TITLE 16

DEPARTMENT OF REGULATORY AGENCIES

CHAPTER 7

# HAWAII MEDICAL MALPRACTICE UNDERWRITING PLAN

Historical Note: Chapter 7 of title 16, Administrative Rules, is based substantially upon Chapter 8, title V, Department of Regulatory Agencies, entitled "Hawaii Medical Malpractice Underwriting Plan." [Eff 3/15/76; R 6/22/81]

## SUBCHAPTER 1

## GENERAL PROVISIONS

§16-7-1 Purpose. The purpose of this chapter is to formulate a plan of operation to implement the joint underwriting plan (hereinafter referred to as the "plan") established under the Hawaii medical malpractice underwriting plan, as specified in chapter 435C, HRS, and shall become effective in accordance with chapter 91, HRS. [Eff 6/22/81] (Auth: HRS §435C-2) (Imp: HRS §§435C-1, 435C-3)

§16-7-2 Membership. (a) All insurers authorized to write casualty insurance within this state on a direct basis shall be members of the plan. Every casualty insurer shall be a member of the plan and shall remain a member as a condition of its authority to continue to transact casualty of insurance in this state.

(b) A member may terminate membership in the plan as of the close of a fiscal year upon terminating its certificate of authority to transact casualty insurance within this state. With respect to all policies in effect on the effective date of a member's termination, the liability of the terminating member shall cease on the expiration date of each policy. Termination of membership shall not discharge or otherwise affect liabilities incurred prior to the expiration date of policies, and the member shall be charged or credited in due course with its proper share of all expenses, losses, and profits allocable thereto.

(c) The fiscal year of the plan shall be determined by the board of directors (hereinafter referred to as the "board"). [Eff 6/22/81] (Auth: HRS [435C-2) (Imp: HRS §435C-3)

SUBCHAPTER 2

THE PLAN

§16-7-3 Members' participation. (a) For the purposes of determining the extent of participation by members, insurers under common management or ownership shall constitute a single member.

(b) All insurers which are members of the plan shall participate in its writings, expenses, servicing allowance, management fees, and losses in proportion that the net direct premiums as defined in section 435C-2(3), HRS, of each 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; provided that any profit realized shall either be considered within the rating structure of the plan or returned to the policyholders as a dividend. When the plan stops writing insurance any ultimate net profit, after deducting contributions, including initial expenses, shall be returned to the policyholders as a dividend. Each insurer's participation in the plan shall be determined annually on the basis of net direct premiums written during the preceding calendar year, as reported in the annual statement and other reports filed by the insurer with the insurance commissioner.

(c) No member shall be obligated in any one year to reimburse the plan on account of its proportionate share in any deficit from operations of the plan in that year an amount in excess of one percent of such member's surplus to policyholders. The aggregate amount not so reimbursed by reason of the application of this provision shall be reallocated among the remaining members in accordance with the method of determining participation described in this section, after excluding from such computation the total net direct premiums of all members not sharing in such excess deficit. In the event the deficit from operations allocated to all members of the plan in any calendar year shall exceed one percent of their respective surplus to policyholders, the amount of the deficit ìshall be allocated to each member in accordance with the method of determining participation prescribed in this section.

(d) Any deficit sustained by the plan shall be recouped by either or both of the following methods:

(1) An assessment upon the policyholders;

(2) A rate increase applicable prospectively. [Eff 6/22/81] (Auth: HRS §435C-2) (Imp: HRS §§435C-3, 434C-4, 435C-5)

§16-7-4 Eligibility. (a) Any physician or hospital as defined in this subsection licensed in the State of Hawaii, excluding self-insurer, on or after the

effective date of the plan of operation shall apply only to the plan for primary medical malpractice liability insurance unless considered ineligible under the plan. Such application may be made on behalf of the applicant by authorized domestic insurer, general agent, subagent, or solicitor.

"Hospital" means a public or private institution licensed under chapter 12 and 12A of the public health regulations of the department of health, State of Hawaii.

"Physician" means a person with an unlimited license to practice medicine in this state under chapters 453 and 460, HRS.

(b) If the plan determines that the applicant meets the underwriting standards of the plan as provided for in the operating principles, and there is no unpaid, uncontested premium due from the applicant for prior insurance, then the plan upon receipt of the premium of such portion thereof as is prescribed in the operating principles shall cause to be issued a policy of medical malpractice liability insurance for a term not exceeding one year.

