STATE OF NEW JERSEY
DEPARTMENT OF BANKING AND INSURANCE

IN THE MATTER OF THE REACTIVATION OF THE MEDICAL MALPRACTICE REINSURANCE ASSOCIATION	)))	HEARING OFFICER'S REPORT

This matter relates to a hearing convened by the New Jersey Department of Banking and Insurance ("Department") pursuant to N.J.S.A. 17:30D-8, for the purpose of determining whether there is readily available sufficient reinsurance for medical malpractice liability insurance in this State, and whether the Medical Malpractice Reinsurance Association (the "Association"), authorized by N.J.S.A. 17:30D-1 et seq. should be reactivated solely to provide reinsurance to medical malpractice insurers in this State.

Procedural History

A public hearing was held on August 6, 2003 at the David J. Goldberg Transportation Building, 1035 Parkway Avenue, Ewing Township, New Jersey. Notice of the hearing was published in the Star Ledger, Asbury Park Press, and Courier Post, on or about July 30, 2003. Notice was also provided to various trade organizations and interested parties, and was posted on the Department's website and at the Department's offices. Notice was also provided to the Office of the Secretary of State for posting in its offices. The purpose of the hearing was to receive comments with respect to whether the Association should be activated solely to provide reinsurance to medical malpractice liability insurers in this State.

The following persons appeared and offered comments at the hearing:

1. Dr. Lena Chang, New Jersey Physicians United Reciprocal Exchange ("NJPURE");

2. Bradley Kading, Reinsurance Association of America ("RAA");

3. Kenneth Sherman, Guy Carpenter and Company;

4. Barry Barron, Conventus Inter-Insurance Exchange;

5. William McDonough, Princeton Insurance Company;

6. Paul Curtis, J.P. Woods and Co.;

7. Manzoor Abidi, M.D., President-Elect, The Medical Society of New Jersey;

8. Joel D. Whitcraft, Medical Protective Company; and

9. Rooney Sahai, Physicians and Patients for Quality Care

Several of these individuals also provided written comments, which either reflected or supplemented their oral comments.

Written comments were also submitted by Senator Martha W. Bark, Assemblyman Francis L. Bodine and Assemblyman Larry Chatzidakis, and Assemblywoman Loretta D. Weinberg regarding this matter. Further, the following entities submitted written comments: MIIX Advantage Insurance Company of New Jersey; the Alliance of American Insurers; Pringle Quinn Anzano (on behalf of ProSelect Insurance Company); the American Academy of Pediatrics – New Jersey Chapter; Elizabeth A. Ryan, Esq., of the New Jersey Hospital Association; and Bollinger Insurance.

The record was held open after the completion of the hearing until August 8, 2003 for the submission of any additional written comments.

Background

During the past three years, the medical malpractice liability insurance market has been strained in New Jersey, as well as throughout the nation. Several insurers have become insolvent (PHICO; Frontier) and others have withdrawn (MIIX Insurance Company; PMSLIC; St. Paul; Zurich American; Clarendon National Insurance Company) in the face of deteriorating financial results. In response, the Department has taken numerous steps to ensure the availability of coverage for doctors and hospitals. The Department's Market Assistance Program directly assists medical practitioners with finding appropriate medical malpractice liability insurance. In addition, while carriers have withdrawn from the medical malpractice liability insurance market here and in other states, the Department has approved the entry of three new carriers, Conventus Inter-Insurance Exchange, New Jersey Physicians United Reciprocal Exchange, and MIIX Advantage Insurance Company of New Jersey. The Commissioner of Banking and Insurance ("Commissioner") also issued Order to Show Cause No. A02-125, which requires medical malpractice liability insurers to offer doctors options in coverage. The Department also addressed the special problem with respect to providers in the obstetrics field due to limited health maintenance organization ("HMO") reimbursements and escalating premiums by encouraging HMOs to increase their reimbursements for high-risk obstetric patients, and initiating a program to help ensure that physicians receive timely payments by insurers and HMOs.

