INSURANCE
DEPARTMENT OF BANKING AND INSURANCE
DIVISION OF INSURANCE

Medical Malpractice Insurance- Prohibited Premium Increase

Adopted New Rules: N.J.A.C. 11:27-5

Proposed: November 1, 2004 at 36 N.J.R. 4878(a).

Adopted: April 26, 2005 by Donald Bryan, Acting Commissioner, Department of Banking and Insurance.

Filed: April 29, 2005 as R. 2005 d. 168, **without change**.

Authority: N.J.S.A. 17:1-8.1, 17:1-15e and 17:30D-31 (P.L. 2004 c. 17, § 32).

Effective Date: June 6, 2005

Expiration Date: June 6, 2010

Summary of Public Comments and Agency Responses:

The Department of Banking and Insurance (Department) received written comments from the following: Raymond E. Cantor, Director of Governmental Affairs, Medical Society of New Jersey; Ervin Moss, MD, Executive Medical Director, New Jersey State Society of Anesthesiologists; the law firm of Pringle Quinn Anzano on behalf of ProSelect Insurance Company; Kieran E. Pillion, Jr. Vice President/General Counsel, Princeton Insurance Company; and Patricia A. Costante, Chairman and Chief Executive Officer, MD Advantage Insurance Company of New Jersey.

COMMENT: One commenter noted that, with the exception of N.J.A.C. 11:1-7.1, the rules do not define the term "medical malpractice insurance." The commenter requested that the Department clarify the definition of "medical malpractice insurance" applicable to these rules.

RESPONSE: Given the presence of the definition of "medical malpractice liability insurance" in the Medical Malpractice Liability Insurance Act, N.J.S.A. 17:30D-1 et seq. at N.J.S.A.

17:30D-3(d), the Department does not believe it is necessary to include a similar definition in N.J.A.C. 11:27. The definition in N.J.S.A. 17:30D-3 would be applicable to references to "medical malpractice liability insurance" and to "medical malpractice insurance" in N.J.A.C. 11:27.

COMMENT: One commenter indicated that it is unclear whether the proposed rules apply to insurance exchanges writing medical malpractice insurance.

RESPONSE: N.J.s.A> 17:30D-23 provides that " …an insurer authorized to transact medical malpractice liability insurance in this State shall not increase the premium of any medical malpractice liability insurance policy…if the insured is dismissed from an action alleging medical malpractice within 180 days…" Insurance exchanges may only make, issue or deliver medical malpractice policies in New Jersey if they have been authorized by the Commissioner to do so. See N.J.S.A. 17:50-11. Thus, the rules in N.J.A.C. 11:27 will be applicable to medical malpractice policies made, issued or delivered in New Jersey by authorized insurance exchanges.

COMMENT: One commenter stated that the proposal was not a panacea and, while it does not protect physicians who are dismissed from cases during the discovery process but after the 180 day limit, it should help some physicians avoid premium increases.

RESPONSE: The Department appreciates the expression of support for the proposal.

COMMENT: Several commenters stated that they support the proposal because it will protect physicians from unfair premium increases.

RESPONSE: The Department appreciates the expression of support for the proposal.

COMMENT: The commenter noted that the Summary to the rule provides that company proposal would have the insurance company absorb all costs to defend physicians who are dismissed from civil suits during the 180-day period. The commenter suggested that the prohibition upon passing these costs on to insureds must be placed in the language of the regulation and not merely stand as a statement of intent.

RESPONSE: The statement to which the commenter referred appeared in the Economic Impact portion of the notice of proposal and not in the Summary. The statement read: "Insurers will also be required to absorb the costs of defending legal actions that were dismissed within the 180 day timeframe referenced in the rules." The purpose of including that sentence was to distinguish costs incurred by insurers prior to dismissal to defend an insured from an "indemnity payment." The sentence must be understood within the context of N.J.A.C. 11:27-5.3(a), which provides that only if no indemnity payment is made would the prohibition upon premium increases upon renewal, based upon the claim to which the dismissed civil action was related apply. Further, as N.J.A.C. 11:27-5.1 clearly states, the purpose of the subchapter is to prohibit premium increases upon renewal based upon a claim that was related to a suit that was dismissed within the 180 day timeframe. N.J.S.A. 17:30D-22, which these new rules implement, does not prohibit insurers from considering a claim, and the cost of defending a suit related to it, that is still pending when the insurer determines the premium to be charged upon the renewal. Thus, while the costs to defend a suit prior to a dismissal are not considered an indemnity payment and are to be absorbed by the insurer, it cannot be said that the Legislature intended that such costs, and the claim to which they relate, may not be considered by an insurer when renewing the policy of an insured while a suit based upon the claim against the insured remains pending. On renewals subsequent to a dismissal within the 180-day timeframe where no indemnity payment

has been made, an insurer may not increase an insured's premium on the basis of the claim to which the now-dismissed suit pertained.