(c) The plan shall have the power on behalf of its members to:

(1) Issue, or to cause to be issued, policies of insurance on a primary limits basis to applicants, including incidental coverages and subject to limits as specified in the operating principles 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;

(2) Underwrite such insurance and to adjust and pay losses with respect thereto, or to appoint service carrier(s) to perform those functions;

(3) Assume reinsurance from its members; and

(4) Cede reinsurance. [Eff 6/22/81] (Auth: HRS §435C-2) (Imp: HRS §435C-3)

§16-7-5 Board of directors. (a) 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 the 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 insurance commissioner shall be the other member and shall be its chairperson.

(b) Each member of the board shall have one vote and the affirmative votes of a majority of the members of the board shall be required to carry a proposition. A majority of the board shall constitute a quorum for the transaction

of business and the acts of a majority of the board members present at a meeting, at which a quorum is present, shall be the acts of the board.

(c) The board shall have authority to exercise all reasonable or necessary powers relating to the operation of the plan which are not specifically delegated in the plan to others or reserved to the members.

(d) Members of the board shall serve without compensation. However, they may be reimbursed by the plan for expenses incurred by them as board members. Expenses shall be submitted to the board for approval and subsequent payment, provided that the approval of a majority of the full board shall be required for a total reimbursement to an individual member which exceeds $100. [Eff 6/22/81] (Auth: HRS §435C-2) (Imp: HRS §435C-6)

§16-7-6 Board meetings. (a) Regular meetings of the board of directors shall be held on the date, at the place within the State approved by the board of directors and the hour as designated by the board of directors.

(b) Special meetings may be called at any time by the commissioner, who shall be the chairperson of the board of directors. A special meeting shall be called by the chairperson of the board of directors whenever requested in writing by any two other members of the board of directors. Notices of special meetings shall state the purpose thereof.

(c) Notices of all regular and special meetings shall be sent to each member of the board of directors and to each person serving as a representative on committees which may be created by the board of directors. Each notice shall state the purpose of the meeting and include any proposed changes in rules or procedures.

(d) Notice of each regular meeting of the members of the board of directors shall be given at least ten days prior to the date of the meeting by ordinary mail to each member of the board of directors at the member's office address according to the records of the plan except that notice of a meeting to amend the plan shall be given in the manner provided above at least thirty days prior to the date of the meeting. Notices of meetings to amend the plan shall include the proposed amendments. The time of all notices shall run from date of mailing the notice. [Eff 6/22/81] (Auth: HRS §435C-2) (Imp: HRS §435C-6)

§16-7-7 Administration. The board may appoint a general manager and such committees and engage such other personnel as it deems appropriate to carry out the operations of the plan. [Eff 6/22/81] (Auth: HRS §435C-2) (Imp: HRS §435C-6)

§16-7-8 Appointment of servicing carriers. The board of directors, pursuant to its operating principles, may designate one or more of its eligible members to act as a servicing carrier. Additional servicing carriers may be designated as necessary. The board of directors 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 approved by the board. Any domestic insurer, general agent, subagent, or solicitor licensed to write casualty insurance in the State of Hawaii shall place business through a designated servicing carrier or carriers. [Eff 6/22/81] (Auth: HRS §435C-2) (Imp: HRS §435C-3)

§16-7-9 Servicing carrier(s). (a) In selecting a servicing carrier or carriers the board should satisfy itself that the servicing carrier possesses sufficiently experienced and qualified personnel to properly underwrite medical malpractice business in the State of Hawaii and to properly service claims that arise therefrom.

(b) The servicing carrier must have the ability to collect the necessary data to disburse commission payments to agents on behalf of the plan and have the ability to store the data and report same to the Internal Revenue Service annually, if required.

(c) The servicing carrier must generate the statistical and accounting information in report format required. The required content and format of these reports are to be set out in the operating principles.

(d) The board of directors, in its sole discretion, may offer or allow a servicing carrier reimbursement in whole or in part for specific extraordinary expense incurred in qualifying for, continuing as or ceasing to be a servicing carrier. The expense must be explained and supported in detail as required by the board of directors, must be in its judgment significantly in excess of the normal additional expense expected to beincurred by the carrier, and must be actually incurred before reimbursement.

(e) The board of directors may in its discretion authorize reimbursement of the servicing carrier for normal operating expenses incurred in connection with plan business. The normal operating 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 the servicing carrier's personnel (including, but not limited to, independent adjusters and agents), and each servicing carrier shall hold the plan harmless from and reimburse it for any loss or expense arising out of fraud or dishonesty charged to the plan.

