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INSURANCE

DEPARTMENT OF BANKING AND INSURANCE

OFFICE OF PROPERTY AND CASUALTY

Changes to Medical Malpractice Liability Insurance Rates

Adopted New Rules: N.J.A.C. 11:27-14

Proposed: July 19, 2010 at 42 N.J.R. 1473(a).

Adopted: January 26, 2011 by Thomas B. Considine, Commissioner, Department of Banking and Insurance.

Filed: January 28, 2011 as R. 2011 d. 070, **with substantive and technical changes** not requiring additional public notice and comment (see N.J.A.C. 1:30-6.3)

Authority: N.J.S.A. 17:1-8.1, 17:1-15e and 17:29AA-1 et seq.

Effective Date: February 22, 2011.

Expiration Date: November 30, 2015.

Summary of Public Comments and Agency Responses:

The Department of Banking and Insurance (Department) timely received written comments from ProAssurance Casualty Company, ISO, The Medical Protective Company, and ProSelect Insurance Company.

COMMENT: One commenter expressed concern with N.J.A.C. 11:27-14.3, which sets forth the procedure by which the Commissioner of Banking and Insurance (Commissioner) shall designate the range of annual rate change pursuant to N.J.S.A. 17:29AA-5.1. The commenter believed that the rule as worded could cause rating deficiencies for specific specialties where the Department makes a finding of a significant restriction on the availability and/or affordability of professional

liability insurance. For example, the commenter stated that if the Commissioner determines that professional liability insurance is difficult for obstetricians to obtain, a limit on rate changes could be applied for that specialty. Over the course of several years, or in the case of adverse experience, a few years for a large insurer, these restrictions could render the rates of a particular insurer deficient for those specialties over time. For smaller or newer insurers who do not have the financial capacity to absorb this restriction and could prove that having this restriction on the rates would have a detrimental effect on the company's financial position, the rates would be allowed to stand as filed. The commenter believed that this could lead to larger insurers not being able to offer coverage to obstetricians in the future and may force obstetricians to obtain medical malpractice liability coverage from the surplus lines market. The commenter stated that this type of process would lead to discrimination against the larger insurers and penalize them for having a larger financial base in that the higher rate would be approved for the smaller insurer and a lesser rate would be approved for the larger insurer for the same specialty or risk. The commenter understood that it could use its own experience for the specialty in New Jersey only, but if an insurer's database is such that there is not sufficient data, it would be difficult to justify rates on a specialty basis. The commenter also stated that it would be preferable to insurers if the range would be established so that companies know the parameters to which they would be subject. Without a range, it would be difficult to adequately determine what, if any, the additional exposure would be if the Commissioner chose to implement a percentage increase or decrease on a particular specialty or rate. The commenter suggested that the rules provide a range or limit or other defining parameters regarding the thresholds that the Commissioner might set. The commenter also suggested that the rules provide that if the increase for a specific specialty is consistent with the overall requested increase (which would be based on actual New

Jersey experience, to the extent it would be considered credible, supplemented with industry information to the extent company data is not credible), and the overall requested increase is fully supported and approved by the Department, then the increase for that specialty would be approved as well.

RESPONSE: Upon review, the Department has determined that no change is required. The issues raised and recommendations made by the commenter are currently addressed in the rule. The Department notes the general statutory requirement in N.J.S.A. 17:29AA-5.1, which establishes a range of annual rate change that the Commissioner shall prescribe, which range may not be less than plus or minus five percent nor more than plus or minus 15 percent, and within which any rate, supplementary rate information, or change or amendment thereof, filed by an insurer or rating organization shall become effective not less than 30 days after the filing. The Department has implemented this statute by establishing the factors by which different ranges may be established. In addition, the statute permits insurers to file for rates outside the range, or for more than one change in a 12-month period, subject to prior approval under N.J.S.A. 17:29A-14. The commenter appears to suggest that it may not be able to justify rates as required by that statute. If an insurer cannot demonstrate that its proposed rates are not excessive, inadequate, or unfairly discriminatory, an insurer is statutorily prohibited from implementing such rates by both N.J.S.A. 17:29A-14 and 17:29AA-10. The Department also notes that the Commissioner's findings shall, as provided in N.J.A.C. 11:27-14.3, be made via a public notice setting forth the proposed findings, which will be disseminated to interested parties, with a 30-day comment period. Accordingly, interested parties, including medical malpractice liability insurers, will be

afforded an opportunity to review and comment on the proposed categories to which the Commissioner proposes to have the particular designated ranges apply.

