PROPOSED REGULATION OF THE

COMMISSIONER OF INSURANCE

LCB File No. R072-02

June 25, 2002

EXPLANATION – Matter in ***italics*** is new; matter in brackets [~~omitted material~~] is material to be omitted.

AUTHORITY: §§1-31, NRS 679B.130, 686B.180, 686B.210 and 686B.230; §32, NRS 679B.130.

Section 1. Chapter 686B of NAC is hereby amended by adding thereto the provisions set forth as sections 2 to 31, inclusive, of this regulation.

Sec. 2. ***As used in sections 2 to 31, inclusive, of this regulation, unless the context otherwise requires, the words and terms defined in sections 3 to 7, inclusive, of this regulation have the meanings ascribed to them in those sections.***

Sec. 3. ***"Association" means the Medical Liability Association of Nevada, a Nevada Essential Insurance Association, established pursuant to NRS 686B.210 and section 9 of this regulation.***

Sec. 4. ***"Board" means the board of directors of the association.***

Sec. 5. ***"Casualty insurance" has the meaning ascribed to it in NRS 681A.020.***

Sec. 6. ***"Medical malpractice liability insurance" means insurance against the medical professional legal liability of physicians and other medical practitioners as the result of negligence in rendering or failing to render expert or professional medical service.***

Sec. 7. ***"Net direct written premiums" means the direct gross premiums written on risks in this state, less return premiums and dividends paid or credited to policyholders on a direct basis. The term does not include premiums on contracts between insurers and reinsurers.***

Sec. 8. ***The provisions of sections 2 to 31, inclusive, of this regulation:***

1. Establish procedures and requirements for a risk-sharing plan to provide medical malpractice liability insurance coverage for eligible physicians and other medical practitioners on a self-supporting basis;

2. Are intended to encourage the improvement of reasonable loss-prevention measures and encourage the maximum use of the voluntary market;

3. Create a nonprofit association that is necessary to advance and protect the health and welfare of the residents of the State of Nevada by providing essential insurance to physicians and other medical practitioners so that the residents of the State of Nevada are provided medical care; and

4. Create such an association as a nonprofit organization to achieve the purposes set forth by the Nevada legislature and the purposes set forth in sections 2 to 31, inclusive, of this regulation by minimizing, to the greatest extent practicable, the imposition of federal income taxes and excise taxes upon assets otherwise available for the health and welfare of the residents of the State of Nevada.

Sec. 9. ***The Medical Liability Association of Nevada, a Nevada Essential Insurance Association, is hereby created pursuant to NRS 686B.210 as a nonprofit association to provide for the issuance of medical malpractice liability insurance at adequate and actuarially sound rate levels for risksharing and to assist eligible applicants in securing medical malpractice liability insurance.***

Sec. 10. ***1. Each insurer authorized to transact casualty insurance in this state shall be deemed to be a member of the association.***

2. Except as otherwise provided in this section, if an insurer authorized to transact casualty insurance in this state loses that authorization, the membership of the insurer in the association shall be deemed to terminate on the last day of the calendar year in which the insurer loses that authorization.

3. An insurer whose membership in the association has been terminated continues to be governed by the provisions of sections 2 to 31, inclusive, of this regulation until the insurer completes all its obligations to the association.

Sec. 11. *1. All physicians and other medical practitioners who are equitably entitled to obtain insurance, as identified by the association, may apply for medical malpractice liability insurance with the association. The association may decline to provide insurance to a physician or other medical practitioner if the association determines that the physician or other medical practitioner is an inappropriate or unacceptable risk. A physician or other medical practitioner who is determined by the association to be an inappropriate or unacceptable risk is not eligible to receive coverage from the association.*

2. Except as otherwise provided in this subsection, the maximum limits of coverage for the type of medical malpractice liability insurance that may be placed in the association are $1,000,000 per claim and $3,000,000 aggregate for all claims in any 1 policy year. Limits in excess of these amounts may be written with the approval of the commissioner, if the increased risk is reinsured on a facultative basis.

3. Coverage must be issued on a claims-made basis.

4. Policies, endorsements and applications may be issued only on forms approved by the commissioner.

5. Rates must be at actuarially sound levels, and only rates and premiums approved by the commissioner may be charged.

6. The board may provide coverage for prior acts or extended reporting dates, or both.

Sec. 12. ***1. The association must be administered by a board of directors under the general supervision of the commissioner. Each member of the board has one vote.***

2. The commissioner will appoint the members of the board, who serve at the discretion of the commissioner. The commissioner will appoint not fewer than five, and not more than nine, members to the board.

