SENATE BILL NO. 122–SENATORS TITUS AND WIENER

FEBRUARY 13, 2003

Referred to Committee on Commerce and Labor

SUMMARY—Makes various changes regarding malpractice insurance and actions. (BDR 57-265)

FISCAL NOTE: Effect on Local Government: Yes.
Effect on the State: Yes.

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

AN ACT relating to malpractice; revising various provisions relating to filings and rates for certain insurers that issue policies of malpractice insurance; providing persons with the right to provide testimony at certain hearings before the Commissioner of Insurance under certain circumstances; establishing various requirements relating to policies of malpractice insurance; authorizing the Commissioner to protect essential medical specialties from certain adverse actions regarding policies of malpractice insurance; requiring the Commissioner to collect certain information and to conduct certain studies relating to policies of malpractice insurance; providing that certain information in certain settlement agreements must not be made confidential; providing penalties; and providing other matters properly relating thereto.

THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

Section 1. NRS 686B.040 is hereby amended to read as follows:

686B.040 [~~The~~]

1. Except as otherwise provided in subsection 2, the Commissioner may by rule exempt any person or class of persons or any market segment from any or all of the provisions of NRS 686B.010 to 686B.1799, inclusive, if and to the extent that he finds

their application unnecessary to achieve the purposes of those sections.

2. The Commissioner may not, by rule or otherwise, exempt an insurer from the provisions of NRS 686B.010 to 686B.1799, inclusive, with regard to insurance covering the liability of a practitioner licensed pursuant to chapter 630, 631, 632 or 633 of NRS for a breach of his professional duty toward a patient.

Sec. 2. NRS 686B.070 is hereby amended to read as follows:

686B.070 ***1.*** Every authorized insurer and every rate service organization licensed under NRS ~~[686B.130]~~ ***686B.140*** which has been designated by any insurer for the filing of rates under subsection 2 of NRS 686B.090 shall file with the Commissioner all:

~~[1.]~~ ***(a)*** Rates and proposed increases thereto;

~~[2.]~~ ***(b)*** Forms of policies to which the rates apply;

~~[3.]~~ ***(c)*** Supplementary rate information; and

~~[4.]~~ ***(d)*** Changes and amendments thereof,

made by it for use in this state.

2. If an insurer makes a filing for a proposed increase in a rate for insurance covering the liability of a practitioner licensed pursuant to chapter 630, 631, 632 or 633 of NRS for a breach of his professional duty toward a patient, the insurer shall not include in the filing any component that is directly or indirectly related to the following:

(a) Capital losses, diminished cash flow from any dividends, interest or other investment returns, or any other financial loss that is materially outside of the claims experience of the professional liability insurance industry, as determined by the Commissioner.

(b) Losses that are the result of any criminal or fraudulent activities of a director, officer or employee of the insurer.

If the Commissioner determines that a filing includes any such component, the Commissioner shall, pursuant to NRS 686B.110, disapprove the proposed increase, in whole or in part, to the extent that the proposed increase relies upon such a component.

Sec. 3. NRS 686B.090 is hereby amended to read as follows:

686B.090 1. An insurer shall establish rates and supplementary rate information for any market segment based on the factors in NRS 686B.060. If an insurer has insufficient creditable loss experience, it may use rates and supplementary rate information prepared by a rate service organization, with modification for its own expense and loss experience.

2. An insurer may discharge its obligation under ***subsection 1 of*** NRS 686B.070 by giving notice to the Commissioner that it uses rates and supplementary rate information prepared by a designated rate service organization, with such information about modifications

thereof as are necessary fully to inform the Commissioner. The insurer's rates and supplementary rate information shall be deemed those filed from time to time by the rate service organization, including any amendments thereto as filed, subject ~~[, however,]~~ to the modifications filed by the insurer.