(f) The designation of a servicing carrier may be withdrawn at the option of the servicing carrier or the board of directors on the giving of four months' written notice to the other. Such arrangement may also be terminated at

any time by mutual agreement of the servicing carrier and the board of directors or terminated by the board of directors for just cause. [Eff 6/22/81] (Auth: HRS §435C-2) (Imp: HRS §435C-3)

§16-7-10 Joint liability for plan business. (a) In the event of the failure of any member, through insolvency or otherwise, to pay promptly its portion of any loss or expense after the board of directors shall have made written demand upon it to pay the loss or expense, the board shall report the delinquency to the insurance commissioner for appropriate action.

(b) If the loss or expense remains unpaid beyond a reasonable period, all of the other members, upon notification by the board, shall promptly pay their respective shares, each contributing its respective share as provided in section 16-7-3 with the basis of sharing adjusted to exclude the premiums written of the member in default. Members which have made contributions shall have the right of recovery therefor against the member in default, provided, the board of directors may enter into an agreement with any such member in default, or with the legal representative thereof, upon an amount which shall constitute a full settlement of all of the obligations of said member to the remaining members. [Eff 6/22/81] (Auth: HRS §435C-2) (Imp: HRS §435C-3)

§16-7-11 Indemnification. (a) Any person or member made a party to any action, suit, or proceeding because the person or member:

(1) Serves or served on the board of directors or a committee of the plan; or

(2) Is or was an officer or employee of the plan, except for the insurance commissioner and the insurance commissioner's representatives,

shall be indemnified by the plan against all costs (including the amounts of judgments and interest thereon, settlements, fines, or penalties) and expenses incurred in connection with the action, suit, or proceeding; provided such indemnification shall not be provided on any matter in which the person or member shall be finally adjudged in any such action, suit, or proceeding to have committed a breach of duty involving bad faith, dishonesty, wilful misfeasance or reckless disregard of the person's responsibilities. Indemnification shall be provided only if the plan is advised by its counsel that the person or member to be indemnified did not in counsel's opinion commit such a breach of duty.

(b) The indemnification shall be paid for by the members, each contributing in accordance with section 16-8-3.

(c) This section is intended to operate as a supplement and additional safeguard to, and not in place of, the immunity granted by section 435C-8, HRS. [Eff 6/22/81] (Auth: HRS §435C-2) (Imp: HRS §§435C-6, 435C-8)

§16-7-12 Records and reports. (a) The books of account, records, reports and other documents of the plan shall be open to inspection by all persons including members at such times and under such conditions and regulations as the board shall determine.

(b) 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 commissioner may, at any time, require the plan to furnish additional matter connected therewith considered to be material and of assistance in evaluating the scope, operation and experience of the plan.

(c) For purposes of establishing a basis for allocation of the servicing carrier's and the board's expenses plus losses, each company licensed to write casualty insurance in this state shall report statistical information required by the operating principles to the board or permit its statistical agencies, designated by the company, to report the statistical information to the board.

(d) This section shall not apply to records which invade the right of privacy of the individual. [Eff 6/22/81] (Auth: HRS §435C-2) (Imp: HRS §435C-9)

§16-7-13 Auditing of members. (a) The board of directors may audit the records of any member relating to the subject matter of the plan of operation or the operating principles and may by rule establish what policies, records, books of account, documents, and related materials are necessary to carry out its functions. Such material shall be provided by the members in the form and with the frequency reasonably required by the plan.

(b) The costs and expenses of the audit shall be paid for by the members in accordance with section 16-7-3(b). [Eff 6/22/81] (Auth: HRS §435C-2) (Imp: HRS §§435C-3, 435C-9, 435C-10)

§16-7-14 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

431-54, HRS. The expenses of every such examination shall be paid by the plan in the manner prescribed by section 431-59, HRS. [Eff 6/22/81] (Auth: HRS §435C-2) (Imp: HRS §435C-10)

§16-7-15 Member termination. (a) In the event a member company discontinues as a member of the plan, it shall continue to pay assessments until its proportionate share has been determined and paid; provided that if the casualty business of a company has been purchased by, transferred to, or reinsured by 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 insurance commissioner, to assume such obligation.

(b) 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; provided the continuing company may be relieved from such obligations if another company has agreed, in a manner satisfactory to the insurance commissioner, to assume such obligations.

