INSURANCE
DEPARTMENT OF BANKING AND INSURANCE
OFFICE OF SOLVENCY REGULATION

Medical Malpractice Liability Insurance

Reporting Requirements

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

Proposed: March 3, 2008 at 40 N.J.R. 1065(a)

Adopted: February 18, 2009 by Steven M. Goldman, Commissioner, Department of Banking and Insurance

Filed: February 20, 2009 as R. 2009 d. 96, with substantive and technical changes not requiring additional public notice or comment (see N.J.A.C. 1:30-6.3).

Authority: N.J.S.A. 17:1-8.1, 17:1-15e and 17:23-20 et seq.

Effective Date: March 16, 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. CNA Insurance Companies;
2. MDAdvantage Insurance Company of New Jersey;
3. The Medical Protective Company;
4. Princeton Insurance Company;
5. American International Group, Inc.;
6. The Reinsurance Association of America;
7. Transatlantic Reinsurance Company;
8. Towers Perrin;

9. Property Casualty Insurers Association of America;

10. N.J. Physicians;

11. The American Insurance Association;

12. Dewey and LeBoeuf; and

13. Guy Carpenter and Co., LLC

COMMENT: Several of the commenters objected to proposed N.J.A.C. 11:27-11.3, which provides that, within 60 days of initiating discussions to enter into a new, renewal of or amendment to any ceded reinsurance contract covering medical malpractice liability insurance, but no later than 30 days prior to the execution of such agreement or amendment, an insurer shall file with the Department for its review a copy of the complete ceded reinsurance agreement, including all amendments; the reinsurance attestation; and the underwriting file related to such agreement. The proposed rule also provides that the insurer shall notify the Department within 10 days of executing the reinsurance agreement.

The commenters generally stated that the requirement is onerous and goes far beyond what is currently required of New Jersey domestic insurers or foreign insurers in their states of domicile. Several commenters stated that it would result in draft agreements being filed with the Department, many of which are never consummated or which result in agreements that differ significantly from drafts initially filed. It was stated that this will increase the work load on the Department and result in a large amount of time expended reviewing draft agreements that may never be executed or may be significantly altered prior to execution. One commenter also noted that there is no materiality threshold for the requirement. Accordingly, the commenter believed that it would significantly increase the Department’s work load without necessarily improving

the solvency of insurers writing medical malpractice liability insurance in New Jersey. In addition, the commenter stated that it would impose additional costs on insurers, which ultimately would be passed through to policyholders. Several commenters believed that it would be more appropriate for the Department to use existing tools, such as Schedule F data of the annual statement and the responses to Annual Statement General Interrogatory 9, to identify insurers with reinsurance programs which may warrant further investigation by the Department.

Several commenters also noted that the annual statement reinsurance attestation does not relate to specific reinsurance agreements, but rather relates to an insurer's entire reinsurance program. One commenter believed that if the Department is concerned about a specific reinsurance contract, it should request a copy of the insurer's risk transfer analysis for that specific reinsurance contract. Another commenter stated that a ceding insurer would be required to create a unique New Jersey-specific financial reporting requirement, outside of the quarterly and annual financial statements.

RESPONSE: Regarding the comment that the requirement in N.J.A.C. 11:27-11.3 is onerous, the Department notes that, upon consideration of all of the comments received describing the process for entering into reinsurance agreements, the Department has determined that it is appropriate to change the rules upon adoption to revise the requirement that an insurer file with the Department a copy of the reinsurance agreement within 60 days of initiating discussions to enter into a new, renewal of, or amendment to a reinsurance agreement. The revision provides that an insurer shall file a copy of such an agreement no later than the earlier of 60 days after the effective date or 30 days after the execution of a new, renewal of or amendment to a reinsurance agreement. The Department is also changing N.J.A.C. 11:27-11.3(b) to require the filing of the

executed agreement, if not previously filed, within 30 days of execution, rather than 10 days, in recognition that the parties executing the agreement may be in several locations throughout the world. This comment, as well as subsequently addressed comments, indicates that finalized agreements may not be available within the time frames proposed, resulting in the filing of draft agreements with the Department which may be of little value in determining an insurer's condition based on its reinsurance portfolio and identifying insurers that may not be establishing adequate reserves. The Department continues to believe that review of this information is reasonable and appropriate. By being proactive in the review of reinsurance agreements, the Department is attempting to avoid situations observed in the past where the purported reinsurance does not provide the anticipated coverage to the insurer when needed. If a reinsurance agreement did not actually transfer risk, as may be demonstrated by compliance with the requirements of SSAP 62 in the NAIC Accounting Practices and Procedures Manual, the ceding insurer would not be permitted to account for the reinsurance as prospective reinsurance, that is, show a reduction in liabilities for the amount of reinsurance ceded. Moreover, the reporting of reinsurance as prospective reinsurance that does not actually transfer risk skews other tests to determine an insurer's financial condition, including risk based capital (RBC) tests, which are based on annual statement data. Thus, an insurer may continue to transact business when, in fact, its actual financial condition is such that its writings should have been curtailed or the insurer placed in supervision or rehabilitation. If an insurer's liabilities are understated due to the use of reinsurance that does not actually transfer risk, it may also establish reserves that are inadequate for its actual liabilities. This could result in substantial rate increases when the insurer's actual financial condition becomes apparent. If the Department's actuarial review indicated that the insurer did not establish an adequate reserve amount, the Department would

have discussions with the insurer and evaluate the financial condition of the insurer based upon the Department's actuary reserve selection. The amount of any reserve deficiency would dictate the subsequent course of action, which could include administrative supervision pursuant to N.J.S.A. 17:51A-1 et seq. or rehabilitation pursuant to N.J.S.A. 17:30C-1 et seq. The potential consequences for an insurer set forth above would potentially impact all insurers in the market. If a significant writer of medical malpractice liability insurance must cease writing such business due to its being in a hazardous financial condition, policyholders must seek coverage elsewhere, and might not receive full coverage on a claim under their policy due to limits of coverage afforded by the New Jersey Property-Liability Insurance Guaranty Association pursuant to N.J.S.A. 17:30A-1 et seq.

These changes thus further the goal of the rules, as set forth above and in the notice of proposal. In addition, as noted in subsequent comments, the timeframe for the filing of agreements under the proposed rules, which was tied to when discussions were "initiated," was found by several commenters to vague and confusing. Thus, the change does not eliminate filings deemed necessary by the Department, but ties the filing deadlines to more definitive benchmarks. The Department is also changing the rules upon adoption to require that an insurer make the underwriting file related to a reinsurance agreement available for Department inspection and review at the Department, rather than requiring the filing of the file with each agreement. This change will ensure adequate access to these files by the Department, which is necessary as set forth in the notice of proposal, while eliminating the cost to filers and the Department of filing and storing underwriting files for every agreement.

