# **02 DEPARTMENT OF PROFESSIONAL AND FINANCIAL REGULATION**

**031 BUREAU OF INSURANCE**

**Chapter 630: RURAL MEDICAL ACCESS PROGRAM**

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**Section 1. Purpose**

The purpose of this Rule is to establish the assessment and premium assistance procedures for the Rural Medical Access Program (“Program”) and to establish standards or procedures to implement the Program. The assessment procedures are intended to result in collections that are adequate for the Program to fulfill its statutory purpose.

**Section 2. Authority**

This Rule is promulgated pursuant to 24-A M.R.S.A. §§ 212, 229(1), 6305, and 6311.

**Section 3. Definitions**

1. “Insurer” is defined as in 24-A M.R.S.A. §6303(1).

2. “Program fund balance” is defined as in 24-A M.R.S.A. §6305(3).

3. “Self-insured” is defined as in 24-A M.R.S.A. §6303(3). In particular, the term includes a physician, hospital, or physician’s employer obtaining coverage from an unauthorized insurer (other than pursuant to the surplus lines law) or a risk retention group. It also includes a physician, hospital, or physician’s employer that has not obtained insurance coverage. A policyholder may be insured in part and self-insured in part, as provided in Subsections 4(3) and 4(~~4~~) of this Rule.

4. “Superintendent” means the Superintendent of Insurance.

5. “Practices medicine” or “practicing medicine” is defined as in 32 M.R.S.A. §3270, whether or not the physician receives compensation.

**Section 4. Assessments**

1. The assessment base for insured policyholders (including holders of excess policies) shall be the actual premium paid for policies issued or renewed with an effective date during July 1 to June 30 of the following calendar year; except that if a policy insuring physicians includes a deductible of less than $100,000 for the physician’s exposure, then the assessment base for insuring physicians shall be the calculated premium by the insurer for an equivalent risk without any deductible. The assessment base on a policy or portion of a policy insuring hospitals that includes a deductible of less than $1,000,000 shall be the calculated premium by the insurer for an equivalent risk without any deductible.

2. Each year, not later than May 1, for purposes of assessments on self-insureds, the Superintendent shall identify the principal writer of physicians' malpractice insurance and the principal writer of hospital malpractice insurance based on direct written premium in the prior calendar year, or the most recent year for which information is available as of May 1.

3. The assessment base for self-insured physicians shall be determined for each physician by using the filed and approved rates and rating rules as of July 1 of each year of the principal writer of physicians’ malpractice insurance in Maine. A physician carrying a deductible coverage of $100,000 or more per claim from an insurer shall be considered self-insured to the extent of his or her self-insured retention. The assessment base shall use the number of years licensed in Maine (unless the physician provides evidence of more recent occurrence-based coverage or extended reporting coverage), appropriate classification as defined by the principal writer, and maximum coverage limits of $1,000,000 per claim, $3,000,000 aggregate per year; except that if the physician retains excess coverage with an underlying retention other than $1,000,000 per claim, $3,000,000 aggregate per year, then the assessment base shall be adjusted based on the principal writer’s increased or reduced limits factors to the attachment point of the excess coverage.

4. The assessment base for self-insured hospitals shall be determined for each hospital by using the filed and approved rates and rating rules as of July 1 for the principal writer of hospital malpractice insurance in Maine. A hospital is considered self-insured if its self-insured retention is at least $1,000,000. The assessment base shall use the claims made years of exposure, appropriate classification as defined by the principal writer, coverage of $1,000,000 per claim, $3,000,000 aggregate per year, no schedule rating, and the number of beds and outpatient visits applicable to each hospital; except that if the hospital retains excess coverage with an underlying retention greater than $1,000,000 per claim, $3,000,000 aggregate per year, then the assessment base shall be adjusted based on the principal writer’s increased or reduced limits factors to the attachment point of the excess coverage.

5. If the assessment amount is less than $5, then it shall be waived.

6. If a physician is licensed in Maine, but does not currently practice in Maine, then he or she is not to be charged an assessment. If a Maine licensed physician practices medicine part of the time in Maine and part of the time elsewhere, the physician is allowed to pro-rate the annual assessment owed to be equal to the pro-rated amount of time practiced in Maine. For purposes of this section, telemedicine and radiology/film consultation performed from outside Maine is not considered practicing medicine in Maine.

7. Up to the coverage limits established in this section, the assessment base applies to all premiums, regardless of whether coverage is by a single policy or multiple policies.

8. Physicians, physicians’ employers, and hospitals covered by a policy issued by an insurer shall remit, after billing by the insurer, the assessment ordered by the Superintendent pursuant to 24-A M.R.S.A. §6305 and this Rule. The insurer shall hold collected funds and invest those funds until premium assistance credits or refunds are authorized or intercompany transfers are ordered. Any interest earned on collected funds shall be credited to the Program. The insurer shall report to the Superintendent, within 60 days after billing, the name and address of any physician, hospital, or physician’s employer that fails to pay the required assessment when due.

9. Self-insured physicians, physicians’ employers, and hospitals shall remit the assessment to the principal writer of physicians’ malpractice insurance in Maine. The Superintendent shall develop a form to be used by reporting self-insureds. Upon receipt on or before July 1 of lists of physicians, physicians’ employers, hospitals, and the last known insurer, if any, from the Board of Licensure in Medicine, the Board of Osteopathic Examination and Registration, and the Department of Health & Human Services’ Division of Licensure and Certification, the Superintendent shall notify all self-insureds of the assessment and the procedure for calculating the assessment base.

