INSURANCE
DEPARTMENT OF BANKING AND INSURANCE
OFFICE OF PROPERTY AND CASUALTY

Medical Malpractice Liability Insurers - Biannual Reporting of Rate Modifiers

Adopted New Rules: N.J.A.C. 11:27-13

Proposed: November 3, 2008 at 40 N.J.R. 6384(a)

Adopted: April 28, 2009 by Steven M. Goldman, Commissioner, Department of Banking and Insurance

Filed: April 29, 2009 as R. 2009 d.177 with technical changes not requiring additional public notice and opportunity to comment (see N.J.A.C. 1:30-6.3).

Authority: N.J.S.A. 17:1-8.1, 17:1-15e, 17:23-20 et seq., 17:29AA-10 and 11, and P.L. 2004, c. 17.

Effective Date: June 1, 2009

Expiration Date: June 6, 2010

Summary of Public Comments and Agency Responses:

The Department of Banking and Insurance (Department) timely received written comments from the following:

1. Property Casualty Insurers Association of America;

2. Princeton Insurance Company; and

3. ProSelect Insurance Company.

COMMENT: One commenter requested that the Department extend the comment period for the proposal to provide the public more time to study and review same. The commenter stated that the proposal was first published in the November 3, 2008 New Jersey Register, and with the number of holidays since this date it has had little time to review the proposal with its members.

The commenter requested that the Department provide an additional 15 days for public comment.

Another commenter stated that the time for comments was insufficient, given the detailed nature of the proposed requirements, the intervening holidays, and the Department's "delayed response to relevant questions."

RESPONSE: The Department denies the request to extend the public comment period. Only three public comments were received, including those from these commenters. There were no issues raised that would warrant an extension of the comment period. None of the commenters demonstrated a "sufficient public interest" to warrant an extension of the comment period deadline, nor was such a request timely submitted. See N.J.A.C. 11:1-15.5 and 1:30-5.4. In addition, the Department believes the comment period was sufficient. The standard timeframe for submission of public comments established under the Administrative Procedure Act (the Act) is 30 days, if a rulemaking calendar was published prior to proposal, and 60 days, if no calendar was published. The Department did not provide a rulemaking calendar, thus a comment period of 60 days was provided pursuant to the Act. The number of holidays during the comment period should not significantly impede the ability of interested parties to review the proposal and formulate and submit comments within the 60-day comment period.

Further, the proposal was published on November 3, 2008. The notice of proposal is also published on the Department's website and sent to interested parties that have requested to be placed on the Department's "distribution list" via e-mail or hard copy. It is incumbent on interested parties to review the proposal at that time and to allocate resources to formulate comments for submission by the stated comment period deadline. Moreover, with respect to the

assertion that the Department's purported "delay" in responding to questions about the proposal impeded this commenter's ability to submit comments by the deadline, such questions are instructive to all interested parties and should be submitted as part of the comments on the proposal so that the Department's response may be seen by all interested parties. Further, the commenter did in fact timely submit a four-page letter containing detailed comments on the proposal, belying its assertion. The Department also notes that this commenter's comments were not filed at the mailing address, e-mail address or fax number specified in the proposal. Rather, they were filed through a portal used for the filing of reports with a separate office of the Department. Consequently, they were not received by the Department's Office of Legislative and Regulatory Affairs until after the comment period deadline had passed. Nevertheless, since these non-complying comments appear to have been received by the Department on January 2, 2009, the comment period deadline, and the Department had not yet finalized the adoption when they were brought to the attention of the Office of Legislative and Regulatory Affairs, the Department will consider the comments in this notice of adoption.

COMMENT: One commenter questioned the Department's authority to "make these changes." The commenter noted that the authority listed for the proposal included N.J.S.A. 17:22A-1 et seq., which has been repealed. In addition, the commenter stated that the proposal may be outside the Department's authority in reviewing rates for medical malpractice liability insurance under N.J.S.A. 17:29AA-1 et seq.

