"**[CHAPTER 435C]**
HAWAII MEDICAL MALPRACTICE UNDERWRITING PLAN

Section

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"   **[§435C-1] Purpose.** The purpose of this chapter is to provide a contingency plan to be instituted by the insurance commissioner upon the unavailability of medical malpractice insurance in this State. [L 1975, c 161, pt of §1]

Cross References

Medical torts, see chapter 671.

"   **§435C-2 Definitions.** As used in this chapter:

"Medical malpractice 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 professional service by any licensed physician or hospital.

"Net direct premiums" means general casualty insurance direct premiums written as reported on the Hawaii State Page of the Exhibit of Premium and Losses of the annual statement under medical malpractice, workers' compensation, and other liability lines of business.

"Plan" means the joint underwriting plan established pursuant to the provisions of this chapter. [L 1975, c 161, pt of §1 and am c 41, §1; am L 1979, c 164, §1; am L 1998, c 204, §1]

Revision Note

Definitions restyled and rearranged.

"   **§435C-3 Joint underwriting plan, establishment.** (a) A joint underwriting plan is established, consisting of all insurers authorized to write and engaged in writing casualty insurance in this State on a direct basis. Each insurer shall be a member of the plan and shall maintain membership as a condition of its licensure to transact such insurance in this State. The purpose of the plan shall be to provide medical malpractice insurance on a self-supporting basis. The plan shall be the exclusive agency through which medical malpractice insurance may be written in this State on a primary basis for physicians and hospitals.

(b) The plan shall, pursuant to the provisions of this chapter and the plan of operation with respect to medical malpractice insurance, have the power on behalf of its members:

(1) To issue, or to cause to be issued policies of insurance to applicants, including incidental coverages and subject to limits as specified in the

plan of operation but not to exceed $100,000 for each claimant under one policy in any one year;

(2) To appoint service companies to underwrite such insurance and to adjust and pay losses with respect thereto;

(3) To assume reinsurance from its members; and

(4) To cede reinsurance.

(c)(1) The commissioner shall, after consultation with the joint underwriting plan, representatives of the public, the Hawaii Medical Association and other affected individuals and organizations, promulgate a plan of operation consistent with the provisions of this chapter within sixty days after the creation of the plan. The plan of operation shall become effective and operational upon order of the insurance commissioner.

(2) The plan of operation shall provide for economic, fair and nondiscriminatory administration and for the prompt and efficient provision of medical malpractice insurance, and shall contain other provisions including, but not limited to, preliminary assessment of all members for initial expenses necessary to commence operation, establishment of necessary facilities, management of the plan, assessment of members to defray losses and expenses, commission arrangements, reasonable and objective underwriting standards, acceptance and cession of reinsurance, appointment of servicing carriers and standards, and procedures for determining amounts of insurance to be provided by the plan.

(3) The plan of operation shall provide that any profit achieved by the plan be added to the reserves of the plan or returned to the policyholders as a dividend.

(4) Amendments to the plan of operation may be made by the directors of the plan, subject to the approval of the insurance commissioner, or shall be made at the direction of the insurance commissioner. [L 1975, c 161, pt of §1; am L 1976, c 219, §5; am L 1984, c 232, §2]

" **§435C-4 Procedures.**

(a)(1) Any licensed physician or hospital shall, on or after the effective date of the plan of operation, apply to the plan for such coverage. Such application may be made on behalf of an applicant by a producer authorized by the applicant.

(2) If the plan determines that the applicant meets the underwriting standards of the plan as provided in the plan of operation and there is no unpaid, uncontested premium due from the applicant for prior insurance (as shown by the insured having failed to make written objection to the premium charges within thirty days after billing), then the plan, upon receipt of the premium, or such portion thereof as is prescribed in the plan of operation, shall cause to be issued a policy of medical malpractice insurance for a term of one year.

(b)(1) The rates, rating plan, rating classifications, territory, and policy forms applicable to the insurance written by the plan and statistics relating thereto shall be subject to sections 431:14-101 to 431:14-117 unless otherwise provided hereto, giving due consideration to the past and prospective loss and expense experience within and outside this State for medical malpractice insurance of all of the member companies of the plan, trends in the frequency and severity of losses, the investment income of the plan, and such other information as the insurance commissioner may require;

(2) Any deficit sustained by the plan in any one year shall be recouped, pursuant to the plan of operation and the rating plan then in effect by one or both of the following procedures:

(A) An assessment upon the policyholders; or

(B) A rate increase applicable prospectively;

(3) Effective after the initial year of operation, rating plans and rating rules, and any provisions of recoupment through policyholder assessment or premium rate increase, shall be based upon the plan's loss and expense experience, together with such other information based upon such experience as the insurance commissioner may deem appropriate. The resultant premium rates shall be on an actuarially sound basis and shall be calculated to be self-supporting;

