S T A T E O F N E W Y O R K

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2009-2010 Regular Sessions

I N A S S E M B L Y

June 10, 2009

Introduced by M. of A. CARROZZA -- read once and referred to the Committee on Insurance

AN ACT to amend the insurance law, in relation to establishing the medical liability insurance association; and repealing certain provisions of such law relating thereto

THE PEOPLE OF THE STATE OF NEW YORK, REPRESENTED IN SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

Section 1. Article 55 of the insurance law is REPEALED and a new article 55 is added to read as follows:

ARTICLE 55

MEDICAL LIABILITY INSURANCE ASSOCIATION

SECTION 5500. TITLE AND PURPOSE.
5501. DEFINITIONS.
5502. MEDICAL LIABILITY INSURANCE ASSOCIATION.
5503. PLAN OF OPERATION.
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S 5500. TITLE AND PURPOSE. THIS ARTICLE MAY BE CITED AS THE "MEDICAL LIABILITY INSURANCE ASSOCIATION ACT". THE PURPOSE OF THIS ARTICLE IS TO ESTABLISH THE MEDICAL LIABILITY INSURANCE ASSOCIATION AS THE PROVIDER OF MEDICAL MALPRACTICE INSURANCE, TO THOSE INSUREDS UNABLE TO OBTAIN SUCH COVERAGE IN THE VOLUNTARY MARKET.

EXPLANATION--Matter in ITALICS (underscored) is new; matter in brackets [ ] is old law to be omitted.

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S 5501. DEFINITIONS. IN THIS ARTICLE:
(A) "ASSOCIATION" MEANS THE MEDICAL LIABILITY INSURANCE ASSOCIATION.
(B) "MEDICAL MALPRACTICE INSURANCE" MEANS INSURANCE AGAINST LEGAL LIABILITY OF THE INSURED, AND AGAINST LOSS, DAMAGE, OR EXPENSE INCIDENT TO A CLAIM OF SUCH LIABILITY ARISING OUT OF THE DEATH OR INJURY OF ANY PERSON DUE TO MEDICAL, DENTAL, PODIATRIC, CERTIFIED NURSE-MIDWIFERY OR HOSPITAL MALPRACTICE BY ANY LICENSED PHYSICIAN, DENTIST, PODIATRIST, CERTIFIED NURSE-MIDWIFE, CERTIFIED REGISTERED NURSE ANESTHETIST OR HOSPITAL.
(C) "HOSPITAL" MEANS:
(1) ANY FACILITY DEFINED AS A HOSPITAL UNDER SECTION TWENTY-EIGHT HUNDRED ONE OF THE PUBLIC HEALTH LAW AND ISSUED AN OPERATING CERTIFICATE AS A HOSPITAL OR NURSING HOME, AND THOSE DISTINCT PARTS OF A FACILITY WHICH ARE SUBJECT TO THE POWERS OF VISITATION, EXAMINATION, INSPECTION AND INVESTIGATION OF THE DEPARTMENT OF MENTAL HYGIENE WHICH PROVIDE HOSPITAL OR NURSING HOME SERVICE.
(2) ANY AMBULANCE SERVICE WHICH IS REGISTERED OR CERTIFIED UNDER ARTICLE THIRTY OF THE PUBLIC HEALTH LAW AND WHICH IS DESIGNED AND EQUIPPED TO PROVIDE DEFINITIVE ACUTE MEDICAL CARE PURSUANT TO RULES AND REGULATIONS OF THE COMMISSIONER OF HEALTH IN ACCORDANCE WITH SUCH ARTICLE CONCERNING THE REQUIREMENTS FOR AN ADVANCED LIFE SUPPORT SYSTEM. SUCH A SERVICE MUST INCLUDE, BUT NOT BE LIMITED TO, THE PROVISION OF ADVANCED LIFE SUPPORT SERVICES.
(3) ANY COMMUNITY MENTAL HEALTH CENTER OPERATED BY A COUNTY, CITY, TOWN OR VILLAGE, HOLDING AN OPERATING CERTIFICATE ISSUED BY AN OFFICE OF THE DEPARTMENT OF MENTAL HYGIENE.
(4) ANY CERTIFIED PUBLIC OR VOLUNTARY NON-PROFIT HOME CARE SERVICE AGENCY WHICH POSSESSES A VALID CERTIFICATE OF APPROVAL ISSUED UNDER ARTICLE TWENTY-EIGHT OR THIRTY-SIX OF THE PUBLIC HEALTH LAW.
(D) "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 SUPERINTENDENT, LESS RETURN PREMIUMS FOR THE UNUSED OR UNABSORBED PORTIONS OF PREMIUM DEPOSITS.
(E) "PERSONAL INJURY LIABILITY INSURANCE" MEANS ALL FORMS OF INSURANCE WRITTEN UNDER PARAGRAPH THIRTEEN OF SUBSECTION (A) OF SECTION ONE THOUSAND ONE HUNDRED THIRTEEN OF THIS CHAPTER, INCLUDING THE LIABILITY COMPONENT OF MULTIPLE PERIL PACKAGE POLICIES.
S 5502. MEDICAL LIABILITY INSURANCE ASSOCIATION. (A) THE MEDICAL LIABILITY INSURANCE ASSOCIATION IS ESTABLISHED, CONSISTING OF ALL INSURERS AUTHORIZED TO WRITE AND ENGAGED IN WRITING, WITHIN THIS STATE, ON A DIRECT BASIS, MEDICAL MALPRACTICE INSURANCE. EVERY SUCH INSURER SHALL BE AND REMAIN A MEMBER OF THE ASSOCIATION AS A CONDITION OF ITS AUTHORITY TO TRANSACT MEDICAL MALPRACTICE INSURANCE IN THIS STATE.
(B) THE ASSOCIATION SHALL BE A NON-PROFIT UNINCORPORATED ASSOCIATION CONSTITUTING A LEGAL ENTITY SEPARATE AND DISTINCT FROM ITS MEMBERS. ALL FUNDS AND RESERVES OF THE ASSOCIATION SHALL BE SEPARATELY HELD AND INVESTED. IT SHALL MAINTAIN COMPLETE ACCOUNTS OF ALL MONIES RECEIVED AND ALL LOSSES AND EXPENSES INCURRED IN CONNECTION WITH ITS OPERATIONS, INCLUDING INVESTMENT INCOME ON PREMIUMS RECEIVED FROM INSUREDS.
(C) THE PURPOSE OF THE ASSOCIATION IS TO PROVIDE A MARKET FOR MEDICAL MALPRACTICE INSURANCE FOR THOSE INSUREDS UNABLE TO OBTAIN SUCH COVERAGE IN THE VOLUNTARY MARKET AND SUBJECT TO REGULATION PURSUANT TO SECTION TWO THOUSAND THREE HUNDRED SEVENTEEN OF THIS CHAPTER.
(D) THE MEDICAL MALPRACTICE INSURANCE POOL OF NEW YORK STATE IS DISSOLVED AS OF THE EFFECTIVE DATE OF THIS ARTICLE AND ALL OF THE POOL'S

