CHAPTER 519A

MEDICAL MALPRACTICE INSURANCE

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519A.1 Intent.

The general assembly finds that a critical situation exists because of the high cost and impending unavailability of medical malpractice insurance. The purposes of sections 519A.2 to 519A.13 are to assure that the public is adequately protected against losses arising out of medical malpractice by providing licensed health care providers with medical malpractice insurance through the requirement that certain liability insurance carriers write medical malpractice insurance for a period of two years upon a finding of an emergency by the commissioner of insurance that either such insurance is not available through normal channels or that it is not available on a reasonable basis because of lack of competition for such insurance, or otherwise; to establish an association to equitably spread the risks for such insurance; and to provide for recoupment of losses resulting from the operation of the association through a stabilization reserve fund contributed to by insureds, a surcharge on future liability insurance policies, or a favorable premium tax treatment.

It is the intent of this chapter to provide only an interim solution to the impending unavailability of medical malpractice insurance. It is not anticipated that this chapter will resolve the underlying causes of the unavailability and high cost which extend beyond the insurance mechanism. It is anticipated that future legislation will be required to deal on a more permanent basis with the underlying causes of the current situation.

[C77, 79, 81, §519A.1]

519A.2 Definitions.

As used in this chapter, unless the context otherwise requires:

1. *"Association"* means the joint underwriting association established pursuant to this section and sections 519A.3 to 519A.13.

2. *"Commissioner"* means the commissioner of insurance or a designee.

3. *"Licensed health care provider"* means and includes a physician and surgeon, osteopathic physician and surgeon, dentist, podiatric physician, optometrist, pharmacist, chiropractor, or nurse licensed pursuant to chapter 147, a hospital licensed pursuant to chapter 135B, and a nursing facility licensed pursuant to chapter 135C.

4. *"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 or injury of any person as the result of negligence or malpractice in rendering professional service by any licensed health care provider.

5. *"Net direct premiums"* means gross direct premiums written on liability insurance as reported in the annual statements filed by the insurers with the commissioner, including the liability component of multiple peril package policies as computed by the commissioner, less return premiums for the unused or unabsorbed portions of premium deposits.

[C77, 79, 81, §519A.2]

95 Acts, ch 108, §20; 2002 Acts, ch 1111, §32; 2008 Acts, ch 1088, §141

Referred to in **§519A.1**, **§519A.3**, **§519A.4**, **§519A.5**, **§519A.10**, **§519A.13**

519A.3 Temporary joint underwriting association.

1. A temporary joint underwriting association is created, consisting of all insurers authorized to write and engaged in writing on a direct basis within this state liability insurance, including insurers covering such peril in multiple peril policies. Every such

insurer shall be a member of the association and shall remain a member as a condition of its authority to continue to write liability insurance in this state.

2. The purpose of the association shall be to provide, for a period not exceeding two years, a market for medical malpractice insurance on a self-supporting basis without subsidy from its members.

3. *a.* The association shall not commence underwriting operations for health care providers until the commissioner, after notice and opportunity for hearing, has determined that medical malpractice insurance is not available at a reasonable cost for a specific type of licensed health care provider in the voluntary market. Upon such determination the association shall be authorized to issue policies of medical malpractice insurance for such specific type of health care provider but need not be the exclusive agency through which such insurance may be written on a primary basis in this state.

b. If the commissioner determines at any time that medical malpractice insurance can be made available in the voluntary market at a reasonable price for any specific type of licensed health care provider, the association shall thereby cease underwriting medical malpractice insurance for that type of licensed health care provider.

4. The association shall, subject to the terms and conditions of sections 519A.2 to 519A.13, have and exercise the following powers on behalf of its members:

a. To issue, or to cause to be issued, policies of insurance to applicants, including incidental coverages and subject to limits as specified in the plan of operation but not to exceed one million dollars for each claimant under one policy and three million dollars for all claimants under one policy in any one year.

b. To underwrite such insurance and to adjust and pay losses with respect thereto, or to appoint service companies to perform those functions.

c. To assume reinsurance from its members.

d. To cede reinsurance.

