situation at least partially reflects the upheaval of an industry trying to respond to major new developments in the marketplace. Unlike in the past, one of those new developments was uniquely dramatic and, despite no obvious connection to med-mal insurance, of substantial consequences to the industry. That development was the terrorist attacks of September 11, 2001 and the resulting global reinsurance crisis. Reinsurance policies are insurance policies for insurance companies. In simple terms, they are a substitute for some of the capital that a company would otherwise need to assure full payment of future claims. Thus, companies that are unable to find or afford reinsurance (or are unwilling to pay higher prices for it) are also unable to cover some or all of their policyholders. In this respect direct insurers are not unlike other insurance consumers. Their ability to run their businesses depends on the availability and affordability of insurance coverage.

While it is difficult to quantify the exact contribution of the reinsurance problem to today's hard market, it is clear that the reinsurance factor was both large – in some individual cases even critical – and not alone. Both it and falling investment income (also associated to some degree with 9-11) compounded existing, problematic developments in the soft market of the 1990s. That decade was characterized by an unusually aggressive competition by insurers for marketshare, typically through premium discounts and a hold-the-line approach to rates, which ultimately pushed prices below sustainable levels.

As seen in other sectors of the economy from time to time – and, to be fair, as also seen most clearly in hindsight – competition in the med-mal business

in the `90s presented many carriers with a Hobson's choice: compete with low rates now and risk a theoretical financial collapse sometime in the future, or boost rates to a more prudent level now and risk a rather-likely financial demise in the present. It's no surprise that most companies chose to survive "in the now" and hope that optimistic projections for the future proved true. It's also no surprise that the soft cycle of the `90s led to the hard cycle of today, just as it should be no surprise when the current cycle turns back again to one that is more favorable for policyholders. Indeed, this is the recurring pattern in many sectors of the economy (and the economy itself), not just med-mal.

Specifically with respect to med-mal, however, the cycles discussed above can be traced to the 1970s and insurer concerns about rising claims and resulting settlements and jury awards. The extent of the so-called "tort problem" was and remains in dispute, with various factions able to produce data that make lawsuits look either inconsequential or the single-biggest cause of each hard market. The truth is likely somewhere in-between these extremes, though there is little doubt that such costs are a real factor, have been a large factor in some cases, and are of particular concern in certain geographic regions where big judgments are more likely. There is also no doubt that several medical malpractice carriers became insolvent or were placed in rehabilitation because claims and loss-adjustment costs exceeded earned premiums, for whatever combination of reasons. But the debate misses the point in a key respect: insurance is fundamentally a gamble, the outcomes are never assured, and the business depends on projections of future developments. What happened during the last three years doesn't matter nearly as much as what's going to happen during the *next* three years. And, right or wrong, the industry now faces projections from experts, such as the consulting firm of Tillinghast-Towers Perrin, that tort costs are likely to rise steeply through 2005. Insurers must put more money aside to cover those upcoming costs and prevent insolvency.[1] That money comes from premiums and investments.

[1] Increasing reserves in anticipation of higher future costs is more than fiscally prudent, regulators generally require it.

Whatever was really happening in the 1970s, the point was that it highlighted for companies the unpredictable nature of this kind of liability insurance. Anxiety about future developments encouraged insurers to invest their capital elsewhere or, at the very least, raise premiums in an effort to stem future losses. Prices went up. Supply failed to keep pace with Demand. Then coverage became unavailable at any price.

The severity of that availability crisis spurred the passage of the Medical Malpractice Liability Insurance Act (N.J.S.A. 17:30D-1 et seq.) on January 30, 1976. The Act created the New Jersey Medical Malpractice Reinsurance Association with the express purpose of making coverage available when insurance carriers in the voluntary market would not. The Association was to achieve this goal by reinsuring private carriers, thus limiting their risk. This approach was apparently of limited success because two years later the Legislature amended the Act to allow the Association to provide coverage directly to providers who could not find a willing insurer in the regular market. By the mid 1980s the Association had a deficit of $64.4 million. The possibility of such losses was anticipated by the Legislature, and the Act created another fund[2] through which the Commissioner could surcharge *all* providers to make up any such deficit.[3]

The market stumbled but generally improved through much of the 1980s as providers turned to new organizations established by doctors and hospitals (the predecessors of MIIX Insurance Co. and Princeton Insurance Co., respectively). This development was perhaps the single-biggest "spark" for the soft-market explosion of the 1990s.