ASSETS AND LIABILITIES WILL BE ASSUMED BY THE MEDICAL LIABILITY INSURANCE ASSOCIATION AS OF SUCH DATE. THE MEDICAL LIABILITY INSURANCE ASSOCIATION SHALL ENTER INTO ANY NECESSARY AGREEMENTS WITH THE MEDICAL MALPRACTICE INSURANCE POOL OF NEW YORK STATE TO ACCOMPLISH: THE DISSOLUTION OF THE POOL; THE ASSUMPTION BY THE ASSOCIATION OF THE POOL'S ASSETS AND LIABILITIES; AND, THE REMOVAL OF THE POOL'S ASSETS AND LIABILITIES FROM MEMBERS' BOOKS. THE HISTORICAL NET IMPACT OF THE POOL ON A MEMBER'S FINANCIAL STATEMENT AS OF THE EFFECTIVE DATE OF THIS ARTICLE SHALL BE REMOVED BY REDUCING TO ZERO ANY ASSET OR LIABILITY DIRECTLY RELATING TO THE POOL AND REFLECTED IN THE MEMBER'S MOST RECENT FILED STATUTORY FINANCIAL STATEMENT, WITH ANY NET DIFFERENCE REFLECTED AS A CHARGE OR CREDIT TO SURPLUS.

(E) THE ASSOCIATION SHALL, PURSUANT TO THE PROVISIONS OF THIS ARTICLE AND THE PLAN OF OPERATION WITH RESPECT TO MEDICAL MALPRACTICE INSURANCE, HAVE THE POWER:

(1) TO ISSUE, OR TO CAUSE TO BE ISSUED, POLICIES OF INSURANCE TO PHYSICIAN, DENTIST AND PODIATRIST APPLICANTS SUBJECT TO PRIMARY LIMITS SPECIFIED IN THE PLAN OF OPERATION NOT IN EXCESS OF ONE MILLION THREE HUNDRED THOUSAND DOLLARS FOR EACH CLAIMANT UNDER ONE POLICY AND THREE MILLION NINE HUNDRED THOUSAND DOLLARS FOR ALL CLAIMANTS UNDER ONE POLICY IN ANY ONE YEAR, AND EXCESS COVERAGE AS PROVIDED IN THIS PARAGRAPH. EACH APPLICANT SHALL BE ENTITLED TO PURCHASE A POLICY PROVIDING PRIMARY LIMITS NOT TO EXCEED ONE MILLION THREE HUNDRED THOUSAND DOLLARS FOR EACH CLAIMANT AND THREE MILLION NINE HUNDRED THOUSAND DOLLARS FOR ALL CLAIMANTS IN ANY ONE YEAR. IN ADDITION, ANY APPLICANT INSURED BY THE ASSOCIATION IN AN AMOUNT EQUAL TO OR GREATER THAN ONE MILLION THREE HUNDRED THOUSAND DOLLARS FOR EACH CLAIMANT AND THREE MILLION NINE HUNDRED THOUSAND DOLLARS FOR ALL CLAIMANTS IN ANY ONE YEAR OR ANY OTHER APPLICANT COVERED UNDER A POLICY OR POLICIES PROVIDING SUCH PRIMARY LEVELS OF INSURANCE AGAINST LIABILITY FOR MEDICAL, DENTAL OR PODIATRIC MALPRACTICE THAT IS ISSUED BY AN AUTHORIZED INSURER, SHALL BE ENTITLED TO PURCHASE A POLICY FROM THE ASSOCIATION PROVIDING EXCESS COVERAGE OF AT LEAST ONE MILLION DOLLARS PER CLAIMANT AND THREE MILLION DOLLARS FOR ALL CLAIMANTS IN ANY ONE YEAR.

(2) TO ISSUE, OR CAUSE TO BE ISSUED, POLICIES OF INSURANCE, INCLUDING INCIDENTAL LIABILITY COVERAGES, TO HOSPITAL APPLICANTS SUBJECT TO LIMITS SPECIFIED IN THE PLAN OF OPERATION WITH LIMITS NOT IN EXCESS OF ONE MILLION DOLLARS FOR EACH CLAIMANT AND SIX MILLION DOLLARS FOR ALL CLAIMANTS IN ANY ONE YEAR; PROVIDED THAT POLICIES FOR COVERAGE IN EXCESS OF ONE MILLION DOLLARS FOR EACH CLAIMANT AND THREE MILLION DOLLARS FOR ALL CLAIMANTS IN ANY ONE YEAR SHALL BE ISSUED ONLY UPON THE OBTAINING OF REINSURANCE FOR SUCH EXCESS COVERAGE FOR THE TERM OF THE POLICY AND THE EXCESS COVERAGE SHALL REMAIN IN EFFECT ONLY SO LONG AS REINSURANCE IS IN EFFECT. THE ASSOCIATION SHALL OBTAIN SUCH REINSURANCE, IF AVAILABLE, FOR COVERAGE IN EXCESS OF ONE MILLION DOLLARS FOR EACH CLAIMANT AND THREE MILLION DOLLARS FOR ALL CLAIMANTS IN ANY ONE YEAR. IF THE ASSOCIATION FAILS TO OBTAIN SUCH REINSURANCE, THE SUPERINTENDENT MAY ORDER IT TO DO SO FOR THE TERM OF THE POLICY FROM SOURCES FOUND BY HIM OR HER TO BE AVAILABLE. THE RATES CHARGED BY THE ASSOCIATION FOR COVERAGE IN EXCESS OF THREE MILLION DOLLARS SHALL NOT BE SUBJECT TO PRIOR APPROVAL BY THE SUPERINTENDENT, AND SHALL EQUAL THE CHARGES TO THE ASSOCIATION FOR SUCH REINSURANCE.

(3) TO UNDERWRITE SUCH INSURANCE AND TO ADJUST AND PAY LOSSES OR TO APPOINT SERVICE COMPANIES TO PERFORM THOSE FUNCTIONS.

S 5503. PLAN OF OPERATION. (A) THE ASSOCIATION SHALL OPERATE IN ACCORDANCE WITH A PLAN OF OPERATION APPROVED BY THE SUPERINTENDENT WHICH

PROVIDES FOR ECONOMIC, FAIR AND NONDISCRIMINATORY ADMINISTRATION AND FOR THE PROMPT AND EFFICIENT PROVISION OF MEDICAL MALPRACTICE INSURANCE.

(B) THE PLAN SHALL CONTAIN OTHER PROVISIONS INCLUDING BUT NOT LIMITED TO ESTABLISHMENT OF NECESSARY FACILITIES, MANAGEMENT OF THE ASSOCIATION, ASSESSMENT OF MEMBERS TO DEFRAY LOSSES AND EXPENSES, SERVICE CHARGES, 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.

(C) AMENDMENTS TO THE PLAN OF OPERATION MAY BE MADE BY THE BOARD OF DIRECTORS OF THE ASSOCIATION, SUBJECT TO THE APPROVAL OF THE SUPERINTENDENT, OR SHALL BE MADE AT THE DIRECTION OF THE SUPERINTENDENT.

