**** Bill No. ****

Introduced By **********

By Request of the *********

A Bill for an Act entitled: "An Act providing for medical malpractice insurance when the insurance is not available; and creating an association consisting of all medical malpractice insurers to provide the insurance."

Be it enacted by the Legislature of the State of Montana:

NEW SECTION. **Section 1. Purpose.** The legislature finds that a crisis exists because of the high cost and possible unavailability of medical malpractice insurance. The purpose of this part is to provide a solution to the unavailability of that insurance. Although [sections 1 through 13] will not resolve the underlying causes of unavailability and high cost, which extend beyond the insurance mechanism, it is anticipated that future legislation will deal on a more permanent basis with the root causes of the current crisis.

NEW SECTION. **Section 2. Definitions.** As used in [sections 1 through 13], the following definitions apply:

(1) "Association" means the joint underwriting association established pursuant to the provisions of [sections 1 through 13].

(2) "Health care provider" has the meaning provided in 27-6-

103.

(3) "Medical malpractice insurance" means insurance coverage against the legal liability of the insured and against loss, damage, or expense incident to a claim arising out of the death of or injury to any person as the result of negligence in rendering professional service by a health care provider.

(4) "Net direct premiums" means gross direct premiums on medical malpractice insurance written pursuant to the provisions of the insurance laws of Montana, including the liability component of multiple peril package policies as computed by the commissioner, less return premiums or the unused or unabsorbed portions of premium deposits.

NEW SECTION. **Section 3. Joint underwriting association -- determination of unavailability of insurance.** (1) A joint underwriting association is created, consisting of all insurers authorized to write and engaged in writing medical malpractice insurance within this state, including insurers writing multiple peril package policies. Each insurer must remain a member of the association as a condition of the insurer's authority to continue to write medical malpractice insurance in this state. The purpose of the association is to provide medical malpractice insurance on a self-supporting basis.

(2) The association may not commence underwriting operations for health care providers other than a health care facility until the commissioner of insurance, after an investigation and hearing, has determined that medical malpractice insurance is not

available for health care providers other than a health care facility in the voluntary market. Upon that determination, the association is the exclusive agency through which medical malpractice insurance may be written in this state on a primary basis for health care providers other than a health care facility.

(3) The association may not commence underwriting operations for health care facilities until the commissioner, after an investigation and hearing, has determined that medical malpractice insurance is not available for those facilities in the voluntary market. Upon that determination, the association members are authorized to issue policies of medical malpractice insurance to health care facilities, but the association need not be the exclusive agency through which the insurance may be written on a primary basis in this state.

(4) If the commissioner determines at any time that medical malpractice insurance is available in the voluntary market for the health care providers referred to in either subsection (2) or subsection (3), the association shall cease its underwriting operations for the medical malpractice insurance which the commissioner has determined is available in the voluntary market.

NEW SECTION. **Section 4. Authority to issue policies.** The association may:

(1) subject to limits specified in the association's plan of operation, but not to exceed $3 million for each claimant under one policy and $9 million for all claimants under one policy in

any one year, issue or cause to be issued policies of insurance to applicants, including incidental coverages;

(2) underwrite the insurance and assume reinsurance from its members; and

(3) cede reinsurance.

NEW SECTION. **Section 5. Plan of operation -- submission -- amendment.** (1) Within 45 days after the creation of the association, the directors of the association shall submit to the commissioner for commissioner's review a proposed plan of operation consistent with the provisions of [sections 1 through 13]. The plan is effective upon order of the commissioner.

(2) The plan of operation must provide for economic, fair, and nondiscriminatory administration and for the prompt and efficient provision of medical malpractice insurance. The plan must contain a preliminary assessment against all members for initial expenses necessary to commence operations and establish necessary facilities and an annual assessment against all members for the costs of managing the association, losses and expenses, commission arrangements, reasonable and objective underwriting standards, acceptance and cession of reinsurance, appointment of servicing carriers, and procedures for determining amounts of insurance to be provided by the association.

(3) The plan of operation must provide that any profit achieved by the association be added to the reserves of the association or returned to the policyholders as a dividend.

(4) Amendments to the plan of operation may be made by the

directors of the association, subject to the approval of the commissioner, or by the commissioner.

NEW SECTION. **Section 6. Application for coverage.** (1) After a determination of unavailability is made under [section 3 (2) or (3)], a health care provider may apply to the association for coverage. The application may be made on behalf of an applicant by a broker or agent authorized by the applicant.