RESPONSE: The Department believes that it has the authority to promulgate these rules. The reference to N.J.S.A. 17:22A-1 et seq. was an error. This statute refers to the Insurance Producer

Licensing Act, which has been repealed and superseded by N.J.S.A. 17:22A-26 et seq. Neither statute was intended to be referenced. Rather, the authority intended to be referenced was N.J.S.A. 17:29AA-10 and 11, which relate to the review of rates for commercial lines insurance, which includes medical malpractice liability insurance.

In addition, the commenter provides no support for its assertion that the Department lacks the authority to promulgate these rules, and the Department disagrees with that assertion. N.J.S.A. 17:23-20 et seq. authorizes the Commissioner of Banking and Insurance or any of his or her examiners to conduct an examination of the assets and liabilities, method of conducting business and all other affairs of any company as often as the Commissioner in his or her sole discretion deems appropriate. See N.J.S.A. 17:23-22. In addition, rates for commercial lines insurance shall not be excessive, inadequate or unfairly discriminatory. See N.J.S.A. 17:29AA-10 and 11. N.J.S.A. 17:29AA-13 provides that if the Commissioner finds, after a hearing, that a rate or policy form in effect for any insurer is not in compliance with that statute, he or she may issue an Order specifying in what respect the rates or policy forms so fails, and stating when, within a reasonable period thereafter, such rate or form shall be deemed no longer effective. In addition, the Order may provide for the retroactive adjustment of rates and require payment or credit of interest to insureds covered during the adjusted rate period. Accordingly, the Commissioner possesses the authority to review rates for commercial lines insurance, including medical malpractice liability insurance, and to take action if he or she finds that such rates are not in compliance with the standards set forth in N.J.S.A. 17:29AA-1 et seq. Moreover, as noted in the proposal Summary, the Legislature enacted the New Jersey Medical Care Access and Responsibility and Patients First Act, P.L. 2004, c. 17, which provides various reforms to address the vital interests of the State in ensuring that health care practitioners can continue to provide

high-quality health care and that such health care continues to be available to residents of this State. The Department is concerned that premiums for medical malpractice liability insurance have been subject to significant variations resulting from underwriting cycles. The Department believes that all of the afore-referenced statutes provide the Department with ample authority to seek information regarding rate modifiers used by medical malpractice liability insurers.

COMMENT: Several commenters expressed concern that the rules request extensive and detailed information with little time for insurers to compile the information. One commenter expressed concern that the rule provides insufficient time for the required data to be submitted accurately. Another commenter requested that the Department extend the initial February 2009 reporting deadline because of these time constraints and consider providing insurers with "more time under the [biannual] reports." This commenter also believed that the reporting requirements in the rules will add additional costs to insurers to compile this information.

RESPONSE: Upon review, the Department has determined that no change is required. Insurers have been aware of these proposed requirements, which appeared in the November 3, 2008 New Jersey Register. In addition, on November 20, 2008, the Department issued Order No. A08-123, which requires the same information referenced in the proposed rules to be submitted by February 1, 2009 for the initial period. Accordingly, insurers have had adequate notice of the filing requirements. The Department also disagrees that extensions of the existing deadlines should be provided. The purpose of the biannual report is to enable the Department to evaluate the impact of rate modifiers on premiums and the medical malpractice liability insurance market annually for the six-month periods January 1 through June 30 and July 1 through December 31.

Extending the timeframe for its receipt of this information will reduce the ability of the Department to properly evaluate the impact of rate modifiers for the previous six-month periods, thwarting the goal of the rules. The Department also notes that, with the exception of several added fields to the spreadsheet report, the information collected pursuant to these rules is a combination of data required to be submitted under Order Nos. A07-105 and A07-106. The combined spreadsheet report under these rules will enable the Department to better monitor the rating and pricing activities occurring in the medical malpractice insurance market. Insurers were also required to submit premium, loss and related data on high level increases for policies covering physicians, podiatrists and nurses pursuant to Order Nos A02-153 and A03-107.

With respect to the comment that the filing requirements will impose additional costs on insurers, as noted in the Economic Impact in the notice of proposal, the Department does not believe that any significant additional costs will be imposed in that the new rules generally codify existing requirements or require the reporting of new information that should be readily available. In any event, for the reasons set forth above and in the notice of proposal, the Department believes that the benefits to be achieved by its timely receipt and review of this information outweigh any minimal additional compliance costs that insurers may incur.