3. The members of the board shall elect a chairman.

4. The members of the board may receive from the assets of the association:

(a) Reimbursement for reasonable expenses incurred by them as members of the board at the rates provided for state officers and employees generally; and

(b) Such reasonable and equitable compensation as may be prescribed by the board and approved by the commissioner.

Sec. 13. ***1. The board shall meet:***

(a) As often as necessary to perform the general duties of the administration of the association; and

(b) Upon the call of the commissioner or the chairman of the board.

2. A simple majority of the members of the board constitutes a quorum.

Sec. 14. ***The board may:***

1. Establish an executive committee that consists of not fewer than three members of the board; and

2. Delegate to the executive committee such specific duties and powers as the board determines prudent.

Sec. 15. *The board may:*

1. Invest, borrow and disburse money;

2. Budget expenses;

3. Impose assessments;

4. Cede reinsurance;

5. Enter into contracts; and

6. Perform all other duties provided in sections 2 to 31, inclusive, of this regulation, as are necessary or incidental to the effective and proper administration of the association.

Sec. 16. *1. The board may develop a catastrophe plan, carrying out appropriate risk management techniques in the event that the physical operations of the association are damaged or destroyed, to ensure the smooth and continued operation of the association.*

2. Such a plan may include, without limitation:

(a) The off-site storage of duplicate records;

(b) The backup of electronic data on a daily basis with a copy of such data stored off-site; and

(c) Contingent arrangements for alternative business sites.

Sec. 17. *The board shall contract with a qualified and professional insurance management company that is adept in the nuances of the operation of an insurance company which issues medical malpractice liability insurance to operate the day-to-day activities of the association, including, without limitation, underwriting, issuance and administration of*

policies, risk management, claims administration, accounting, billing and collections, investigations and general office procedures.

Sec. 18. ***1. Except as otherwise provided in this section, if the combined losses and expenses incurred by the association during any calendar year are greater than the sum of the premiums earned by, and the investment income of, the association for that calendar year, the board may:***

(a) Impose monetary assessments in amounts sufficient to cover the deficit on the physicians and other medical practitioners insured by the association; and

(b) Collect the assessed amounts.

2. A physician or other medical practitioner who exercises the option available in section 19 of this regulation must not be assessed for the year for which the option is exercised.

3. The total amount of assessments imposed on each insured physician or other medical practitioner during any annual policy term must not exceed an amount set by the board, which must not be greater than an amount equal to the annual premium that would be charged for the insured physician or other medical practitioner in that rating class at the time of the assessment.

4. Nonpayment of an assessment in the time provided by the board shall be deemed to be the nonpayment of a premium and is a sufficient ground for the cancellation of the policy in accordance with applicable statutory provisions for cancellation for nonpayment of premiums.

Sec. 19. ***The board shall, in accordance with subsection 3 of NRS 686B.230, develop a cost-stabilization option for insured physicians and other medical practitioners that would enable the insured physician or other medical practitioner to pay a determinate fee to the***

association in lieu of any assessment subsequently levied on the member by the board during the calendar year.

Sec. 20. ***1. The association may impose a monetary assessment on the members of the association in an amount sufficient to pay the necessary obligations of the association. A member shall pay the amount assessed within 30 days after the date on which the assessment is imposed.***

2. The assessment imposed on each member of the association must be in the proportion that the net direct written premiums of the member for the preceding calendar year bear to the net direct written premiums of all members of the association for the preceding calendar year. A member of the association must not be assessed in any year an amount greater than 5 percent of its net direct written premiums for the preceding calendar year.

3. The board shall report to the commissioner each failure of a member of the association to pay an assessment imposed by the association pursuant to this section.

Sec. 21. ***The board shall establish underwriting standards, manuals and rules, in consultation with the professional insurance management company with which the board contracts pursuant to section 17 of this regulation, that provide for sound risk selection and underwriting practices.***

Sec. 22. ***1. An application from a physician or other medical practitioner for medical malpractice liability insurance must be accompanied by the appropriate premium and be submitted through a producer licensed in this state to transact casualty insurance.***

2. Such applications are not evidence of insurance. No producer may bind the association to any coverage. The association may bind coverage for up to 90 days only after having a completed application and appropriate premium in hand for the risk to be bound. Such a

binder must not be extended. If the risk is rejected after the binder has been provided, the premium must be calculated on a prorata basis for the period of the binder. Risks that are bound but later rejected must not have a reporting period beyond the expiration date of the binder unless such coverage is offered by the association and purchased by the applicant.