Sec. 4. NRS 686B.110 is hereby amended to read as follows:

686B.110 1. The Commissioner shall consider each proposed increase or decrease in the rate of any kind or line of insurance or subdivision thereof filed with him pursuant to ***subsection 1 of*** NRS 686B.070. If the Commissioner finds that a proposed increase will result in a rate which is not in compliance with NRS 686B.050 ~~[,]~~ ***or subsection 2 of NRS 686B.070,*** he shall disapprove the proposal. The Commissioner shall approve or disapprove each proposal no later than 60 days after it is determined by him to be complete pursuant to subsection 4. If the Commissioner fails to approve or disapprove the proposal within that period, the proposal shall be deemed approved.

2. Whenever an insurer has no legally effective rates as a result of the Commissioner's disapproval of rates or other act, the Commissioner shall on request specify interim rates for the insurer that are high enough to protect the interests of all parties and may order that a specified portion of the premiums be placed in an escrow account approved by him. When new rates become legally effective, the Commissioner shall order the escrowed funds or any overcharge in the interim rates to be distributed appropriately, except that refunds to policyholders that are de minimis must not be required.

3. If the Commissioner disapproves a proposed rate and an insurer requests a hearing to determine the validity of his action, the insurer has the burden of showing compliance with the applicable standards for rates established in NRS 686B.010 to 686B.1799, inclusive. Any such hearing must be held:

(a) Within 30 days after the request for a hearing has been submitted to the Commissioner; or

(b) Within a period agreed upon by the insurer and the Commissioner.

If the hearing is not held within the period specified in paragraph (a) or (b), or if the Commissioner fails to issue an order concerning the proposed rate for which the hearing is held within 45 days after the hearing, the proposed rate shall be deemed approved.

4. The Commissioner shall by regulation specify the documents or any other information which must be included in a proposal to increase or decrease a rate submitted to him pursuant to subsection 1. Each such proposal shall be deemed complete upon its filing with the Commissioner, unless the Commissioner, within 15

business days after the proposal is filed with him, determines that the proposal is incomplete because the proposal does not comply with the regulations adopted by him pursuant to this subsection.

Sec. 5. NRS 686B.115 is hereby amended to read as follows:

686B.115 1. Any hearing held by the Commissioner to determine whether rates comply with the provisions of NRS 686B.010 to 686B.1799, inclusive, must be open to members of the public.

2. All costs for transcripts prepared pursuant to such a hearing must be paid by the insurer requesting the hearing.

3. At any hearing which is held by the Commissioner to determine whether rates comply with the provisions of NRS 686B.010 to 686B.1799, inclusive, and which involves rates for insurance covering the liability of a practitioner licensed pursuant to chapter 630, 631, 632 or 633 of NRS for a breach of his professional duty toward a patient, if a person is not otherwise authorized pursuant to this title to become a party to the hearing by intervention, the person is entitled to provide testimony at the hearing if, not later than 2 days before the date set for the hearing, the person files with the Commissioner a written statement which states:

(a) The name and title of the person;

(b) The interest of the person in the hearing; and

(c) A brief summary describing the purpose of the testimony the person will offer at the hearing.

4. If a person provides testimony at a hearing in accordance with subsection 3:

(a) The Commissioner may, if he finds it necessary to preserve order, prevent inordinate delay or protect the rights of the parties at the hearing, place reasonable limitations on the duration of the testimony and prohibit the person from providing testimony that is not relevant to the issues raised at the hearing.

(b) The Commissioner shall consider all relevant testimony provided by the person at the hearing in determining whether the rates comply with the provisions of NRS 686B.010 to 686B.1799, inclusive.

Sec. 6. Chapter 690B of NRS is hereby amended by adding thereto the provisions set forth as sections 7 to 16, inclusive, of this act.

Sec. 7. ***As used in sections 7 to 16, inclusive, of this act, unless the context otherwise requires, the words and terms defined in sections 8 to 11, inclusive, of this act have the meanings ascribed to them in those sections.***

Sec. 8. ***"Claims-made policy" means a policy of professional liability insurance that provides coverage only for claims that arise***

from incidents or events which occur while the policy is in force and which are reported to the insurer while the policy is in force.