COMMENT: One commenter stated that medical malpractice claims dismissed within 180 days of the filing of the last responsive pleading may have been an integral part of an insurer's filed and approved rating structures. The commenter suggested that the Department will have to delay the operative date beyond the effective date of the adoption of this regulation, because insurers must be given an opportunity to estimate the financial impact of this change and to revise their rating structures to appropriately account for that impact. The commenter stated that, while it is appropriate that a previous rate increase based upon a pending claim be rescinded if the claim is dismissed within the 180-day period, the proposal should also provide that any increased premium that had been paid be refunded to the physician. The commenter stated that to do otherwise would be to violate the intent of the underlying law. The commenter also suggested that the regulation should go even further and prohibit any rate increase on a pending case until the 180-day period has expired. The commenter stated that what is needed is an explanation of the 180 day limit. The commenter stated that, per the proposal, in order for a physician not to have a premium increase the insured must be dropped from the case within 180 days of the filing of the last responsive pleading of the action. The commenter stated they saw no need for a time limit.

RESPONSE: The Department agrees that claims dismissed within 180 days of the filing of the last responsive of pleading may have been an integral part of an insurer's filed and approved rating structure. The statute and the rule do not, however, provide a mechanism for a refund through an offset or otherwise. The Department disagrees with the commenter's suggestion that

the Department will have to delay the operative date because insurers must be given an opportunity to estimate the financial impact of this change and to revise the rating structures to appropriately account for the impact. The intent of the statute and the regulations is to promptly pass on the reduction in costs from dismissals within 180 days to those who are insured under medical malpractice liability policies.

With regard to the commenter's observation that a previous rate increase on a pending claim will be rescinded if the claim is dismissed within 180 days, the rule provides that, upon the renewal next succeeding a 180-day dismissal, the fact that the suit no longer exists shall be taken into consideration in the calculation of a renewal premium.

The Department disagrees with the suggestion of the commenter that any increase in premium that had been paid should be refunded to the physician and that to do otherwise would violate the intent of the underlying law. The Department believes that the intent of the statute was to ensure that the filing of the dismissed claim would not affect the insured's premiums subsequent to the dismissal. The statute does not provide for retroactive refunds.

The Department also disagrees with the suggestion that the regulation should prohibit any rate increase on a pending case until the 180-day period has expired. As previously noted, the statute is prospective, and the administrative complications from this suggestion would be unwieldy.

Finally, the Department believes it was the intent of the Legislature to impose a cutoff date and that the Legislature determined that the cutoff date would be 180 days after the filing of the last responsive pleading. The time frame of 180 days proposed in the rule is exactly what is set out in the statute. Thus, the commenter's position that there is no need for a time limit is not consistent with the statute, in which the Legislature has spoken definitively on this issue.

COMMENT: One commenter stated that they believe that the proposed regulations need to prohibit the policy of many insurance companies of not renewing policies of physicians if they have been named in a lawsuit. The commenter urged that, at a minimum, these regulations should prohibit using lawsuits that have been dropped during this 180-day period as any criteria to not renew a policy and that to do otherwise would be to defeat the underlying intent of the legislation, which they stated is to protect innocent physicians from being penalized when they are improperly named in a medical liability lawsuit. The commenter continued that it makes no sense to prohibit premium increases but to allow the nonrenewal of policies. The commenter suggested the Department should go further and totally prohibit companies from not renewing policies against physicians merely because they have been named in suits, especially when there has been no payout. The commenter recognizes that these lawsuits cost money to defend, but the fact that there was no payout indicates that there was no liability and thus no fault on the part of the physician. The commenter continued that because of the very poor medical liability market, it is unfair to penalize physicians for the litigious nature of patients in this State and for the unprofessional behavior of the plaintiff's bar in overreaching by naming too many physicians in their individual complaints. The commenter stated that while the underlying legislation did not explicitly address the concern of nonrenewal when there has been no payout, the Department is within its power to adopt a regulation to remedy it.

