

Notices of Adopted Summary Rulemaking

Telephone: (602) 912-8456

Fax: (602) 912-8452

- 5. An explanation of the rule, including the agency's reasons for initiating the rule:
The statutory authority for these rules was repealed in 1992 and 1993. Therefore, the Department does not have authority to enforce these rules.
- 6. A showing of good cause why the rule is necessary to promote a statewide interest if the rule will diminish a previous grant of authority of a political subdivision of this state:
Not applicable.
- 7. The preliminary summary of the economic, small business and consumer impact:
The Department does not anticipate that the repeal of the rules will have an economic impact on small businesses or consumers.
- 8. The name and address of agency personnel with whom persons may communicate regarding the accuracy of the economic, small business and consumer impact statement:
Name: Gregory Y. Harris
Address: Arizona Department of Insurance
2910 North 44th Street, Suite 210
Phoenix, Arizona 85018
Telephone: (602) 912-8456
Fax: (602) 912-8452
- 9. The time, place and nature of the proceeding for the adoption, amendment, or repeal of the rule:
The Department will schedule a hearing if one is requested by a member of the public within 30 days of the publication of this notice. The Department will accept written comments which are received by 5 p.m. on July 18, 1998, or postmarked no later than that date.
- 10. An explanation of why summary proceedings are justified:
The Department's statutory authority for these rules was repealed in 1992 and 1993, thereby removing the Department's statutory authority to enforce these rules. Pursuant to A.R.S. 41-1027(A)(1), summary proceedings are justified when repeals of rules made obsolete by the repeal of an agency's statutory authority occurs.
- 11. Any other matters prescribed by statute that are applicable to the specific agency or to any specific rule or class of rules:
Not applicable.
- 12. Incorporations by reference and their location in the rules:
Not applicable.
- 13. The full text of the rules follows:

TITLE 4. PROFESSIONS AND OCCUPATIONS

CHAPTER 32. JOINT UNDERWRITING PLAN BOARD OF DIRECTORS

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- R4-32-105. Participation.
- R4-32-106. Administration of plan.
- R4-32-107. Servicing carrier.
- R4-32-108. Inspection of plan documents; audits of servicing carriers.
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- R4-32-202. Authority to bind coverage and issue policies.
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ARTICLE 8. POTENTIAL CLAIM COVERAGE

- R4-32-801. Reinsurance authorized.

ARTICLE 9. ESCROW ACCOUNT FOR SELF INSURERS

- R4-32-901. Establishment of account; report of valuation.

ARTICLE 10. JOINT UNDERWRITING PLAN FUND

- R4-32-1001. Deposits; claims for reimbursement; disbursements.

ARTICLE 1. GENERAL PROVISIONS

R4-32-101. Adoption of rules and standards
The Arizona Joint Underwriting Plan Board of Directors pursuant to the authority granted in Arizona Revised Statutes Title 20, Chapter 7, Article 1, and pertinent paragraphs of A.R.S. § 20-1704 hereby adopts the following rules, regulations and standards for the establishment and operation of the Joint Underwriting Plan.

R4-32-102. Purpose of provisions
The purpose of these rules or regulations is to implement the intent and purpose of A.R.S. Title 20, Chapter 7, Article 1 creating this Joint Underwriting Plan, hereinafter referred to as the "Plan."

R4-32-103. Definitions

- A. "Board" means the Board of Directors of the Plan.
- B. "Director" means the Director of the Department of Insurance of the State of Arizona.
- C. "Net written premiums" means gross direct premiums written in this state on casualty insurance as defined in A.R.S. § 20-252 including the casualty portion of multi-peril package policies premium as determined by the Director less dividends and return premiums and other similar returns paid or credited to policyholders within this state and not reapplied as premiums for new additional or extended insurance.
- D. "Participating insurer" means each insurer required to participate in the Plan.
- E. "Professional liability 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 or failing to render professional service by any licensed physician or hospital or other licensed health care provider.
- F. "Licensed health care provider" means a person, corporation, or institution licensed or certified by the state to provide health care, medical services, nursing services or other health related services and, in relation to insurance coverage for such licensed health care provider, includes officers, employees and agents thereof working under the supervision of such person, corporation or institution in providing such health care, medical services, nursing services or other health related services.