[C77, 79, 81, §519A.3]

2012 Acts, ch 1023, §157

Referred to in **§519A.1**, **§519A.2**, **§519A.4**, **§519A.5**, **§519A.10**, **§519A.13**

519A.4 Plan of operation.

1. *a.* The association shall submit a plan of operation to the commissioner, together with any amendments necessary or suitable to assure the fair, reasonable, and equitable administration of the association consistent with sections 519A.2 to 519A.13. The plan of operation and any amendments thereto shall become effective only after promulgation of the plan or amendment by the commissioner as a rule pursuant to section 17A.4: Provided that the initial plan may in the discretion of the commissioner become effective immediately upon filing with the secretary of state pursuant to section 17A.5, subsection 2, paragraph "*b*", subparagraph (1).

b. If the association fails to submit a suitable plan of operation within twenty-five days following the effective date of this chapter or if at any time thereafter the association fails to submit suitable amendments to the plan, the commissioner shall adopt rules necessary to effectuate sections 519A.2 to 519A.13. Such rules shall continue in force until modified by the commissioner or superseded by a plan submitted by the association and approved by the commissioner.

2. The plan of operation shall provide for economic, fair and nondiscriminatory administration, and for the prompt and efficient provision of medical malpractice insurance. The plan shall contain other provisions including, but not limited to, preliminary assessment of all members for initial expenses necessary to commence operations, establishment of necessary facilities, management of the association, assessment of members to defray losses and expenses, commission arrangements, reasonable and objective underwriting standards, acceptance and cession of reinsurance, appointment of servicing carriers or other servicing arrangements and procedures for determining amounts of insurance to be provided by the association.

3. All member insurers shall comply with the plan of operation.
[C77, 79, 81, §519A.4]
2012 Acts, ch 1023, §157

519A.5 Policy forms and rates.

1. The rates, rating plans, rating classifications, and policy forms and endorsements applicable to insurance written by the association and the statistical and experience data relating thereto shall be subject to sections 519A.2 to 519A.13 and to the provisions of the general insurance code which are not inconsistent with the purposes and provisions of this chapter.

2. All policies issued by the association shall provide for a continuous period of coverage beginning with their respective effective dates. All policies shall terminate at 12:01 a.m. two years from the date of finding of an emergency by the commissioner, or earlier in accordance with sections 519A.2 through 519A.13; or because of failure of the policyholder to pay any premium or stabilization reserve fund charge or portion of either when due. All policies shall be issued subject to the group retrospective rating plan and the stabilization reserve fund authorized by this chapter. No policy form shall be used by the association unless it has been filed with and approved by the commissioner.

3. The commissioner shall specify whether policy forms and the rate structure shall be on a "claims-made" or "occurrence" basis and coverage shall be provided by the association only on the basis specified by the commissioner. The commissioner shall specify the "claims-made" basis only if the contract makes provision for residual "occurrence" coverage upon the retirement, death, disability or removal from this state of the insured. Provision may be made for a premium charge allocable to any such residual "occurrence" coverage and such premium charges for such residual coverage shall be segregated and separately maintained for such purpose which may include the reinsurance of all or a part of that portion of the risk.

4. The rates, rating plans, rating rules, and rating classifications applicable to the insurance written by the association shall be on an actuarially sound basis, giving due consideration to the group retrospective rating plan and the stabilization reserve fund, and shall be calculated to be self-supporting.

5. All policies issued by the association shall be subject to a nonprofit group retrospective rating plan to be approved by the commissioner under which the final premium for all policyholders of the association, as a group, will be equal to the administrative expenses, loss and loss adjustment expenses and taxes, plus a reasonable allowance for contingencies and servicing. Policyholders shall be given full credit for all investment income, net of expenses and a reasonable management fee, on policyholder supplied funds. The standard premium, before retrospective adjustment, for each policy issued by the association shall be established for portions of the policy period coinciding with the association's fiscal year on the basis of the association's rates, rating plans, rating rules, and rating classifications then in effect. The maximum final premium for all policyholders of the association, as a group, shall be limited as provided in section 519A.6, subsection 5. Since the business of the association is subject to the nonprofit group retrospective rating plan required by this subsection, there shall be a presumption that the rates filed and premiums imposed by the association are not unreasonable or excessive.