RESPONSE: The suggestion by the commenter that the proposed rules need to prohibit insurance companies from nonrenewing the policies of physicians merely because they have been named in a lawsuit is beyond the scope of the proposal. The Department disagrees with the commenter that the failure of the rules to prohibit the use of lawsuits that were dismissed during

the 180-day period as a basis upon which an insurer may non-renew a policy would defeat the underlying intent of the legislation. The Department believes that the plain language of the statute and the intent of the Legislature expressed therein was to preclude an increase in the premium of a medical malpractice liability insurance policy based on a claim that was dismissed within 180 days of the filing of the last responsive pleading. The Department further believes that the intent of this statute was to relieve physicians of the burden of continually, over a course of years, paying increased premiums because of the filing of a claim that eventually was dismissed within the 180-day time period. The Department believes the rule as proposed is consistent with the express language of the statute, which imposed a prohibition upon increasing a premium based on a suit dismissed within 180 days of the filing of the last responsive pleading. The Department feels however, that the commenter has raised a legitimate concern. If medical malpractice insurance carriers implement practices which are inconsistent with the spirit of the legislation, such as by nonrenewing policies based solely on the filing of claims that were dismissed within the 180-day timeframe, the Department will consider adopting appropriate rules to address such a development.

COMMENT: One commenter stated that they were not sure about what happens when a case has been pending for some time and then the court allows the plaintiff to amend the complaint, either to assert additional claims or to bring in new parties. The commenter stated those actions all require the filing of a responsive pleading and wondered does that start the 180-day clock running all over again. The commenter asked what would happen if the insurer obtained summary judgment or some other form of dismissal within 180 days after that pleading was filed. The commenter wondered if the insurer is still precluded from increasing the premium

even though it has spent a lot of time, money and effort in getting to a point where it is finally able to persuade the court or the plaintiff to dismiss its lawsuit. The commenter stated that the legislative intent to protect the insured if he or she is dismissed early at a relatively little litigation expense to the insurer is being undermined under these scenarios.

RESPONSE: The Department notes the unusual situations that could arise in the examples given by the commenter; however, the Legislature was very clear when it used the term "last responsive pleading." The Department notes that in the vast majority of cases where a dismissal within 180 days of the last responsive pleading will be entered, it will occur before much of the pre-trial discovery, the retaining of experts, the taking of depositions, the filing of motions and the trial will have occurred, so that substantial expenses will have been saved.

COMMENT: One commenter stated they were not sure of how to apply the rule in the very unusual case where amendments are allowed or made at trial to "conform the pleadings to the proofs" and then the jury returns a verdict in the insured's favor. The commenter wondered whether insurers are not allowed to increase the premium even though they have taken the case through trial.

RESPONSE: The Department does not anticipate that such an amendment at trial would require a responsive pleading. An amendment to conform the pleadings to the proofs at trial is not the situation described by the statute or rule. The statute and rule provide that the 180 days begins to run at the filing of the last responsive pleading. Thus, unless a responsive pleading is filed, the 180-day window would not begin to run.

COMMENT: One commenter suggested that the proposed rule specify that an insurer has been precluded from increasing the premium only where the insured is dismissed within 180 days of

his or her initial responsive pleading being filed. The commenter stated that this would address the concerns raised in the questions, and be consistent with the legislative intent not to penalize insureds who are really dismissed early.

RESPONSE: The Department drafted the rule using the phrase "last responsive of pleading," because that is the phrase used in the underlying statute. If the Department accepted the commenter's suggestion, it would be in clear conflict with the statutory language.

COMMENT: One commenter suggested that the definition of "action" be limited to a civil action commenced in the New Jersey State Courts or Federal courts in which the law of New Jersey governs. The commenter stated that the Legislature drafted the enabling legislation anticipating that the timeframes applicable in such actions, and the standards of professional responsibility and the tort laws in New Jersey would be applicable. The commenter stated that requiring that insurers be prohibited from adjusting premiums based on actions not governed by New Jersey laws and court rules could not have been the Legislature's intent.

RESPONSE: The Department disagrees. The statute speaks of "a claim of medical negligence or malpractice against the insured" and does not specify that the claim must be made in a court in which New Jersey law governs. The Department believes that accepting the commenter's suggestion to so limit the rules scope would violate the legislative intent of the law.

COMMENT: One commenter stated that, while N.J.A.C. 11:27-5.3(c) requires that an insurer "file a manual rule as to this provision," such a filing is unnecessary since the regulation and enabling statute clearly define the provision's applicability. The commenter continued that if the

filing of such a rule is required, the regulation should further clarify its purpose and expected content.

RESPONSE: The Department disagrees that filing a manual rule is unnecessary. The Department believes that such a filing would help clarify the issue for insurance company staff. The Department would not expect such staff to have access to all appropriate administrative rules when they are underwriting a risk; however, they certainly would have their individual company manual. In addition, any necessary clarification and expected content of the manual rule can be obtained by communication with Department staff, or if necessary, by way of issuance of a bulletin by the Commissioner.

Federal Standards Statement

The adopted new rules are not subject to any Federal standards or requirements. Therefore a Federal standards analysis is not required.

Full text of the adopted new rules follows:

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