COMMENT: One commenter stated that it appears that the proposed rules are intended to determine what, if any, impact rate modifiers may have on premiums in the market generally. Accordingly, the commenter believed that this is a short-term project and opposed “institutionalizing” the collection of this information through rulemaking. The commenter stated that, at the end of the Department’s initial review, if it is determined that there is a need for biannual collection of this information, the Department could propose such a rule at that time.

The commenter believed that it is premature for the Department to institutionalize the reporting of this data and suggested that the Department set a two-year period for this new requirement only.

RESPONSE: The Department disagrees. The Department has been collecting this type of data since 2007 pursuant to Order No. A07-105, and continues to believe that the reporting of this data will be required into the future. As these requirements are ongoing in nature, it is appropriate that the requirements be codified in a rule in accordance with the Administrative Procedure Act. If the Department determines at a later date that such information is no longer needed or should be modified, the Department can propose appropriate amendments or propose to repeal the rules at that time.

COMMENT: The commenters stated that some of the data that the Department is seeking is not available. One commenter cited as examples the requirements in Exhibit 1 listed as "Lost Quote" and "Reasons for Departure," which the commenter asserted are not usually available to the insurer and may never become available given that the insured has left that insurer. The commenter suggested that the insurer be permitted to enter "not available" where appropriate on the Exhibit 1 report form. Another commenter stated that it is uncertain what "new business" is when compared to "renewal business" and requested that the Department further clarify these issues and hold the insurer harmless if it is unable to provide all of the information that the Department is seeking.

RESPONSE: If certain data is not currently available because an insurer has not heretofore collected such information, it may enter "not available." However, the Department does not agree that insurers are unable to capture the data required to be reported. Insurers should begin to collect the required data if they are not currently doing so.

With respect to what is meant by "new" vs. "renewal" business, the Department believes that these terms are self-explanatory. New business refers to a new applicant and renewal business refers to renewal of existing policyholders. It is unclear from what the commenter is requesting that an insurer be held harmless. As noted above, an insurer may enter "not available" if it has not heretofore collected the required data. However, as also noted above, insurers should begin to capture the required data if they are not currently doing so.

COMMENT: One commenter believed that the brief amount of time provided between the close of comments for the proposed rules and the February 1 due date of the report required by Order No. A08-123 suggests that adequate consideration may not be afforded substantive comments or objections.

RESPONSE: The Department disagrees. All comments are always considered by the Department in the review of any proposed rule, and have been so considered herein. The Department could determine to modify the rules or repropose as necessary based upon the comments submitted.

COMMENT: One commenter disagreed with the assertion by the Department in the notice of proposal that any additional costs to insurers to comply with the rules should be minimal in that

insurers are either currently required to file such information pursuant to Order No. A07-105, or the information is otherwise readily available. The commenter asserted that the information required under these rules is not currently required pursuant to Order No. A07-105. The commenter cited as the most "dramatic difference" that Order No. A07-105 required information on an aggregate basis, whereas the rules require information to be broken out on an individual insured basis. The commenter stated that while this requirement may not significantly affect carriers writing a smaller number of policies, for larger companies (the commenter stated that it provides coverage for more than 3,000 healthcare providers in New Jersey), the requirements impose a significant burden. In addition, the commenter asserted that not all information required by the report is readily available. The commenter maintained that the rules require a whole new set of reports and effort on the insurer's part to report the requested information, which will increase the cost of doing business in New Jersey, which costs ultimately will be passed on to insured through increased premiums.

RESPONSE: Upon review, the Department has determined that no change is required. The report in the rules is a combination of the reports required pursuant to Order Nos. A07-105 and A07-106, the latter of which required information on an individual policy basis. Insurers thus have collected and reported such data in the past. With respect to the comment that not all requested information is readily available, the Department reiterates a response to a previous comment that where such information is not available, the insurer may so indicate on the report, but should begin collecting such information so as to be in a position to report such information in the future. With respect to the comments regarding potential costs of compliance, the Department reiterates that insurers should be in a position to collect the required information,

and further reiterates that these reports will better enable the Department to monitor and evaluate the underwriting cycles for medical malpractice liability insurance for the reasons set forth previously.