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[2] The New Jersey Medical Malpractice Reinsurance Recovery Fund (N.J.S.A. 17:30D-9).

[3] i.e., whether the provider was covered by the Association or a regular carrier in the voluntary market.

Provider-owned med-mal operations changed the landscape dramatically by changing the priorities – and thus the business decisions – of the insurer. Such insurers were not focused on profits per se, on stockholder returns, or on risking their capital on new ventures in hopes of new levels of return. Nor were they engaged in other lines of business that, given normal market fluctuations, would periodically seem to be a better repository for capital. Being owned by providers, these operations appeared more interested in the priorities of providers. They tended to be more aggressive in fighting claims they perceived as frivolous instead of paying settlements to head off even the slight chance of a large judgment down the road. They also fostered the spread of "occurrence" policies instead of the "claims-made" policies that remain the most common form of med-mal coverage nationally.[4]

Providers liked these operations. New Jersey's own examples, MIIX and Princeton, began a long reign as the state's largest med-mal insurers, reaching a combined market share of 80 percent. Further, whether through good management or external market forces, or some combination of the two, the companies posted unexpectedly good returns. Such success doesn't go unnoticed, and traditional insurers re-entered the New Jersey market in search of a piece of the action. Supply and competition both soared. Prices stayed down. And the fierce competition for policyholders ultimately contributed to the financial problems of more than one company.

An example of the new price war can be seen in the entry to the New Jersey market of Zurich American Insurance Company. Zurich offered substantially lower prices, luring providers from companies such as MIIX and Princeton and pressuring those companies to push down their own premiums in an

[4] A claims-made policy covers claims *made* during the year in which the policy is in force, regardless of when the events that led to the claims took place. An occurrence policy covers claims arising from *events in the year in which the policy is in force*, regardless of when those claims are made. The risks associated with occurrence policies are more difficult to predict, but the coverage may be considered more comprehensive.

effort to stay competitive. But Zurich was unable to sustain this strategy and in 2001 attempted to leave New Jersey through comprehensive non-renewals of their policyholders.[5] Another example is PHICO Insurance Co, which likewise tried to compete in New Jersey through aggressive pricing but ultimately ended up in liquidation.[6]

It was also within the context of the fierce competition of the soft market that MIIX decided to diversify, as recommended by knowledgeable sources such as the AM Best insurance rating agency. Facing challenges from traditional companies that were larger or more diversified, or making money in multiple states, MIIX chose to expand beyond its traditional role. This decision was supported by well over 90% of its members/policyholders, and no objections were voiced at a public hearing on the matter. But MIIX's moves into other states (and into a stock market on the verge of an unanticipated downswing) weakened the company and contributed to the solvent run-off now being administered by the Department. Those decisions were not, at the time, clearly doomed to failure.[7] Several forces conspired to create the bad outcome. But in hindsight doctors and patients alike may have been better served by a MIIX that responded to the competitive pressures of the soft market by rededicating itself to its traditional focus on New Jersey physicians. The recent creation of MIIX Advantage suggests that the company has come to a similar conclusion – and that the market may be taking yet another turn. In any event, the constriction of the state's single-largest med-mal insurer, and the resulting loss of capital that the marketplace needs to support future business, is one of the contributors to the anxiety being felt today.

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[5] The Department determined that many of these non-renewals were not permissible and stepped in to stop them. While the Department's action prevented loss of coverage for those providers, Zurich then raised rates significantly -- and for a much higher percentage of their policyholders than other companies in the market. The result was the voluntary movement of some providers to less-expensive carriers.