(c) For purposes of this section only, insurers under common management or ownership shall not constitute a single member. Extent of participation will still be governed by section 16-7-3. [Eff 6/22/81] (Auth: HRS §435C-2) (Imp: HRS §§435C-3, 435C-5)

§16-7-16 Plan fund. There is established a fund into which payments by insurers and others, as may be prescribed or permitted by the board of directors, shall be deposited and held by the board and from which disbursements may be made upon authorization of the board of directors for carrying out the purposes of the plan. The funds may be invested and reinvested in such investments as are permitted under chapter 431, HRS. [Eff 6/22/81] (Auth: HRS §435C-2) (Imp: HRS §§435C-3, 435C-4)

## SUBCHAPTER 3

## OPERATING PRINCIPLES

§16-7-17 Policy forms and rates. (a) All policies issued by the plan shall be written for a period of one year to commence at 12:01 a.m. on their respective

effective dates and terminating at l2:01 a.m. one year thereafter; provided policies issued by the plan may be written for a period of less than one year in order to provide for a common expiration date of all policies. As determined by the board, all such policies issued by the plan, which shall be written on either the "occurrence" basis or the "claims made" basis, shall not contain a provision which requires as a condition precedent to settlement or compromise of any claim, the consent or acquiescence of the insured.

(b) Policies issued by the plan may not be cancelled or refused renewal by the plan except when:

(1) The license of an insured physician is revoked or suspended by the board of medical examiners; or

(2) Premium payments are not made after a reasonable demand therefor; or

(3) The board reasonably believes that a licensed physician or hospital is no longer an insurable risk.

(c) In the event of cancellation or non-renewal, the plan shall continue coverage to the date of expiration, or for thirty days following notice, whichever occurs first. Within fifteen days of the cancellation date, the plan shall refund the pro rata unearned portion, if any, of any prepaid premium. Written notice by certified mail shall be given to the insured and the insurance commissioner not less than thirty days prior to the effective date of the cancellation or non-renewal. The mailing of the notice shall be sufficient proof of notice of cancellation or non-renewal.

(d) The rates, rating plans, rating rules, rating classifications, and territories applicable to the insurance written by the plan, and statistics relating thereto shall be subject to sections 431-691 to 431-707, HRS, giving due consideration to the past and prospective loss experience for medical professional liability within and outside this State, trends in frequency and severity of losses, the investment income of the plan, and such other information as the insurance commissioner may require. All rates shall be on an actuarially sound basis and shall be calculated to be self-supporting and may give consideration to any other factors deemed appropriate by the board of directors.

(e) Any deficit sustained by the plan shall be recouped as provided for in section 16-7-3(d).

(f) In the event that sufficient funds are not available for the sound financial operation of the plan, then, pending recoupment as provided for in section 16-7-3(d), all members shall, on a temporary basis, contribute to the financial requirements of the plan in the manner provided in section 16-7-3(b). Any such contribution shall be reimbursed to the members by recoupment as provided in section 16-7-3(d). [Eff 6/22/81] (Auth: HRS §435C-2) (Imp: HRS §§435C-3, 435C-4)

§16-7-18 Underwriting standards. New and renewal applications for insurance under the plan shall be submitted to the servicing carrier through the office of the plan. All new and renewal applications shall be reviewed by the carrier for completeness, and subjected to the regular scrutiny for the purposes of evaluation as to insurability. If the servicing carrier determines that an application does not meet the standards for insurability, taking into consideration claims history, ethical violations, mode of practice, physical conditions, safety practices, and other factors material to the risk, the servicing carrier shall refer the application to the office of the plan and in turn it will be referred to such subcommittee as necessary to determine the insurability.

Review boards consisting of not less than five nor more than nine members appointed by the board of directors from a list of nominees submitted by the Hawaii Medical Association and the Hawaii Hospital Association shall be established. The members of the review boards shall serve for terms of two years providing that primary appointments shall be made in such a manner that not more than two-thirds of the review board shall leave office in any one year. The review board shall examine all applications that are referred to it by the board of directors.

The review board may confer with consultants, examine records of peer review committees relating to the applicant, and conduct such other investigatory procedures that they deem necessary to arrive at a satisfactory evaluation of such application. The review board may recommend to the board of directors non-issuance of the policy that has been applied for, the issuance of a binder for a limited time, or the issuance of a policy. The applicant may appeal the decision as provided for under section 435C-7, HRS. [Eff 6/22/81] (Auth: HRS §435C-2) (Imp: HRS §435C-3)

§16-7-19 Reports. The plan shall provide for the making of detailed reports of casualty insurance assumed or cancelled, for the drawing up of annual budgets of the plan and for the rendering of accounts to each member at least every twelve months during the continuance of membership. The books of account of the servicing carrier may be audited by a firm of independent auditors designated by the board of directors. [Eff 6/22/81] (Auth: HRS §435C-2) (Imp: HRS §§435C-3, 435C-9)