Despite these efforts, however, the medical malpractice liability insurance market has continued to experience problems. Recently Princeton Insurance Company, which had a 53 percent market share of the physicians and insured 85 percent of the acute care hospitals in this State as of the end of 2002, announced that it will no longer write new business. One of the

reasons cited by Princeton for this action was the lack of available reinsurance. In response to these developments, the Commissioner directed that a hearing be held to determine whether there is sufficient reinsurance capacity available for medical malpractice liability insurance in this State and whether the Association should be reactivated solely to provide reinsurance. The hearing did not entertain the prospect of the Association writing coverage directly considering that eight companies are writing medical malpractice insurance in this State. In light of the implications that a decision on providing coverage directly would entail, it was noted that a separate hearing and decision on that matter would be warranted only if the insurers providing this coverage were to cease doing so.

The Medical Malpractice Liability Insurance Act, N.J.S.A. 17:30D-1 et seq. (the "Act"), which became effective January 30, 1976, was enacted after several medical malpractice liability insurers began canceling coverage for physicians and hospitals. The Act created the Association to assure that medical malpractice insurance was available during a period of crisis in the market. N.J.S.A. 17:30D-2a provides that the purpose of the Act is: "to assure that medical malpractice liability insurance is readily available to licensed medical practitioners and health care facilities by ... establishing a reinsurance association to equitably spread the risk for such insurance, … and to grant the [Commissioner] temporary emergency powers to set up and operate the reinsurance association if such insurance is unavailable for any class of licensed medical practitioners or health care facilities." Pursuant to N.J.S.A 17:30D-4, the member insurers of the Association constitute all insurers within this State authorized to write personal injury and property damage liability insurance, except those who wrote only workers' compensation and employees' liability insurance. Originally, the Association was activated to provide reinsurance

to hospitals. The Association was then activated to provide reinsurance with respect to coverage for physicians and surgeons.

In 1978 the Act was amended to permit the Association to write medical malpractice liability insurance on a direct basis. During the time that the Association provided only reinsurance, it accumulated no deficit. The Association was activated to provide medical malpractice liability insurance on a direct basis for physicians and surgeons on April 1, 1979. In 1982, the then Commissioner deactivated the Association after determining that there was a sufficient commercial market for medical malpractice insurance for physicians, podiatrists and hospitals. Due to its function as a direct insurer, the Association had developed a deficit of $64 million by the mid-1980s which, pursuant to the Act, was paid by surcharges on medical malpractice liability insurance premiums. See N.J.S.A. 17:30D-10. The surcharges were discontinued in 1997.

Based on recent events in the medical malpractice liability insurance market as set forth above, the Commissioner is considering whether to reactivate the Association solely to provide reinsurance.

Discussion and Recommendation

Reinsurance can take numerous forms. In brief, reinsurance is insurance for insurance carriers. It permits insurers to transfer to another insurer, for a price, a portion of the liability for risks that they write. Reinsurance may provide for a sharing of losses or assume losses of the direct insurer above a certain dollar amount or attachment point. An insurer may receive credit for reinsurance, which generally means a reduction in its liabilities for the amount of risk transferred to a reinsurer, provided the reinsurer meets specified criteria set forth in N.J.S.A.

17:51B-1 et seq. and N.J.A.C. 11:2-28. By absorbing potentially substantial losses that an insurer would otherwise have to absorb itself, reinsurance lessens the impact on an insurer's surplus from losses that may occur. Capacity of the direct insurer to transact business is increased since it does not have to maintain reserves for liabilities assumed by the reinsurer.

Those presenting testimony or written comments were almost evenly split between those that supported reactivation of the Association to provide reinsurance and those that opposed such reactivation. Those in support were Senator Bark and Assemblymen Bodine and Chatzidakis; Princeton Insurance Company; MIIX Advantage Insurance Company of New Jersey; the Medical Society of New Jersey; Paul Curtis, of J.P. Woods; Elizabeth Ryan of the New Jersey Hospital Association; and Bollinger Insurance. Those opposed were New Jersey Physicians United Reciprocal Exchange; the Reinsurance Association of America; Kenneth Sherman of Guy Carpenter and Company; Conventus Inter-Insurance Exchange; the Medical Protective Company; and the Alliance of American Insurers. Assemblywoman Weinberg expressed concerns that the Commissioner should consider in reactivating the Association. ProSelect Insurance Company raised several questions, and neither opposed nor supported reactivation of the Association.