(D) THE ASSOCIATION SHALL BE SUBJECT TO THE PROVISIONS OF THIS CHAPTER APPLICABLE TO PROPERTY/CASUALTY INSURERS IN THE CONDUCT OF ITS BUSINESS, IN ORDER TO PROVIDE FOR THE FAIR TREATMENT OF POLICYHOLDERS AND CLAIMANTS.

(E) THE ASSOCIATION SHALL, ON THE EFFECTIVE DATE OF THIS ARTICLE, ASSUME THE PLAN OF OPERATION PREVIOUSLY APPROVED FOR THE MEDICAL MALPRACTICE INSURANCE ASSOCIATION OF NEW YORK STATE UNTIL SUCH TIME AS THE PLAN MAY BE AMENDED.

S 5504. POLICIES. (A) NO POLICY FORM SHALL BE USED BY THE ASSOCIATION UNLESS IT HAS BEEN FILED WITH THE SUPERINTENDENT AND EITHER HE OR SHE HAS APPROVED IT, OR THIRTY DAYS HAVE ELAPSED AND HE OR SHE HAS NOT DISAPPROVED IT AS MISLEADING OR VIOLATIVE OF PUBLIC POLICY.

(B)(1) EXCEPT AS PROVIDED IN PARAGRAPH TWO OF THIS SUBSECTION, NO CANCELLATION NOTICE OR NONRENEWAL NOTICE SHALL BE EFFECTIVE UNLESS THE ASSOCIATION, AT LEAST FORTY-FIVE DAYS PRIOR TO THE EFFECTIVE DATE OF SUCH CANCELLATION OR THE END OF THE POLICY PERIOD, AS THE CASE MAY BE, MAILS OR DELIVERS SUCH NOTICE TO THE INSURED AT THE ADDRESS SHOWN ON THE POLICY AND TO SUCH INSURED'S LICENSED REPRESENTATIVE.

(2) WHERE THE CANCELLATION IS FOR NONPAYMENT OF PREMIUM OR LOSS OF LICENSE TO PRACTICE OR, IF THE INSURED IS A HOSPITAL, IT NO LONGER POSSESSES A VALID OPERATING CERTIFICATE UNDER SECTION TWENTY-EIGHT HUNDRED ONE-A OF THE PUBLIC HEALTH LAW, SUCH CANCELLATION NOTICE MUST BE MAILED OR DELIVERED AT LEAST FIFTEEN DAYS PRIOR TO THE EFFECTIVE DATE OF THE CANCELLATION.

(3) UPON WRITTEN REQUEST BY AN INSURED OR SUCH INSURED'S LICENSED REPRESENTATIVE, THE ASSOCIATION SHALL MAIL OR DELIVER LOSS INFORMATION AS PROVIDED IN SUBSECTION (G) OF SECTION THREE THOUSAND FOUR HUNDRED TWENTY-SIX OF THIS CHAPTER TO SUCH INSURED OR SUCH INSURED'S LICENSED REPRESENTATIVE WITHIN TEN BUSINESS DAYS OF SUCH REQUEST.

(4) ALL CANCELLATION NOTICES OR NONRENEWAL NOTICES SHALL STATE THE GROUNDS UPON WHICH THE POLICY IS CANCELLED OR NONRENEWED AND THAT, UPON WRITTEN REQUEST OF AN INSURED OR SUCH INSURED'S LICENSED REPRESENTATIVE, THE ASSOCIATION WILL FURNISH THE FACTS ON WHICH THE CANCELLATION OR NONRENEWAL IS BASED. GROUNDS FOR NONRENEWAL SHALL BE LIMITED TO THE SAME GROUND AS FOR CANCELLATION. ALL CANCELLATION NOTICES OR NONRENEWAL NOTICES SHALL ALSO PROVIDE OR BE ACCOMPANIED BY A STATEMENT ADVISING THE INSURED OF THE AVAILABILITY OF THE LOSS INFORMATION SPECIFIED IN SUBSECTION (G) OF SECTION THREE THOUSAND FOUR HUNDRED TWENTY-SIX OF THIS CHAPTER.

(C) A POLICY OF INSURANCE ISSUED BY THE ASSOCIATION MAY BE TERMINATED OTHER THAN FOR NON-PAYMENT OF PREMIUMS IF THE INSURED:

(1) IS NOT COMPLYING SUBSTANTIALLY WITH ANY TERM OR CONDITION OF SUCH CONTRACT.

(2) HAS KNOWINGLY MADE, OR CAUSED TO BE MADE, ANY FALSE STATEMENT OR MISREPRESENTATION OF A MATERIAL FACT FOR USE IN APPLYING FOR INSURANCE.