(4) In the event that sufficient funds are not available for the sound financial operation of the plan, pending recoupment as provided in paragraph (3) of this subsection, all members shall, on a temporary basis contribute to the financial requirements of the plan in the manner provided for in section 435C-5. Any such contribution shall be reimbursed to the members

following recoupment as provided in paragraph (3) of this subsection; and

(5) The commissioner shall consider requiring the plan to offer policies on a claims made or occurrence basis; provided that the premium rate charged for the policies shall be at rates established on an actuarially sound basis and that are calculated to be self-supporting. [L 1975, c 161, pt of §1; am L 1998, c 204, §2; am L 2002, c 155, §105; am L 2004, c 122, §94]

" **§435C-5 Participation.** All insurers that are members of the plan shall participate in its expenses, profits, and losses in the proportion that the net direct premiums of each such member (excluding that portion of premiums attributable to the operation of the plan) written during the preceding calendar year bears to the aggregate net direct premiums written in this State by all members of the plan. Insurers that are members of the plan may also be appointed by the insurance commissioner as servicing companies to underwrite the medical malpractice insurance. Each insurer's participation in the plan shall be determined annually on the basis of such net direct premiums written during the preceding calendar year, as reported in the annual statements and other reports filed by the insurer with the insurance commissioner. No member shall be obligated in any one year to reimburse the plan on account of its proportionate share in the deficit from operations of the plan in that year in excess of one per cent of its policyholders' surplus and the aggregate amount not so reimbursed shall be reallocated among the remaining members in accordance with the method of determining participation prescribed in this section after excluding from the computation the total net direct premiums of all members not sharing in the excess deficit. In the event that the deficit from operations allocated to all members of the plan in any calendar year shall exceed one per cent of their respective policyholders' surplus, the amount of such deficit shall be allocated to each member in accordance with the method of determining participation prescribed in this section. [L 1975, c 161, pt of §1; am L 1998, c 204, §3]

" **[§435C-6] Directors.** The plan shall be governed by a board of eleven directors, ten to be selected annually. Five directors shall be elected by cumulative voting by the members of the plan, whose votes in such election shall be weighted in accordance with each member's net direct premiums written during the preceding calendar year. Three directors shall be appointed by the insurance commissioner as representatives of the medical

profession. Two directors shall be appointed by the insurance commissioner as representatives of the public. The five member companies serving on the first board shall be elected at a meeting of the members, or their authorized representatives, which shall be held at a time and place designated by the insurance commissioner. The insurance commissioner shall appoint the five directors serving on the first board on or before the date of such meeting. The insurance commissioner shall be the other member and shall be its chairperson. [L 1975, c 161, pt of §1]

" **[§435C-7] Appeals and judicial review.** Any applicant to the plan, any person insured pursuant to this chapter, or their representatives, or any affected insurer, may appeal to the insurance commissioner within thirty days after any ruling, action or decision by or on behalf of the plan, with respect to those items the plan of operation defines as appealable matters.

All orders of the insurance commissioner made pursuant to this chapter shall be subject to judicial review as provided in section 431:14-118. [L 1975, c 161, pt of §1]

Revision Note

Section "431:14-118" substituted for "431-705".

" **§435C-8 Privileged communications.** There shall be no liability on the part of, and no cause of action of any nature shall arise against the plan, its agents or employees, an insurer, any producer, or the insurance commissioner or the commissioner's authorized representatives, for any statements made in good faith by them in any reports or communications concerning risks insured or to be insured by the plan, or at any administrative hearing conducted in connection therewith. [L 1975, c 161, pt of §1; gen ch 1985; am L 2002, c 155, §106]

Cross References

Required reports privileged by statute, see §626-1, rule 502.

" **[§435C-9] Annual statements.** The plan shall file in the office of the insurance commissioner annually on or before the fifteenth day of March, a statement which shall contain information with respect to its transactions, conditions, operations and affairs during the preceding year. Such statement shall contain such matters and information as are prescribed and shall be in such form as is approved by the insurance commissioner. The insurance commissioner may, at any

time, require the plan to furnish additional information with respect to its transactions, condition, or any matter connected therewith considered to be material and of assistance in evaluating the scope, operation and experience of the plan. [L 1975, c 161, pt of §1]

" **[§435C-10] Examinations.** The insurance commissioner shall make an examination into the affairs of the plan at least annually. Such examination shall be conducted and the report thereon filed in the manner prescribed in section 431:2-302. The expenses of every such examination shall be borne and paid by the plan in the manner prescribed by section 431:2-306. [L 1975, c 161, pt of §1]

Revision Note

Sections 431:2-302 and 431:2-306 substituted for sections 431-54 and 431-59, respectively.

" **[§435C-11] Initiation of plan.** The plan becomes operational at the direction of the insurance commissioner, upon a finding that medical malpractice insurance is not or will not be readily available in this State to the majority of the physicians and hospitals. Upon a finding by the insurance commissioner that medical malpractice insurance has become readily available in the voluntary market, the commissioner may direct the plan to cease writing medical malpractice insurance.

The plan, being a temporary measure, shall not remain in existence for more than three years after the plan becomes operational. [L 1975, c 161, pt of §1; gen ch 1985]