Sec. 9. *"Extended reporting endorsement" means an endorsement to a claims-made policy which requires the payment of a separate premium and which provides coverage for claims that arise from incidents or events which occur while the claims-made policy is in force but which are reported to the insurer after the claims-made policy is terminated.*

Sec. 10. *"Practitioner" means a practitioner who provides health care and who is licensed pursuant to chapter 630, 631, 632 or 633 of NRS.*

Sec. 11. *"Professional liability insurance" means a policy of insurance covering the liability of a practitioner for a breach of his professional duty toward a patient.*

Sec. 12. *If an insurer offers to issue a claims-made policy to a practitioner, the insurer shall:*

1. Offer to issue an extended reporting endorsement to the practitioner; and

2. Disclose to the practitioner the cost formula that the insurer uses to determine the premium for the extended reporting endorsement. The cost formula must be based on:

(a) An amount that is not more than twice the amount of the premium for the claims-made policy at the time of the termination of that policy; and

(b) The rates filed by the insurer and approved by the Commissioner.

Sec. 13. *1. Except as otherwise provided in this section, if an insurer issues a policy of professional liability insurance to a practitioner who delivers one or more babies per year, the insurer shall not set the premium for the policy at a rate that is different from the rate set for such a policy issued by the insurer to any other practitioner who delivers one or more babies per year if the difference in rates is based in whole or in part upon the number of babies delivered per year by the practitioner.*

2. If an insurer issues a policy of professional liability insurance to a practitioner who delivers one or more babies per year, the insurer may set the premium for the policy at a rate that is different, based in whole or in part upon the number of babies delivered per year by the practitioner, from the rate set for such a policy issued by the insurer to any other practitioner who delivers one or more babies per year if the insurer:

(a) Bases the difference upon actuarial and loss experience data available to the insurer; and

(b) Obtains the approval of the Commissioner for the difference in rates.

3. The provisions of this section do not prohibit an insurer from setting the premium for a policy of professional liability insurance issued to a practitioner who delivers one or more babies per year at a rate that is different from the rate set for such a policy issued by the insurer to any other practitioner who delivers one or more babies per year if the difference in rates is based solely upon factors other than the number of babies delivered per year by the practitioner.

Sec. 14. ***1. On or before April 1 of each year, the Commissioner shall:***

(a) Determine whether there are any medical specialties in this state which are essential as a matter of public policy and which must be protected pursuant to this section from certain adverse actions relating to professional liability insurance that may impair the availability of those essential medical specialties to the residents of this state; and

(b) Make a list containing the essential medical specialties designated by the Commissioner and provide the list to each insurer that issues policies of professional liability insurance to practitioners who are practicing in one or more of the essential medical specialties.

2. If an insurer intends to cancel, terminate or otherwise not renew a specific policy of professional liability insurance that it has issued to a practitioner who is practicing in one or more of the essential medical specialties designated by the Commissioner:

(a) The insurer must provide 120 days' notice to the practitioner before its intended action becomes effective; and

(b) The Commissioner may require the insurer to delay its intended action for a period of not more than 60 days if the Commissioner determines that a replacement policy is not readily available to the practitioner.

3. If an insurer intends to cancel, terminate or otherwise not renew all policies of professional liability insurance that it has issued to practitioners who are practicing in one or more of the essential medical specialties designated by the Commissioner:

(a) The insurer must provide 120 days' notice of its intended action to the Commissioner and the practitioners before its intended action becomes effective; and

(b) The Commissioner may require the insurer to delay its intended action for a period of not more than 60 days if the Commissioner determines that replacement policies are not readily available to the practitioners.

4. The Commissioner may adopt any regulations that are necessary to carry out the provisions of this section.

5. Until the Commissioner determines which, if any, medical specialties are to be designated as essential medical specialties, the following medical specialties shall be deemed to be essential medical specialties for the purposes of this section:

(a) Emergency medicine.