[6] The Pennsylvania Department of Insurance is administering the PHICO liquidation.

[7] Such expansions were encouraged by insurance analysts, who concluded that companies like MIIX were too focused on one market and had become vulnerable.

Other contributing factors range from the general hardening of the property/liability insurance market as a whole (across all product lines and across the country), to the financial woes of individual New Jersey-licensed insurers. In the last two years, PHICO was declared insolvent in Pennsylvania, and Frontier, a New York-based company, began running off its claims in receivership. St. Paul Group decided to exit the med-mal business nationwide because of almost $1 billion in losses. Clarendon joined Zurich in moving to end coverage for certain sublines, specialties or programs because of the loss of reinsurance. And Princeton Insurance Co., the one major carrier that remains in New Jersey, faces challenges of its own as it emerges from the bruising competition of the 1990s.

These individual developments and the various global forces that have been described (the cyclical nature of the market; the problem of rising costs and shrinking availability in reinsurance; the significance of falling investment income; and the causes and results of business decisions that look worse today than they did when they were made) explain the recent emergence of another hard market and help inform discussions about possible remedies. However, the existence of such forces does not by itself answer the question, "are current premiums appropriate?" Rising prices (and shrinking availability) may be inevitable at this point in the economic cycle, but to what degree?

CURRENT PREMIUMS

One way to judge New Jersey's med-mal situation is to compare it with situations in other parts of the nation. Data from the National Association of Insurance Commissioners (NAIC) indicate that New Jersey's recent experiences of premium increases and company financial problems are consistent with the national marketplace as a whole. Several states (including Florida, Texas and Virginia) fair substantially worse in key NAIC measures such as marketshare concentration and the Herfindahl Index of competitiveness.[8] National data also shows total claims costs exceeding premium income for each of the last few years, to the point where companies were spending an average of $1.50 or more on claims for each $1.00 that the companies received in premium in 2001.

Comparative data on recent premium increases in the various states is not available on a comprehensive basis, but individual examples suggest that New Jersey's experience has not been exceptional. Ohio recently reported statewide med-mal rate increases of more than 21 percent in 2001 and more than 30 percent in the first half of 2002 – about twice that of New Jersey.[9] And a recent Texas Department of Insurance analysis of 28 jurisdictions placed New Jersey among the least expensive of those jurisdictions for med-mal insurance in the four specialties examined: anesthesiology; neurosurgery; OB/GYN; and family practice.

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[8] The Herfindahl Index is the standard measurement of competitiveness in a given marketplace. The Justice Department uses the Index for anti-trust purposes when reviewing corporate mergers. The Index shows that the total number of companies in a given marketplace is less important for competitiveness than the combined marketshare of that market's dominant companies.

[9] As based on the limited rate data available under NJ law. Ohio also has one of the least competitive med-mal markets in the nation, according to the Herfindahl score reported by NAIC.

Providing other information to better understand the appropriateness of current premiums in New Jersey was one of the purposes of P.L. 2002, c.55, which required the submission of insurer data that the Department typically would not otherwise have, given its limited regulatory role as set forth in the Commercial Deregulation Act of 1982 (N.J.S.A. 17:29AA-1 et seq.).

