

Summary of the Insurance Department's Rulemaking Proposal For the New Hampshire Medical Malpractice Joint Underwriting Plan N.H. Administrative Rule Ins 1700

On May 24, 2010, the New Hampshire Insurance Department (the "Department") announced that it was filing amendments to N.H. Admin. Rule Ins 1700, relative to the continued operation of the New Hampshire Medical Malpractice Joint Underwriting Plan (the "Plan"). This summary provides an explanation of the proposed amendments to the Plan's governing rule.

The information in this Summary provides a brief overview of the proposed amendments to Ins 1700. The actual terms of the proposed rule may be subject to change during the rulemaking process, pursuant to the provisions of RSA 541-A. For more complete information, please review the proposed rule and the current rule, both available on the Department's website.

Background and History

The Plan was originally established in 1975 under the authority of state law, RSA Chapter 404-C. The Plan was created by the Department after the Commissioner determined that medical providers were being refused medical malpractice coverage or could only purchase this insurance at exorbitant cost. Since its creation in 1975, the Plan has offered medical malpractice insurance to any medical provider at commercial market rates, even to those medical providers that the private insurers refuse to cover. Without the Plan, many high-risk providers (providers with previous claims filed against them or who work in high risk areas like OBGYN) could not continue to practice medicine in New Hampshire. The public purpose of the Plan is to ensure the availability of adequate medical malpractice liability insurance to healthcare providers where such insurance is not readily available from private insurance companies and therefore to promote the public interest of ensuring that consumers of health care services in New Hampshire have adequate access to needed care.

Ins Chapter 1700 is a New Hampshire administrative rule that establishes and governs the operations of the Plan. Administrative rules are promulgated in accordance with the process set forth in state law (RSA Chapter 541-A). The original governing rule for the Plan was promulgated by the Department in 1975. The rule governing the Plan has been amended many times since 1975, all in accordance with the process set forth in RSA 541-A.

The Tax-Exempt Status of the Plan

At the time of the establishment of the Plan, the Department sought and obtained a determination from the Internal Revenue Service that the Plan is exempt from federal income tax because it is an agency or instrumentality of the State of New Hampshire. In January 1976, the IRS issued a written determination concluding that the Plan "is an integral part of state government and is exempt from taxation." The Department and the Plan have relied upon this IRS determination since that time. Accordingly, the Plan has never filed federal tax returns, and it has not paid any federal income taxes.

Examination of the Plan

The governing statute, RSA Chapter 404-C, provides the Commissioner with the continuing responsibility to ensure that the Plan is properly structured, administered and operated and acts in the public interest. During the course of the recent litigation in the *Tuttle* case, it became clear that the current rule that establish the governance of the Plan left many important issues unclear or unanswered.

Promptly upon the issuance of the Supreme Court’s final order in the *Tuttle* case, the Commissioner determined that an examination was required to review the Plan’s tax status, operations and finances. The goal for this examination is to ensure that the Plan can continue to perform its vital public purpose: guaranteeing the availability of medical malpractice insurance to all New Hampshire healthcare providers so that New Hampshire citizens have adequate access to quality healthcare.

Amendments to Ins 1700 Will Clarify Plan Operations and Governance and Will Confirm and Preserve the Tax-Exempt Status of the Plan

The Department’s examination has uncovered several important operational and governance issues that are not addressed by the current rule. These unanswered questions need to be resolved to prevent any further confusion to the public and to those who purchase Plan policies.

In addition to these operational and governance issues, the examination has focused on a federal income tax issue that is of significant concern. Some arguments of the plaintiffs in the *Tuttle* case and statements made by the lower court in that case, have challenged the Plan’s status as a public entity and, therefore, have threatened the plan’s exemption from taxation by the federal government.

If the Plan is a private entity, as the plaintiff’s in *Tuttle* claimed, then the Plan could be subjected to claims by the IRS that the Plan is not tax-exempt, but instead owes taxes, interest and penalties to the federal government for the past 35 years. This liability could exceed \$100 million. The Plan’s financial statements have never contemplated a federal tax liability and the Plan has not set aside reserves for payment of federal taxes.

