CHAPTER 62F
MEDICAL PRACTICE INSURANCE

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62F.01 CITATION.

Subdivision 1. **Name of act.** Sections 62F.01 to 62F.14 may be cited as the "Joint Underwriting Association Act."

Subd. 2. [Repealed by amendment, 1986 c 455 s 15]

History: *1976 c 242 s 2; 1978 c 571 s 1; 1980 c 596 s 8; 1982 c 374 s 1; 1986 c 455 s 15*

62F.02 JOINT UNDERWRITING ASSOCIATION.

Subdivision 1. **Creation.** There is created a Joint Underwriting Association to provide medical malpractice insurance coverage to any licensed health care provider unable to obtain this insurance through ordinary methods, who practices or provides professional services within the state of Minnesota and obtains at least 60 percent of gross revenues from patients who are residents of the state of Minnesota. Every insurer authorized to write and writing personal injury liability insurance in this state shall be a member of the association as a condition to obtaining and retaining a license to write insurance in this state.

Subd. 2. **Directors.** The association shall have a board of directors composed of 11 persons chosen for a term of four years as follows: five persons elected by members of the association at a meeting called by the commissioner; three members who are health care providers appointed by the commissioner prior to the election by the association; and three public members, as defined in section 214.02, appointed by the governor prior to the election by the association. If the commissioner determines that it is no longer cost-effective or efficient to operate a separate board of directors to administer the Medical Malpractice Joint Underwriting Association, the commissioner shall deactivate the board and assign all of the board's authority and responsibilities under this chapter to the Minnesota Joint Underwriting Association Board of Directors established under section 62I.02.

Subd. 3. **Merger.** Effective January 1, 2008, the association is merged into the joint underwriting association under chapter 62I.

History: *1976 c 242 s 3; 1986 c 455 s 16; 1994 c 425 s 13; 1995 c 258 s 42; 1996 c 446 art 1 s 42; 2008 c 344 s 14*

62F.03 DEFINITIONS.

Subdivision 1. **Scope.** As used in sections 62F.01 to 62F.14, the following words shall have the meanings given.

Subd. 2. **Association.** "Association" means the Joint Underwriting Association.

Subd. 3. **Commissioner.** "Commissioner" means the commissioner of commerce.

Subd. 4. **Medical malpractice insurance.** "Medical malpractice insurance" means insurance 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.

Subd. 5. **Member.** "Member" means every insurer authorized to write and writing personal injury liability insurance in this state.

Subd. 6. **Net direct premiums.** "Net direct premiums" means gross direct premiums written on personal injury liability insurance, 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. Net direct premiums do not include policyholder dividends.

Subd. 7. **Personal injury liability insurance.** "Personal injury liability insurance" means insurance described in section 60A.06, subdivision 1, clause (13).

Subd. 8. **Professional services.** "Professional services" means services performed by a licensed health care provider which are undertaken with the objective of: providing prevention care, rehabilitative care, treatment of specific diseases, injuries, or conditions, or care rendered with the intent of stabilizing the patient's condition and to prevent further deterioration or injury. Professional services does not include services provided by licensed health care providers who rely solely on spiritual or divine intervention as the only means of care or treatment.

History: *1976 c 242 s 4; 1983 c 289 s 114 subd 1; 1984 c 655 art 1 s 92; 1986 c 455 s 17; 1994 c 425 s 14; 1996 c 446 art 1 s 43*

62F.04 AUTHORIZATION TO ISSUE INSURANCE.

Subdivision 1. **Commissioner's determination.** If the commissioner determines after a hearing that medical malpractice insurance cannot be made available for either physicians, hospitals or other specific types of health care providers in the voluntary market, the commissioner shall authorize the association to issue medical malpractice insurance on a primary basis for physicians, hospitals or other health care providers. If the commissioner determines after a hearing that insurance issued by the association can be made available in the voluntary market, the commissioner shall revoke the association's authorization to issue that insurance which can be made available.

Subd. 1a. [Repealed, 2002 c 307 art 1 s 2]

Subd. 2. **Association's duty.** If the association is authorized by the commissioner to issue insurance, it shall:

(a) issue or cause to be issued insurance policies to applicants, including incidental coverages, subject to limits as specified in the plan of operation but not to exceed $1,000,000 for each claimant under one policy and $3,000,000 for all claimants under one policy in any one year;

(b) underwrite the insurance and adjust and pay losses with respect thereto, or appoint service companies to perform those functions;

(c) assume reinsurance from its members; and

(d) cede reinsurance.