That Act gives the Department authority with respect to licensing and solvency regulations, but exempts commercial lines insurance, including med-mal, from the prior approval of rates (in contrast to personal lines such as auto insurance). The Act generally presumes Department approval and exempts from rate-filing requirements "special risks," which are defined in part as risks producing minimum annual premiums in excess of $10,000 (N.J.S.A. 17:29AA-3, subsection k.). This premium limit is exceeded by the medical malpractice policies of all hospitals. The limit is also exceeded by the policies of many individual health-care providers, particularly those providers engaged in major surgery or in high-exposure fields such as obstetrics. The Act essentially requires that med-mal insurers follow a "file and use" process for policy forms and, in cases of annual premiums not in excess of the $10,000 limit, a "use and file" process for rates. In the former case, policy forms are filed with the Commissioner 30 days before becoming effective. In the latter case, rates and any subsequent changes or amendments to them need not be filed with the Commissioner until 30 days after becoming effective. No explicit approval is required for the rates that are filed and, as noted above, rate filings themselves are not required in cases of special risks. Still, the Commissioner does have a limited ability to act in egregious cases. New Jersey insurance law generally prohibits rates that are "excessive, inadequate or unfairly discriminatory," and the Act itself allows the Commissioner to order that a rate or form be deemed no longer effective if, after a hearing, the Commissioner can demonstrate the ways in which the rate or form has violated the Act. The fact that a rate is high or has substantially increased is not sufficient proof under the statutes that it is

"excessive." Such a finding would require a substantial expert actuarial demonstration that the rate charged grossly exceeds risk of the losses and expenses being accepted by the insurer.[10]

Pursuant to the new legislation, however, on August 23 the Commissioner issued Order No. A02-129 requiring New Jersey-licensed med-mal insurers to submit premium, loss and related data on certain premium increases for physicians, podiatrists and nurses. The Order required the submission of data in 19 areas, including the number of years in practice, the number of medical malpractice settlements and the number of medical malpractice judgments, of insureds whose premiums have increased by 30 percent or more as of January 1, 2002, or who have been notified that such increases will occur on their next policy renewals. The Department requested the specified data from 14 insurers. Seven companies that represent most of the New Jersey market responded. The remaining seven companies indicated that the Order was inapplicable to their operations. Unfortunately, the data provided in these responses was in a number of cases inaccurate and/or incorrectly reported, prompting the Commissioner to issue Order A02-153 on December 4. Order A02-153 required the submission of corrected and additional data, as well as information regarding insurers' explanations for premium increases exceeding 30 percent. The Department is in the process of analyzing these submissions and expects to report on them shortly.

The responding companies and their respective marketshare:[11]

MIIX Insurance Co.	37%
Princeton Insurance Co.	36
Zurich American Insurance. Co.	8

[10] If such a finding were made, an order directing a rate reduction would not affect any policy already issued, or even policies issued prior to a "reasonable" future date that the Commissioner must specify in the order (N.J.S.A. 17:29AA-13).

[11] Based on NAIC-reported Direct Premiums Written in 2001, the latest figures available.

Proselect Insurance Co.	4
GE Medical Protective Co.	3
St. Paul Fire and Marine Ins. Co.	1
The Doctors Co.	0.2
	89.2%[12]

How widespread are premium increases of 30 percent or more? Princeton Insurance Co. and MIIX Insurance Co., representing a marketshare of more than 70 percent during the reporting period, charged such increases to **5.99 percent** of their policyholders. The seven companies combined charged such increases to a total of **7.44 percent** of their policyholders.[13]

As seen in the following tables, the likelihood of an increase has depended on the type of medical practice involved. Higher risk specialties such as obstetrics, orthopedic surgeons and radiologists show a higher than average number of large increases.

[12] Most of the difference between this figure and 100% is attributable to the fact that PHICO and other companies in business during the reporting period subsequently became insolvent or withdrew from the NJ market.

[13] The 7.44 percent figure reflects the disproportionately high number of increases levied by Zurich American, which started with substantially lower rates than other companies in the New Jersey market.

Total Physicians and Nurses by Specialty for MIIX and Princeton and The Comparable Number of Physicians That Experienced 30% or More Premium Increases For the 2002 Time Periods Cited In DOBI Order A02-129

	Total # Insured Phys. and Nurses	Total w/30% or more Premium Increase	Percentage of Total Insured
SPECIALTY			
OB/GYN	339	30	8.85%
Neurosurgeons	29	4	13.79
Orthopedic Surgeons	381	72	18.9
General Surgeons	200	34	17.0
Radiologists	620	52	8.39
Anesth. and Pain Mgmt.	726	26	3.58
Emergency Medicine	276	25	9.05
Internal Medicine (GP, Family, Pediatrician)	4395	382	8.69
Podiatrists	334	48	14.37
Nurses	3284	8	0.24
All Other	5837	311	5.33
TOTALS	**16,421**	**984**	**5.99%**