All of those in support of reactivating the Association stated that reinsurance was not readily available. Princeton stated that it had attempted to purchase traditional reinsurance coverage to attach over a primary retention of $500,000.00 and was unable to secure this coverage. William McDonough, the Chief Operating Officer of Princeton, stated that his company met with 12 US-based reinsurers, including American Re and Employers Reinsurance Corporation, as well as the European and London markets. He stated that "no reinsurers have been willing to participate in what they consider the working layer, which is the attachment

points below $1 million." This included reinsurers that had been long-time participants in Princeton's excess program, offering coverage at limits above $1 million. Only one reinsurer would offer terms attaching at $1 million, and only a few, including the London market, offered coverage attaching at $2 million, and then only with a variable rate plan. Princeton stated that it added thousands of qualified physicians to its policyholder base as a result of withdrawals by other carriers from the medical malpractice liability insurance market in New Jersey. However, it was noted that as its premium base increased, its leverage ratios also increased, which has strained its capacity and financial rating. Due to the unavailability of reinsurance coverage at levels below $1 million, Princeton determined to temporarily cease accepting new business.

The Medical Society of New Jersey believed that reactivation of the Association was appropriate, but questioned who would set the reinsurance premiums and how they would be established, and was concerned about the Association incurring unfunded liabilities.

MIIX Advantage stated that it began issuing policies on September 1, 2002, and that it needed to have reinsurance in place before that date. It stated that its business plan, which was filed and approved by the Department, required excess of loss reinsurance for coverage over $1 million. MIIX Advantage stated that it was extremely difficult to acquire such coverage. Although its broker discussed potential reinsurance with 27 reinsurers, only one reinsurer offered MIIX Advantage a quote in time for its September 1, 2002 start date. The terms of the quote required MIIX Advantage to raise its medical malpractice rates eight percent for coverage offered over $1 million, included expensive swing rated terms, and expired after one year; the reinsurer refused to commit thereafter. It was further stated that MIIX Advantage subsequently received two other offers, which were more onerous than the offer accepted. MIIX Advantage concluded that it was currently in the process of negotiating renewal of its current policy while

seeking alternative reinsurance offers and did not anticipate the process would be any less difficult than it had been last year.

Paul Curtis, of J. P. Woods, a reinsurance intermediary, was the reinsurance broker for Princeton, and generally reiterated Princeton's comments regarding his difficulty in obtaining reinsurance. He stated that he had approached over 25 reinsurers and "[none] of these reinsurers would consider a contract with an attachment point below $1 million...."

The Medical Society of New Jersey and the New Jersey Hospital Association both supported reactivation of the Association to provide reinsurance, but both stated that this is an initial step and that more should be done to address the medical malpractice liability insurance availability problem. Both also expressed concern that the reinsurance should be priced so that the Association does not incur unfunded liabilities. The Hospital Association further stated the future financial stability of Princeton is of great concern, in that Princeton has approximately a 53 percent market share of the physicians and insures approximately 85 percent of the acute care hospitals in this State.

Bollinger Insurance generally supported reactivation for substantially the reasons previously set forth. In addition, Senator Bark and Assemblymen Bodine and Chatzidakis specifically supported reactivation of the Association.

Those who expressed opposition to reactivation of the Association generally testified that the reactivation was a "bail-out" for Princeton. They testified that reactivation would distort the existing reinsurance market. For example, the RAA stated that "[reinsurance] is widely available for medical malpractice carriers in New Jersey," and that "other carriers in this market are able to obtain reinsurance." They believe that other insurers in the voluntary market could assume the business that would not or could not be written by Princeton. The opponents did not refute

Princeton's testimony about its difficulties in obtaining reinsurance. Rather, they asserted that the fact that Princeton could not obtain reinsurance at the levels that it sought or at the price it sought does not mean that it is not available in the market. These groups also expressed concern that the Association would develop a deficit resulting in increased costs for insurers and ultimately health care practitioners. In addition to these concerns, specific issues were raised as follows.