R4-32-104. Board of directors

- A. The Plan shall be administered by a Board of Directors which shall consist of not less than seventeen members in accordance with A.R.S. § 20-1703.
- B. Any vacancy on the Board shall be filled in the same manner as that membership on the Board was initially filled.

C. The Director shall serve as Chairman. A secretary and other officers, as deemed necessary, shall be elected by the Board from among Board members. In the event the chairman is unavailable, the secretary is authorized to conduct the meeting of the Board.

D. At any meeting of the Board, each member of the Board, except those appointed by the President of the Senate and the Speaker of the House, shall have one vote. A Majority of the Board members eligible to vote shall constitute a quorum for the transaction of business and the acts of a majority of such members eligible to vote present at a meeting at which a quorum is present shall be the acts of the Board. Any member not present may request that his written statement be recorded in the minutes of the Plan.

E. Members of the Board appointed by the Governor shall receive a per diem subsistence allowance pursuant to Title 38, Chapter 4, Article 2. The Board may authorize payment of the actual and necessary expenses incurred by the Board in the performance of its duties.

R4-32-105. Participation

A. Each insurer (except the State Compensation Fund and as provided under A.R.S. § 20-1723) authorized to transact within this state any type of casualty insurance as defined in Section 20-252 on a direct basis shall participate in the Plan as a condition of its authority to continue to transact such kind of insurance in this state.

B. Participation in the Plan shall terminate as of the close of a fiscal year upon termination of authority to transact such kind of insurance within this state. With respect to all policies issued by the Plan in effect on the effective date of an insurer's termination, the liability of the terminating insurer shall cease on the anniversary date of each such policy during the succeeding year. Termination of participation shall not discharge or otherwise affect liabilities incurred prior to the anniversary date of such policies, and the insurer shall be charged or credited in due course with its proper share of all expenses and losses allocable thereto.

C. In the event of termination of participation in the Plan, the insurer shall continue to pay assessments until its proportionate share has been determined and paid; provided, however, that if the casualty business of a company has been purchased by or transferred to another company, the latter shall receive the assessments of the former until the proportionate share of the former has been determined and paid, unless another company has agreed, in manner satisfactory to the Board, to assume such obligation.

In the event that a company is merged with another company or there is a consolidation of companies, the continuing company shall receive the assessments of the company merged or consolidated until the proportionate share of such merged or consolidated company prior to such merger or consolidation has been determined and paid, providing, however, the continuing company may be relieved from such obligations if another company has agreed in a manner satisfactory to the Board, to assume such obligations. The continuing or successor company shall be entitled to any unused premium tax deduction to which the initial insurer would have been entitled.

D. The Director, on behalf of the Board, shall make initial assessment of fifty dollars on each participating insurer to defray the initial operating expenses of the Plan. The initial assessment shall be refunded by the Plan within one year after payment of the assessment.

E. If an assessment remains unpaid on account of insolvency of a participating insurer beyond a reasonable period, all of the other insurers, if notified by the Board, shall promptly pay

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their respective shares, each contributing its respective share as provided in Article 4 with the basis of sharing adjusted to exclude the premiums written of the insurer in default. The Board shall have the right of recovery therefore against the receiver of such company, provided however, the Board may enter into an agreement with any such receiver for an amount which shall constitute a full settlement of all of the obligations of said member to the remaining participating insurers, and such amount shall be deposited in the Joint Underwriting Plan Fund.

R4-32-106. Administration of plan

- A. The Plan shall offer either primary or excess coverage, or both, upon a determination by the Director, after notice and hearing, that professional liability insurance for physicians or hospitals or other licensed health care providers is not readily available or will not be readily available from admitted insurers. Excess coverage for physicians and hospitals shall be offered by the Plan without a determination of unavailability of such insurance.
- B. Upon call of the Director, the Board shall meet as often as may be required, on such date, at such place within the state and at such hour as may be designated by the Director, to perform the general duties of administration of the Plan. A Board meeting shall also be called by the Director whenever requested in writing by at least twenty-five percent of the members of the Board. Notices of all meetings shall be given to each Board member.
- C. The Board shall have the power on behalf of the Plan to consider and act upon any matters deemed by it to be necessary and proper for the administration of the Plan of Operations.
- D. The Board may appoint such committees or advisory committees and engage such other personnel as it deems appropriate to carry out the operation of the Plan.
- E. The Director, following each year in which the Plan is in operation, shall report each January to the Legislature and the Governor on the operation of the Plan.
- F. Accounting and record-keeping procedures of the Plan shall be conducted by the Board in accordance with the rules and regulations adopted by the Division of Finance, Department of Administration.