10. The principal writer of physicians’ and hospitals’ malpractice insurance shall receive and maintain funds collected, shall invest funds held and credit interest earned to the Program, shall review the calculation on the prescribed submission form, and shall report quarterly to the Superintendent the receipts, earnings, disbursements, and balance of the fund. The principal writer shall report quarterly to the Superintendent a listing of all self-insureds remitting the assessment and the amount paid.

11. The Superintendent shall review the Program fund balance each year after collecting substantially all of the assessments for the current policy year. The purpose of this review is to determine the Program assessment rate consistent with the statutory requirements to provide an adequate and reliable funding source for the Program and to allow for the orderly and prudent drawdown of any long-term Program fund balance. The Superintendent may include in this review, without limitation, such considerations as the then-current condition of and reasonably anticipated trends in the medical malpractice insurance market in Maine, the size of this market’s assessment base, and recent and expected requests for assistance from the Program.

When the Superintendent identifies the principal writer of physicians’ and hospital malpractice insurance pursuant to Subsection 2, the Superintendent shall notify the principal writer and other affected parties of the assessment rate for the upcoming policy year.

When the Program fund balance is above $50,000, the Superintend shall select an assessment rate at three-fourths of one percent (0.75%) or less, or may waive the assessment entirely. For the policy year starting July 1, 2014 and each policy year thereafter until the Superintendent selects a different rate, the assessment rate is two-tenths of one percent of premium (0.2%).

When the Program fund balance is $50,000 or less, the Superintendent shall select an assessment rate no less than three-fourths of one percent (0.75%) but not to exceed one percent (1.0%).

The Superintendent may in no event select an assessment rate expected to result in collections exceeding $500,000 for the upcoming policy year.

**Section 5. Reporting, transfers**

1. Each insurer shall report annually, on or before September 1, the assessments collected on policies issued between July 1 of the prior year and June 30 of the current year. The report shall contain the name of each physician, hospital, or physician’s employer, the physician’s Maine license number, the policy number, the policy effective date, and the assessment collected or credited. This detailed report shall be made available in an electronic format acceptable to the Superintendent. The insurer shall also report in aggregate, on a quarterly basis, funds collected, interest earnings, disbursements, and a net balance. The quarterly statements are due at the Bureau within 30 days of the end of each calendar quarter.

2. If an insurer reports or projects a negative fund balance or if the Superintendent finds that transfers of funds are desirable to effectively administer the Program, the Superintendent may order intercompany transfers among insurers.

**Section 6. Premium assistance**

1. The Superintendent shall apply the standards of prioritization adopted by the Commissioner of Human Services to determine the physicians who shall receive premium assistance.

2. No premium assistance shall be authorized to a physician not found eligible by the Department of Human Services or who owes premiums to any insurer for any policy year prior to the year for which assistance is sought.

3. For each physician eligible for assistance, the Superintendent shall calculate the difference between the medical malpractice premium with and without obstetrical care coverage. For purposes of this calculation, the Superintendent shall use the policy with an effective date occurring in the eligibility period, without regard for any subsequent cancellations and endorsements. The assistance per physician shall be adjusted to comply with the $5,000 minimum and $15,000 maximum established in 24-A M.R.S.A. §6308(2).

4. In determining the difference between the physician’s medical malpractice insurance premium with obstetrical care coverage and without obstetrical care coverage, the Superintendent shall consider the following:

(A) The services performed and the applicable insurance rating classification during the Program eligibility period.

(B) The services performed other than obstetrical care and the applicable insurance rating classification without obstetrical care during the Program eligibility period.

(C) The rates and rating rules of the physician’s insurer or principal writer during the period for which assistance is sought.

(D) If necessary, the services performed and the applicable insurance rating classification immediately preceding eligibility for Program assistance.

(E) For physicians newly entering practice, and if necessary for other applicants, the training and certification of that physician immediately prior to eligibility for Program assistance.

5. No assistance shall be provided to a class of eligible physicians until all eligible physicians in the next higher priority class have received the entire indicated assistance.

6. If the funds available for distribution to a class of physicians with equal priority are insufficient to provide the amount of assistance indicated, then the amount of assistance shall be adjusted by the ratio the amount available for distribution bears to the calculated cost of premium assistance for the physicians in the priority class.

7. Physicians receiving premium assistance must fully comply with this Rule and rules adopted by the Department of Human Services. Failure to comply may result in the recoupment of the value of assistance already given and withholding of further assistance.

8. The annual premium credit based on the difference in premium shall be determined using the physician’s actual premium and coverage, except that if coverage limits exceed $1,000,000 per claim, $3,000,000 aggregate per year, then the premium difference shall be determined at $1,000,000 /$3,000,000 limits.

**Section 7. Appeals**

A physician, hospital, or physician’s employer aggrieved by the imposition of an assessment may request a hearing before the Superintendent. A request for hearing shall be made not more than 30 days from the date the applicant knew or reasonably should have known of the action causing the grievance, shall be in writing, and shall state the reason or reasons for the grievance and the requested relief.

**Section 8. Severability**

If any section or provision of this Rule is adjudged invalid for any reason, the judgment shall not impair or invalidate any other section or provision of the Rule, and the remaining sections or provisions shall remain in full force and effect.

**Section 9. Effective date**

The effective date of this Rule is January 29, 1992. The effective date of the 2008 amendments to this Rule is August 10, 2008. The 2014 amendments are effective May 5, 2014.

STATUTORY AUTHORITY:24-A M.R.S.A. §§ 212, 229(1), and 6311

EFFECTIVE DATE:

January 29, 1992

EFFECTIVE DATE (ELECTRONIC CONVERSION):

January 14, 1997

AMENDED:

August 10, 2008 – filing 2008-339

May 5, 2014 – filing 2014-086

APAO WORD VERSION CONVERSION (IF NEEDED) AND ACCESSIBILITY CHECK: July 18, 2025