(b) Neurosurgery.

(c) Obstetrics and gynecology.

(d) Orthopedic surgery.

(e) Pediatrics.

(f) Trauma surgery.

Sec. 15. *1. The Commissioner shall collect all information which is pertinent to monitoring whether an insurer that issues professional liability insurance is complying with the applicable standards for rates established in NRS 686B.010 to 686B.1799, inclusive. Such information must include, without limitation:*

(a) The amount of gross premiums collected with regard to each medical specialty;

(b) Information relating to loss ratios;

(c) Information reported pursuant to NRS 690B.045; and

(d) Information reported pursuant to NRS 679B.430 and 679B.440.

2. In addition to the information collected pursuant to subsection 1, the Commissioner may request any additional information from an insurer:

(a) Whose rates and credit utilization are materially different from other insurers in the market for professional liability insurance in this state;

(b) Whose credit utilization shows a substantial change from the previous year; or

(c) Whose information collected pursuant to subsection 1 indicates a potentially adverse trend.

3. If the Commissioner requests additional information from an insurer pursuant to subsection 2, the Commissioner shall:

(a) Determine whether the additional information offers a reasonable explanation for the results described in paragraphs (a), (b) or (c) of subsection 2; and

(b) Take any steps permitted by law that are necessary and appropriate to assure the ongoing stability of the market for professional liability insurance in this state.

4. On an ongoing basis, the Commissioner shall:

(a) Analyze and evaluate the information collected pursuant to this section to determine trends in and measure the health of the market for professional liability insurance in this state; and

(b) Prepare and submit a report of his findings and recommendations to the Director of the Legislative Counsel

Bureau for transmittal to members of the Legislature on or before November 15 of each year.

Sec. 16. ***1. If an agreement settles a claim or action against a practitioner for a breach of his professional duty toward a patient, the following terms of the agreement must not be made confidential:***

(a) The names of the parties;

(b) The date of the incidents or events giving rise to the claim or action;

(c) The nature of the claim or action as set forth in the complaint and the answer that is filed with the district court; and

(d) The effective date of the agreement.

2. Any provision of an agreement to settle a claim or action that conflicts with this section is void.

Sec. 17. 1. The Commissioner of Insurance shall conduct a study to determine whether legislation enacting tort reform has benefited or will benefit the market for professional liability insurance in this state. On or before February 1, 2005, the Commissioner shall prepare a report that contains the findings of the study and submit the report to the Director of the Legislative Counsel Bureau for transmittal to the 73rd Session of the Nevada Legislature.

2. If the constitutionality of any legislation enacting tort reform is upheld by the Nevada Supreme Court, the Commissioner shall:

(a) Not later than 60 days after the date of the decision of the Nevada Supreme Court, obtain from each insurer that is offering professional liability insurance in this state a rating plan that describes the extent to which the insurer will incorporate the expected decrease in loss costs into its premiums for professional liability insurance;

(b) Review and evaluate each such rating plan to determine whether the rating plan is reasonable;

(c) Prepare a report which summarizes the rating plans and the evaluations made by the Commissioner and which contains recommendations as to whether the rating plans should be implemented; and

(d) Submit the report to the Director of the Legislative Counsel Bureau for transmittal to the next regular session of the Nevada Legislature following submission of the report.

3. As used in this section, "professional liability insurance" means a policy of insurance covering the liability of a practitioner who provides health care for a breach of his professional duty toward a patient.

Sec. 18. 1. The provisions of sections 12 and 13 of this act apply only to a policy of professional liability insurance, as defined in section 11 of this act, which is offered, issued or renewed on or after October 1, 2003.

2. The provisions of section 16 of this act apply only to a cause of action which accrues on or after October 1, 2003.

Sec. 19. This act becomes effective:

1. Upon passage and approval for the purposes of adopting regulations and performing any other preparatory administrative tasks that are necessary to carry out the provisions of this act; and

2. On October 1, 2003, for all other purposes.

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