COMMENT: The commenter expressed concern with N.J.A.C. 11:27-14.6(d), which provides that "filers shall account for impacts [from] significant changes to legislative, regulatory, social, economic, or operational factors that have an impact on loss frequency or severity, or on loss adjustment or underwriting expenses." The commenter believed that this is too broad and would allow for a broad range of subjective interpretations and could subject insurers to unknown factors with no guidelines. The commenter suggested that this provision be deleted and, as specific issues are identified, appropriate rules be promulgated.

RESPONSE: Upon review, the Department has determined that no change is required. The regulation serves as guidance to insurers to include items that should be reflected in any rate filing, regardless of the line of business. The Department notes that similar language is found in the Statement of Principles Regarding Property and Casualty Insurance Ratemaking developed by the Casualty Actuarial Society.

COMMENT: One commenter objected to N.J.A.C. 11:27-14.7(f), which provides that if the Department requests further information from a filer, the filer shall submit the information to the Department within 10 days of the receipt of the request. The commenter believed that this could be difficult if the request is extensive and personnel availability is an issue. The commenter suggested that the 10-day response time be revised to either 10 business days or 15 calendar days.

RESPONSE: Upon review, the Department has determined not to change this provision. The 10-day time period has been used in other contexts and proven to be an adequate timeframe within which companies may respond to requests for additional information. If a company cannot respond within that time, the Department will, as it has in the past, entertain requests for extensions of the timeframe if such requests are made within the 10-day period. It should be noted that the timeframe for the Department's review of the filing would be tolled during any extension.

COMMENT: One commenter noted that N.J.A.C. 11:27-14.3 sets forth the designation of the range of annual rate change. The commenter noted that the rule establishes three categories for the range of annual rate change within which a rate filing may be implemented under the "file and use" process as follows: a five percent annual range, a 15 percent annual range, and an unlimited, or no specified, annual rate change range.

The commenter stated that it is not clear what is intended by the words "singly or in combination" in N.J.S.A. 17:29AA-5.1 and 5.2, presumably intending to refer to N.J.A.C. 11:27-14.3(a)1 and 2. The commenter stated that if either of the first two conditions apply, the Commissioner would declare a five percent annual range. The commenter questioned whether it is the intent of the Department that the third condition must also apply when either of the first two apply since the connector used is "and." In other words, the commenter questioned whether the Department intended that the five percent annual range limitation will only apply if doing so will always result in "no significant impact to the capitalization and reserve requirements necessary to insure the solvency of insurers." If this is the Department's intent, the Department

should so state and the commenter recommended that N.J.A.C. 11:27-14.3(a)1 be revised to read as follows (this reflects final wording suggested by the commenter, without additions and deletions specifically noted):

1. If the Commissioner finds that either of the following conditions exist:

i. There is a significant restriction on the availability and the affordability of medical malpractice liability insurance for a category, subcategory, specialty or subspecialty of health care provider, and there is no significant negative impact to the capitalization and reserve requirements necessary to insure the solvency of insurers; or

ii. There are significant limitations on access to care by the citizens of this State to a category, subcategory, specialty or subspecialty of health care provider and there is no significant negative impact to the capitalization and reserve requirements necessary to insure the solvency of insurers then the range of annual rate change shall be plus or minus five percent for that category, subcategory, specialty or subspecialty of health care provider.

RESPONSE: Upon review, the Department agrees with the commenter as to its concerns with respect to the clarity of N.J.A.C. 11:27-14.3(a)1 and 2. The use of the phrase "singly or in combination" may be confusing and may not adequately reflect the Department's intent. The phrase essentially can be read as "and" or "or," and may engender confusion as to its application, given the other text in those paragraphs. Accordingly, for the reasons expressed in the comment, those paragraphs are being clarified upon adoption as suggested by the commenter to clarify that the condition or requirement that there be no significant negative impact to the capitalization and

reserve requirements necessary to ensure the solvency of the insurer apply to both criteria set forth in N.J.A.C. 11:27-14.3(a)1i and ii.

