LCB File No. E001-02

EMERGENCY REGULATION OF THE COMMISSIONER OF INSURANCE

(Effective for 120 days after March 15, 2002)
(Proposed as LCB File No. R072-02)

ESTABLISHES THE MEDICAL LIABILITY ASSOCIATION OF NEVADA, A NEVADA ESSENTIAL INSURANCE ASSOCIATION

Section 1. Chapter 686B of NAC is hereby amended by adding thereto the provisions set forth as sections 2 to 27, inclusive, of this regulation.

Sec 2. ***1. This regulation implements the Medical Liability Association of Nevada (Association), a Nevada Essential Insurance Association in accordance with NRS 686B.180 to 686B.250, inclusive. It establishes procedures and requirements for a risk-sharing plan to provide medical professional liability insurance coverage for eligible physicians and other appropriate medical professionals on a self-supporting basis. This regulation is also intended to encourage the improvement in reasonable loss prevention measures and encourage the maximum use of the voluntary market. The Medical Liability Association of Nevada will not directly compete with the voluntary market.***

2. The Medical Liability Association of Nevada shall be a non-profit association. The formation of the non-profit association is necessary to advance and protect the health and welfare of the citizens of the state of Nevada by providing essential insurance to physicians so that the citizens of the state of Nevada are provided medical care. To achieve the purposes set forth by the Nevada Legislature and specifically those set forth herein, the Association is a non-profit organization for the purpose of minimizing, to the greatest extent practicable, the

imposition of federal income and excise taxes upon assets otherwise available for the health and welfare of the citizens of the State.

Sec. 3. ***1. The "Medical Liability Association of Nevada" means the non-profit, unincorporated association established by this regulation to provide for the issuance of medical malpractice liability insurance at adequate and actuarially sound rate levels for risk sharing and to assist eligible applicants in securing medical malpractice liability insurance.***

2. "Medical malpractice liability insurance" means insurance against medical professional legal liability of the insured as the result of negligence in rendering or failing to render expert or professional service.

3. "Net direct written premiums" mean direct gross premiums written on risks in this state, less return premiums and dividends paid or credited to policyholders on such direct basis. Such term does not include premiums on contracts between insurers and reinsurers.

4. "Board" means the Board of Directors of the Association.

5. "Commissioner" means the Commissioner of Insurance.

6. "Regulation" means sections 2 to 28, inclusive.

Sec. 4. ***1. Each insurer authorized to transact casualty insurance business, as defined in subsection 1 of NRS 681A.020, is a member of the Association.***

2. Membership terminates when an insurer is no longer authorized to write insurance in Nevada, effective the last day of the calendar year in which the insurer loses its authorization.

3. A terminated insurer continues to be governed by the provisions of this regulation until it completes all of its obligations to the Association.

Sec. 5. ***1. All authorized physicians or other medical professionals who are equitably entitled to obtain insurance shall be eligible to apply for insurance with the Association. However, the Association shall have the right to decline to insure any applicant that it deems to be an unacceptable risk. Any applicant who is an unacceptable risk shall be deemed to be ineligible for coverage with this Association.***

2. The maximum limits of coverage for the type of medical malpractice liability insurance defined in section 3 of this regulation, which may be placed in this Association, are $1,000,000 per claim and $3,000,000 aggregate for all claims in any one policy year. Limits in excess of these amounts may be written with the approval of the Commissioner, provided the increased risk is reinsured on a facultative basis with an approved reinsurer and at an acceptable rate.

3. The coverage will be issued on a claims-made basis with no coverage provided for acts committed or discovered prior to the inception date of the policy issued by the Association.

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

5. Rates will be at actuarially sound levels and only rates and premiums approved by the Commissioner will be charged.

Sec. 6. ***1. This Association shall be administered by a Board of Directors under the general supervision of the Commissioner. Each board member has one vote.***

2. Board members are appointed by the Commissioner and serve at the discretion of the Commissioner.

3. The number of board members may range from as few as five to as many as nine, as

determined by the Commissioner.

4. Board members may be reimbursed from the assets of the Association for the reasonable expenses incurred by them as board members at the state prescribed rates.

5. Board members may receive a reasonable and equitable compensation as may be prescribed by the Board and as approved by the Commissioner.