6. The association shall certify to the commissioner the estimated amount of any deficit remaining after the stabilization reserve fund has been exhausted in payment of the maximum final premium for all policyholders of the association. Within sixty days after that certification the commissioner shall authorize the members of the association to commence recoupment of their respective shares of the deficit by deducting their share of the deficit from past or future premium taxes due the state of Iowa. The association shall amend the amount of its certification of deficit to the commissioner as the values of its incurred losses become finalized and the members of the association shall amend their recoupment procedure accordingly.

7. In the event that sufficient funds are not available for the sound financial operation of the association, all members shall contribute to the financial requirements of the association

in the manner provided for in section 519A.8. Any contribution shall be reimbursed to the members by recoupment as provided in subsection 6.

[C77, 79, 81, §519A.5]

2002 Acts, ch 1111, §33

Referred to in §519A.1, §519A.2, §519A.3, §519A.4, §519A.10, §519A.13

519A.6 Stabilization reserve fund.

1. There is created a stabilization reserve fund. The fund shall be administered by three directors, one of whom shall be the commissioner. The remaining two directors shall be appointed by the commissioner: One shall be a representative of the association and the other a representative of its policyholders.

2. The directors shall act by majority vote with two directors constituting a quorum for the transaction of any business or the exercise of any power of the fund. The directors shall serve without salary, but each director other than the commissioner shall be reimbursed for actual and necessary expenses incurred in the performance of official duties as a director. The directors shall not be subject to any personal liability with respect to the administration of the fund for acts or decisions made in good faith pursuant to the provisions of this chapter.

3. Each policyholder shall pay to the association a stabilization reserve fund charge determined by the directors which shall not exceed the amount of one annual premium due for insurance through the association. Such charge shall be separately stated in the policy. The association shall cancel the policy of any policyholder who fails to pay the stabilization reserve fund charge.

4. The association shall promptly pay to the fund all stabilization reserve fund charges which it collects from its policyholders and any retrospective premium refunds payable under any group retrospective rating plan approved by the commissioner under the provisions of this chapter.

5. All moneys received by the fund shall be held in trust by a corporate trustee selected by the directors. The corporate trustee may invest the moneys held in trust, subject to the approval of the directors. All investment income shall be credited to the fund, and all expenses of administration of the fund shall be charged against the fund. The moneys held in trust shall be used solely for the purpose of discharging when due any retrospective premium charges payable by policyholders of the association under the group retrospective rating plan approved by the commissioner. Payment of retrospective premium charges shall be made by the directors upon certification to them by the association of the amount due. If all moneys accruing to the fund are finally exhausted in payment of retrospective premium charges, all liability and obligations of the association's policyholders with respect to the payment of retrospective premium charges shall there upon terminate and shall be conclusively presumed to have been discharged. Any moneys remaining in the fund after all such retrospective premium charges have been paid shall be returned to policyholders pursuant to procedures authorized by the directors.

[C77, 79, 81, §519A.6]

Referred to in §519A.1, §519A.2, §519A.3, §519A.4, §519A.5, §519A.10, §519A.13

519A.7 Procedures.

1. Upon a finding by the commissioner, after notice and opportunity for hearing, that medical malpractice insurance is not available at a reasonable cost for a specific type of licensed health care provider in the voluntary market and upon notification of that finding to the association, any licensed health care provider of the type specified in the commissioner's finding shall be entitled to apply to the association for medical malpractice insurance coverage. The application may be made on behalf of a licensed health care provider by an authorized agent.

2. If the association determines that the applicant meets the underwriting standards of the association as prescribed in the plan of operation, then the association, upon receipt of the premium or such portion thereof as is prescribed in the plan of operation, shall cause to be issued a policy of medical malpractice insurance.