COMMENT: One commenter requested clarification on N.J.A.C. 11:27-14.3(a)2 regarding the 15 percent range. Similar to the previous comment, the commenter stated that it is not clear what is intended by the words "singly or in combination" in this section. The commenter stated that by using the word "singly," a proper interpretation of this section would conclude that only if the limitations in paragraph (a)1 did not significantly exist (that is, there were no restrictions on availability and affordability in health care and there were no limitations on access to health care) then a 15 percent range would apply. The commenter did not believe that this was the Department's intent. Rather, the commenter believed that the intent is that if none of the limitations in paragraph (a)1 apply, and either of the following two conditions exist (that is, data indicates high frequency/severity of claims or data indicates upward trends in expenses) then the 15 percent range would apply. To more clearly reflect this intent, the commenter suggested that paragraph (a)2 be revised to read as follows:

2. If the Commissioner finds that the limitations in (a)1 above do not significantly exist, and that either of the following conditions exist:

i. Data indicate high frequency and severity of medical malpractice liability insurance claims; or

ii. Data indicate upward trends in the costs of investigating, defending and settling claims;

then the range of annual rate change shall be plus or minus 15 percent for that category, subcategory, specialty or subspecialty of health care provider.

RESPONSE: The Department agrees for the reasons set forth in the response to the previous Comment. As was noted therein, the use of the phrase "singly or in combination" may be confusing and may not adequately reflect the Department's intent. The phrase essentially can read as "and" or "or," and may cause confusion as to its application, given the other text in those paragraphs.

COMMENT: One commenter expressed concern with N.J.A.C. 11:27-14.3(a)3, which provides that if the Commissioner finds one of the circumstances set forth in subparagraphs (a)3i, ii or iii, then no range shall be established. The commenter believed that this paragraph is confusing. The commenter questioned the need for N.J.A.C. 11:27-14.3(a)3i, since, if neither of the circumstances in paragraphs (a)1 nor (a)2 exist, the Commissioner would not have made a flex finding and this section would not be necessary. The commenter therefore suggested that paragraph (a)3 be revised to delete subparagraph (a)3i and to add the following phrase in paragraph (a)3 after the word "following":

"with respect to a category, subcategory, specialty or subspecialty."

RESPONSE: The Department agrees with the suggestion to change paragraph (a)3 to add language after "following" to clarify the rule. The Department does not agree, however, that subparagraph (a)3i is redundant and should be deleted. The rule text is intended to provide that the Commissioner may find that no range applies for a category, subcategory, specialty or subspecialty where neither of the conditions in paragraphs (a)1 or 2 exist, in addition to the grounds in subparagraphs (a)3ii and iii. The Department believes that this subparagraph is

necessary to provide a basis for and afford to the Commissioner the option to make such a preliminary finding.

COMMENT: One commenter noted that the statute provided that with respect to medical malpractice liability insurance rates, the Commissioner shall issue an order prescribing each designated range of annual rate change and the categories of providers whose medical malpractice liability rate changes shall be subject to each range. The commenter stated that to date, no such order has been issued and questioned whether the Department intended to issue an order specifying the ranges and categories.

RESPONSE: N.J.S.A. 17:29AA-5.1a provides that with respect to medical malpractice liability insurance, the Commissioner "shall prescribe by regulation" a designated range of annual rate change, which shall be an increase or decrease of between not less than five percent and not more than 15 percent. The statute also provides that the Commissioner may determine, "pursuant to regulation," the categories, subcategories, specialties and subspecialties of health care provider to which the application of the designated range shall apply. The rules implement the statute by establishing the factors the Commissioner shall consider to determine the range that shall apply in N.J.A.C. 11:27-14.3. N.J.A.C. 11:27-14.4 sets forth the procedures by which the order referenced by the commenter shall be issued. Before any such order is issued, the Department shall issue a public notice setting forth the Commissioner's proposed findings in accordance with N.J.A.C. 11:27-14.3 not earlier than 60 days prior to the effective date thereof. Interested parties shall have 30 days from the date of the posting of the public notice on the Department's website to provide written comments or additional data for the Commissioner's

determination. After giving due consideration to any comments and data received, the Commissioner shall thereafter issue an order prescribing each designated range of annual rate change and the categories or providers subject thereto. The Department intends to issue the public notice in the near future.

COMMENT: One commenter urged the Department to provide the greatest degree of flexibility in the determination of a rate filing's qualification within the range. This type of framework can serve to motivate companies to make greater use of this "file and use" provision. A flexible framework will encourage insurers to file more frequently and in a more moderate fashion if they have the ability to recognize substantive variations in risks that may, at a specialty or subspecialty level, exceed the annual rate change, but adhere to the range on an overall basis.

RESPONSE: The Department agrees and believes that the proposed rules implement the intent of the Legislature to provide such a process. The Department reiterates, however, that pursuant to the statute, if a company seeks to implement rates in excess of the established range for a specialty, subspecialty, category or subcategory of provider, such rates are subject to prior approval pursuant to N.J.S.A. 17:29A-14.