Furthermore, the Department believes that any additional costs imposed by the rules, as modified, should be minimal in that the information required either is currently required to be

maintained by insurers in accordance with the instructions to the NAIC Annual Statement required to be filed with the Department annually pursuant to N.J.S.A. 17:23-1, or should otherwise be readily available. While it is true that additional duties will be placed upon Department staff to review the documents filed, as is noted above and in the proposal Summary, the Department believes that these rules, as modified, are reasonable and appropriate. In New Jersey, healthcare providers are required to maintain minimum levels of medical malpractice liability insurance. As was also noted in the proposal Summary, the impact upon residents of the State from availability and affordability problems for medical malpractice liability insurance can be exacerbated by the volatility in rates that has existed with respect to the provision of this line of insurance. The effects of this volatility and the cyclical nature of rates for medical malpractice liability insurance have far reaching implications with respect to public health. The Department thus believes that the costs attributable to any additional duties imposed on insurers by these rules are far outweighed by the potential benefits to be achieved through the review of this information in an attempt to ascertain the causes of and ameliorate the effects of such volatility.

The Department also disagrees that it could use existing tools, such as Schedule F data and Interrogatory 9 to the Annual Statement. While the information set forth in the Annual Statement may be helpful, it does not contain all of the information or the level of detail related to reinsurance agreements that can impact an insurer's reserves as set forth above. In particular, Schedule F merely shows a summary of amounts of reinsurance, it does not show the terms of the reinsurance agreement.

With respect to the comment that the reinsurance attestation relates to an insurer's entire reinsurance program, the Department recognizes this but continues to believe that its receipt of

the information contained therein is appropriate. For the vast majority of insurers that write this line of business in New Jersey, medical malpractice liability insurance is the only line written or represents the majority of insurance written by the company. Consequently, in most cases the attestation provides relevant information related to an insurer's medical malpractice liability insurance writings. Moreover, as set forth above, if an insurer's financial condition is not accurately reflected its established reserves may be inadequate, resulting in significant rate increases to address such inadequacy. Further, the Department is merely requesting a copy of a document currently required to be maintained by the insurer. Accordingly, any additional costs imposed on insurers writing medical malpractice liability insurance should be minimal.

With respect to the comment that the Department should request a copy of the insurer's risk transfer analysis for a specific reinsurance contract if the Department has concerns, the Department recognizes that it has the authority to do so, but the goal of these rules is not only the review of individual insurers' financial conditions based on solvency concerns and to identify trends in the medical malpractice insurance market, but to review the medical malpractice liability insurance market as a whole in an attempt to ascertain the causes and ameliorate the effects of the volatility in rates which has significant implications on public health in this State.

With respect to the comment that the Department is creating a unique New Jersey-specific financial reporting requirement, the Department believes that while it may be unique, for the reasons set forth above it is reasonable and appropriate to require that such information be provided. Given that New Jersey is not the only state that has experienced problems related to the medical malpractice liability insurance market in recent years, it is also possible that some of the states in which such problems have occurred may impose the same or similar requirements. As was also noted above, the Department has modified the rules upon adoption to help minimize

costs to insurers, while ensuring that the Department continues to have access to relevant documents.

Moreover, in an effort to provide more flexibility to insurers and reduce costs associated with the provision of the required information, the Department is changing the rule upon adoption to allow for the submission of all required data electronically by e-mail, if the file is no larger than 10 megabytes (MB) (the limit of the Department's e-mail system), or by CD-ROM, if the file is larger than 10 MB.

COMMENT: Several commenters stated that by the nature of how reinsurance is bought and sold, proposed N.J.A.C. 11:27-11.3 is impractical because it ignores industry practice. Among the reasons cited in support of this assertion is that negotiations for renewal contracts may begin many months prior to the effective date. However, the rule would require the ceding insurer to submit a completed contract months prior to the effective date of the contract, while terms of the contract are still being negotiated. In addition, it is standard industry practice to issue at, or prior to, the effective date of the reinsurance agreement, binding documentation outlining contract terms, rather than completed contracts. One commenter noted that this practice is recognized in the National Association of Insurance Commissioners (NAIC) SSAP 62, paragraph 23 which states "it is not uncommon for a reinsurance arrangement to be initiated before the beginning of a policy period but not [be] finalized until after the policy period begins." The commenter stated that this provision allows for reinsurance agreements to be negotiated and reduced to written form with the signature of the parties within nine months of the effective date. The commenter maintained that the rule appears to ignore this nationally recognized accounting principle. Moreover, it was noted that ceding insurers may be negotiating with a number of different

reinsurers and that ceding insurers would have to file completed contracts and other information for each of the interested reinsurers prior to the effective date while negotiations are continuing. Many of the commenters believed that the rules could work to foreshorten the negotiating period in order to lessen the reporting burdens, resulting in non-optimal terms for New Jersey insurers.

It was also noted that the Department currently has the capability to access associated underwriting files through its examination process. Several of the commenters stated that since the information requested is already available to the Department, the requirements are redundant and questions whether these rules are necessary.

RESPONSE: The Department did not intend to ignore or foreshorten the time needed for the negotiation of reinsurance contracts. As noted in the Response to the previous Comment, the Department has changed the rules upon adoption to require only that the insurer file a copy of the new, renewal of or amendment to a reinsurance agreement, within the earlier of 60 days of the effective date or 30 days of execution of an agreement; and to require that the underwriting file be made available for Department inspection and review, rather than filed with each agreement. The Department believes that these revisions should address the commenters' concerns.

With respect to the comment that because the information requested is already available to the Department through the examination process the requirements are redundant, the Department notes that information obtained through the examination process may not be timely and may relate to actions months or years prior to the date of review. The Department believes that these rules are reasonable and appropriate given the significant potential impact on public health as set forth in the Response to the previous Comment.

COMMENT Several commenters expressed concern that the rules apply to domestic and non-domestic insurers and their reinsurance carriers. For many large commercial carriers, it was stated that reinsurance contracts are negotiated and placed on a "global book" basis. In other words, one reinsurance contract may cover medical malpractice and other lines of business. It was stated that, as a result, commercial carriers would be required to submit reinsurance contracts that cover all of their casualty lines of business, if medical malpractice were included in the business ceded even if the amount of business related to medical malpractice is minimal. Several commenters believed that this could act as a disincentive to carriers to participate in the New Jersey market.

Another commenter stated that during the negotiation process cedants and reinsurers exchange sensitive proprietary information concerning terms and conditions of coverage as well as rates. The commenter stated it is not clear whether, under the proposed new rule, cedants would now be required to file each and every quote offered by each and every reinsurer during the process within the time period set forth in the rule. If so, this commenter believed that it may undermine the cedants' ability to achieve optimum terms and conditions of coverage inherent in the negotiating process.