NJPURE specifically stated that it had been able to secure reinsurance at a retention level of $250,000.00. NJPURE also stated that "[normally], reinsurance coverage is very difficult to acquire [for newly created entities because] they do not have any historical data [for the reinsurers to assess the risks that are being assumed]." However, NJPURE maintained that it, and the other newly licensed medical malpractice insurers, have obtained reinsurance at retention levels needed for them to issue policies. NJPURE asserted that the reason Princeton is unable to obtain reinsurance is that its financial rating has been downgraded three times by A.M. Best and that the reinsurance risk it presents is high. NJPURE stated that to reactivate the Association and provide reinsurance to Princeton at low retention levels would be asking the Association to provide reinsurance to a known high-risk insurer. It was also stated that the Association was originally activated to provide reinsurance because there was no reinsurance for two start-up reciprocals to provide medical malpractice liability insurance and that there were no other medical malpractice liability insurers in existence that would insure hospitals and physicians at large. In addition, it was stated that when the Association was first created, no prior years' incidents would result in claims made against the Association, because at that time only "occurrence" policies were in existence. NJPURE stated that Princeton's policies are mostly on a claims-made basis. NJPURE stated that this means that even if the Association was reactivated

to reinsure Princeton prospectively as of January 1, 2004, the Association would cover most of the claims filed against Princeton insureds after 2004, even if they related to medical incidents incurred in prior years, since those would be covered by Princeton's 2004 claims-made policies.

Conventus stated that, as a preliminary matter, it does not believe that the statute permits the Commissioner to reactivate the Association without first finding that direct medical malpractice insurance is not readily available. Conventus believed that professional liability insurance is readily available to physicians. Moreover, Conventus stated that "[it] was granted a license last year along with [two] other carriers to promote competition [in] the marketplace. The activation of the [Association] may defeat that purpose." Conventus further stated that it "can handle an unlimited amount of new business generated as a result of Princeton's...announcement [to cease writing new business]." Conventus stated, however, that if the Commissioner did find there is a need to reactivate the Association, steps should be taken to promote future stability in the market. For example, the Department should impose certain conditions that will decrease Princeton's market share, as a condition of reactivating the Association. Further, the Department should identify those practice areas that genuinely would benefit from the assistance of the Association prior to activating the Association.

The Medical Protective Company stated that if the reinsurance terms available through the Association are comparable to or more stringent than those available in the private market, it will have no impact on the primary market. Conversely, if companies are able to obtain reinsurance at artificially low rates through the Association, the true cost of medical malpractice liability insurance will ultimately be passed through the Association and spread among the payers who had no stake in the underlying decision to insure the risk. Rather than reactivate the Association, Medical Protective Company believed that the Department should evaluate and

address underlying issues that have influenced the profitability and financial condition of medical malpractice insurers.

The Alliance of American Insurers expressed similar concerns and comments as those previously cited.

Assemblywoman Weinberg stated that the Department should ensure that "bad doctors" are not indirect beneficiaries of the reactivation of the Association. She referred to a Public Citizen report which states that six percent of the doctors are responsible for 55 percent of all medical malpractice payouts between 1990 and 2002. In addition, Assemblywoman Weinberg stated that if the Association is reactivated, the Department should ensure that reinsurance coverage would apply to a claim against a provider incurred during the period of its operation, even if the claim is filed after the Association was deactivated.

ProSelect Insurance Company neither opposed nor supported reactivation of the Association. Rather, ProSelect stated that it could not determine whether to support reactivation unless various questions were addressed, including: how the Association would be funded; whether the Association has a deficit and if so, how will its activities be funded; whether the Association would return surcharge premiums; whether the statute authorizes the Commissioner to activate the Association on the basis of lack of available reinsurance; how the Association will operate; and whether an insurer could continue to transact reinsurance without becoming a qualified provider.