Subd. 2a. **Higher limits for long-term care providers.** In addition to the policies described in subdivision 2, the association may issue policies to long-term care providers who are members of an activated class with limits not to exceed $2,000,000 for each claimant under one policy and $4,000,000 for all claimants under one policy in any one year, provided that the association finds that the applicant needs the higher limits in order to conduct its business. Prudent business practice or mere desire to have higher limits is not a sufficient standard for the association to issue such policies.

Subd. 3. **Avoidance of grave risk.** Because the activities of certain persons or entities present a risk that is so great, the association shall not offer insurance coverage to any person or entity the board of directors of the association determines is outside the intended scope and purpose of the association because of the gravity of the risk of offering insurance coverage.

History: *1976 c 242 s 5; 1986 c 444; 1986 c 455 s 18; 1996 c 446 art 1 s 44; 2002 c 307 art 1 s 1; 2004 c 212 s 1*

62F.041 [Expired, 1986 c 313 s 4; 1987 c 337 s 72]

62F.05 PLAN OF OPERATION.

Subdivision 1. **Submission; provisions.** Within 45 days following April 14, 1976, the directors of the association shall submit to the commissioner for review, a proposed plan of operation, consistent with the provisions of sections 62F.01 to 62F.14.

The plan of operation shall provide for economic, fair and nondiscriminatory administration and for prompt and efficient providing of medical malpractice insurance. It may 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.

Subd. 2. **Approval.** The plan of operation shall be subject to approval by the commissioner after consultation with the members of the association, representatives of the public and other affected individuals and organizations. If the commissioner disapproves all or any part of the proposed plan of operation, the directors shall within 15 days submit for review an appropriate revised plan of operation or part thereof. If a revised plan is not submitted within 15 days, the commissioner shall promulgate a plan of operation or part thereof, as the case may be. The plan of operation approved or promulgated by the commissioner shall become effective and operational upon order of the commissioner.

Subd. 3. **Amendments.** Amendments to the plan of operation may be made by the commissioner or by the directors of the association, subject to the approval of the commissioner.

History: *1976 c 242 s 6; 1986 c 444*

62F.06 POLICY FORMS AND RATES.

Subdivision 1. **Policy regulation; filing.** A policy issued by the association may not extend beyond a period of one year from the date on which the authorization under section 62F.04 ends. The policy shall be

issued subject to the group retrospective rating plan and the stabilization reserve fund authorized by section 62F.09. The policy shall be written to apply to claims first made against the insured and reported to the association during the policy period. No policy form shall be used by the association unless it has been filed with the commissioner, and the commissioner may disapprove the form within 30 days if the commissioner determines it is misleading or violates public policy.

Subd. 2. **Cancellation; insured failure to pay stabilization reserve fund.** If an insured fails to pay a stabilization reserve fund charge the association may cancel a policy by mailing or delivering to the insured at the address shown on the policy at least ten days' written notice stating the date the cancellation is effective.

Subd. 3. **Rate regulation.** The rates, rating plans, rating rules, rating classifications and territories applicable to the insurance written by the association and statistics relating thereto shall be subject to chapter 70A. Rates shall be on an actuarially sound basis, giving consideration to the group retrospective rating plan and the stabilization reserve fund. The commissioner shall take all appropriate steps to make available to the association the loss and expense experience of insurers previously writing medical malpractice insurance in this state.

Subd. 4. **Retrospective rating plan.** All policies issued by the association are subject to a nonprofit group retrospective rating plan approved by the commissioner under which the final premium for the insureds 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, rating classifications and territories then in effect. The maximum premium for all policyholders of the association, as a group, shall be limited as provided in sections 62F.01 to 62F.14.

Subd. 5. **Commissioner's power to examine.** The commissioner shall examine the business of the association as often as the commissioner deems appropriate to insure that the group retrospective rating plan is operating in a manner consistent with sections 62F.01 to 62F.14. If the commissioner finds that the operation is deficient or inconsistent with sections 62F.01 to 62F.14, the commissioner may order the association to take corrective action.

Subd. 6. **Deficit recovery procedures.** 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 60 days after such certification, the commissioner shall authorize the association to recover the members' respective shares of the deficit by one of the following procedures:

(a) applying a surcharge determined by the association at a rate not to exceed two percent of the annual premiums on future policies affording those kinds of insurance which form the basis for their participation in the association; or

(b) deducting the members' share of the deficit from past or future premium taxes due the state.