Another commenter stated that the proposed rules assume that reinsurance agreements will be in a sufficient state of completeness to share with the Department within the stated timeframes, which is often not the case. Similar to others, the commenter stated that a shortened timeframe will reduce the negotiating leverage of insurers transacting medical malpractice insurance business in New Jersey, which may limit the ability of existing medical malpractice liability insurers to expand their current writings and the number of new insurers willing to enter this market, contrary to the Department's goals. Related to the reinsurance attestation, as other

commenters noted, the attestation in the NAIC annual statement instruction applies to all of a company's ceded reinsurance contracts and ceding insurers do not attest to each reinsurance agreement individually.

RESPONSE: The Department believes that many of the issues raised by the commenters have been addressed by the changes made upon adoption discussed above. Also, the Department recognizes that reinsurance contracts may cover multiple lines of business. However, the Department believes that the rules are reasonable and appropriate given the significant potential impact on public health regarding the provision of medical malpractice liability insurance in this State as set forth in a response to a previous comment. The Department will not be approving or disapproving reinsurance agreements. Accordingly, the Department does not believe that the rules will act as a disincentive to carriers to participate in this State. In any event, the Department believes that such an assertion is speculative and premature.

Regarding the concern that insurers would be required to file each and every quote offered by each and every reinsurer, and will shorten the timeframe for negotiations, this is not the Department's intent, and has been addressed by the changes as set forth above.

Finally, the Department recognizes that the annual statement reinsurance attestation applies to all of a company's ceded reinsurance contracts. However, the Department currently does not receive the attestation for foreign insurers. The Department believes that the attestation is necessary given the potential adverse impact on public health from the disruption in the availability or affordability of medical malpractice liability insurance as set forth in the response to a previous comment. In addition, as was also set forth previously, the Department believes that medial malpractice liability insurance represents either the sole line or the major line for the

companies writing such business. The document is an attestation that that there was a transfer of risk under the agreement and that the reinsurance is properly accounted for. Finally, as was also noted previously, the Department believes that concerns regarding disincentives for insurers to enter the New Jersey market are speculative and premature.

COMMENT: One commenter stated that compliance with the 60-day prior notification rule in N.J.A.C. 11:27-11.3 will be difficult because the precise date on which such discussions are initiated may be difficult to identify and could be subject to interpretations and not upon facts. For example, if representatives from a ceding company and reinsurer see one another at a conference and talk about entering into a reinsurance arrangement, there is subsequently a follow-up call to discuss further the possibility of entering into such an agreement and later a meeting where actual negotiations begin, the commenter questioned whether discussions were deemed "initiated" at the conference, during the call or at the meeting, for purposes of the rule. Similarly, this commenter stated that, with respect to the requirement that the filing be made no later than 30 days prior to execution of the agreement, the Department is assuming that the parties will know the execution date more than 30 days in advance. The commenter stated that there are some cases where this is not the case. The commenter further stated that the requirement that the Department be provided a "complete ceded reinsurance agreement, including all amendments thereto" within the 60-day/30-day timeframe assumes that such an agreement will be completed within those timeframes. The commenter stated that if there is no such written agreement available within those timeframes, the ceding insurer will have to violate the rule because compliance will not be possible. In the alternative, as also noted by other commenters, the best document that may be available would be an incomplete draft of an

agreement that would be subject to substantial revision. The commenter stated that it is unclear what the Department would gain by receiving a copy of a draft that would bear little resemblance to the final agreement actually executed.

RESPONSE: The Department has changed the rules upon adoption to delete the "prior notification" requirement, as set forth in the Responses to previous Comments. As also noted in the Responses to previous Comments and the proposal Summary, the Department believes that the rules are necessary to better enable the Department to effectively monitor changes in the medical malpractice liability insurance market as a whole with respect to the setting of reserves and reinsurance agreements. Flawed reserving practices contribute to the volatility in rates that has significant implications for the affordability and availability of medical malpractice liability insurance in this State, and the attendant impact upon public health.

COMMENT: Several commenters expressed concern with N.J.A.C. 11:27-11.4, which requires the filing with the Department, by March 15 of each year, of a copy of the actuarial opinion summary and, by June 1 of each year, of a copy of the actuarial report that is maintained pursuant to the instructions to the NAIC annual statement. In addition, the rules provide that the actuarial report shall include the actuarial estimate and/or range for the reserves recommended to be established by the insurer. The rule also requires that insurers provide, with the actuarial report, a detailed justification supporting the management decision for the level of reserves selected, signed by the chief executive officer and chief financial officer of the insurer, which shall also include a justification for the selection by the management of the insurer of applicable loss sensitive items as set forth in the rule. One commenter noted that N.J.S.A. 17:23-1 provides

that every insurance company transacting business in New Jersey shall annually, on or before March 1, file with the Department a statement, subscribed and sworn to by its president and secretary, or, in their absence, by two of its principal officers, showing its financial condition. One commenter objected to the requirement for separate certifications on specific entries in an insurer's NAIC annual statement and objected to the requirement for a separate justification of the level of reserves selected. This commenter stated that annual statements contain extensive detailed information on the financial condition of insurers and that almost every page has several numeric entries. Requiring separate certifications for different entries on different pages would become an administrative burden with no additional assurance of accuracy than is currently provided under N.J.S.A. 17:23-1.

RESPONSE: Upon review, the Department has determined that no change is required. The Department does not believe that the requirements impose significant additional burdens on insurers. As noted in the Responses to previous Comments, the Department believes that these requirements are reasonable and necessary given the volatile nature of medical malpractice liability insurance rates and the significant potential impacts on public health related thereto. The annual statement does not show practices, but only conclusions, such as the reserves actually booked. The actuarial opinion provides a statement that the actuary believes that the reserves are reasonable within a range, which can be a wide range. For reinsurance, the annual statement shows numeric information on reinsurance, not details regarding the agreements. The justification will show the reasoning of management in selecting the level of reserves. If the level selected is lower than that recommended by the actuary, rates ultimately could be inadequate, which could necessitate a substantial increase in the future.

COMMENT: One commenter, similar to others, stated that a ceding insurer would be required to file a separate New Jersey attestation outside of that already required as part of both the quarterly and annual statement filings. Moreover, the commenter stated that there is no universally accepted definition of the term “underwriting file” and the content of such files varies from company to company. This commenter similarly stated that the Department already has access to all of the company’s “underwriting files” during market conduct or financial examinations.