Upon review of the record and other information developed by the Department's surveillance and analysis of the market over the past two years, I find that reinsurance for writers of medical malpractice insurance in New Jersey is not readily available. Therefore I recommend that the Medical Malpractice Reinsurance Association should be reactivated solely to provide

reinsurance to medical malpractice liability insurance carriers. In making this finding, I note that as of year-end 2002, Princeton's market share for physician policies was approximately 53 percent. MIIX Insurance Company, which is currently in runoff, and MIIX Advantage, the successor to MIIX Insurance Company, had a combined market share for physician policies of approximately 24 percent. In addition, Princeton insures 85 percent of the acute care hospitals in this State. In evaluating actions a regulatory agency should take and the impact on the market, I believe that it is reasonable and appropriate to consider the impact of such action (or non-action) on companies with the largest number of insureds, in this case, health care professionals, in this State. Princeton and MIIX have indicated that there is a lack of sufficient reinsurance at desired attachment points to enable them to sufficiently provide direct coverage. Indeed, Princeton has had to cease accepting new business. Princeton, and MIIX and MIIX Advantage, represent over 75 percent of the medical malpractice liability insurance market for physicians as of December 31, 2002, and Princeton insured 85 percent of the acute care hospitals. While other insurers may have the ability to grow, they may not currently possess the financial resources and infrastructure to be able to assume Princeton's excess business. Moreover, as noted earlier, the New Jersey market continues to be severely strained regarding obstetricians and other higher risk specialties.

One of the arguments put forth by several of the commenters against reactivating the Association is that it would unfairly benefit Princeton and that Princeton's market share grew substantially over the last year. Many of the comments in opposition are generally of the tenor that reactivation would result in an unfair competitive advantage to Princeton Insurance Company, a competitor of several of the commenters, and enable it to retain its substantial market share. If this proved true, it would not be prudent to create a market in which smaller marketshare insurers, newly licensed entities or new entrants were at a competitive disadvantage

to larger, established insurers. Nevertheless, as further discussed below, appropriate controls are available to minimize intrusion into the market and to avoid unreasonable competitive advantages that might adversely impact competitors such as Conventus, Medical Protective Company and NJPURE. Additionally, I note that Association reinsurance would, upon activation, be available for these insurers as well.

With respect to the argument that the Commissioner lacks the statutory authority to activate the Association on the basis of the lack of available reinsurance as opposed to the lack of available primary insurance, I find that activating the Association for reinsurance only is not inconsistent with the enabling statutes. The continuing ultimate effect of lack of reinsurance is that the primary insurance market will be further constricted. It is not unreasonable or inconsistent with the Legislative intent and the statutory framework established under N.J.S.A. 17:30D-1 et seq. to activate the Association to stabilize the market by helping to ensure availability of medical malpractice liability insurance in this State. Initially the Act sought to support the market through the reinsurance mechanism, and its scope was only extended to include the provision of direct insurance when all or virtually all insurers had exited the market. The definition of "medical malpractice liability insurance" should be construed broadly to include reinsurance, consistent with the statute's goals.

With respect to the concern that the Association not indirectly benefit "bad doctors," I note that, as set forth herein, one of the areas of appropriate oversight for the Association would be a direct insurer's underwriting practices. Regarding the concern that reinsurance apply to any claim incurred during the time the Association were activated, even for claims filed after the Association may be deactivated, I believe that that issue is appropriately addressed through the policy between the direct insurer and the insured.

The comments regarding the need for oversight of the Association are consistent with the Department's responsibilities for the New Jersey insurance marketplace. I believe that any reactivation of the Association should be effectuated and managed in such a way as to minimize any potential distortion to the market or interference with the existing private reinsurance and direct insurance markets. This approach also seems consistent with the intent of the Act and should avoid problems experienced when the Association was activated for direct insurance in the past.

I recognize and share many of the concerns of the parties that testified in opposition to activation, which should not be accomplished in a fashion that provides undue competitive advantage to particular market competitors. I note, however, that different direct insurers may have very different reinsurance needs depending upon their business plan, market conditions and other individual issues. Reinsurance contracts issued by the Association will necessarily vary, as in the commercial reinsurance market. But in developing individual contracts, care must be exercised in order to balance the need to avoid favoring certain companies and providing competitive advantage.