(2) If the association determines that the applicant meets the underwriting standards of the association as prescribed in the plan of operation and that there is no unpaid, uncontested premium due from the applicant for prior insurance, as shown by the insured having failed to make written objections to the premium charges within 30 days after billing, then an association member, upon receipt of the premium or the portion of the premium that is prescribed in the plan of operation, shall issue a policy of medical malpractice insurance for a term of 1 year.

NEW SECTION. **Section 7. Rates -- approval -- recoupment of deficit.** (1) The rates, rating plans, rating rules, rating classifications, territories, policy forms applicable to the insurance written by the association members, and related statistics are subject to the insurance laws of Montana, giving due consideration to the past and prospective loss and expense experience for medical malpractice insurance of the members of the association, trends in the frequency and severity of losses, the investment income of the members, and other information that

the commissioner may require.

(2) Within the time directed by the commissioners, the association shall submit for the approval of the commissioner an initial filing of policy forms, classifications, rates, rating plans, and rating rules applicable to medical malpractice insurance to be written by the association members. If the commissioner disapproves the initial filing in whole or in part the association shall amend it in accordance with the direction of the commissioner.

(3) Any deficit sustained by the association must be recouped pursuant to the plan of operation and the rating plan then in effect by one or both of the following procedures:

(a) an assessment upon the members as provided in [section 9];

(b) a premium rate increase applicable prospectively.

(4) After the initial year of operation, rates, rating plans, rating rules, and any provision for recoupment through member assessment or premium rate increase must be based upon the association members' loss and expense experience, together with other information based upon that experience that the commissioner considers appropriate. Any resulting member assessment or premium rate increase must be on an actuarially sound basis and be calculated to make the association self-supporting.

NEW SECTION. **Section 8. Claims made policies and occurrence-based policies.** The commissioner shall require the

association members to offer policies on both a claims made and occurrence basis so that applicants may select either policy at their option. The premiums charged for both claims made and occurrence basis policies must be established on an actuarially sound basis.

NEW SECTION. **Section 9. Financial participation by association members.** (1) Each member of the association must participate in the association's insurance policies, expenses, profits, and losses in the proportion that the net direct premiums of the member during the preceding calendar year, after excluding that portion of premiums attributable to the operation of the association, bears to the aggregate net direct premiums of all members of the association.

(2) Each member's participation in the association must be determined annually on the basis of the net direct premiums written during the preceding calendar year as reported in the annual statements and other reports filed by the insurer with the commissioner.

(3) A member is not obligated to reimburse the association for the member's proportionate share in a deficit from operations of the association in a given year in excess of 1% of the member's surplus to policyholders, and the aggregate amount not so reimbursed must be reallocated among the remaining members in accordance with the method of determining participation after excluding from the computation the total net direct premiums of all members not sharing in the excess deficit. If the deficit

from operations allocated to all members of the association for a calendar year exceeds 1% of their respective surpluses to policyholders, the amount of the deficit must be allocated to each member in accordance with the method of determining participation.

NEW SECTION. **Section 10. Directors.** The association must be governed by an annually elected board of directors. Eight directors must be elected by cumulative voting of members of the association, whose votes must be weighted in the proportion that a member's net direct premiums during the preceding calendar year bears to the net direct premiums of all the members during the preceding calendar year. Three directors must be appointed by the commissioner as representatives of the medical profession, and the appointments must be made at or before each annual meeting. The eight directors serving on the first board who are to be elected by members of the association must be elected at a meeting of the members held at a time and place designated by the commissioner.

NEW SECTION. **Section 11. Appeals and judicial review.** For matters that the law or the plan of operation defines as appealable, an applicant for insurance, insurer person, or insurer may appeal to the commissioner within 30 days after a decision by or on behalf of the association. An order of the commissioner is subject to judicial review as provided in Title 33.

NEW SECTION. **Section 12. Annual statements.** The association shall file in the office of the commissioner on or before March 1 of each year a statement containing information with respect to the association's transactions, condition, operations, and affairs during the preceding calendar year. The statement must contain the matters and information and be in the format prescribed by the commissioner. The commissioner may at any time require the association to furnish additional information that the commissioner believes to be material and of assistance in evaluating the scope, operation, and experience of the association.

NEW SECTION. **Section 13. Examination of association's affairs.** The commissioner shall examine the affairs of the association at least annually.

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