The Supreme Court expressly declined to decide whether or not the Plan is a private entity or is part of state government. However, it is important to the continued operation of the Plan that it remain exempt from federal taxation and from any claim by the IRS for back taxes. As part of the examination, experts have been hired to examine the operation of the Plan and the Plan’s tax status.

These examiners have made recommendations to the Commissioner for appropriate changes to Ins 1700 that are consistent with the Plan’s longstanding tax-exempt status as an integral part of state government.

The Rule Will Apply Prospectively and Not Retrospectively

The proposed amendments to Ins 1700 would be effective on a prospective basis only. The new rule will not apply to any policyholder who has purchased a Plan policy before the effective date of the new rule. Once the rulemaking process is completed, the Plan will update the language in the policies it issues. These new policies will conform to the new rule. The updated policies will be issued after the effective date of the new rule to any medical provider that purchases a new Plan

policy or renews coverage when an existing policy expires. The new rule will not be applied retrospectively to current policyholders.

Overview of Rule Changes

In overview, the proposed amendments to Ins 1700 would reorganize the three sections of the current rule into nine sections, each addressing a separate and distinct aspect of the operation of the Plan.

Pursuant to RSA 541-A, the Department will conduct a public hearing to receive public comments on the proposed amendments. The Department will post notice of the date and time of the public hearing on its website.

There are four key aspects of the proposed amendments as follows.

(1) The Proposed Amendments Provide Greater Clarity Regarding the Operation and Governance of the Plan

The proposed amendments clarify the authority and duties of the board of directors and the servicing organization (the servicing organization is hired to administer the Plan). The amendments state the Commissioner's long-standing authority to direct, supervise and approve acts of the board of directors and the servicing organization. The amendments are not anticipated to change the day-to-day operation of the Plan, but will instead more clearly describe the roles of the parties involved.

The proposed amendments include changes intended to follow the governing statute more precisely. For example, the amendments refer to "required participants" instead of "members." The use of the term "members" was misleading and inconsistent with RSA 404-C:3. Also, the name of the Plan has changed to better reflect its operation and purpose as a mandatory risk sharing plan created by the Commissioner (and not the insurance industry) by administrative rule.

The proposed amendments also establish a clear process to determine the necessary capital and reserves required for the operation of the Plan, as well as to determine whether the Plan has assets in excess of necessary capital and reserves. The proposed rule states that these determinations shall be made by the Commissioner, with the advice of the Board of Directors and through an evaluation by an independent actuarial firm.

The proposed amendments eliminate provisions related to the funding of the Stabilization Reserve Fund by surcharge as these provisions are now obsolete. The Stabilization Reserve Fund is the Plan's run-off account for its pre-1986 business.

The proposed amendments provide for a change in the accounting rules the Plan uses to prepare, present, and report its financial statements. The amendments change the standards from the current "Statutory Accounting Principles" established by the National Association of Insurance Commissioners to the accounting principles established by the Governmental Accounting Standards Board (GASB) and "Generally Accepted Accounting Principles" (GAAP). The accounting year for the Plan has also been changed from a calendar year to a fiscal year ending June 30th.

The proposed amendments clarify long-standing practice that, as a public body, the Plan is subject to the State's right-to-know law (RSA 91-A).

Also consistent with the long-standing practice of the Plan, the proposed amendments clarify that the volunteer board of directors of the Plan are entitled to the protections of RSA Chapter 99-D, the law that protects those in state service who may be subject to claims and lawsuits related to the performance of official state duties. The Plan retains the existing indemnification provisions that protect members of the board of directors.

(2) The Proposed Amendments Change Provisions That Govern Distributions, Surcharges and Assessments

New Hampshire consumers who (under the current rule) would be required to pay a surcharge if the Plan faces a deficit, will no longer be surcharged under the proposed amendments. The current rule discusses surcharges at Ins 1703.07(f) and Ins 1703.08(b).

The current rule provides for a surcharge on:

- Any medical provider that buys medical malpractice insurance from a private insurance company or from the Plan in New Hampshire, and/or
- Any consumer purchasing a homeowners, automobile or other property and casualty insurance policy from a private insurance company in New Hampshire.

