

MODIFIED RURAL MEDICAL LIABILITY FINANCIAL REINSURANCE PLAN

1. Purpose

The purpose of this document is to establish procedures for the State Accident Insurance Fund Corporation (SAIF) administered reinsurance program for medical professional liability insurance policies issued by authorized insurers to eligible doctors and nurse practitioners. That program was created by chapter 781, Oregon Laws 2003 and modified by Senate Bill 183 (2007). This modified plan is based on the following assumptions:

- SAIF's cost will not exceed an average of \$5 million per year for the eight years of the program: calendar years 2004 through 2011.
- The Department of Consumer and Business Services (DCBS) will credit SAIF's annual assessment under ORS 656.612 for all paid premium reductions and allowed expenses under this program.
- The financial reinsurance program will reduce the medical professional liability insurance premium of each eligible doctor and nurse practitioner accepted under this plan.
- SAIF will not be liable for any losses, loss expenses, or other expenses of any medical professional liability insurance company.

This modified plan meets the requirements of section 6 of Senate Bill 183 (2007).

2. Eligibility requirements for doctors and nurse practitioners

- A. "Medical provider" means doctor of medicine or osteopathy or nurse practitioner.
- B. "Eligible medical provider" means doctor of medicine or osteopathy or nurse practitioner who meets eligibility requirements for the Rural Medical Liability Financial Reinsurance Plan contained herein.
- C. "Medicaid" means medical assistance provided under 42 U.S.C. 1396a, section 1902 of the Social Security Act.
- D. "Medicare" means the "Health Insurance for the Aged Act," Title XVIII of the Social Security Amendments of 1965.
- E. "Rural" means a practice that meets the criteria established by the Office of Rural Health (ORH) that applied as of January 1, 2004, for the purposes of ORS 315.613, excluding urbanized areas, as defined by the United States Census Bureau according to the most recent federal decennial census taken pursuant to the authority of the United States Department of Commerce under 13 U.S.C. 141(a); or rural means a

practice located in an urbanized area as described in section 6 subsection D of this plan.

- F. "Authorized insurer" is an insurer who meets the definition of ORS 731.066(1), and does not include DCBS listed insurers pursuant to ORS 735.300 to 735.365 and ORS 735.400 to 735.495
- G. A medical provider whose coverage is provided through a health care facility as defined in ORS 442.400 and meets the requirements set in section 2 subsection E. of this plan, is eligible to participate in the plan beginning January 1, 2008 if ORH determines that the medical provider, as of the later of January 1, 2007, or the date on which the medical provider first commences a rural practice, satisfies each of the following requirements:
- (1) The medical provider is not an employee of the health care facility;
 - (2) The medical provider is covered by a medical professional liability insurance policy that names the medical provider and separately calculates the premium for the medical provider; and
 - (3) The medical provider fully reimburses the health care facility for the premium calculated for the medical provider.
- H. To be eligible to receive premium reductions under this program, a medical provider must:
- (1) be a doctor of medicine or osteopathy or a nurse practitioner;
 - (2) have a rural medical practice that amounts to at least 60 percent of the medical provider's medical practice. The extent to which a medical provider's practice is "rural" shall be determined on the basis of actual time spent in practice each week in hours or days, whichever is considered by ORH to be more appropriate. (ORS 315.613 (1); Office of Rural Health, Policy No. 12-40-010);
 - (3) hold an active, unrestricted license under ORS chapter 677 to practice medicine in Oregon, if a doctor;
 - (4) be currently certified as a nurse practitioner by the Oregon State Board of Nursing, if a nurse practitioner;
 - (5) have an in-force policy of medical professional liability insurance, issued to an individually named medical provider with a separate identified premium and rated according to an individual medical provider's experience history, with an authorized insurer with minimum limits of coverage of \$1 million per occurrence and \$1 million in aggregate to maximum limits of \$1 million per occurrence and \$3 million aggregate;
 - (6) be willing to serve patients with Medicare coverage and patients receiving medical assistance provided under Medicaid in at least the same proportion to their total number of patients as the Medicare and Medicaid populations represent to the total number of patients in need of care in the rural areas of the counties in which the medical providers practice as determined by ORH (This requirement does not

- apply to nurse practitioners participating in the program who are employed by licensed doctors); and
(7) be willing to make an annual attestation of compliance with subsection (6).