Sec. 7. ***1. The Board shall meet as often as may be required to perform the general duties of the administration of the Association or on the call of the Commissioner or chairman of the Board. A simple majority of board members constitutes a quorum.***

Sec. 8. ***1. The Board may delegate specific duties and powers as they deem prudent to an Executive Committee which shall consist of not fewer than three members of the Board.***

Sec. 9. ***1. The Board shall be empowered to invest, borrow and disburse funds, budget expenses, levy assessments, cede reinsurance, make contracts, and perform all other duties provided herein as necessary or incidental to the effective and proper administration of the Association.***

Sec. 10. ***1. The Board shall develop a catastrophe plan, implementing appropriate risk management techniques in the event the physical operations of the Association are damaged or destroyed, to assure the smooth and continued operation of the Association. Such plan shall include, but is not limited to, off-site storage of duplicate records, backup of electronic data on a daily basis with a copy of such backup stored off site and contingent arrangements for***

alternative business sites. The Board shall also secure insurance or appropriately arrange for addressing any business and premises liability exposures of the Association. Such arrangements may be made through the management operations agreement in NAC 686B.230.

Sec. 11. ***1. The Board shall contract with a qualified and professional insurance management company, adept in the nuances of medical malpractice insurance company operations, to operate the day to day activities of the Association, including but not limited to underwriting, policy issuance and administration, risk management, claims administration, accounting, billing and collections, investigation, and general office procedures.***

Sec. 12. ***1. The Board shall secure adequate and sufficient treaty reinsurance on the policies issued.***

Sec. 13. ***1. In the event the combined losses and expenses incurred by the Association during any calendar year are greater than the sum of premiums earned and the investment income for that calendar year, the Board shall assess and collect monies from the insured medical professionals in an amount sufficient to cover the deficit.***

2. The Board shall assess from each medical professional insured during the calendar year, other than those insured medical professionals who exercise one of the options available under section 15 of this regulation for that year, an equitable portion of the amount needed to cover the deficit.

3. The total amount of assessments for each insured medical professional during any

annual policy term may not exceed an amount equal to the annual premium which would be charged for the insured medical professional in that rating class at the time of assessment.

4. Non-payment of an assessment in the time provided is sufficient grounds for policy cancellation and shall be reported to the Commissioner.

Sec. 14. ***1. The Association may assess Association members in an amount sufficient to pay necessary obligations.***

2. The assessment of each Association member doing the kind of insurance set forth in NRS 681A.020(1) shall be in the proportion that the net direct written premiums of the Association member for the preceding calendar year bear to the net direct written premiums of all Association members for the preceding calendar year. An Association member may not be assessed in any year an amount greater than five percent of its net direct written premiums for the preceding calendar year.

3. The Board is empowered to develop an assessment credit plan, subject to the approval of the Commissioner, wherein an Association member may receive a credit against an assessment levied, based upon the Nevada voluntarily written medical malpractice liability insurance premiums.

4. Non-payment of an assessment shall be reported to the Commissioner.

Sec. 15. ***1. The Board shall develop a cost stabilization option which would enable an insured medical professional to pay a determinate fee to the Association in lieu of any assessment subsequently levied by the Board during any calendar year in accordance with NRS 686B.230(3).***

Sec. 16. ***1. The Board shall establish underwriting standards, manuals, and rules, in concert with the professional management company as contracted with pursuant to section 11 of this regulation, which provide for sound risk selection and underwriting practices. Such underwriting standards, manuals and rules shall be submitted to the Commissioner. Deviation from such standards are only permissible within sound underwriting judgement, wherein the file is specifically documented providing the specific reason or reasons for the deviation. A copy of all such documentation shall be forwarded to the Commissioner's office on a monthly basis on each underwriting deviation made during that month.***

Sec. 17. ***1. Any physician or other appropriate medical professional may apply to the Association for insurance. Applications must be accompanied by the appropriate premium and be submitted through a producer licensed in this state to transact casualty insurance. To assure a reasonable and orderly marketing force, the Board shall determine the qualifications and limitations of producer appointments with the Association, and submit to the Commissioner the qualifications and limitations determined by the Board.***

2. Applications are not evidence of insurance; no producer shall be authorized to bind the Association to any coverage. The Association may bind coverage only after having a completed application and appropriate premium in hand for the risk to be bound, for a period of up to 90 days. Such binder shall not be extended. If the risk is rejected after the binder has been provided, the premium shall be calculated on a pro-rata basis for the period of the binder. Risks bound, but later rejected, shall not have a reporting period beyond the binder expiration date.