COMMENT: One commenter stated that the production of the required report is overly labor intensive relative to the stated goals of the proposal, when it is not clear to the commenter that the information sought will affect the Department's ability to control underwriting cycles in the insurance market. The commenter stated that the data requested is not readily available in report form and will require manually researching each policy for several data elements, including, but not limited to, the following: (1) matching expiring premium to renewal premium, particularly when policy numbers have changed for either the entire policy or the individual physician; (2) Reasons for Change/Departure, which must be manually investigated for each entry. The commenter stated that this will result in substantial increase in staff expense for overtime to conduct this research, particularly for carriers with high physician policy counts. The commenter stated that these expenses will have an adverse impact on physician premiums; and (3) Renewals Lost to Competitors, which data the commenter stated will be labor-intensive to collect. First, all policies that cancel or fail to renew must be manually reviewed to determine which policies were lost to competitors, rather than lost because of non-payment, moving to another state, moving to another policy or because of a reason of which it is not aware. The commenter stated that insurers are not always given information on why a policy was not-renewed or cancelled, and often the agent is also not aware. Researching this information is a manual process that will significantly increase staff overtime costs.

RESPONSE: As noted in a Response to a previous Comment, to the extent information requested by the reports is not currently collected and available to the insurer, the insurer may simply state "not available." However, as was also previously noted, insurers should begin to collect this information so that they will be able to provide the data requested in the future. Collecting the information up front will obviate the need for manual researching the data as suggested by the commenter. The Department also believes that the information requested is relevant to its review of the medical malpractice liability insurance market for the reasons set forth in a response to a previous comment.

COMMENT: One commenter stated that information regarding reasons for renewals lost to competitors and a prior carrier for new business is not consistently available.

RESPONSE: The Department refers the commenter to the Response to the previous Comment.

COMMENT: One commenter stated that it is unclear where the line between New Business and Renewal Business should lie. In particular, with regard to policyholders who have left one insurer and returned to that insurer as well as those physicians who move from one group policy to another, there is no guidance to determine whether a physician should be counted as new or renewal business.

RESPONSE: The Department believes that such terms are clear and have their usual and customary meanings. If a policyholder leaves one insurer, and then later returns after an

intervening policy period, such a policy would counted as “new business.” “Renewal business” relates to the renewal of an existing policy by the same insurer.

COMMENT: Regarding Item (1) in the reports under all headings, “Policy Count,” because a single policy may cover several physicians, the commenter stated that it is unclear whether the Department seeks a response to this question on an individual physician or policy basis. The commenter stated that if it is to be given on an individual physician basis, it is unclear if the count should always be “one” or if some other approach should be taken.

RESPONSE: The Department is seeking information on an individual physician basis. Each row of “policy count” should count up from “one,” “two,” etc., for each physician covered.

COMMENT: One commenter sought additional guidance regarding Item (2) under all headings, “Predominant Specialty.” The commenter stated that if “Policy Count” is on a per policy basis, it is unclear how to determine “Predominant Specialty” across a group of covered physicians. The commenter stated that if reporting is done on a per physician basis, then each physician would have only one specialty to report.

RESPONSE: The commenter is correct. As noted above, the reports should be on a per physician basis, and each physician would have their specialty identified in each row.

COMMENT: One commenter requested clarification regarding Item (6), “Policy Effective Date.” The commenter stated that if policy counts should be on a per physician basis, it is

unclear whether the response should include the effective date of the policy itself or the effective date for each individual physician. In addition, the commenter stated that if insurers are reporting the policy's effective date, additional guidance is needed to determine whether the premium should then be annualized for physicians added mid-term or if the report should show actual premium.

RESPONSE: As physicians may be added mid-term, insurers should use the policy effective date, with the premium annualized for physicians added mid-term.

COMMENT: Under Item (5) under all headings, "Separate Limit for Corporation (Y/N)," the commenter stated that it is unclear whether this should consider solo corporations as well. In addition, if there is no corporation, the commenter questioned whether N/A would be an acceptable response.