(D) ANY TERMINATION SHALL APPLY TO CARE OR SERVICES PROVIDED AFTER THE EFFECTIVE DATE OF TERMINATION, EXCEPT THAT INSURANCE COVERAGE MAY CONTINUE FOR UP TO THIRTY DAYS AFTER TERMINATION WITH RESPECT TO CARE OR SERVICES TO PATIENTS WHICH ARE A CONTINUATION OF A TREATMENT BEGUN PRIOR TO THE EFFECTIVE DATE OF TERMINATION.

(E)(1) THE ASSOCIATION SHALL ISSUE OR RENEW POLICIES OF MEDICAL MALPRACTICE INSURANCE FOR PHYSICIANS ON A CLAIMS-MADE OR OCCURRENCE BASIS, AS PRESCRIBED BY THE SUPERINTENDENT BY REGULATION.

(2) A CLAIMS-MADE POLICY SHALL CONTAIN THE FOLLOWING PROVISIONS:

(A) IF THE INSURED HAS PURCHASED A CLAIMS-MADE POLICY FROM AN ADMITTED INSURER OR THE ASSOCIATION FOR A PERIOD OF FIVE OR MORE CONSECUTIVE YEARS AND THE INSURED, AFTER ATTAINING THE AGE OF SIXTY-FIVE OR OLDER, RETIRES PERMANENTLY AND TOTALLY FROM THE PRACTICE OF MEDICINE OR IF THE INSURED HAS PURCHASED A CLAIMS-MADE POLICY FOR A PERIOD OF TEN OR MORE CONSECUTIVE YEARS AND THE INSURED, AFTER ATTAINING THE AGE OF FIFTY-FIVE OR OLDER, RETIRES PERMANENTLY FROM THE PRACTICE OF MEDICINE, THE ASSOCIATION SHALL, WITHOUT CHARGING AN ADDITIONAL PREMIUM THEREFOR AT THE TIME OF, OR SUBSEQUENT TO, SUCH RETIREMENT, ALSO COVER ALL OCCURRENCES BETWEEN THE INCEPTION DATE OF THE FIRST SUCH CONSECUTIVE POLICY FROM SUCH ASSOCIATION AND SUCH RETIREMENT DATE WHICH, SUBSEQUENT TO THE TERMINATION DATE, ARE REPORTED IN ACCORDANCE WITH STATUTORY AND POLICY REQUIREMENTS;

(B) IF THE INSURED DIES OR BECOMES PERMANENTLY DISABLED AND UNABLE TO PRACTICE MEDICINE WHILE COVERED BY SUCH POLICY THE ASSOCIATION SHALL, WITHOUT CHARGING AN ADDITIONAL PREMIUM THEREFOR AT THE TIME OF, OR SUBSEQUENT TO, SUCH EVENT, ALSO COVER ALL OCCURRENCES BETWEEN THE INCEPTION DATE OF THE FIRST SUCH CONSECUTIVE POLICY FROM SUCH ASSOCIATION AND THE DEATH OR DISABILITY OF THE INSURED; AND

(C) THE ASSOCIATION SHALL MAKE AVAILABLE AND SHALL ADVISE THE INSURED OF THE AVAILABILITY AND COST OF COVERAGE FOR OCCURRENCES BETWEEN THE INCEPTION DATE OF THE FIRST SUCH CONSECUTIVE POLICY FROM SUCH ASSOCIATION AND THE TERMINATION OF SUCH POLICY WHICH, SUBSEQUENT TO THE TERMINATION DATE, ARE REPORTED IN ACCORDANCE WITH STATUTORY AND POLICY REQUIREMENTS, PURSUANT TO SUCH TERMS AND CONDITIONS AS MAY BE SPECIFIED BY THE SUPERINTENDENT BY REGULATION. THE INSURED SHALL HAVE THE OPTION OF PURCHASING SUCH COVERAGE EITHER IN A SINGLE PAYMENT OR IN THREE ANNUAL INSTALLMENTS WITH AN ADDITIONAL FINANCE CHARGE.

(3) SUCH REGULATION SHALL ALSO PROVIDE THAT IF THE COVERAGE OF AN INSURED WHO CONTINUES TO PRACTICE IN THIS STATE IS TRANSFERRED FROM AN ADMITTED INSURER OR THE ASSOCIATION TO ANOTHER ADMITTED INSURER OR THE ASSOCIATION WITHOUT ANY GAP IN COVERAGE, THE INSURED SHALL BE ENTITLED TO THE BENEFITS OF THIS PROVISION AS IF SUCH INSURED HAD BEEN CONTINUOUSLY COVERED BY THE SUCCESSOR ENTITY DURING THE ENTIRE PERIOD OF CONSECUTIVE YEARS OF COVERAGE.

(F) THE ASSOCIATION SHALL, ON THE EFFECTIVE DATE OF THIS ARTICLE, ASSUME AND UTILIZE THE POLICY FORMS APPROVED FOR THE MEDICAL MALPRACTICE INSURANCE POOL OF NEW YORK STATE UNTIL SUCH TIME AS THEY MAY BE AMENDED BY THE ASSOCIATION.