RESPONSE: The Department disagrees that a ceding insurer would be required to file a separate New Jersey attestation outside of that already required as part of the quarterly and annual statement filings. The reinsurance attestation required to be filed under N.J.A.C. 11:27-11.3 is the same attestation required to be maintained pursuant to the NAIC Annual Statement instructions. The Department also disagrees that there is no universal definition of the term “underwriting file.” The term is defined by the NAIC in the Annual Statement instructions, and means documentation related to risk transfer and the economic intent of the reinsurance contract. Regarding the comment that the Department has access to the company’s “underwriting files” during market conduct or financial examinations, as noted in the Response to a previous Comment, the Department has changed the rules upon adoption to delete the requirement that the underwriting file be filed in each case, but rather that it be made available for Department inspection and review.

COMMENT: Several commenters objected to provision of the actuarial report as required under N.J.A.C. 11:27-11.4. One commenter stated that while it would have no objection to making the report available for Department review at its home office, when printed out its actuarial report fills several filing cabinets.

Several of the commenters also expressed concern regarding the confidentiality of the information provided. One commenter stated that it was concerned that third parties could obtain access to the actuarial report, notwithstanding N.J.A.C 11:27-11.5, which states that the actuarial report is confidential and not subject to the Open Public Records Act, N.J.S.A. 47:1A-1 et seq. (OPRA). This commenter noted that N.J.A.C. 11:27-11.4(a) indicates that the actuarial report and detailed justification of reserve level would be submitted as part of the annual statement filing required by N.J.S.A. 17:23-1. That statute provides that only quarterly statements are not public records, and that the annual statement thus is a public record. This commenter is concerned that the actuarial report and justification of reserve level would be considered part of the annual statement filing and thus be subject to public inspection and copying. The commenter cited the case of HIP of New Jersey, Inc. v. New Jersey Dept. of Banking and Ins., 309 N.J. Super. 538 (App. Div. 1998). In that case, the Appellate Division held that the phrase "records which are required by law to be made, maintained or kept on file," as used in the Right to Know Law, includes documents that are specifically required by law to be submitted to a government agency. The commenter believed that, under this holding, the actuarial reports submitted pursuant to N.J.A.C. 11:27-11.4 ultimately may be subject to disclosure to an interested third party. This commenter suggested that the Department utilize information about an insurer that is available in an insurer's Insurance Regulatory Information Systems (IRIS), ratios, NAIC annual statement Schedule P information and the actuarial opinion.

If, after reviewing this information and reviewing the actuarial report in its home office, the Department still had questions relating to the thought process that led to an insurer's selection of reserves, the Department can direct an inquiry to the insurer pursuant to the examination authority in N.J.S.A. 17:23-22. The commenter stated that this approach would ensure confidentiality of the information provided under N.J.S.A. 17:23-24f, which provides that working papers, etc., obtained by or disclosed to the Commissioner of Banking and Insurance or any other person in the course of an exam shall be confidential.

RESPONSE: With respect to the comment that an insurer can make the report available for Department review at its home office, the Department believes that the approach provided in these rules is more appropriate and cost-effective for the insurer. Examining data at an insurer's home office could require the Department to utilize outside consultants sent to the company's offices at the company's expense. Reviews by outside consultants may cost significantly more than reviews performed by Department staff, and the use of outside consultants would cost more than the cost of sending such information to the Department as provided under the rules. Regarding the volume of the information required, the Department notes that it has changed the rules upon adoption to permit the filing of such information electronically by e-mail, if the file is no larger than 10 MB (the limit of the Department's e-mail system), or by CD-ROM, if the file is larger than 10 MB, thereby providing more flexibility to insurers. As noted previously, the information required will help the Department to assess the reserves set by the insurer, which can have public health implications.

Regarding concerns about maintaining the confidentiality of the data submitted, the Department believes that OPRA provides the authority to the Department to maintain such

information as confidential. The Department has provided that such information shall be kept confidential at N.J.A.C. 11:27-11.5. The Department does not agree that N.J.A.C. 11:27-11.4(a) requires that the actuarial report and justification of reserve level be submitted as part of the annual statement required to be filed. Rather, the rule requires that insurers file such information that is required to be maintained pursuant to the annual statement instructions. Further, regarding the HIP of New Jersey case cited by the commenter, the Department notes that that case related to an interpretation of the Right-To-Know Law, which has been supplanted by OPRA. The HIP case was decided in 1998; the OPRA was enacted in 2002. The standard for determining confidentiality has been significantly changed under OPRA, which recognizes that proprietary, trade secret information, financial information, and information that can be used to benefit competitors are not public records, and shall be held as confidential. See N.J.S.A. 47:1A-1.1. The Department also notes that insurers impacted by an OPRA request have the right to intervene in a Government Records Council Proceeding under certain circumstances where a third party seeks public disclosure of information provided by the insurer. See DOBI – Gill v. New Jersey Department of Banking and Insurance, 404 N.J. Super. 1 (App. Div. 2008). The Department does not believe that the information provided in IRIS ratios, in Schedule P and the actuarial opinion data provide the detailed information required by the rules to enable the Department to ascertain insurer actions in setting reserves to evaluate the condition of the medical malpractice liability insurance market in this State. The Department reiterates that the purpose of the rules is not solely to address an individual insurer's financial condition, but rather to evaluate and identify causes for the volatility in rates in the medical malpractice liability insurance market. For the reasons set forth in previous Responses, the Department believes that these rules are reasonable and appropriate.

COMMENT: One commenter stated that the additional reporting requirements regarding a copy of the actuarial opinion summary, actuarial report, and detailed justification supporting management decision-making for the level of selected reserves appear to be in conflict with existing Department procedures and national standards as promulgated by the NAIC. The commenter stated that actuarial reporting and risk transfer rules are already in place. The proposed new rules do not give the Department any additional powers or tools to monitor financial solvency and further increase the regulatory burden on New Jersey insurers. The NAIC annual statement requires corporate officer attestation on reinsurance risk transfer and the New Jersey examination powers enable the Department to review corporate records of any kind at any time. Moreover, the commenter stated that it is management's responsibility to establish its best estimate for reserves and to attest to those reserves. The appointed independent actuary's responsibility is to opine on the reasonableness of those reserves. The purpose of the actuarial report is to support and document that opinion. The commenter asserted that the Department believes that the actuarial report constitutes a "reserve recommendation." The commenter stated, however, that the actuarial report does not contain a reserve recommendation. Accordingly, the commenter believed that requiring management to submit a detailed justification of the level of reserves selected, when the actuary has already opined on the reasonableness of the reserves, is unnecessary. In addition, the rule applies to licensed commercial insurers in which medical malpractice reserves may be a small fraction of overall reserves. Accordingly, the commenter believed that the requirement will not enhance the ability of the Department to assess the adequacy of medical malpractice reserves or enhance insurer solvency. The commenter also

believed that it would drive commercial insurers from the medical malpractice liability insurance market in New Jersey.