R4-32-107. Servicing carrier

- A. The Board may, pursuant to the rules of the Plan, contract with one or more eligible insurers to act as a servicing carrier. The Board shall provide for the establishment of the scope, terms, standards and compensation applicable to the services to be provided. Servicing carriers so designated must meet the eligibility requirements for servicing carriers prescribed in Article 2. Any agent or broker licensed to write personal injury liability insurance in the State of Arizona shall be entitled to place insureds through the Plan with a designated servicing carrier.
- B. If the Board so determines, the Plan shall perform directly those functions which would otherwise have been performed by a servicing carrier, in which case such licensed agent or broker shall be entitled to place such business directly with the Plan.

R4-32-108. Inspection of plan documents, audits of servicing carriers

- A. The books of account, records, reports and other documents of the Plan shall be open to inspection only in accordance with the provisions of A.R.S. Title 38 and A.R.S. Title 39, except that claim and underwriting material relating to any specific risk, plaintiff or defendant shall be and remain confidential.
- B. The books and accounts of the servicing carriers shall be audited by a firm of independent auditors designated by the

Board or by an audit committee of participating insurers, designated by the Board.

R4-32-109. Appeals

Any applicant to the Plan or any person insured thereby, or his representative or any affected insurer aggrieved with respect to any ruling, action or decision of the Board, or the Plan, or any committee thereof, may appeal such action, pursuant to Sections 20-161 through 20-166, to the same manner and to the same extent as if such action or failure to act was that of the Director.

ARTICLE 2. SERVICING CARRIERS

R4-32-201. Selection of servicing carrier

In selecting a Servicing Carrier, the Board shall satisfy itself that the insurer is eligible to be a Servicing Carrier, pursuant to A.R.S. § 20-1705, and possesses sufficiently experienced and qualified personnel to underwrite, administer and market professional liability insurance in the State of Arizona and to service properly claims that arise therefrom.

R4-32-202. Authority to bind coverage and issue policies

The Plan may authorize the Servicing Carrier to bind coverage and issue policies on behalf of the Plan and do those things necessary and incidental thereto, including the collection and transmittal of premium to the Board.

R4-32-203. Operating requirements

- A. The Servicing Carrier, if directed to do so by the Plan, may bind coverage for up to 30 days and where possible issue policies on behalf of the Plan, but if coverage is bound, Servicing Carriers must issue insurance policies to applicants by the expiration date of the 30-day binders if the applicant meets the qualification standards promulgated by the Board.
- B. Servicing Carriers must have the ability to carry out all subsequent policy transactions and servicing of claims on a timely basis.
- C. Servicing Carriers must have the ability to carry out all necessary accounting procedures as outlined in R4-32-106F.
- D. Servicing Carriers must generate the statistical and accounting information in report format prescribed by the Board, including the maintenance of statistical information required pursuant to A.R.S. § 20-1704(6).

R4-32-204. Selection of carrier; reimbursement for expenses and insurance business losses

- A. During the first year of operation, the Board may select an eligible Servicing Carrier or Carriers on the basis of competitive bid or on any other basis which it may deem appropriate. For any contracting extending beyond the initial year of the Plan's operation and for any contract executed after the initial year of operation, the Servicing Carrier shall be selected in accordance with the provisions of Title 41, Chapter 6.1.
- B. The Board shall allow a Servicing Carrier reimbursement in whole or in part for all reasonable and necessary expenses incurred in qualifying for, continuing as or ceasing to be a Servicing Carrier. Such expenses must be explained and supported in such detail as required by the Board.
- C. The Board shall authorize reimbursement of Servicing Carriers for normal insurance business losses and expenses incurred in connection with Plan business. Such normal business losses and expenses shall be defined and designated by the Board but shall not include any loss or expense incurred as a result of fraud or dishonesty on the part of a Servicing Carrier's personnel (including but not limited to independent adjusters) other than licensed insurance agents and brokers. Each Servicing Carrier shall hold the Plan harmless from and reimburse it for any such loss or expense arising out of such fraud or dishonesty charged to the Plan.