3. The Association shall, within a reasonable time after receipt of an application, notify the applicant or the producer of the acceptance or rejection of the application. Coverage does not begin until the application has been reviewed and the risk is accepted in accordance with the underwriting rules or with appropriate documentation as provided in section 16 of this regulation. Rejection of coverage by the Association will be accompanied by a full refund of the premium, unless bound for a period, and is evidence for the applicant to seek coverage from the non-admitted insurance market.

Sec. 18. *1. The Board shall cause all policies written by the Association to be separately coded so that appropriate records may be compiled for purposes of calculating the adequate premium level for each classification of risk and performing loss prevention and other studies of the operation of the Association.*

Sec. 19. *1. The Board shall prescribe, and provide to the Commissioner, a schedule of fees which permits producer commissions of not more than five percent of the amount of the policy premium written.*

2. Upon cancellation of the policy, or if an endorsement is issued which 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 such commissions were originally paid.

Sec. 20. *1. All rates must be set on an actuarially sound basis and calculated so that the Association will be self-supporting in accordance with the Association's purpose.*

Sec. 21. ***1. All cancellations and return premiums shall be calculated on a pro-rata basis.***

Sec. 22. ***1. The Board shall give deference to the decision to reject an application by the professional management company. The Commissioner shall give deference to the Board on an upholding of such a rejection. Understanding such standards:***

(a) An applicant for insurance may appeal to the Board within 30 days after any final ruling, action or decision by the Association;

(b) The Board must consider each appeal and render a decision within a reasonable time; and

(c) An appeal from any decision of the Board may be made to the Commissioner. Any decision made by the Commissioner on an appeal is a final administrative action. If the Commissioner fails or refuses to review the appeal from the Board's decision on the application rejection within 30 days, such non-review constitutes upholding the Board's decision on the matter.

Sec. 23. ***1. The Board shall report to the Commissioner the name of any member or producer who fails to:***

(a) Comply with the provisions of this regulation or with any other regulation; or

(b) Pay any assessment levied within 30 days.

Sec. 24. ***1. There shall be an annual meeting of the Association membership on a date and at a place fixed by the Board.***

2. A special meeting may be called at any time by the Board and shall be called within 40

days after receipt of a written request which specifies the reasons for such request, from any 10 Association members, not more than one of which may be in a group under the same management or ownership.

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

Sec. 25. ***1. The Commissioner and the Board of the Medical Liability Association of Nevada shall take all reasonable and necessary steps 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, shall be accomplished under the supervision of the Commissioner in an equitable and reasonable manner.***

Sec. 26. ***1. In addition to the financial or other reports herein enumerated and as may be required under statutory authority, the Board shall provide to the Commissioner, without delay, any and all records, documents, papers, tapes, electronic data, or other information requested as may be related in any fashion, directly or indirectly, to the Association.***

Sec. 27. ***1. There is no liability on the part of, and no cause of action may arise against the Medical Liability Association of Nevada, its Board of Directors, its producers, or persons acting under this regulation for any good faith action taken by them in the performance of their powers and duties under this regulation.***

Sec. 28. NAC 686B.610 is hereby amended to read as follows:

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 professional liability***, burglary, glass, fidelity, or boiler and machinery rating plans.

STATEMENT OF EMERGENCY

The Insurance Commissioner of the State of Nevada made a determination in an Order, Cause No. 02.031, that there is overwhelming evidence that medical malpractice insurance is not readily available in the voluntary market in Nevada. Based on this determination, the Insurance Commissioner has made a finding that an emergency arising from such medical malpractice insurance unavailability exists, and that the adoption of the above Emergency Regulation is appropriate.

March 15, 2002.

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ALICE A. MOLASKY-ARMAN
Commissioner of Insurance

I, Governor Kenny C. Guinn, endorse Commissioner of Insurance Alice A. Molasky-Arman's statement of emergency.

March ______, 2002.

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KENNY C. GUINN
Governor