S 5505. RATES. (A) THE RATES, RATING PLANS, RATING RULES, RATING CLASSIFICATIONS, TERRITORIES AND STATISTICS APPLICABLE TO THE INSURANCE WRITTEN BY THE ASSOCIATION SHALL BE SUBJECT TO ARTICLE TWENTY-THREE OF THIS CHAPTER, GIVING DUE CONSIDERATION TO THE PAST AND PROSPECTIVE LOSS AND EXPENSE EXPERIENCE FOR MEDICAL MALPRACTICE INSURANCE WRITTEN AND TO BE WRITTEN IN THIS STATE, TRENDS IN THE FREQUENCY AND SEVERITY OF LOSSES, THE INVESTMENT INCOME OF THE ASSOCIATION, AND SUCH OTHER INFORMATION AS THE SUPERINTENDENT MAY REQUIRE.

(B) ALL RATES SHALL BE ON AN ACTUARIALLY SOUND BASIS, BE CALCULATED TO BE SELF-SUPPORTING, BE BASED UPON REASONABLE STANDARDS, AND MAY GIVE CONSIDERATION TO SUCH FACTORS AS THE EXPERIENCE OF THE INSURED, GEOGRAPHICAL AREA AND SPECIALTIES OF PRACTICE. THE SUPERINTENDENT 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. THE PREMIUMS SHALL BE FIXED AT THE LOWEST POSSIBLE RATES CONSISTENT WITH THE MAINTENANCE OF SOLVENCY OF THE ASSOCIATION AND OF REASONABLE RESERVES AND SURPLUS THEREFOR.

(C) THE ASSOCIATION SHALL, ON THE EFFECTIVE DATE OF THIS ARTICLE, ASSUME AND UTILIZE THE RATES, RATING PLANS, RATING RULES, RATING CLASSIFICATIONS TERRITORIES AND STATISTICS APPROVED FOR AND APPLICABLE TO THE MEDICAL MALPRACTICE INSURANCE POOL OF NEW YORK STATE UNTIL SUCH TIME AS THEY MAY BE AMENDED BY THE ASSOCIATION.

S 5506. PROCEDURES. (A) ANY LICENSED PHYSICIAN, DENTIST, PODIATRIST, CERTIFIED NURSE-MIDWIFE, CERTIFIED REGISTERED NURSE ANESTHETIST OR HOSPITAL IS ENTITLED TO APPLY TO THE ASSOCIATION FOR COVERAGE PURSUANT TO THIS ARTICLE. APPLICATION MAY BE MADE DIRECTLY TO THE ASSOCIATION BY THE APPLICANT, IN WHICH EVENT NO SERVICE FEE SHALL BE CHARGED. IF THE APPLICANT AUTHORIZES A BROKER OR AGENT TO MAKE THE APPLICATION, THE ONLY CHARGE FOR SUCH SERVICES SHALL BE A SERVICE FEE AS LIMITED BY THE PLAN OF OPERATION AND IN COMPLIANCE WITH THE PROCEDURE ESTABLISHED IN SUBSECTIONS (C) AND (D) OF SECTION TWO THOUSAND ONE HUNDRED NINETEEN OF THIS CHAPTER.

(B) A POLICY SHALL BE ISSUED WHEN THE ASSOCIATION DETERMINES THAT THE APPLICANT IS DULY LICENSED AND RECEIVES THE PREMIUM OR THE PORTION PRESCRIBED IN THE PLAN OF OPERATION.

S 5507. PARTICIPATION. EVERY MEMBER OF THE ASSOCIATION SHALL BE SUBJECT TO ASSESSMENT ON THE BASIS DESCRIBED IN SUBSECTION (C) OF SECTION FIVE THOUSAND FIVE HUNDRED THIRTEEN OF THIS ARTICLE 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 OF THE ASSOCIATION. EACH MEMBER'S PARTICIPATION IN THE ASSOCIATION 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 MEMBER WITH THE SUPERINTENDENT.

S 5508. DIRECTORS. (A) THE ASSOCIATION SHALL BE GOVERNED BY A BOARD OF SEVEN VOTING DIRECTORS. THE SUPERINTENDENT OR HIS OR HER DULY AUTHORIZED REPRESENTATIVE SHALL SERVE AS A NON-VOTING DIRECTOR. THE SEVEN DIRECTORS SHALL BE ELECTED BY CUMULATIVE VOTING BY THE MEMBERS OF THE ASSOCIATION, WHOSE VOTES IN SUCH ELECTION SHALL BE WEIGHED IN ACCORDANCE WITH EACH MEMBER'S NET DIRECT PREMIUMS WRITTEN DURING THE PRECEDING CALENDAR YEAR. THE SEVEN DIRECTORS SERVING ON THE BOARD SHALL BE ELECTED ANNUALLY AT A MEETING OF THE MEMBERS.