RESPONSE: With respect to the comment that the requirements are inconsistent with existing Department procedures and national standards as provided by the NAIC, the Department's procedures are being modified by these rules, and the Department believes that the requirements set forth therein are consistent, although not necessarily identical to, the Model Annual Audited Financial Reporting rule. Consequently, the Department does not believe that the requirements in these proposed rules will impose an additional burden on insurers. These requirements provide an additional tool to the Department which provides more "real time" and detailed information in order to enable the Department to monitor the conditions related to the medical malpractice liability insurance market in this State. The Department does not believe that it is requiring a "reserve recommendation" as the commenter asserted, but rather believes that the rules require a justification for the reserves selected. The rules do not require the insurer to select different reserves from that opined upon by the actuary. Rather, the Department is attempting to ascertain where in the range the company established its reserves. Also, as noted previously, the range may be very wide, and can range from company solvency, at one end of the range, to potential insolvency, at the other end.

Regarding the comment that the rules are unnecessary because the actuary has already opined on the reasonableness of reserves, the Department notes that the actuary usually provides a wide range for acceptable reserves. The Department is interested in ascertaining the reason that a particular point on that range was selected by the insurer. The Department has had experience where an insurer picks a point other than that selected by the actuary which, had the

insurer selected the actuary's pick, would have resulted in the insurer experiencing an RBC action level event. The Department also disagrees that the requirement will not enhance the ability of the Department to assess the adequacy of medical malpractice reserves or enhance an insurer's solvency. The purpose of the rules is not necessarily to enhance an individual insurer's solvency, but rather, as noted previously, to enable the Department to better monitor conditions related to the medical malpractice liability insurance market as a whole and assess the extent to which the volatility in rates may be related to reserves. Inadequate reserves can indicate rate inadequacy. For example, if a company's results show a combined ratio significantly lower than what the combined ratio would be if reserves were set properly, the company may not recognize this situation in a timely matter, so that it may need to significantly increase rates or curtail writings through revision of its acceptance criteria. Through this approach, reserve adequacy may be enhanced related to medical malpractice liability insurance. Finally, the Department believes that the assertion that the rules will "drive" commercial insurers from the medical malpractice liability insurance market in New Jersey is speculative and premature.

COMMENT: One commenter stated that while it does not object to filing the actuarial opinion summary, it proposes that the Department delete the requirement that the actuarial report be filed for the following reasons. First, the report would be extensive, well over one hundred pages, and when exhibits and work papers are included, the report may be several thousand pages. Further, in the case of a Sarbanes-Oxley (SOX) compliant entity, or a direct or indirect wholly-owned subsidiary of a SOX compliant entity, these reports are already reviewed by external auditors to ensure that the company is operating in a sound manner. This commenter proposed that an

attestation that the report has been created and there are no financial deficiencies would be sufficient to ensure sound financial operations.

RESPONSE: Upon review, the Department has determined that no change is required. Regarding the comment related to the extensive nature of the information required, the Department notes that the rules have been changed upon adoption to permit electronic filing of such information.

Further, while reports may have been reviewed by external auditors in the case of a SOX compliant entity or a direct or indirect wholly-owned subsidiary of a SOX compliant entity, the Department notes that this does not achieve the goal of these rules, which is to permit the Department to review and ascertain the reinsurance and reserving practices of medical malpractice liability insurers. The Department does not believe that merely providing an attestation that a report has been created and that there are no financial deficiencies would achieve the goal of the rules for the reasons set forth in the Responses to previous Comments. This would not provide a justification of why a particular reserve amount was selected.

COMMENT: Several commenters stated in general that the rules go significantly beyond the requirements that currently exist for either New Jersey domestic insurers or foreign insurers. The commenter objected to the adoption of more stringent requirements for medical malpractice insurers than are required by statute in the domiciles of foreign insurers. The commenter stated that the general philosophy of the NAIC Accreditation System is uniform financial regulation of insurers, with the primary oversight provided by the insurer's domestic regulator. Adopting more stringent regulation on foreign reinsurers than is required in their state of domicile would

not be consistent with the philosophy underlying the NAIC Accreditation System. It would also act as a disincentive to "traditional" foreign insurers entering the admitted New Jersey insurance market. In addition, adoption of these differing standards could lend support to the assertion that a patchwork of 50 inconsistent regulatory standards exists in the state regulatory environment bolstering arguments for Federal regulation of insurance.

RESPONSE: As noted in the Responses to previous Comments, the rules are intended to address the operations of medical malpractice liability insurers in this State in order to moderate the volatility and cyclical nature of rates that can have significant public health implications. While the Department recognizes that, generally, as recognized by the NAIC Accreditation Program, states usually rely on domiciliary regulators as the primary regulator of insurers, states are not precluded from regulating specific aspects of an insurance market in their state, which will necessitate the application of laws and requirements to all insurers. The Department also notes that it has changed the rules upon adoption to minimize burdens to insurers, while ensuring that the Department will continue to have access to relevant documents.

The Department further believes that the assertion that the requirements will act as a disincentive to foreign insurers entering the New Jersey insurance market is speculative and premature.

COMMENT: Several commenters requested that the Department provide additional clarification that the filing of stated agreements would be for informational purposes only and that there would be no approval process associated with the filing. One commenter additionally proposed adding a confidentiality provision with respect to filings under N.J.A.C. 11:27-11.3(a)

to ensure that this information is kept confidential. This commenter also suggested that an exemption be provided from filing for new, renewal or amendment to any ceded reinsurance by or between parent companies, subsidiaries, or affiliated entities.

Another commenter requested that the Department establish and publish standards of review to advise carriers of the expectations that need to be met by insurers and reinsurers when preparing reinsurance agreements.

Another commenter stated that it is not clear whether the information is required to be filed only for Department information purposes or could serve as a predicate for some action or prior approval by the Department. If it is the latter, this commenter stated that reinsurers may resist regulatory intervention into the negotiating process, and choose not to participate in the New Jersey market rather than have contractual terms and conditions imposed on them by "regulatory fiat." If it is the former, that is, to gain information, the commenter suggested that there currently exists various means of obtaining such information without intervening in the reinsurance negotiation process. For example, such information can be gleaned through regular financial examinations or through the conduct of specific market conduct examinations. Another commenter requested that the Department articulate the standards it will apply in its review of such documents. This commenter noted that the NAIC's Accounting Practices and Procedures manual contains no defined standard regarding transfer of underwriting risk within a reinsurance contract. This commenter questioned whether the Department will unilaterally, apart from the NAIC, develop a standard and then make it public. This commenter also questioned why the Department believes that these rules are required solely for medical malpractice line of business and whether the Department is looking for "veto authority" over terms and conditions in reinsurance transactions. The commenter reiterated other comments that the existing rules are

sufficient to protect the interests of New Jersey policyholders and health care consumers. Another commenter stated that if the information is provided to effect better oversight, will the Department be obligated to provide some response relating to the reinsurance agreements filed under the rules.