RESPONSE: The heading applies to solo corporations. If no corporation is involved, "N/A" is an acceptable response.

COMMENT: One commenter stated that the final column under the Renewal Business heading asks for "Reasons for Change." The commenter stated that it is unclear whether there is a percentage of change threshold at which a reason is required. The commenter stated that it is conceivable that smaller changes could be the result of rounding differences while no change has been made to the rate modifiers. The commenter suggested that an appropriate threshold would

be +/- 10 percent. The commenter believed that this would reduce the amount of manual work required to research each deviation and would exclude the need to report rounding issues.

RESPONSE: Upon review, the Department has determined that no change is required. The Department is seeking information as to why the premium modifier applied to the policy changed from the previous modifier. The use of a +/-10 percent threshold could eliminate the reporting of a significant amount of data, impeding the Department's review of the underwriting cycles of medical malpractice liability insurance, which the Department believes is necessary for the reasons set forth in the proposal Summary and the responses to previous comments.

COMMENT: One commenter stated that Item (11) under "Renewals Lost to Competitors" requests the amount charged to a lost quote. The commenter believed that the use of the term "charged" is inappropriate as no charge is created for a lost quote. The commenter believed that a better term would be "quoted."

RESPONSE: The Department agrees for the reason set forth by the commenter. Accordingly, Exhibit 1 in the Appendix to the rules has been changed upon adoption to replace the word "charged" in Item (11) under "Renewals Lost to Competitors" with the word "quoted."

COMMENT: Item (9), "Departure" and subheading "Reasons for Departure" under the heading "New Business Written" repetitively use the word "departure," which creates confusion as to whether "Reasons for Departure" refers to the change in premium in Item (9) or to the departure of the insured from a previous insurer. The Renewal Business report asks for reasons for change,

where the New Business Written report asks for reasons for departure, when the same information is being requested. The commenter believed that it would be better to use the word "difference" where the terms "departure" or "change" are used throughout the report.

RESPONSE: The Department agrees that the use of the word "departure" may be confusing. Accordingly, Exhibit 1 in the Appendix is changed upon adoption to use the term "modification." The Department believes that this term accurately describes the data requested.

Summary of Agency-Initiated Changes:

The Department is changing the subchapter heading of the rules to refer to "biannual," which means twice a year, rather than "biennial," which means once every two years, to reflect the six-month timeframes for the reporting of the data as referenced in the text of the rule and the Summary in the notice of proposal. This change will be made to the subchapter heading, N.J.A.C. 11:27-13.1(a), the section heading of N.J.A.C. 11:27-13.3 and the reference in N.J.A.C. 11:27-13.3(a).

Federal Standards Statement

A Federal standards analysis is not required because the adopted new rules are not subject to any Federal requirements or standards.

Full text of the adoption follows (additions to proposal indicated in boldface with asterisks ***thus***; deletions from proposal indicated with brackets with asterisks *[thus]*):

(<u>Agency Note</u>: The text of N.J.A.C. 11:27-13 Appendix reproduced below appears in as adopted form, incorporating the changes upon adoption described in the Responses to the last two Comments above in this notice without the use of changes upon adoption symbolism.)

SUBCHAPTER 13. MEDICAL MALPRACTICE LIABILITY INSURERS - *[BIENNIAL]* ***<u>BIANNUAL</u>*** REPORTING OF RATE MODIFIERS

11:27-13.1 Purpose and scope

(a) The purpose of this subchapter is to provide for the *[biennial]* ***<u>biannual</u>*** reporting of information related to rate modifiers used by medical malpractice liability insurers writing physicians and surgeons coverage in this State.

11:27-13.3 *[Biennial]* ***<u>Biannual</u>*** reporting requirements

(a) All insurers shall file with the Department *[biennially]* ***<u>biannually</u>*** the information set forth in Exhibit 1 in the Appendix to this subchapter, incorporated herein by reference, no later than August 1 and February 1 of each year, for the immediately preceding six month periods of January 1 through June 30 and July 1 through December 31, respectively, as applicable.

(b) - (c) (No change from proposal.)