(B) THE DIRECTORS SHALL SERVE WITHOUT COMPENSATION BUT SHALL BE REIMBURSED FOR THEIR ACTUAL AND NECESSARY EXPENSES INCURRED IN THE PERFORMANCE OF THEIR DUTIES UNDER THIS ARTICLE.

S 5509. APPEALS. ANY APPLICANT TO THE ASSOCIATION, ANY PERSON INSURED UNDER THIS ARTICLE, OR THEIR REPRESENTATIVES, OR ANY AFFECTED INSURER, MAY APPEAL TO THE SUPERINTENDENT WITHIN THIRTY DAYS AFTER ANY RULING, ACTION OR DECISION BY OR ON BEHALF OF THE ASSOCIATION, WITH RESPECT TO THOSE ITEMS THE PLAN OF OPERATION DEFINED AS APPEALABLE MATTERS.

S 5510. ANNUAL STATEMENT. (A) THE ASSOCIATION SHALL ANNUALLY FILE A STATEMENT IN THE OFFICE OF THE SUPERINTENDENT ON OR BEFORE THE FIRST DAY

OF MARCH. THE STATEMENT SHALL BE IN A FORM APPROVED BY AND CONTAIN INFORMATION PRESCRIBED BY THE SUPERINTENDENT WITH RESPECT TO ITS TRANSACTIONS, CONDITION, OPERATIONS AND AFFAIRS DURING THE PRECEDING YEAR.

(B) THE SUPERINTENDENT MAY, AT ANY TIME, REQUIRE THE ASSOCIATION TO FURNISH ADDITIONAL INFORMATION WITH RESPECT TO ITS TRANSACTIONS, CONDITION OR ANY MATTER CONNECTED THEREWITH WHICH HE OR SHE CONSIDERS TO BE MATERIAL AND WHICH WILL ASSIST HIM OR HER IN EVALUATING THE SCOPE, OPERATION AND EXPERIENCE OF THE ASSOCIATION.

S 5511. EXAMINATIONS. (A) THE SUPERINTENDENT SHALL MAKE AN EXAMINATION INTO THE AFFAIRS OF THE ASSOCIATION AT LEAST ANNUALLY. THE EXAMINATION SHALL BE CONDUCTED AND THE REPORT FILED IN THE MANNER PRESCRIBED IN ARTICLE THREE OF THIS CHAPTER.

(B) THE EXPENSES OF THE EXAMINATION SHALL BE PAID BY THE ASSOCIATION IN THE MANNER PRESCRIBED BY SECTION THREE HUNDRED THIRTEEN OF THIS CHAPTER.

S 5512. IMMUNITY. NO LIABILITY OR CAUSE OF ACTION SHALL EXIST AGAINST THE ASSOCIATION, ITS AGENTS OR EMPLOYEES, THE SUPERINTENDENT OR HIS OR HER AUTHORIZED REPRESENTATIVES OR ANY LICENSED AGENT OR BROKER FOR ANY STATEMENTS MADE IN GOOD FAITH BY THEM DURING ANY PROCEEDINGS OR CONCERNING ANY MATTERS WITHIN THE SCOPE OF THIS ARTICLE.

S 5513. OTHER PROVISIONS. (A) THE ASSOCIATION SHALL NOT BE CONSIDERED AN AUTHORIZED INSURER FOR THE PURPOSES OF ARTICLE SEVENTY-SIX OF THIS CHAPTER.

(B) THE ASSOCIATION SHALL NEITHER BE SUBJECT TO THE PROVISIONS OF ARTICLE SEVENTY-FOUR OF THIS CHAPTER NOR BE REQUIRED TO MAINTAIN ANY MINIMUM SURPLUS.