§16-7-20 Extra hazardous risks. If an applicant presents a risk which is greater than that contemplated by the rate normally applicable hereunder, the servicing carrier shall consult with the board before submission to the insurance commissioner for an increase in such rate. An increase in rate approved by the

insurance commissioner shall be deemed to include any applicable additional charge. Rates for such extra hazardous risks must comply with section 431-694(h), HRS. [Eff 6/22/81] (Auth: HRS §435C-2) (Imp: HRS §435C-3)

§16-7-21 Commissions. The commission payable to general agents by the servicing carrier on business written pursuant to the plan shall be at the following rates:

(1) Five per cent of written premium for the first $2,500;

(2) Three per cent of written premium for the next $2,500; and

(3) Two per cent of written premium over $5,000. [Eff 6/22/81] (Auth: HRS §435C-2) (Imp: HRS §435C-3)

§16-7-22 Servicing carrier(s). (a) 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 transmission of premium to the plan and payment of commission to the general agent.

(b) The servicing carrier shall pay premium taxes at a rate of 2.6325 per cent on plan business.

(c) Companies applying to the board to be servicing carriers will be required to estimate any start-up and shut-down expense. It will be the responsibility of the board of directors to make the judgments as to what costs are extraordinary, and give due consideration to any extraordinary expense reimbursement applied for or expected.

(d) The servicing carrier, if directed to do so by the plan may bind coverage for up to thirty days and will issue policies on behalf of the plan but if coverage is bound the servicing carrier must issue insurance policies to applicants by the expiration date of the thirty-day binders.

(e) The servicing carrier must have the ability to carry out all necessary accounting procedures as outlined by these operating principles. These insurance accounting procedures, if applicable, will include, but not be limited to:

(1) Billing and collection.

(2) Commission payments and statements to producers.

(f) To generate the statistical and accounting information of the plan, the servicing carrier must use the services of a statistical organization such as the Insurance Services Office or the National Association of Independent Insurers. [Eff 6/22/81] (Auth: HRS §435C-2) (Imp: HRS §435C-3)

§16-7-23 Servicing carrier allowances. (a) Servicing carrier shall be reimbursed for plan business on the following basis:

(1) Ten percent of written premium for operating costs, which shall include loss prevention and inspection services, but exclude claim expense, agents' commissions, and taxes;

(2) Actual dollars of commission paid to the authorized agent;

(3) Actual amount of premium taxes paid;

(4) Allocated loss adjustment expenses shall be charged against the plan as part of the incurred loss; and

(5) Unallocated loss adjustment expenses shall be charged at an amount equal to ten per cent of the sum of the reported losses incurred plus the allocated loss adjustment expense.

(b) The board of directors shall reimburse a servicing carrier in whole or in part for all reasonable and necessary expenses directly or under contractual arrangements with others, incurred in qualifying for, or ceasing to be a servicing carrier. The expense must be explained and supported in detail as may be required by the board of directors.

(c) The board shall direct the reimbursement of servicing carrier for normal operating expenses incurred in connection with plan business. The operating expenses shall include any losses or expenses paid or incurred directly or under contractual arrangements with others, not otherwise reimbursed under subsection (a), or which are in excess of the allowances provided thereunder, 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 and agents).

(d) Losses or expenses reimbursable under subsections (b) and (c) for which sufficient funds are not otherwise available, shall be obtained by the board of directors through an assessment against the members of the plan or through an assessment of the policyholders.

(e) Joint underwriting plan business written by servicing carrier shall not be included in determining a servicing carrier's share of market for membership assessment or other purposes.

(f) Losses and expenses shall be payable solely out of the funds provided by the joint underwriting plan.

(g) The amounts allowed under subsection (a) shall be subject to periodic review by the board of directors. [Eff 6/22/81] (Auth: HRS §435C-2) (Imp: HRS §435C-3)

DEPARTMENT OF REGULATORY AGENCIES

Chapter 7, Hawaii Medical Malpractice Underwriting Plan Rules of Practice and Procedure, on the Summary Page dated May 28, 1981 was adopted on May 28, 1981 following a public hearing held on May 28, 1981, after public notice was given in the Honolulu Star-Bulletin on May 8, 1981.

These rules shall take effect ten days after filing with the Office of the Lieutenant Governor.

/s/ Mary G.F. Bitterman
MARY G.F. BITTERMAN
Director of Regulatory Agencies

APPROVED AS TO FORM:

/s/ Ruth I. Tsujimura
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GEORGE R. ARIYOSHI
Governor
State of Hawaii

Date: June 10, 1981

June 12, 1981
Filed