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R4-32-205. Advisory loss engineering program
The Servicing Carrier shall develop an Advisory Loss Engineering Program for health care providers insured by the Plan for primary coverage in accordance with procedures established by the Board.

R4-32-206. Transition to subsequent carriers
The Servicing Carrier shall make available copies of such materials that may be necessary to make orderly transition to any subsequent Servicing Carriers.

ARTICLE 3. ELIGIBILITY FOR COVERAGE IN THE PLAN

R4-32-301. Application for coverage
Any licensed health care institution or any other licensed health care provider practicing in the State of Arizona on or after the commencement of operations with respect to that class of business and that level of coverage offered by the Plan shall be entitled to apply to the Plan for professional liability insurance. Such application may be made on behalf of an applicant by a broker or agent whose license authorizes him to place those lines of insurance provided by the Plan.

R4-32-302. Issuance of policy
If the applicant meets the qualifications for application set forth in A.R.S. § 20-1702 B. (3-), C. or D., the Plan, upon receipt of the application and the premium or such portion thereof as is prescribed herein, shall cause to be issued a policy of professional liability insurance.

ARTICLE 4. ASSESSMENT OF PARTICIPATING INSURERS

R4-32-401. Assessments
All insurers required to participate in the Plan shall, in the event of a deficit in either Plan account, be assessed for the balance of the deficit in the proportion that the net written premiums of each such insurer written during the preceding calendar year bears to the aggregate net written premiums written in this State by all such insurers in such year.

R4-32-402. Notice, determination of insufficiency
No assessment shall be made of any participating insurer until notice shall have been given to each such insurer and until the Director finds, after notice and hearing, that funds in a Plan account are insufficient to pay the losses and costs attributable to such account.

R4-32-403. Amortization of payment of assessment
Payment of the assessment may be amortized by the Director if he finds after notice and hearing that immediate full payment would place the insurer in non-compliance with any financial requirement of A.R.S. Title 20. The potential liability of participating insurers for assessments pursuant to this Rule shall not be considered a risk on any one subject of insurance for the purposes of A.R.S. § 20-260(A).

R4-32-404. Determination of assessment ratio
The Board shall provide for the annual examination of the Annual Statement of each participating insurer, pursuant to criteria determined by the Director for the purpose of determining the assessment ratio of each such insurer, as provided in R4-32-401, for the year following the establishment of the assessment ratio.

R4-32-405. Remittance; failure to pay
After the Director has determined pursuant to R4-32-402 that a deficit exists in either Plan account, the Board shall assess each participating insurer in accordance with the assessment ratio established pursuant to R4-32-404 on forms developed by the Board. Upon

receipt of an assessment notice, the participating insurer shall remit to the Board the amount stated in the assessment notice within 45 days after receipt thereof. The Board shall notify the Director of any participating insurer failing to pay any assessment due in accordance with the provisions of this Rule.

ARTICLE 5. RECOUPMENT OF ASSESSMENT

R4-32-501. Premium tax deduction
Each participating insurer shall, following payment of any assessment levied by the Plan, commence recoupment of that assessment by deduction of such assessment from the Arizona premium tax due, in accordance with A.R.S. § 20-1707 C.

ARTICLE 6. TERMINATION OF THE PLAN AND CLOSING OF PLAN ACCOUNTS

R4-32-601. Replacement coverage
If coverage in any account is terminated or declared invalid pursuant to a final judicial determination, the Director shall use all monies in such account (except monies contributed by participating insurers) to purchase replacement professional liability insurance coverage, to the extent available, for risks previously insured by the Plan through such account. If the Director is unable to procure such coverage within sixty days after such judicial determination, the funds shall revert in the order of priority established in A.R.S. § 20-1707 D.

R4-32-602. Distribution of funds upon cessation of plan
Except as provided in R4-32-601, if any funds remain in the Plan upon cessation of its operations and payment or provision for payment of all Plan losses, such remaining funds shall be distributed pursuant to the priority set forth in A.R.S. § 20-1707 D.