COMMENT: One commenter stated that, with respect to N.J.A.C. 11:27-14.3(a)1 and 2, to ensure consistency and clarity, the Department's findings under those sections should include both an ISO code and a description of the category, subcategory, specialty and subspecialty of health care provider. For example, if obstetricians are listed as a designated specialty, falling into either N.J.A.C. 11:27-14.3(a)1 or 2, questions may arise as to whether gynecologists or

family practice physicians performing obstetrics would also fall into the same category of health care provider.

RESPONSE: The issues raised by the commenter will be addressed in the public notice containing the Commissioner's proposed findings pursuant to N.J.A.C. 11:27-14.4. All relevant data will be considered, including data provided by interested parties.

COMMENT: One commenter noted that under N.J.A.C. 11:27-14.3(a)3, the annual rate change shall not apply to certain risks. The phrase "shall not apply" seems to indicate that the rate for such health care providers may be outside of the annual rate change, but the language is unclear as to whether the rate must still be "file and use" or if the filing does not need to be filed with the Department, but only maintained by the company. In addition, without definitions or guidelines in subparagraphs (a)3ii and iii, the language is vague and unclear as to the required level of complexity of the risk with a process to determine if the risk is "unusual" in nature. It appears that these unique or complex risks would require an individual risk filing that could be subject to this rate filing rule. The commenter suggested that individual risk filings be explicitly excluded from the current "file and use" and "prior approval" provisions in the rules so as to avoid any impediment to the timely and complete negotiation of coverage terms for unique risks.

RESPONSE: Upon review, the Department has determined that no change is required. The Department believes that the rules are clear. N.J.A.C. 11:27-14.5 expressly provides that any medical malpractice liability insurance rate changes, unless such changes are required to be filed for prior approval pursuant to the subchapter, shall be filed with the Department no later than 30

days prior to the implementation thereof, and thereafter may be implemented unless disapproved by the Department within the 30-day period (that is, "file and use"). Further, guidance will be provided in the public notice setting forth the Commissioner's proposed findings. Providing more specificity in these rules would reduce the flexibility needed to address market conditions. The Department also reiterates that interested parties will have an opportunity to comment on the proposed findings.

COMMENT: One commenter stated that numerous discussions with the Department had occurred regarding the definition of "special risks" and the potential adverse impact on larger, more significant medical malpractice risks that typically require and negotiate more complex terms than the average health care provider. The commenter suggested that the rule should include an exemption for or a definition of "special risks." The commenter believed that it is essential to find categories of health care providers to be "large commercial risks" and exempt such risks from these requirements. Such risks could be defined by the number of employed health care providers, assets, revenue, or some combination of these criteria. This would allow insurers to more readily respond to the needs of these types of risks and provide flexibility in the insurance program that they often require. The commenter further stated that if N.J.A.C. 11:27-14.3(a)3 is intended to be the "special risk" or "large commercial risk" rule, the commenter encouraged the Department to further clarify this section. If the Department did not intend the rule to be the "special risk" or "large commercial risk" rule, the commenter requested that the Department address these types of risks in the rule.

RESPONSE: Upon review, the Department has determined that no change is required. The Department reiterates that the statute provides for no exception based on large or "special risks" per se, as defined in N.J.S.A. 17:29AA-2. In fact, in amending the statute, the Legislature specifically exempted medical malpractice liability insurance from the definition of "special risk." However, as set forth in the proposal Summary, and in the Responses to previous Comments, the rules specify numerous factors that the Commissioner may consider in proposing annual rate change ranges and the application thereof, with the provision for public input on such findings.

COMMENT: One commenter stated that N.J.A.C. 11:27-14.5 provides that a filing not required to be filed for prior approval "may be implemented by the company unless disapproved by the Department within a 30-day period." The commenter noted that under N.J.A.C. 11:27-14.7(e), "the Department shall advise the filer if the filing, requiring prior approval, is incomplete not later than 15 days after receipt of the filing." The commenter suggested that the Department provide the same notice regarding the completeness of a filing within the 15 days of either a filing requiring prior approval or a filing submitted under "file and use."

RESPONSE: While the Department agrees that the Department would advise a filer of deficiencies before the expiration of the 30-day period, the Department does not believe it would be appropriate to so provide in the rules in that it may be misleading in that a filing, although complete (or not found to be deficient), could still be disapproved within the 30-day period on substantive grounds.