[C77, 79, 81, §519A.7]

Referred to in §519A.1, §519A.2, §519A.3, §519A.4, §519A.5, §519A.10, §519A.13

519A.8 Participation.

All members of the association shall participate in its writings, expenses, servicing allowance, management fees and losses in the proportion that the net direct premiums of each member, excluding that portion of premiums attributable to the operation of the association, written during the preceding calendar year bears to the aggregate net direct premiums written in this state by all members of the association. Each member's proportion shall be determined annually on the basis of the annual statements and other reports filed by the insurer with the commissioner.

[C77, 79, 81, §519A.8]

Referred to in **§519A.1**, **§519A.2**, **§519A.3**, **§519A.4**, **§519A.5**, **§519A.10**, **§519A.13**

519A.9 Governing board.

1. The association shall be governed by a board of eleven directors of whom three shall be appointed annually by the commissioner to represent the licensed health care providers. Eight members shall be elected annually, except as provided in subsection 2, by the members of the association. Vacancies on the board shall be filled for the remaining period of the term by majority vote of the remaining directors subject to approval of the commissioner.

2. *a.* The commissioner shall designate a time and place for a meeting of the members of the association at which the eight elected members serving on the board shall be elected. The commissioner shall appoint the appointive members of the board on or before the date of the meeting.

b. The commissioner may, prior to the first meeting of the members of the association, appoint an interim governing board of the association consisting of eight member insurers and three representatives of the licensed health care providers. The eight member insurers of that interim governing board shall serve until their successors are elected by the members of the association. In appointing members of the association to the interim governing board, the commissioner shall consider among other things whether all member insurers are fairly represented.

[C77, 79, 81, §519A.9]

2002 Acts, ch 1111, §34; 2012 Acts, ch 1023, §157

Referred to in **§519A.1**, **§519A.2**, **§519A.3**, **§519A.4**, **§519A.5**, **§519A.10**, **§519A.13**

519A.10 Appeals and judicial review.

1. Any applicant or any person insured pursuant to section 519A.7, or a legal representative, or any affected insurer, may appeal to the commissioner within thirty days after any ruling, action or decision by or on behalf of the association, with respect to those items the plan of operation defines as appealable matters.

2. All orders of the commissioner made pursuant to sections 519A.2 to 519A.13 shall be subject to judicial review as provided in the Iowa administrative procedure Act, chapter 17A.

[C77, 79, 81, §519A.10]

2003 Acts, ch 44, §114

Referred to in **§519A.1**, **§519A.2**, **§519A.3**, **§519A.4**, **§519A.5**, **§519A.13**

519A.11 Annual statements.

The association shall file in the office of the commissioner on or before the first day of March each year, a statement as prescribed by the commissioner. The statement shall contain matters and information required by the commissioner including, but not limited to, information with respect to its transactions, condition, operations and affairs during the preceding year, and shall be in a form approved by the commissioner. The commissioner may, at any time, require the association to furnish additional information with respect to matters considered to be material to the scope, operation and experience of the association.

[C77, 79, 81, §519A.11]

Referred to in **§519A.1**, **§519A.2**, **§519A.3**, **§519A.4**, **§519A.5**, **§519A.10**, **§519A.13**

519A.12 Examinations.

The commissioner shall make an examination of the association at least annually. The expenses of each examination shall be paid by the association.

[C77, 79, 81, §519A.12]

Referred to in **§519A.1**, **§519A.2**, **§519A.3**, **§519A.4**, **§519A.5**, **§519A.10**, **§519A.13**

519A.13 Privileged communications.

There shall be no liability on the part of, and no cause of action of any nature shall arise against the association, the commissioner, or any other person or organization, for any statements made in good faith by any of them in any report or communication concerning risks insured or to be insured by the association, or during any proceedings within the scope of sections 519A.2 to 519A.12 and this section.

[C77, 79, 81, §519A.13]

Referred to in **§519A.1**, **§519A.2**, **§519A.3**, **§519A.4**, **§519A.5**, **§519A.10**