Secondly, it is imperative that the Association avoid developing unfunded liabilities, as occurred when the Association was activated for direct insurance. As noted at the hearing, however, the current problem is that some forms of reinsurance previously available in the market are no longer available, at least to insurers with substantial marketshares. But the extent to which that kind of reinsurance was previously available – and may continue to be available to others in limited amounts – confirms that there exists a body of commercially reasonable terms and conditions that should be utilized by the Association in developing its contracts with direct insurers. These include terms relating to price, or the portion of the direct premium that is

adequate to cover the reinsurer's portion of losses as well as reinsurer expenses. If the Association operates in accordance with commercial reinsurance standards and its contracts contain commercially reasonable terms and conditions, then deficits or unfunded liabilities may be avoided so long as the direct insurers maintain adequate direct rates. I further note that direct insurers have substantially increased rates over the last two years, and that the Department has and will continue to evaluate those rates to maintain their adequacy.

Similarly, the Association should be subject to appropriate Department oversight with respect to the provision of reinsurance. This oversight is provided by statute through approval of the Association plan of operation, but might be enhanced to include Department review and approval of the reinsurance contracts executed between the Association and medical malpractice insurers in this State. Further, it will be necessary for the Association to engage the services of an experienced reinsurance manager both to negotiate the terms of contracts and to perform necessary functions like a commercial reinsurer. The reinsurance manager utilized to manage the reinsurance program must be free of conflicting interests; Department approval of the person or firm engaged to perform these important tasks is a necessary check. Finally, the Association should not be designed to provide reinsurance indefinitely, but should only be authorized to provide reinsurance for such time as necessary to stabilize the existing market. Limits on the duration of the contracts and periodic assessment of the need to renew them likewise provide appropriate controls.

I note that the current Governing Board of the Association includes individuals that represent some of the direct insurers presently in the market. In order to avoid any appearance of impropriety or perceived unfairness in the operation of the Association, I recommend that the

plan of operation be amended to prohibit clearly any conflict of interest or the perception of a conflict of interest by board members.

Finally, it seems essential to minimize the intrusion into the market by the Association so that market forces that will, eventually, correct current deficiencies will not be unduly deterred. The Association must not displace existing reinsurers in the market or discourage the entry of others. The Association needs to be able to exit the market as soon as market conditions are sufficiently remedied. Therefore, it is important that the reinsurance activities of the Association be closely coordinated with the Department's market surveillance and financial regulatory responsibilities in order to assure that a healthy, viable market eventually emerges. To that end, I recommend that the Department continue to monitor and evaluate the participation and market shares of insurers transacting medical malpractice liability insurance, as well as their financial stability and the business plans of domestic insurers, in order to promote the stability and viability of insurers and the market.

Conclusion

For the foregoing reasons, I recommend that the Commissioner reactivate the Association solely to provide reinsurance for medical malpractice liability insurers in this State. I further recommend that, as part of this reactivation, the Association board be directed to draft such amendments to its plan of operation as may be necessary to reflect that the Association is activated solely to provide reinsurance and not as a direct writer.

I further recommend that appropriate controls be established to coordinate the activities of the Association with the Department's market surveillance and financial oversight functions in order to ensure that this intrusion into the market is limited in its nature and duration.

These controls should be reflected in the Association's plan of operation, and should include amendments to eliminate any potential conflict of interest of members on the board who may receive a benefit from such reactivation. Other appropriate controls established through the plan of operation could also include: that any reinsurance plan shall be subject to review and approval by the Department; the reinsurance manager shall be acceptable to the Commissioner; the duties of the reinsurance manager may include appropriate evaluation and monitoring of the risks of its ceding insurers and performing such audits as are necessary with respect to claims and underwriting practices, consistent with the provision of reinsurance in the private market; and the rates and policy terms for reinsurance shall be consistent with those provided in the private market and should be actuarially adequate for the risks assumed.

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Gale P. Simon
Assistant Commissioner

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