COMMENT: One commenter reiterated concerns previously raised with the Department that the statute removed medical professional liability insurance risks from the definitions of "special risks" in New Jersey Commercial Deregulation Act, N.J.S.A. 17:29AA-1 et seq. The commenter reiterated its prior proposal that the statute apply only to medical professional liability risks that are individuals. The commenter believed that this would accommodate both the concerns of the Department regarding individual physician and surgeon premiums and its concerns about larger, more sophisticated accounts, such as facilities and large physician groups. The commenter provided suggested language for the statute.

The commenter also stated that placing hospitals and large practice groups on the exportable list would not be equitable because doing so will only open up admitted carriers to increased competition from the excess and surplus lines market and would be detrimental to the ability of admitted carriers in this State to continue to serve the medical community. The commenter also stated that it is impossible for the Department to regulate any large risk premium that is lost to the non-admitted market because non-admitted or surplus lines carriers are not subject to regulation by the Department.

RESPONSE: The Department notes that the concerns expressed by the commenter relate to the statute, and thus are outside the scope of this proposal. The Department has attempted to provide flexibility with the designation of the ranges or the designation that no range shall apply based on various factors as set forth in N.J.A.C. 11:27-14.3. The Department believes that this provides sufficient flexibility to address many of the commenter's concerns. The Department also notes that interested parties will be provided prior notice of the Commissioner's proposed findings of

the applicable range(s) of annual rate change and the categories, subcategories, specialties and subspecialties to which they apply, with 30 days to comment prior to issuance of any final order.

COMMENT: One commenter requested the repeal of N.J.A.C. 11:27-13, which provides for the biannual reporting of information related to rate modifiers, as it believed this information is redundant and no longer necessary given the regulation of medical malpractice liability insurance rates pursuant N.J.S.A. 17:29AA-5.1 and these rules.

RESPONSE: The comment is outside this scope of proposal. This same comment was submitted in connection with the proposed readoption of N.J.A.C. 11:27 and will be addressed in the notice of adoption of that proposal.

COMMENT: One commenter noted that the rule provides that the Commissioner has 60 days to review prior approval filings, with an additional 30 days as deemed necessary. While this timeframe is shorter than an earlier timeframe which had been suggested, the commenter continues to believe that, given the narrow focus and size of the medical professional liability market, as opposed to the private passenger automobile insurance line, such a protracted review is unnecessary and will only impede the speed to market factor that is important to its policyholders. The commenter thus requested that the Department's review period be reduced to 30 days with 30 additional days permitted as necessary.

RESPONSE: The Department believes that 60 days is reasonable and appropriate. The Department notes that this is an "outside limit" timeframe and that the Department routinely does not take the full time to complete its review of a filing.

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 adopted new rules follows (additions to proposal indicated in boldface with asterisks ***thus***; deletions from proposal indicated in brackets with asterisks *[thus]*):

11:27-14.3 Designation of range of annual rate change limitation

(a) The Commissioner shall designate the range of annual rate change pursuant to N.J.S.A. 17:29AA-5.1 as set forth in this section.

1. If the Commissioner finds *[singly, or in combination,]* that ***either of the following conditions exist, then the range of annual rate change shall be plus or minus five percent for that category, subcategory, specialty or subspecialty:**

i.* *[there]* ***There*** is a significant restriction on the availability and affordability of medical malpractice liability insurance for a category, subcategory, specialty or subspecialty of health care provider, ***and there is no significant negative impact to the capitalization and reserve requirements necessary to ensure the solvency of insurers;*** or

ii. *[there]* ***There*** are significant limitations on access to care by the citizens of this State to a category, subcategory, specialty or subspecialty of health care provider*[;]* *,* and there is no significant negative impact to the capitalization and reserve requirements necessary to ensure the solvency of insurers*[, then the range of annual rate change shall be plus or minus five percent for that category, subcategory, specialty or subspecialty of health care provider]*.

2. If the Commissioner finds *[either singly or in combination,]* that the limitations in (a)1 above do not significantly exist, ***and that one of the following conditions exist, then the range of annual rate change shall be plus or minus 15 percent for that category, subcategory, specialty or subspecialty of health care provider:***

i. *[if data]* ***Data*** indicate high frequency and severity of medical malpractice liability insurance claims; or

ii. *[if data]* ***Data*** indicate upward trends in the costs of investigating, defending and settling claims*[, then the range of annual rate change shall be plus or minus 15 percent for that category, subcategory, specialty or subspecialty of health care provider]*.

3. If the Commissioner finds one of the following ***with respect to a category, subcategory, specialty or subspecialty of healthcare provider***, then the range of annual rate change shall not apply to that category, subcategory, specialty or subspecialty:

i. – iii. (No change from proposal.)