It is important to note that "premium increases," as shown in the table above, are distinct from "rate increases." Premium increases encompass all higher coverage costs actually paid by the policyholder. These costs can rise even when the "rate" stays the same. A typical example occurs when the prior premium reflected a discount that the insurer will no longer offer to the policyholder. Such discounts were common in the soft market of the 1990s as companies competed for marketshare. Companies began to scale back or cease offering such discounts when losses started to mount. Another example of actual premiums rising more than rates is seen with new physicians. Initial premiums for new physicians are relatively low but subsequent premiums rise along with the number of years the physician has been in practice (since the number of patients and thus the potential claims are also rising).

Number of Total Physicians and Nurses by Company and Specialty and the Comparable Number of Physicians that Experienced 30 % of More Premium Increases for the **2002 Time Period*** Cited in DOBI Order A02-129

MIIX Insurance Company

	(1)	(2)	(3)
Company Name	**Total # of Insured Phys & Nurses**	**Total Insuredc w/ 30% or More Premium increases**	**% of Insured with increases [Col (2) / Col(1)]**
OB / GYN	**301**	**20**	**6.64%**
Neurosurgeons	**16**	**2**	**12.50%**
Orthopedic Surgeons	**309**	**60**	**19.42%**
General Surgeons	**126**	**22**	**17.46%**
Radiologists	**536**	**33**	**6.16%**
Anesthesiologist & Pain mgmt	**648**	**19**	**2.93%**
Emergency Medicine	**32**	**2**	**6.25%**
Internal medicine & General/Pediatrician/ Family	**2301**	**91**	**3.95%**
Podiatrists	**91**	**2**	**2.20%**
Nurses	**84**	**0**	**0.00%**
All Other Specialists	**3829**	**107**	**2.79%**
Total for "MIIX Insurance Co"	***8273***	***358***	***4.33%***

Princeton Insurance Company

	(1)	(2)	(3)
Company Name	**Total # of Insured Phys & Nurses**	**Total Insuredc w/ 30% or More Premium increases**	**% of Insured with increases [Col (2) / Col(1)]**
OB / GYN	**38**	**10**	**26.32%**
Neurosurgeons	**13**	**2**	**15.38%**
Orthopedic Surgeons	**72**	**4**	**5.56%**
General Surgeons	**74**	**12**	**16.22%**
Radiologists	**84**	**19**	**22.62%**
Anesthesiologist & Pain mgmt	**78**	**7**	**8.97%**
Emergency Medicine	**244**	**23**	**9.43%**
Internal medicine & General/Pediatrician/ Family	**2094**	**291**	**13.90%**
Podiatrists	**243**	**46**	
Nurses	**3200**	**8**	**0.25%**
All Other Specialists	**2008**	**204**	**10.16%**
Total for "Princeton Insurance Cc	***8148***	***626***	***7.68%***

The Doctor’ Company

Company Name	(1) Total # of Insured Phys & Nurses	(2) Total Insuredc w/ 30% or More Premium increases	(3) % of Insured with increases [Col (2) / Col(1)]
OB / GYN	**1**	**0**	**0.00%**
Neurosurgeons	**0**	**0**	**0.00%**
Orthopedic Surgeons	**0**	**0**	**0.00%**
General Surgeons	**2**	**0**	**0.00%**
Radiologists	**0**	**0**	**0.00%**
Anesthesiologist & Pain mgmt	**0**	**0**	**0.00%**
Emergency Medicine	**0**	**0**	**0.00%**
Internal medicine & General/Pediatrician/ Family	**0**	**0**	**0.00%**
Podiatrists	**0**	**0**	
Nurses	**5**	**0**	**0.00%**
All Other Specialists	**89**	**1**	**1.12%**
Total for “Doctor's Company”	***97***	***1***	***1.03%***