- I. ORH will determine the eligibility of medical providers under subsection G (1),(2), and (3) and subsection H (2), (6), and (7) and provide that information to SAIF. To qualify for coverage under this program for a calendar quarter, a medical provider must apply no later than the last day of the preceding calendar quarter. For example, in order to qualify for the first quarter of a year, the medical provider must apply not later than December 31 of the preceding year. Similarly, in order to qualify for the second quarter of a year, the medical provider must apply not later than March 31 of the year. A medical provider meets a deadline date only if ORH has received and date-stamped the doctor's or nurse practitioner's affidavit on or before the deadline date. A medical provider who has met a deadline date will qualify for coverage only if the following conditions are satisfied not later than the 15th day of the quarter for which coverage is applied:
- (1) ORH must certify to SAIF that the medical provider meets ORH standards for being an eligible medical provider; and
 - (2) the eligible medical provider's insurer must confirm to SAIF that the eligible medical provider is insured by the insurer and that any other identifying information required by SAIF is accurate.
- J. Authorized insurers will determine the eligibility of medical providers under subsection H (5) of this plan.
- K. SAIF will verify the eligibility of medical providers under subsection H (1), (3), and (4) of this plan.

3. Exclusions

An authorized insurer will not calculate a premium reduction, nor shall SAIF provide any payment for premium reduction, for any of the following:

- any medical provider who does not meet the eligibility requirements referred to in section 2 of this plan;
- premium for limits that exceed either or both of the following:
\$1 million per occurrence; \$3 million annual aggregate;
- ancillary personnel;
- any premium charged for hospital, clinic, or insurance company liability;
- director and officer liability and/or errors and omissions coverage;
- any medical provider who insures with an insurer other than an authorized insurer;
- reduced premiums collected while a medical provider is not practicing (leave of absence, etc.);

- premium for adverse experience of an individual medical provider;
- prior acts coverage (for any coverage for claims that occur prior to the retroactive date of the current policy); or
- extended reporting coverage.

4. Insurer participation

An authorized insurer, new to this plan, shall notify SAIF of its intent to participate in this plan not later than 45 days prior to the beginning date of the next calendar quarter. Failure to provide that notice will make the insurer's otherwise eligible medical provider policyholders ineligible to participate in this plan for that quarter.

A participating authorized insurer choosing not to continue participation in the plan shall notify SAIF of its intent not to participate at least 90 days prior to the beginning date of the next calendar quarter. The authorized insurer shall notify its insured medical providers participating in the plan of its intent to not participate at least 60 days prior to the beginning date of the next calendar quarter.

5. Premium reduction procedure

Within 30 days after the end of each billing period (monthly or quarterly), each authorized insurer will electronically submit a report, as described in section 9, to SAIF showing information for each eligible medical provider who was eligible for a premium reduction as of the end of the billing quarter under this plan.

Based on that report, SAIF will make the appropriate premium reduction payments to the authorized insurers.

If SAIF determines that an insured eligible medical provider received an inappropriate premium reduction, the authorized insurer is required to collect the appropriate premium from the insured. Upon receipt of that premium, the authorized insurer will remit the appropriate amount to SAIF.

An insurer may reduce the premium charged to insured eligible medical providers according to the requirements of chapter 781, Oregon Laws 2003 by administrative means determined by the insurer to be the simplest and most efficient for its purpose, that:

- bills for premium net of the premium reduction; or
- refunds or credits premiums already paid.

6. Premium reduction percentages

SAIF will be responsible for the calculation of the premium reduction percentages for each eligible medical provider class based on the following procedures:

- A. SAIF will base its calculations of the premium reduction percentages on the information provided by ORH and the respective authorized insurers as described in section 9 of this plan.
- B. Relying on the accuracy of that information, SAIF will calculate the premium reduction percentages to ensure the percentages do not exceed:
 - (1). 80 percent for eligible doctors specializing in obstetrics and eligible nurse practitioners certified for obstetric care;
 - (2). 60 percent for eligible doctors specializing in family or general practice who provide obstetrical services; and
 - (3). Up to 40 percent for eligible doctors and nurse practitioners engaging in one or more of the following practices:
 - A. family practice without obstetrics
 - B. general practice
 - C. internal medicine
 - D. geriatrics
 - E. pulmonary medicine
 - F. pediatrics
 - G. general surgery
 - H. anesthesiology
 - (4). Up to the following percentages for eligible doctors and nurse practitioners other than those included in subsections (1), (2), and (3) of this section:
 - A. 35 percent for calendar year 2008
 - B. 25 percent for calendar year 2009
 - C. 15 percent for calendar year 2010
 - D. 15 percent for calendar year 2011
- C. The premium reductions set out above shall be a percentage of the actual premium charged for medical professional liability insurance in the market of authorized insurers for limits purchased of up to \$1 million per occurrence and \$3 million annual aggregate.

For eligible medical providers referred to in section 6 subsection B (3) and (4), whether new or existing in the program, the premium reduction shall be calculated according to the lesser amount of:

- the percentage of actual premium paid at the rate in force at the time of the billing; or

- the percentage of actual premium paid at the rate in force for calendar year 2007.