If the commissioner fails to authorize a procedure in 60 days, the association may recover its deficit pursuant to clause (b). The association shall submit an amended certification and shall adjust the recovery procedure as its incurred losses become finalized.

Subd. 7. **Temporary member contributions.** If sufficient funds are not available for the sound financial operation of the association, pending recovery as provided in subdivision 6, all members shall, on a temporary basis contribute to the association in the manner provided in section 62F.07. The contribution shall be reimbursed to the members by the recovery procedure authorized in subdivision 6.

History: *1976 c 242 s 7; 1980 c 596 s 9; 1982 c 374 s 2; 1986 c 313 s 5; 1986 c 444; 1987 c 337 s 73*

62F.07 PARTICIPATION.

A member of the association shall participate in its writings, expenses, servicing allowance, management fees and losses in the proportion that the net direct premiums of the 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. The member's participation in the association shall be determined annually on the basis of net direct premiums written during the preceding calendar year, as reported in the annual statements and other reports filed by the member with the commissioner.

History: *1976 c 242 s 8*

62F.08 PROCEDURES.

Subdivision 1. **Application.** Beginning on the effective date of the plan of operation, a licensed health care provider may apply to the association for medical malpractice insurance. An application may be made by an authorized agent of the health care provider.

Subd. 2. **Policy issuance.** If the association determines that the applicant meets the underwriting standards of the association as described in the plan of operation and there is no unpaid, uncontested premium due from the applicant for prior insurance, including failure to make written objection to premium charges within 30 days after billing, the association, upon receipt of the premium or portion thereof as is prescribed in the plan of operation, shall issue a policy of medical malpractice insurance.

History: *1976 c 242 s 9*

62F.09 STABILIZATION RESERVE FUND.

Subdivision 1. **Creation.** There is created a stabilization reserve fund administered by the association or its designee.

Subd. 2. **Policyholder charge.** Each policyholder shall pay to the association a stabilization reserve fund charge of 33 percent of each premium payment due for insurance through the association. This 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.

Subd. 3. **Association payments.** The association shall promptly pay into the stabilization reserve fund charges which it collects from its policyholders and any retrospective premium refunds payable under the group retrospective rating plan.

Subd. 4. **Handling of fund assets.** All money paid into the fund shall be held in trust by a corporate trustee selected by the directors. The corporate trustee may invest the money held in trust, subject to the approval of the association. All gains or losses from the investment of stabilization reserve fund money

shall be credited to the fund. All expenses of administration of the fund shall be charged against the fund. Stabilization reserve fund money 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. Payment of retrospective premium charges shall be made upon certification by the association of the amount due. If all moneys accruing to the fund are 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 terminate and shall be conclusively presumed to have been discharged. Any money remaining in the fund after all retrospective premium charges have been paid shall be returned to policyholders under procedures authorized by the association.

History: *1976 c 242 s 10; 1986 c 313 s 6*

62F.10 INVESTIGATION.

The commissioner shall investigate the association at least annually. The investigation shall be conducted and a report filed in the manner prescribed in section 60A.031. The expenses of the examination shall be paid by the association in the manner prescribed by section 60A.03, subdivision 5.

History: *1976 c 242 s 11*

62F.11 PRIVILEGED COMMUNICATIONS.

No cause of action of any nature shall arise against the association, the commissioner or the commissioner's authorized representatives or any other person or organization, for any statements made in good faith by them during any proceedings or concerning any matters within the scope of sections 62F.01 to 62F.14.

History: *1976 c 242 s 12; 1986 c 444*

62F.12 APPEALS; JUDICIAL REVIEW.

Any applicant to the association, any person insured pursuant to sections 62F.01 to 62F.14, or their representatives, or any affected insurer, may appeal to the commissioner within 30 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.

History: *1976 c 242 s 13*

62F.13 PUBLIC OFFICERS OR EMPLOYEES.

No director of the stabilization reserve fund who is otherwise a public officer or employee shall forfeit that person's office or employment or lose the rights and privileges pertaining thereto, by reason of membership on the board of directors of the stabilization reserve fund.

History: *1976 c 242 s 14; 1986 c 444*

62F.14 ANNUAL STATEMENTS.

On March 1 of each year the association shall file with the commissioner, a report of its transactions, financial condition, and operations during the preceding year. The report shall be in a form approved by the

commissioner. The commissioner may at any time require the association to furnish additional information to assist in evaluating the scope, operation and experience of the association.

History: *1976 c 242 s 15*