Zurich American Insurance Company

Company Name	Total # of Insured Phys & Nurses	Total Insuredc w/ 30% or More Premium increases	% of Insured with increases [Col (2) / Col(1)]
OB / GYN	**131**	**76**	**58.02%**
Neurosurgeons	**4**	**0**	**0.00%**
Orthopedic Surgeons	**28**	**15**	**53.57%**
General Surgeons	**4**	**2**	**50.00%**
Radiologists	**13**	**0**	**0.00%**
Anesthesiologist & Pain mgmt	**7**	**2**	**28.57%**
Emergency Medicine	**0**	**0**	**0.00%**
Internal medicine & General/Pediatrician/ Family	**9**	**4**	**44.44%**
Podiatrists	**0**	**0**	
Nurses	**0**	**1**	**0.00%**
All Other Specialists	**24**	**7**	**29.17%**
Total for “Zurich America”	***220***	***107***	***48.64%***

GE Medical Protective Company

Company Name	Total # of Insured Phys & Nurses	Total Insuredc w/ 30% or More Premium increases	% of Insured with increases [Col (2) / Col(1)]
OB / GYN	**107**	**17**	**15.89%**
Neurosurgeons	**3**	**0**	**0.00%**
Orthopedic Surgeons	**39**	**2**	**5.13%**
General Surgeons	**11**	**2**	**18.18%**
Radiologists	**0**	**0**	**0.00%**
Anesthesiologist & Pain mgmt	**27**	**7**	**25.93%**
Emergency Medicine	**33**	**0**	**0.00%**
Internal medicine & General/Pediatrician/ Family	**6**	**0**	**0.00%**
Podiatrists	**0**	**0**	**0.00%**
Nurses	**13**	**0**	**0.00%**
All Other Specialists	**40**	**12**	**30.00%**
Total for "GE Medical Protective"	***279***	***40***	***14.34%***

St. Paul Companies

Company Name	Total # of Insured Phys & Nurses	Total Insuredc w/ 30% or More Premium increases	% of Insured with increases [Col (2) / Col(1)]
OB / GYN	**0**	**0**	**0.00%**
Neurosurgeons	**0**	**0**	**0.00%**
Orthopedic Surgeons	**1**	**1**	**100.00%**
General Surgeons	**0**	**0**	**0.00%**
Radiologists	**0**	**0**	**0.00%**
Anesthesiologist & Pain mgmt	**0**	**0**	**0.00%**
Emergency Medicine	**0**	**0**	**0.00%**
Internal medicine & General/Pediatrician/ Family	**1**	**1**	**100.00%**
Podiatrists	**0**	**0**	**0.00%**
Nurses	**3**	**3**	**100.00%**
All Other Specialists	**25**	**25**	**100.00%**
Total for "St. Paul Companies"	***30***	***30***	***100.00%***

ProSelect

Company Name	Total # of Insured Phys & Nurses	Total Insuredc w/ 30% or More Premium increases	% of Insured with increases [Col (2) / Col(1)]
OB / GYN	**14**	**1**	**7.14%**
Neurosurgeons	**9**	**0**	**0.00%**
Orthopedic Surgeons	**4**	**0**	**0.00%**
General Surgeons	**30**	**12**	**40.00%**
Radiologists	**32**	**29**	**90.63%**
Anesthesiologist & Pain mgmt	**2**	**0**	**0.00%**
Emergency Medicine	**27**	**2**	**7.41%**
Internal medicine & General/Pediatrician/ Family	**189**	**52**	**27.51%**
Podiatrists	**7**	**3**	**42.86%**
Nurses	**1**	**0**	**0.00%**
All Other Specialists	**171**	**43**	**25.15%**
Total for "ProSelect"	***486***	***142***	***29.22%***