RESPONSE: The Department confirms that there is no approval process associated with the filing of the information required under the rules. The primary purpose of the rules is to enable the Department to better ascertain the practices of insurers in the medical malpractice liability insurance market to address the cyclical nature of and volatility in the rates related thereto, given the significant public health implications noted in responses to previous comments.

The Department does not believe that an additional confidentiality provision with respect to filings under N.J.A.C. 11:27-11.3(a) is needed in that N.J.A.C. 11:27-11.5 applies to all filings made under the subchapter. The Department also does not believe that it is necessary to exempt filings by or between parent companies, subsidiaries or affiliated entities. Domestic insurers generally would be required to file that information in any case under N.J.S.A. 17:27A-4. This would not, however, apply with respect to foreign insurers. Accordingly, adoption of the commenter's suggestion could preclude the Department from reviewing information from a significant segment of the medical malpractice liability insurance market in this State.

Regarding the comments that the required information may be gleaned through other means, as noted in the Responses to previous Comments, the Department does not believe that such information would be as timely or detailed as that provided for under these rules.

The Department also does not believe that it is necessary to articulate any standards that it will apply in the review of such documents in that the Department is not reviewing the

documents for purposes of approval or disapproval. Rather, the Department will review and compile the information received. If the Department believes that there will be a problem with the market or an individual company's reinsurance program, based on various risk transfer analysis tests and SSAP 62, the Department would reach out to the company at that time to discuss any problems, as would be the case during the normal financial analysis of an insurer.

Regarding the comment whether the Department will, apart from the NAIC, develop a standard and make it public related to the transfer of underwriting risk, the Department notes that there currently is no formal standard. The Department considers a number of factors when evaluating reinsurance agreements including compliance with SSAP 62

With respect to the question why the Department believes that these rules should be required solely for medical malpractice line of business, the Department refers back to the proposal Summary and the Responses to previous Comments related to the significant public health implications related to this line of business. As noted above, the Department is not looking for "veto authority" over terms and conditions in reinsurance transactions. The Department reiterates responses to previous comments that it does not believe that existing tools and rules are sufficient with respect to its concerns regarding volatility in the medical malpractice liability insurance market. The Department also does not believe that it is necessary to provide a response to insurers related to reinsurance agreements filed under the rules. As noted previously, the Department will review the information provided to ascertain the condition not only of individual insurers, but of the market as a whole.

COMMENT: One commenter requested that the Department define several of the reserves set forth in N.J.A.C. 11:27-11.4(b), as some of the reserves appear to be repetitive or overlapping.

RESPONSE: While the list of reserves may be overlapping, not all insurers or contracts address all of the items set forth in N.J.A.C. 11:27-11.4(b). Insurers will provide justification for the applicable items set forth in the rule.

COMMENT: Several commenters expressed concern with the confidentiality of data to be submitted. One commenter specifically stated that it was unsure what would constitute the underwriting file required to be filed, as the term is undefined. The commenter objected to providing information that is highly sensitive, confidential and/or proprietary. This commenter recommended that the rules be amended to require that the Department review and analyze such information at the offices of an insurer, with the provision that no copies or electronic records of such information can be made or taken from the insurer's offices.

Other commenters noted that N.J.A.C. 11:27-11.5 provides that the information in records filed pursuant to the rule be treated as confidential. The commenters expressed concern over the inclusion of underwriting files as part of the filing requirement. While many reinsurance contracts contain standard language and clauses, underwriting files contain confidential and proprietary information. While recognizing the Department's attempts to keep this proprietary information confidential, the commenters are concerned that challenges could be made by third parties to gain access to this type of information. The consequences of disclosure of such proprietary and confidential underwriting information would be extremely damaging to medical malpractice liability insurers. Another commenter raised similar concerns with respect to reinsurance agreements.

RESPONSE: Regarding the comment that the term “underwriting file” is not defined, the Department disagrees. The term “underwriting file” is defined by the NAIC in the Annual Statement instructions. Regarding the concern that the information is highly sensitive, confidential and proprietary, the Department reiterates that the rules provide that such information shall not be considered a public record and shall be kept confidential under the Open Public Records Act, pursuant to N.J.A.C. 11:27-11.5. The Department notes that the rules have been changed to require that the underwriting file be made available for inspection and review by the Department, rather than filed with the Department is each instance. The Department, however, does not believe that it is reasonable and appropriate to provide in the rules that the Department will review and analyze such information at the offices of an insurer, for the reasons set forth in a response to a previous comment. While the Department recognizes that requests and challenges may be made to obtain information that is considered confidential under the rules, the Department does not believe that this obviates the need for the information set forth in the rules, or precludes the Department from requiring that such information be filed. Much of the information reviewed by the Department contains proprietary and trade secret information, including rate filing data, projections, etc. If the Department were precluded from ever requesting or requiring the filing and review of information that is proprietary in nature, the Department would be unable to fulfill its regulatory responsibilities as set forth in Titles 17 and 17B of the New Jersey Statutes.

COMMENT: One commenter stated that, while the rules would increase the Department’s oversight, and may be instructive for some companies, especially certain insurers that have failed to establish appropriate reserves at the amount or range recommended by the actuary, for certain

insurers with substantial financial strength and stability, compliance with the rules would be overly burdensome, time consuming, and expensive. This commenter suggested that the rules provide an exception for any company that meets certain standards, for example, for an entity that has a certain rating criteria, surplus size, or that is SOX compliant, or that is a direct or indirect wholly-owned subsidiary of an entity that is SOX compliant. Another commenter suggested an exception be provided where the rules would only apply to non-AM Best rated companies or companies that are in financial distress.

RESPONSE: Upon review, the Department has determined that no change is required. As noted previously, the Department does not believe that these rules are overly burdensome, time consuming or expensive. The Department also does not believe that it would be reasonable and appropriate to provide exceptions from the rules for an entity based on its rating, surplus size, or that is SOX compliant, or to apply the rules only to non-AM Best rated companies or companies that are in financial distress. As noted previously, the purpose of the rules is not primarily to prevent the insolvency of individual medical malpractice liability insurers. While this is one of the goals, the primary intent of the rules is to enable the Department to evaluate the medical malpractice liability insurance market as a whole with respect to reinsurance and reserving practices, as the Department has found that these activities may exacerbate the volatile nature of medical malpractice liability insurance rates. Thus, the issue to be addressed by these rules is not an insurer solvency issue, but rather a medical malpractice liability insurance “culture” issue.

COMMENT: One commenter stated that it is unclear whether the Department is attempting to impose its filing requirements on surplus lines carriers writing medical malpractice liability

insurance as well as admitted ceding insurers. If so, the commenter asserted that the Department lacks the authority to do so.