In determining the lesser amount, claims-made step increases in the premium will not be considered. The claims-made step shall be the step the eligible medical provider had at year-end 2007. For an eligible medical provider moving to a claims-made step policy from an occurrence policy, the percentage of actual premium paid shall be calculated using the eligible medical provider's claims-made step 1 factor.

- D. Eligible doctors who specialize in obstetrics or family practice or general practice and provide obstetrical services, or nurse practitioners certified for obstetric care, and whose practice is located in an urbanized area of Jackson County as defined by the United States Census Bureau according to the most recent federal decennial census taken pursuant to the authority of the United States Department of Commerce under 13 U.S.C. 141(a), and who meet the program eligibility requirements as set out in section 2 of this plan, are eligible for a reduction in premium of:
- (1). 80 percent for eligible doctors specializing in obstetrics;
 - (2). 60 percent for eligible doctors specializing in family or general practice who provide obstetrical services or eligible nurse practitioners certified for obstetrical care.
- E. If the funds available to provide premium reductions are insufficient to provide the maximum reduction, the plan will lower or eliminate the amount provided for the eligible medical providers covered under section 6 subsection B (4). If after eliminating the amount provided under section 6 subsection B (4), there still leaves an insufficient amount in the fund, the plan will lower or eliminate the amount provided for the eligible medical providers covered under section 6 subsection B (3).
- F. The premium reduction percentages may change quarterly as the number of eligible medical providers, the mix of specialties, the underlying rates, and associated schedule premium reductions change over time.

7. Effective dates

Premium reductions under this plan apply only to those medical professional liability insurance policies issued by authorized insurers for payments for coverage during the period of January 1, 2008 through December 31, 2011, regardless of the policy effective date. Premium reductions shall be effective beginning with the first premium payment in each calendar year under the reinsurance program.

This modified plan pursuant to Senate Bill 183 (2007) will supersede the current, in-force Rural Medical Liability Financial Reinsurance Plan (dated October 29, 2003) on January 1, 2008.

8. Disclosure requirements

Each authorized insurer will provide eligible medical providers with the following information each quarter this program is in effect:

- A. The quarterly premium due before the premium reduction is applied;
- B. The amount of the premium reduction; and
- C. The premium after the premium reduction is applied.

The authorized insurer will display those three figures on each billing statement of an eligible doctor or nurse practitioner.

9. Reporting requirements

The reports that the authorized insurers must submit to SAIF, described in section 5, will include the information listed below. "Electronically" means Microsoft Excel or any compatible spreadsheet application.

- medical provider's name
- Oregon Board of Medical Examiners license number or Oregon State Board of Nursing certification number.
- insurer's name
- medical provider's specialty
- medical specialty class
- ISO code
- policy number
- policy effective date
- billing period coverage start date
- billing period coverage end date
- current in-force annual premium for minimum limits of coverage of \$1 million per occurrence and \$1 million aggregate, to maximum limits of \$1 million per occurrence and \$3 million aggregate
- current quarter premium billed after subtracting premium for adverse experience of the individual doctor or nurse practitioner, if any, based on minimum limits of coverage of \$1 million per occurrence and \$1 million aggregate, to maximum limits of \$1 million per occurrence and \$3 million aggregate
- premium reduction percentage
- dollar amount of premium reduction
- explanation of any adjustments under this program from previous reports
- identification of medical providers that were not on the eligible list at the beginning of the quarter
- policy coverage limits

- billing frequency (annually, quarterly, monthly)
- claims-made or occurrence policy
- if claims-made policy, number of years from retroactive date (the claims-made step). The claims-made step shall be the claims-made step the eligible medical provider held as of year-end 2007 for eligible medical providers referred to in section 6 subsection B (3) and (4).

In addition to those items, the authorized insurer will inform SAIF of the base rates and increased limits factors table from their current rate filing for Oregon whenever those rates and tables change.

10. Copies of ORH lists

SAIF will forward, to each of the authorized insurers participating in this plan, the list of eligible medical providers that it receives from ORH. The list forwarded to the authorized insurers will include the medical provider's name, mailing address (if available), specialty, and Oregon Board of Medical Examiners number or Oregon State Board of Nursing number.

11. SAIF payments

Upon receipt of an authorized insurer's report, as described in section 9 of this plan, SAIF will review the report for accuracy, and forward the total due for premium reduction under this program for undisputed items to the authorized insurer within 30 days of receipt.

12. Dispute resolution process

In the event of questions whether a particular medical provider's medical practice is "rural" under the criteria described in section 2 subsection E or section 6 subsection D of this plan, ORH will make the final determination. ORH has the sole authority to resolve any dispute relating to the eligibility of a medical provider under section 2 subsection G (1), (2), and (3), and section 2 subsection H (2), (6), and (7) of the plan.