ARTICLE 7. ESTABLISHMENT OF PREMIUM

R4-32-701. Premium rates for primary coverage
Premium rates for primary coverage provided by the Plan shall be twice the actuarially sound rate for such coverage as determined by the Board, with due regard to the experience and risk characteristics of the individual applicant. Nothing contained herein is intended to prevent the establishment of reasonable risk classification. No premium rate for primary coverage shall become effective until after notice has been given to each participating insurer and a hearing has been conducted by the Board.

R4-32-702. Premium rates for excess coverage
A: Premium rates for excess coverage for licensed health care providers, other than health care institutions, shall be established pursuant to A.R.S. § 20-1706 B. The premium rate for any eligible self-insured applicant shall be the applicable percentage of that premium which would have been paid by the applicant for occurrence basis primary coverage, as determined by the Board.
B: Premium rates for excess coverage for health care institutions shall be established pursuant to A.R.S. § 20-1706 C. The premium rate for any eligible self-insured applicant, who has primary coverage on a basis other than an occurrence policy, shall be the applicable percentage of that premium which would have been paid by the applicant for occurrence basis primary coverage, as determined by the Board.

ARTICLE 8. POTENTIAL CLAIM COVERAGE

R4-32-801. Reinsurance authorized
Prior to October 1, 1979, the Board may reinsure all of the obligations of the Plan with respect to claims reported after October 1, 1979, with an insurer or reinsurer authorized to transact such business in Arizona.

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ARTICLE 9. ESCROW ACCOUNT FOR SELF-INSURERS

- R4-32-901. Establishment of account; report of valuation**
- A.** Each applicant for excess coverage who has not purchased primary coverage from an insurer authorized to sell such coverage in Arizona, or from the Plan, shall establish an escrow account in a financial institution, as defined in A.R.S. § 6-101, in the State of Arizona, and shall deposit in such account cash or securities, at the then current market value, in the amount of one hundred thousand dollars. Any securities in such account shall be valued on the first day of each month and the applicant shall be required to maintain that amount at a current market value of one hundred thousand dollars. Failure to so maintain the account shall be treated in the same manner as an initial failure to establish such account and the Director shall immediately terminate the excess coverage provided and excess coverage for the applicant shall not be re-established until the escrow account established by the applicant contains cash or eligible securities in the amount of one hundred thousand dollars.
- Only those securities described in Sections 20-537, 20-538, 20-539 and 20-540 shall be eligible for deposit in the escrow account.
- The escrow account established hereunder shall be maintained solely for the purpose of paying medical malpractice claims or judgments against the applicant who establishes the account and in no event shall be used to pay legal fees and costs incurred in connection with the defense or settlement of any claim or judgment.
- B.** The applicant, in establishing an escrow account pursuant to this Rule, shall require the depository where such account is maintained to report within five days after the first day of each

- month to the Director the value of any securities, and the cash deposit in the escrow account.
- C.** The insured shall file a report with the Director within five days after the first day of each month which reports the status of any pending claims or settlements against the insured.
- D.** Failure to file reports required pursuant to Subsections B. and C. of this Rule shall constitute cause for termination of excess coverage for the insured.

ARTICLE 10. JOINT UNDERWRITING PLAN FUND

- R4-32-1001. Deposits; claims for reimbursement; disbursements**
- A.** All monies received by the Board as premiums or assessments upon participating insurers, either directly or from the servicing carriers, shall be transmitted by the Board to the State Treasurer for deposit in the Joint Underwriting Plan Fund.
- B.** All claims for reimbursement against either Plan account shall be completed on claim forms supplied by the Division of Finance, Department of Administration, and shall be forwarded to the Division of Finance, Department of Administration, for approval and payment.
- C.** When the Board has ceased issuing policies and has procured insurance coverage for potential claims against Plan insureds, the Director may determine, in accordance with A.R.S. § 20-1707 (D), the manner of distribution of funds remaining in the Joint Underwriting Plan Fund. The Director shall submit a claim to the Division of Finance of the Department of Administration for the disbursement of the remaining funds and shall request that after such disbursement has been made that the Joint Underwriting Plan Fund accounts be closed.