RESPONSE: The rules by their terms only apply to authorized or admitted insurers and thus do not apply to eligible surplus lines insurers.

COMMENT: One commenter stated that while most would agree that the availability and affordability of insurance are important issues and do affect access to health care, they are not factors associated with the appropriateness of rates or the financial condition of an insurer. The commenter also stated that it is not clear where these requirements, particularly where they differ from NAIC model requirements, will improve the Department's effective oversight of insurers. As noted by other commenters, given the additional requirements, they may lead to reduced availability and affordability of medical malpractice insurance. The commenter also stated that the Department has and utilizes its existing authority over rates and insurer financial condition, presumably asserting that the proposed rules are unnecessary.

Another commenter stated that if a company deciding whether or not to write medical malpractice business in New Jersey believes rate adequacy is subject to affordability, they are likely to look for other ways or locations to write business.

RESPONSE: Upon review, the Department has determined that no change is required. Regarding the question whether the requirements will improve the Department's effective oversight of insurers, the Department refers back to the Responses to the previous Comments. The Department also reiterates that concerns regarding the adoption of these rules resulting in

reduced availability and affordability of medical malpractice liability insurance are speculative and premature.

With respect to the comment that the Department has existing authority over rates and insurer financial condition, the Department notes that these rules do not relate to rate control. Moreover, the Department's authority over rates is limited in that rates for medical malpractice liability insurance are generally subject to use and file under N.J.S.A. 17:29AA-1 et seq. Further, as noted previously, the financial condition of individual insurers is not the main issue to be addressed by these rules.

COMMENT: One commenter noted that insurers are currently required to file an actuarial opinion statement that is consistent with NAIC requirements. The rules differ from the NAIC in requiring a filed actuarial report that includes restatement of the same information contained in an actuarial opinion summary. It also differs from the NAIC in requiring a detailed justification of selected reserves and several other specified loss sensitive items.

RESPONSE: Upon review, the Department has determined that no change is required. While the actuarial opinion summary contains certain information, it does not include a statement of the same information at the same level of detail as is provided in the actuarial report. Further, the Department has seen circumstances where the actuarial opinion statements filed by multi-line companies do not specifically address medical malpractice liability insurance reserves at all in the establishment of reserves. The Department thus believes that it is reasonable and necessary to require specific information on, and justification of such reserves.

COMMENT: Several commenters noted that the actuarial opinion summary, reports, etc., reflect all lines and geography results and may not even identify or refer to New Jersey medical malpractice anywhere in the documents required. One commenter stated that it is doubtful that the requested information would be helpful to the Department and that it is unclear whether it is appropriate for this State to be using aggregate information to make State-specific determinations.

RESPONSE: Upon review, the Department has determined that no change is required. While it is true that the actuarial opinion summary and reports may not identify New Jersey specific data, in most cases, the information is grouped together by States with similar legal environments. Consequently, the Department will be able to draw reasonable inferences regarding activities in this State. The Department thus believes that the information is relevant and helpful for the reasons set forth in the Responses to previous Comments.

COMMENT: One commenter stated that management sets reserves, and that the actuarial opinion is intended to document that the reserves are reasonable considering actuarial indications. The commenter stated that it is reasonable to expect management should have a basis for setting the reserves, but that requiring the filing of detailed justification of the several items noted in the rules imposes an undue additional burden. The commenter believed that a more reasonable approach would be to request such documentation based on a review of the actuarial opinion summary and/or the actuarial report if determined necessary.

RESPONSE: Upon review, the Department has determined that no change is required. The Department believes that the rules are reasonable and appropriate given the significant public health implications that can result from the volatility and cyclical nature of medical malpractice liability insurance rates. To the extent reserving practices have contributed to such volatility, the Department believes that it is necessary for an insurer's management to justify the reserves selected within the range that may be allowed. The Department does not believe that it would be appropriate to selectively request such documentation based on a review of the actuarial opinion summary or report in that the goal of these rules is to provide the Department with the reinsurance agreement, reinsurance attestation, and actuarial report from all medical malpractice liability insurers so as to construct a more complete picture of the medical malpractice liability insurance market as a whole.

COMMENT: One commenter believed that the rules are appropriate and supported their adoption. The commenter also encouraged the Department not only to require companies to provide details on the terms of reinsurance agreements that are in place (for example, whether they are claims-made and whether they are fully collateralized), but also the financial stability of the reinsurers themselves. If a large portion of risk is transferred to a financially weak reinsurer, the physician does not enjoy the level of protection that he or she believes has been purchased. The commenter also suggested that the Department use the authority under the rules to examine the list of approved actuaries that companies may hire to comment on annual reports. These actuaries should be completely independent from the insurer, and, as with auditors, should not be permitted to hold a long-term relationship with the carrier, at least without a "second opinion" requirement from a completely independent actuarial firm.

RESPONSE: The Department appreciates the support of its proposal. The Department notes that the other comments are outside the scope of the proposal. The suggestions by the commenter relate to the regulation of the reinsurance market and reinsurers, which are outside the scope of the proposal. The Department notes that, with respect to review of a reinsurer's financial condition, the credit for reinsurance requirements set forth in N.J.S.A. 17:51B-1 et seq. and N.J.A.C. 11:2-28 provide specific requirements for reinsurers in order for a ceding insurer to receive credit or reduction from liability for risks ceded to a reinsurer. The suggested requirements for auditors or actuaries are similarly outside the scope of the proposal, and would be inconsistent with the current NAIC Model Annual Audited Financial Reports rule.

COMMENT: One commenter questioned the authority for the reporting requirements set forth in the rules. The commenter believed that the requirement extends beyond the examination authority in N.J.S.A. 17:23-20 et seq., and that the additional cited authorities are too general to authorize the specific requirements of these rules.

RESPONSE: The Department disagrees and believes that its authority under N.J.S.A. 17:23-20 et seq. extends beyond the periodic financial examination of an insurer, and by its terms authorizes the Department to examine the affairs and operations of any insurer transacting business in this State as often as it deems necessary.

COMMENT: One commenter stated that the rules are problematic because the definition of "insurer" includes insurers that are not actually writing medical malpractice liability insurance in New Jersey.

RESPONSE: The Department agrees that the definition of "insurer" may not reflect the intent of the rules. The intent of the rules is to apply to insurers actually transacting medical malpractice liability insurance in this State. Accordingly, the definition of "insurer" and the purpose and scope of the rules at N.J.A.C. 11:27-11.1 are changed upon adoption to confirm and clarify the intent of the rules. In the definition of "insurer," "an entity authorized . . . to transact" is changed to "an entity . . . that is writing," and, at N.J.A.C. 11:27-11.1(a) and (b), "insurers transacting" is changed to "insurers that are writing."