Under the current rule, surcharges are imposed when the consumer purchases an insurance policy. All funds collected from these consumers are then turned over to the Plan.

Under the proposed amendments, consumers purchasing insurance would no longer be subject to a surcharge. Instead, insurance companies that write liability insurance in New Hampshire would be required to pay an assessment to fund any deficit of the Plan. While the current rule provides for repayment to insurance companies that pay an assessment, the proposed rule does not include these repayment provisions. Instead any assessment imposed on insurance companies can (but are not required to) be listed as an expense in the company's rate filing with the Department.

The proposed amendments also require that, if an assessment is imposed on insurance companies, any assessment paid by these companies must be considered when calculating whether the Plan has excess assets. An amount equal to the total amount of assessments paid by insurance companies cannot be considered as excess assets, but must be held by the Plan and applied against (and be used to reduce) any future assessment. This provision protects insurance carriers from the risk of repeated assessments.

The proposed amendments also eliminate provisions in the current rule that created the possibility of a distribution of Plan assets to Plan policyholders. Elimination of these provisions is required in order for the Plan to remain consistent with its status as a public entity created to serve purely public interests and to retain its tax-exempt status. If Plan policyholders are not obligated to pay a surcharge or assessment in the

event of a shortfall, it is consistent and fair that any possibility of distribution also be eliminated. Eliminating the policyholder distribution provisions is also required because Plan policyholders have not been the only consumers who have been subject to, or have actually paid, surcharges to fund Plan deficits.

The new rule continues to require the Plan to repay all medical providers who have paid a surcharge to help fund the Plan. Medical providers who purchased a medical malpractice insurance policy from a private insurance company or from the Plan between January 1986 and December of 1993, were subject to a surcharge. This surcharge provided needed funds to cover the run-off of the pre-1986 policies issued by the Plan. Thus, the Stabilization Reserve Fund (SRF) account holds money to pay for claims filed against policies issued by the Plan before 1986. It is not used to pay claims on policies issued after 1986, and it was not the account at issue in the Tuttle case. Under the proposed amendments, when the SRF account is finally closed, the policyholders who paid the surcharge between 1986 and 1993 will be repaid, to the extent that funds are available. See Proposed Admin. Rule Ins 1707.06(c).

The surcharge imposed between 1986-1993 on all medical providers, purchasing medical malpractice insurance from private insurance companies or the Plan, is the only surcharge or assessment that has been imposed by the Plan since its inception in 1975. This surcharge funded the account paying claims and expenses on policies issued before 1986-- this was not the account at issue in the Tuttle litigation. Neither medical providers nor other consumers have had to pay any surcharge to fund the account that is the subject of continuing litigation with the Tuttle plaintiffs.

(3) The Proposed Amendments Clarify the Procedure for Termination of the Plan

The current rule provides for dissolution of the SRF account and (after repayment to the medical providers that paid a surcharge as described in (2) above) a transfer of any funds remaining in this account to the general account of the Plan. The current rule is entirely silent on dissolution of the Plan itself, and this silence was noted by the Supreme Court in the Tuttle case.

The proposed amendments establish a process for dissolution not only of the SRF account, but also of the Plan itself. The proposed rule requires that any Plan assets remaining after payment of all debts and obligations shall be distributed to: (1) a successor state plan established under RSA 404-C, (2) the general fund of the state for programs that the purpose of the Plan, or (3) as otherwise directed by law. This is consistent with the prohibition on “private inurement” as discussed below.

The proposed rule also sets out for both the SRF and for the Plan, a public process (including public hearings) to determine whether dissolution is appropriate and to develop the plan of dissolution.

(4) The Proposed Amendments Clarify the Public Purpose of the Plan and its Program

The proposed amendments expressly state that no private party can profit from a distribution of any earnings or assets of the Plan. This provision is required to maintain the tax-exempt status of the Plan. There can be no “private inurement” in a public program that is exempt from federal income tax. This provision also reflects the communications between the Department and the IRS when the Plan was

created, describing the Plan as an integral part of state government and not as a private entity.