3. The association shall, within a reasonable time after receipt of an application, notify the applicant or producer of the acceptance or rejection of the application. Coverage under a policy must not begin until the application has been reviewed and the risk is accepted in accordance with the underwriting rules of the association or is accepted with appropriate documentation.

4. Rejection of coverage by the association must be accompanied by a full refund of the premium unless coverage has been or will be provided for a specific period.

5. Rejection of coverage by the association is a necessary part of the diligence required by surplus lines brokers pursuant to NRS 685A.040 and subsection 1 of NAC 685A.215 before insurance from a surplus line insurer may be written for medical malpractice for a physician or group of physicians.

Sec. 23. *The board shall cause all policies written by the association to be separately coded so that appropriate records may be compiled to calculate the adequate premium level for each classification of risk and to perform loss-prevention and other studies of the operation of the association.*

Sec. 24. *1. The board shall prescribe, and provide to the commissioner, a schedule of fees that permits the payment of commissions to producers of not more than 5 percent of the amount of policy premiums written by those producers.*

2. Upon the cancellation of a policy, or if an endorsement is issued that requires the premium to be returned to the insured, the producer shall refund commissions on the return premium to the association at the same rate at which the commissions were originally paid.

Sec. 25. *All rates must be set on an actuarially sound basis and calculated so that the association will be self-supporting in accordance with the purpose of the association.*

Sec. 26. *All cancellations and return premiums must be calculated on a prorata basis.*

Sec. 27. *The board shall report to the commissioner the name of any member of the association and of any producer who fails:*

1. To comply with any provision of Title 57 of NRS or any regulations adopted pursuant thereto, or any provision of sections 2 to 31, inclusive, of this regulation; or

2. To pay any assessment within 30 days after the assessment is imposed.

Sec. 28. *1. The board shall hold an annual meeting of the members of the association on a date and at a placed fixed by the board.*

2. The board:

(a) May call a special meeting of the members of the association at any time; and

(b) Shall call a special meeting of the members of the association within 40 days after receipt of a written request for a special meeting, which must specify the reasons for the request, from any 10 or more members of the association, not more than one of which may be in a group under the same management or ownership as any of the other members requesting the special meeting.

3. The time and place of all meetings must be reasonable, and adequate notice must be given.

Sec. 29. ***The commissioner will, and the board shall, take all reasonable and necessary actions to dissolve the association at the earliest date after essential insurance becomes readily available in the private market. The dissolution of the association, including its assets and liabilities, must be accomplished under the supervision of the commissioner in an equitable and reasonable manner.***

Sec. 30. ***In addition to any financial or other reports the association is otherwise required to file as an insurer transacting insurance in this state pursuant to Title 57 of NRS and any regulations adopted pursuant thereto, the board shall provide to the commissioner, without delay, all records, documents, papers, tapes, electronic data and all other information requested by the commissioner or division that is related directly or indirectly to the association and its operation.***

Sec. 31. ***In accordance with NRS 686B.250, there is no liability on the part of, and no cause of action of any nature arises against, the association, its board, its producers or any other persons acting under sections 2 to 31, inclusive, of this regulation, for any good faith action taken by them in the performance of their duties under sections 2 to 31, inclusive, of this regulation.***

Sec. 32. NAC 686B.610 is hereby amended to read as follows:

686B.610 1. For the purposes of this section, "schedule rating" means application of judgment credits and debits to the risk rate or premium charge which has been developed through the use of base rate or class rate modified by:

(a) Package discounts where applicable; and

(b) Any other approved rating plan which does not duplicate credits or debits.

2. The commissioner will accept individual risk premium modification plans if:

(a) Schedule rating factors apply only to individual risk characteristics which reflect potential hazards.

(b) Schedule rating applies only to risks which develop at least $500 annual premium or $1,500 3-year prepaid premium. When schedule credits are being applied, the resulting premium must be $500 or more for 1 year, or $1,500 or more for 3 years.

(c) The schedule rating plan must provide for debits and credits, and is subject to maximum total debits or credits of 25 percent.

(d) No risk may be modified except after inspection of the property. The insurer shall retain adequate supporting data, including copies of inspection reports, which may be inspected by the division.

3. Each filing of an individual risk premium modification plan must be accompanied by a statement by the filing official affirming that the filing conforms to the provisions of this section.

4. This section does not apply to automobile liability, automobile physical damage, general liability, ***medical malpractice liability,*** burglary, glass, fidelity or boiler and machinery rating plans.