COMMENT: One commenter stated that N.J.A.C. 11:27-11.3 should refer to the reinsurance attestation associated with the most recently filed annual statement.

RESPONSE: Upon review, the Department has determined that no change is required. Insurers are required to provide whatever information is required to be maintained pursuant to the NAIC Annual Statement instructions. The Department believes that additional clarification is not necessary.

COMMENT: One commenter expressed concern with what it stated is the ambiguity of N.J.A.C. 11:27-11.4, as it calls for a "detailed justification supporting the management decision for the level of reserves selected" as well as a "justification for the selection by the management

of the insurer of applicable loss sensitive items." The commenter stated that the Department has considerable authority under the examination statutes for reviewing the adequacy of insurer reserves and is free to question that adequacy at any time. The commenter believed that establishing a requirement for an undefined "justification" statement creates unknown peril to management in making day-to-day business decisions. Accordingly, the commenter suggested that N.J.A.C. 11:27-11.4(b) be deleted. Another commenter similarly expressed concern with this rule. The commenter stated that the insurer is "left at its peril" to determine what else should be explained. The commenter stated that the annual statement already reflects reserve information and the actuarial opinion filed by each insurer with its state of domicile must contain information sufficient to assure domestic regulators that reserves are properly set and adequate to cover the insurer's liabilities. The commenter believed that the requirement thus would impose burdensome, redundant and unnecessary filings by insurers.

RESPONSE: Upon review, the Department has determined that no change is required. As noted previously, the Department believes that the information provided under these rules will be more timely than relying on the examination process. The Department also reiterates that it is not approving reinsurance transactions under these rules. The Department also does not agree that the "justification" statement creates unknown peril to management in making day-to-day business decisions. The Department believes that it is reasonable and appropriate that management pay particular attention to the establishment of reserves for this line of business, given the cyclical and volatile nature of rates that may be directly tied to the establishment of such reserves. The Department also is unclear as to the commenter's concern with respect to its assertion that an insurer is "left at its peril" to determine what else is to be explained under the

rules. While the actuarial opinion summary provides information related to the range of reserves, management is responsible for booking their best estimate of reserves within that range which, as previously discussed, provides a wide latitude as it pertains to the reported financial strength of the insurer. As noted in the Responses to previous Comments, given the significant public health implications related to the volatility and cyclical nature of medical malpractice liability insurance rates, the Department believes that these rules are reasonable and appropriate. The Department does not "accept" or "reject" the justifications. The Department will note them and consider them when addressing the financial condition of a particular insurer and how such decisions affected or may affect volatility in medical malpractice liability insurance rates.

COMMENT: One commenter noted that every insurer is required to file Schedule F Part 3, ceded insurance, as part of its annual statement. This schedule sets forth all ceded premium, paid losses, paid loss adjustment expenses (LAE), known case reserves, known case LAE, incurred but not reported losses (IBNR), IBNR reserves and unearned premium. The annual statement must be attested to by the appropriate corporate officers under penalty of perjury. Since the annual statement is already required by every state and must accurately reflect an insurer's financial condition, the commenter did not believe that filing reinsurance contracts would in any way assist the Department in achieving its goals. The commenter also stated that the Department has the authority to inspect reinsurance contracts during financial examinations or at any time if it believes that the insurer's solvency is in peril. For foreign companies, those insurers' domiciliary regulators have that same ability. The rules do not provide that the Department will review reinsurance contracts or perform a qualitative analysis of their provisions. The

commenter thus saw no regulatory benefit in a mere filing requirement, especially when the impact of reinsurance on an insurer's financial condition will be reflected in its annual statement.

RESPONSE: The Department disagrees. The Department believes that the rules will assist the Department in achieving its goals for the reasons set forth in the responses to previous comments. As noted previously, the information provided under these rules will provide more detail than that included in currently required filings. Moreover, the information will be provided on a more timely basis and enable the Department to ascertain the activities of insurers in a more timely manner.

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 in brackets with asterisks *[thus]*):

11:27-11.1 Purpose and scope

(a) The purpose of this subchapter is to establish reporting requirements regarding reinsurance agreements and loss reserves established by insurers *[transacting]* ***that are writing*** medical malpractice liability insurance in this State.

(b) Except as set forth in this subchapter, this subchapter shall apply to insurers *[transacting]* ***that are writing*** medical malpractice liability insurance in this State. This subchapter shall not apply to any insurer that has less than $1,000,000 of direct written premiums in medical malpractice liability insurance on a countrywide basis as of December 31 immediately preceding, or an insurer that has less than $1,000,000 of direct written premiums in medical malpractice liability insurance in this State as of December 31 immediately preceding and that do not write coverage for physicians or surgeons for the relevant period.

11:27-11.2 Definitions

The words and terms, as used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise.

. . .

"Insurer" means an entity authorized pursuant to N.J.S.A. 17:17-1 et seq. or admitted pursuant to N.J.S.A. 17:32-1 et seq. *[to transact]* ***that is writing*** medical malpractice liability insurance in this State.

. . .

11:27-11.3 Reinsurance agreements

(a) ***[**Within 60 days of initiating discussions to enter into**]*** ***No later than the earlier of 60 days after the effective date of or 30 days after the execution of*** a new, renewal of or amendment to any ceded reinsurance contract covering medical malpractice liability insurance, ***[**but no later than 30 days prior to the execution of such reinsurance agreement or amendment to any existing agreement,**]*** whether such agreement covers medical malpractice liability as a single line or in combination with other lines, an insurer shall file with the Department:

1. A copy of the complete ceded reinsurance agreement, including all amendments thereto; ***and***

2. The reinsurance attestation maintained in accordance with the instructions to the NAIC annual statement, required pursuant to N.J.S.A. 17:23-1***[**; and**]*** ***.***

[**3. The underwriting file related to such agreement.**]

(b) ***[**The**]*** ***Unless an executed agreement was previously filed pursuant to (a)1 above, the*** insurer shall also notify the Department within ***[**10**]*** ***30*** days of executing the reinsurance agreement ***[**filed pursuant to (a)1 above**]***, which notification shall also, if applicable, set forth any changes to a previously filed agreement with same reinsurer.

(c) The insurer shall also make available for Department inspection and review the underwriting file related to such agreement.

[**(c)**] ***(d)*** (No change from proposal.).

(e) An insurer may file the information required by this rule electronically by e-mail, if the file is no larger than 10 megabytes (MB), by filing the information to: medmalreporting@dobi.state.nj.us, or by CD-ROM, if the file is larger than 10 MB.

11:27-11.4 Actuarial reports

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

(d) An insurer may file the information required by this rule electronically by e-mail, if the file is no larger than 10 megabytes (MB), by filing the information to: medmalreporting@dobi.state.nj.us, or by CD-ROM, if the file is larger than 10 MB.

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