If within 60 days SAIF and an authorized insurer cannot resolve a dispute, including but not limited to a dispute regarding the appropriate percentage reduction in premium, either party may request the director of DCBS to resolve the dispute.

13. Audits

SAIF reserves the right to conduct periodic audits to determine the accuracy of the eligible medical provider list to be provided by ORH. ORH will make available the necessary information and cooperate with such audits.

SAIF reserves the right to conduct periodic audits to determine the accuracy of the billing information presented to SAIF by authorized insurers and to ensure that the insurers are complying with the requirements of sections 2 and 2a of Senate Bill 183 (2007) that the insurer has reduced the premium charged to the eligible medical provider in a manner that fully recognizes savings made available by coverage offered under Senate Bill 183 (2007). Authorized insurers receiving premium reduction payments will make available the necessary information and cooperate with such audits.

SAIF will notify DCBS of any audit performed under this section, and SAIF will provide DCBS with a copy of the audit findings.

14. Accounting

All moneys received by SAIF for payment to the Rural Fund shall be deposited to and shall become part of the Rural Fund. All payments authorized to be made by SAIF for coverage under the reinsurance program shall be made from the Rural Fund. SAIF may transfer funds from the Industrial Accident Fund (IAF) to the Rural Fund to carry out the requirements of Senate Bill 183 (2007). SAIF may take a credit against assessments due to DCBS of up to an average of \$5 million per year for amounts paid under the plan.

SAIF will incorporate the accounting and reporting for the plan within its current structure. A separate legal entity will not be established. Separate general ledger accounts will be established to keep the transactions of the Rural Fund separate from SAIF's workers' compensation operations.

Transactions and accounting will occur as follows:

- Billing received from authorized medical professional liability insurers for credits provided to eligible medical providers. Billing is reviewed, authorized for payment, and submitted to SAIF's accounts payable for payment within 30 days of receipt as provided in section 11.
- SAIF transfers the amount of the bill from the IAF to the Rural Fund. Rural Fund would have a unique general ledger account and the balance would be included in SAIF's cash balances reported in SAIF's statutory financial statements and on Schedule E.
- SAIF processes the bill for payment. Payment is made from SAIF's Emergency Fund under the authority of ORS 656.642(2)(d). The expense is charged to a unique general ledger account number as an assessment expense per SSAP 35, becoming an underwriting expense and reported as Taxes, Licenses, and Fees on the Underwriting and Investment Exhibit Part 3 Expenses.
- SAIF transfers funds from the Rural Fund to the IAF or to the Emergency Fund to reimburse for payments made under the plan. This is SAIF's normal systems processing, where SAIF transfers funds from the IAF to the Emergency Fund to fund all payments.

- Quarterly, SAIF will reduce the premium assessment liability and payment to DCBS by the amount paid out during the quarter for the plan. Supporting documentation as required by DCBS will be provided to support the premium assessment credit being taken.

15. Application of insurance code

SAIF is an authorized assuming insurer with respect to reinsurance for medical professional liability insurance for the purposes of ORS 731.509.

16. Agreements with authorized medical professional insurance companies

SAIF will enter into agreements with authorized medical professional liability insurance companies to implement the details of this plan. SAIF will provide DCBS with a copy of any agreement described in this section.

17. No entitlement

Nothing in this plan or in Senate Bill 183 (2007) creates an entitlement for any medical provider or insurer.

18. Reporting to DCBS

SAIF will provide DCBS with the following information:

- any changes in premium reduction percentages;
- copies of any agreements with authorized medical professional liability insurance companies described in section 16 of this plan;
- notification of any changes in authorized medical professional liability insurance companies participating in the plan;
- notification of any audit that SAIF performs under section 13 of this plan, and a copy of the audit findings; and,
- any information determined by the director of DCBS to be needed for monitoring the program.

19. Approval

- A. SAIF will submit this plan, under the provisions of section 6 (1) (a) of Senate Bill 183 (2007), for approval to ORH and the director of DCBS. ORH and the director of DCBS shall approve, disapprove, or require changes to the plan as promptly as reasonably possible in order for SAIF to have the plan operational by January 1, 2008. The parties may implement this plan only after joint approval by ORH and the director of DCBS.

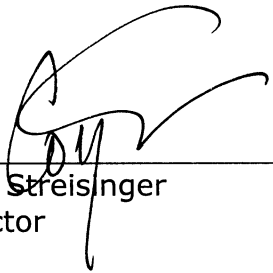
B. SAIF will submit any changes to this plan for approval to ORH and the director of DCBS. ORH and the director of DCBS shall jointly approve, disapprove or require changes as promptly as reasonably possible.

Approved:
Department of Consumer and
Business Services

Approved:
Office of Rural Health

11/28/07
Date

12/4/07
Date

/s/ 
Cory Streisinger
Director

/s/ 
Scott Ekblad
Director