FAQs Regarding the Insurance Department's Proposed Rule Ins 1700 and the Supreme Court's Decision in the *Tuttle* Case

Q. Is the proposed rule consistent with the New Hampshire Supreme Court's decision in the *Tuttle* case?

A. Yes, the proposed rule is completely consistent with the Court's decision in the *Tuttle* case and carefully implements the guidance provided by the Court.

The Supreme Court ruled that a law passed by the New Hampshire Legislature (HB 2) improperly transferred funds from the New Hampshire Medical Malpractice Joint Underwriting Association (the "Plan"). The Supreme Court prohibited the transfer because it concluded that the law would impact the contract rights of current policyholders in violation of the New Hampshire Constitution. Under the New Hampshire Constitution, the State is not permitted to pass laws that reach back and change the terms of existing contracts. This is called an unconstitutional "impairment of contract."

The Supreme Court decided that HB 2 was an unconstitutional impairment of a contract because HB 2 would apply retroactively—that is, HB 2 would apply to policies that were in existence *before* the law took effect—and because it would impair a "beneficial interest" of policyholders under these contracts. The Supreme Court said that its decision would be different if HB 2 had applied only to policyholders who purchased a policy *after* HB 2 was enacted. The court said: "if the legislature had addressed policyholders' rights prospectively—that is, effective upon issuance of new policies—our analysis would of necessity be different."

The proposed rule is consistent with the court's decision. Any impact on policies resulting from the change in the rule will not affect policies that already have been issued. The rule change will only apply to policies issued or renewed after the proposed rule becomes law. The proposed rule does not apply retroactively but prospectively and does not result in any unconstitutional impairment of contract.

Finally, the proposed rule will become law only after a public rulemaking process, including public hearings. Policyholders will, therefore, have the chance to have input on the proposed rule and will also have time to decide whether to continue to purchase insurance from the Plan in accordance with the new rule, or instead, purchase insurance from a private insurance company.

Q. Didn't the Court say that the Plan funds are owned by the policyholders and should be given to those policyholders?

A. No. The Supreme Court said that current policyholders have a "beneficial" and not a "possessory" interest in the assets of the Plan. This means that the policyholders do not own the excess surplus and do not have the right to demand a distribution of the excess surplus. Neither the Superior Court nor the Supreme Court said the Board or the Insurance Commissioner had to give the Plan assets to current policyholders. There is no court order or decision that says the Board or the Insurance Commissioner must or should make a distribution to the policyholders.

In addition, the Supreme Court said that individuals or entities whose insurance policies have expired cannot assert a claim that a law change is an unconstitutional impairment of an expired contract. Therefore, these policyholders with expired contracts do not have a "beneficial" interest in the assets of the Plan.

Q. The proposed rule removes the possibility that future Plan policyholders will receive a distribution from excess surplus. Is this fair?

A. The proposed rule eliminates the possibility that future Plan policyholders will receive a distribution from excess surplus. At the same time, the proposed rule also eliminates the possibility that policyholders will be called upon to pay an assessment or surcharge if the Plan needs money to operate. It is fair to eliminate the possibility of distributions for policyholders if these policyholders will not be asked to pay a future assessment or surcharge under the proposed rule.

It is important to note that, even under the current rule, policyholders insured under the Plan are not the only ones who face a possible assessment or surcharge if the Plan needs funds. In fact, under the current rule, medical providers purchasing insurance from private insurance companies and consumer that purchases an automobile, homeowners or other property and casualty insurance policy (even those consumers who have never purchased a policy from the Plan) could be subject to a surcharge to cover the deficits of the Plan. Furthermore, Plan policyholders have <u>never</u> had to bear the burden of paying a surcharge or assessment alone. The only surcharge imposed by the Plan in its 35 year history was a surcharge imposed between 1986 and 1993. That surcharge was paid not just by Plan policyholders, but also by those medical providers that bought medical malpractice insurance from <u>private</u> insurance companies.

The Department has determined that the current rule must be amended to make it clear that the Plan is for the public good and is not intended to benefit private interests. The Department also believes that the rule must be amended because it would not be fair to give Plan policyholders a potential right to a distribution when Plan policyholders have not been the only consumers who have paid surcharges to support the Plan.

Q. Didn't the Court say that the Plan is not a "state entity" and therefore that the Plan's funds are private funds?

A. No. The Supreme Court said it would not rule on whether the Plan is a state entity or a private entity. The Supreme Court did not adopt the lower court's finding that the Plan was a "quasi-public/private" entity and not a state entity. Therefore the final decision of the Supreme Court did not affirm the lower court's ruling.

Q. Isn't the Plan a private insurance company that has to pay federal income tax?

A. No. In a 1976 letter, the IRS said that the Plan is operated under the Insurance Department of the State of New Hampshire and is therefore "an integral part of the State of New Hampshire" and "is exempt from taxation." Since 1976, the Plan has operated under the Insurance Department and has been controlled by the same laws that gave the Commissioner authority to create the Plan and decide how the Plan will operate. The Plan's tax-exempt status is only now at issue because the plaintiffs argued that the Plan is not an integral part of the state and the lower court said that the Plan is a "quasi-public/private entity" and "not part of the executive branch of the State government." However, the IRS has stated that the Plan is exempt from federal tax because it was created as an "integral part of state government." The Department believes that it is important to get confirmation from the IRS that the Plan is tax-exempt in light of any question raised by the decision of the lower court and the continued assertions of the Tuttle plaintiffs that the Plan is not part of the state government.

Q. How big could the federal tax liability be?

A. The Department of Insurance is still examining the Plan's financial statements for the last 34 years, and has not yet finished its analysis. However, it is possible that the worst-case federal tax liability, including both taxes and accumulated interest (but not any penalties) could exceed $100 million. The Department intends to seek a determination from the IRS that the Plan is an integral part of the state, is not required to pay federal taxes, and therefore it has no liability for unpaid federal taxes.

Q. How long could it take to get confirmation from the IRS of the Plan's tax-exempt status?

A. Once we have completed our examination of the Plan's finances, we will approach the IRS to seek confirmation of the Plan's longstanding tax-exempt status. This process could be a lengthy one, and it is unlikely that we would receive any formal confirmation for at least 6 months. Of course, it is also possible that the IRS could disagree with our analysis, which could lead to even lengthier litigation over the tax status of the Plan.

Q. Why is it important for the Plan to be tax-exempt?

A. The Plan was established to serve an important public purpose: to ensure that professional medical malpractice insurance is available in New Hampshire. The plan functions as the "insurer of last resort" and cannot refuse to provide insurance to any medical provider so long as the provider pays for the cost of coverage. The Plan is a state safety net, providing insurance that the private insurance market cannot or will not provide. By offering coverage to even the highest risk medical providers, the Plan ensures that New Hampshire citizens have access to insured doctors, hospitals and other medical providers in rural areas and in high risk professions and practices. The Plan has served this vital public purpose well, and has been an extremely

successful state sponsored program, consistent with the legislature's original statutory authorization.

In addition, because the Plan is a tax-exempt public program, it is able to provide medical malpractice coverage at rates equivalent to the market rates, despite its obligation to insure high risk medical providers who are rejected by the private market. If the Plan is not exempt from tax, the IRS will demand that the Plan pay back taxes and interest and future federal income tax. As a result, the Plan will need to change how it operates and will need to find a way to provide for these additional costs. This may include premium increases for Plan policyholders or the need for regular assessments. The Plan's important public purpose is best served by taking all necessary steps to retain the Plan's tax exempt status as an integral part of state government and avoid this tax liability.