Summary for all Specialties, all Companies

Specialty	Total # of Insured Phys & Nurses	Total Insuredc w/ 30% or More Premium increases	% of Insured with increases [Col (2) / Col(1)]
OB / GYN	**592**	**124**	**20.95%**
Neurosurgeons	**45**	**4**	**8.89%**
Orthopedic Surgeons	**453**	**82**	**18.10%**
General Surgeons	**247**	**50**	**20.24%**
Radiologists	**665**	**81**	**12.18%**
Anesthesiologist & Pain mgmt	**762**	**35**	**4.59%**
Emergency Medicine	**336**	**27**	**8.04%**
Internal medicine & General/Pediatrician/ Family	**4600**	**439**	**9.54%**
Podiatrists	**341**	**51**	**14.96%**
Nurses	**3306**	**12**	**0.36%**
All Other Specialists	**6186**	**399**	**6.45%**
Total for All Specialties	***17533***	***1304***	***7.44%***

Note: The preceding tables present data from the Reporting Period as defined in Order A02-129, wbich was issued pursuant to P.L.2002, c.55. The Reporting Period covered policies renewed on or after January 1, 2002, and in effect as of August 3, 2002, which experienced premium increases of 30 percent or more upon renewal *or for which the insurer notified the insured that the premium <u>will</u> increase by 30 percent or more upon the <u>next</u> renewal.

SUMMARY

Insurance company data submitted pursuant to P.L. 2002, c.55, and Order A02-129 indicate that relatively few providers (approximately 7.4 percent) experienced large premium increases during the reporting period, which encompassed roughly the first three quarters of 2002. Even in high-risk specialties, such increases usually occurred for less than 10 percent of policyholders in the specialty and in all but one case less than 20 percent of policyholders.[14]

These findings do not, however, mean that New Jersey's med-mal market is in excellent health. Premium increases of 50 percent to 100 percent or more – in some cases representing perhaps $50,000 to $100,000 or more per year – have convinced some physicians to scale back, relocate or leave their professions prematurely. And while the number of impacted doctors in a given specialty may be small, so is the total number of doctors in that specialty. For example, MIIX and Princeton reported a combined total of only 29 policyholders that are neurosurgeons. Only a few would need to leave in order to significantly reduce patient access to such providers.

Beyond this premium problem is the concern about availability. Financial losses, insolvencies and solvent run-offs have reduced the amount of money available to cover all of the state's providers. As a result some providers are having difficulty obtaining policies regardless of cost. The Department has been successful in finding coverage for such providers but future conditions may be more challenging. It is possible, though by no means inevitable, that New Jersey will become unable to cover all of its physicians (estimated at 20,000) and nurses

[14] The exception is OB/GYNs, due to the disproportional number of these providers charged substantially higher rates by Zurich. As seen in the tables, less than nine percent of OB/GYNs covered by MIIX and Princeton received such increases.

unless new insurers, or new investments by existing insurers, bring in more capital and reserves. The impact of such a scenario on patients could be very significant.

As discussed more fully in the Introduction to this report, the situation appears to have sprung from market forces that were largely beyond the control of insurers, regulators or providers. The market was exceptionally good throughout the 1990s and is now in a painful downturn. Such cycles have always occurred and are likely to continue. The question is what, if anything, can be done to mitigate the problems caused by this or future hard cycles. The answer appears as difficult and multifaceted as the problem itself. Capping jury awards and weeding out doctors with multiple claims might help, but neither approach is a silver bullet – or without unpleasant side effects for consumers. Likewise with proposals to cap premium increases. The reactivation of New Jersey's Medical Malpractice Reinsurance Association would, according to the law that created it, require a situation in which coverage was not readily available – not the problem of affordability that is the main feature of today's hard market from the perspective of providers. What is more, past experience with the Association suggests the possibility of higher premiums for providers, including providers who did not benefit from the Association's assistance. All such solutions raise both thorny public policy issues and the specter of unintended consequences – of cures that might be worse than the disease. The most prudent approaches may be those that are measured and incremental, whatever their focus.