(C) THE ASSOCIATION SHALL CONDUCT ITS BUSINESS SO LONG AS IT HAS ASSETS SUFFICIENT TO PAY ITS EXPENSES AND CLAIMS ARISING UNDER EITHER POLICIES ISSUED BY THE ASSOCIATION OR ASSUMED FROM THE MEDICAL MALPRACTICE INSURANCE POOL OF NEW YORK STATE. THE ASSOCIATION IS AUTHORIZED, SUBJECT TO THE WRITTEN PRIOR APPROVAL OF THE SUPERINTENDENT AND AS CIRCUMSTANCES AND CASH FLOW DEMANDS REQUIRE, TO ASSESS AND ISSUE A CASH CALL TO ITS MEMBERS ON AN ANNUAL BASIS SUFFICIENT TO PROVIDE THE ASSOCIATION WITH THE FUNDS NECESSARY, WHEN COMBINED WITH PREMIUMS TO BE RECEIVED, TO CONDUCT ITS BUSINESS DURING SUCH YEAR. EACH ASSESSMENT SHALL BE FOR ONE YEAR ONLY AND MEMBERS SHALL NOT ANTICIPATE ANY ASSESSMENTS NOT APPROVED BY THE SUPERINTENDENT OR ANTICIPATE ANY FUTURE ASSESSMENTS IN PREPARING THEIR FINANCIAL STATEMENTS. ANY SUCH ASSESSMENT ON A MEMBER SHALL BE INCLUDED IN SUCH MEMBER'S FUTURE RATE REQUESTS AND SHALL BE INCLUDED IN ANY POLICY SURCHARGE IMPOSED ON A MEMBER PURSUANT TO THE PROVISIONS OF SECTION FORTY OF CHAPTER TWO HUNDRED SIXTY-SIX OF THE LAWS OF NINETEEN HUNDRED EIGHTY-SIX, AS AMENDED.

S 5514. EVALUATION. THE SUPERINTENDENT SHALL FROM TIME TO TIME REPORT TO THE GOVERNOR AND THE LEGISLATURE EVALUATING THE OPERATION OF THIS ARTICLE.

S 2. Subsections (b) and (c) of section 7436 of the insurance law, as added by chapter 266 of the laws of 1986, are amended to read as follows:

(b) If the order of liquidation, rehabilitation or conservation is entered against an insurer which has issued medical malpractice policies on a claims-made basis, then notwithstanding the entry of such order, the superintendent shall comply with the requirements for claims-made policies as set forth in subsections (b), (c) and (d) of section three thousand four hundred thirty-six of this chapter [and paragraphs two, three and four of subsection (f) of section five thousand five hundred four of this chapter].

(c) In the event that an insured, who has been issued a medical malpractice policy on a claim-made basis by an insurer against which an order of liquidation has been entered pursuant to this article, chooses to purchase coverage from a successor insurer, the superintendent shall expedite the transfer of coverage that has been accrued, for claims based on occurrences prior to the termination of the policy which are reported after the termination of the policy, to the successor insurer of each insured, in accordance with the requirement for claims-made policies as set forth in subsections (b), (c) and (d) of section three thousand four hundred thirty-six [and paragraphs two, three and four of subsection (f) of section five thousand five hundred four] of this chapter.

S 3. Subparagraph (H) of paragraph 1 of subsection (a) of section 7603 of the insurance law, as amended by chapter 89 of the laws of 1989, is amended to read as follows:

(H) any obligation for the return of unearned premiums on any policy specified in subparagraphs (A), (B), (C), (D), (E), (F) and (G) hereof, which shall, for the purposes of this article, be deemed to include the obligations of an insurer and the medical malpractice insurance association under medical malpractice claims-made policies to pay to successor entities the actuarially appropriate amounts for the provision of coverage to comply with the requirements of subsections (b), (c) and (d) of section three thousand four hundred thirty-six [and paragraphs two, three and four of subsection (f) of section five thousand five hundred four] of this chapter.

S 4. Paragraph 1 of subsection (a) of section 9111-b of the insurance law, as amended by chapter 147 of the laws of 2000, is amended to read as follows:

(1) For the privilege of conducting business in this state and in addition to any other requirements therefor, every insurance company subject to the franchise tax imposed by subdivision (a) of section fifteen hundred ten of the tax law, other than insurance companies whose premiums are received solely as consideration for accident and health insurance policies, shall pay a franchise tax of one percent of all gross direct premiums, less return premiums thereon, written during the "event year", as such term is defined in the following sentence, on risks located or residing in this state. For the purposes of this section, "event year" shall mean (A) the calendar year preceding the February fifth on which the superintendent fails to provide a certification to the [state] commissioner of taxation and finance that the return of premium amounts to the hospital excess liability pool that has been authorized by subsection (a) of section five thousand five hundred seventeen-a of this chapter has been made or (B) the calendar year preceding the year in which a final judicial determination invalidating some or all of the provisions of such section five thousand five hundred seventeen-a requires a return from the hospital excess liability pool of any or all of the premium amounts returned to such pool pursuant to such section five thousand five hundred seventeen-a [or (C) calendar year nineteen hundred ninety-nine if the superintendent directs and the association fails to make the transfer and deposit to the hospital excess liability pool pursuant to subsection (d) of section five thousand five hundred nine of this chapter or (D) the calendar year preceding the year in which a final judicial determination invalidating some or all of the provisions of such section five thousand five hundred nine requires a return from the hospital excess liability pool of any or all of the

amounts transferred and deposited to such pool pursuant to subsection (d) of section five thousand five hundred nine].

S 5. This act shall take effect on the first of September next succeeding the date on which it shall have become a law.