



General Assembly

February Session, 2004

Raised Bill No. 61

LCO No. 684

00684_____PRI

Referred to Committee on Program Review and Investigations

Introduced by:
(PRI)

**AN ACT ESTABLISHING A HEALTHY CONNECTICUT FUND, A
PATIENT COMPENSATION FUND AND A REINSURANCE FUND.**

Be it enacted by the Senate and House of Representatives in General Assembly convened:

1 Section 1. (NEW) (*Effective from passage*) (a) As used in this section
2 and section 2 of this act: (1) "Licensed health care provider" or
3 "provider" means a physician or surgeon; director, officer or trustee of
4 a hospital or nursing home; nurse; oral surgeon; dentist; pharmacist;
5 chiropractor; optometrist; podiatrist; hospital or nursing home; (2)
6 "fund" means the Healthy Connecticut Fund established in subsection
7 (b) of this section; and (3) "commissioner" means the Insurance
8 Commissioner.

9 (b) There is established a Healthy Connecticut Fund for the purpose
10 of reimbursing any portion of a medical malpractice claim, settlement
11 or judgment which represents the deductible applicable to a provider's
12 coverage. The fund shall be liable only for (1) payment of such
13 deductibles pursuant to claims, settlements or judgments against
14 licensed health care providers who comply with the provisions of this
15 section where the claim, settlement or judgment arises from an event
16 that occurs on or after the effective date of the first plan of operation

17 established pursuant to this section, and (2) reasonable and necessary
18 expenses incurred in payment of such deductibles and the fund's
19 administrative expenses. The fund may contain any moneys required
20 by law to be deposited in the fund and shall be held by the State
21 Treasurer separate and apart from all other moneys, funds and
22 accounts. The interest derived from the investment of the fund shall be
23 credited to the fund. Amounts in the fund may be expended only
24 pursuant to the direction of the Insurance Commissioner in accordance
25 with this section. Any balance remaining in the fund at the end of any
26 fiscal year shall be carried forward in the fund for the fiscal year next
27 succeeding.

28 (c) Any Connecticut-licensed health care provider may participate
29 in the fund.

30 (d) Any deficit in the fund shall be paid by assessment pursuant to
31 section 2 of this act. The state shall not be responsible for any costs,
32 expenses, liabilities, judgments or other obligations of the fund.

33 (e) All books, records and audits of the fund shall be public records,
34 as defined in section 1-200 of the general statutes.

35 (f) On or before December thirty-first of each year the Auditors of
36 Public Accounts shall audit the records of the fund and shall furnish an
37 audited financial report to the board, commissioner, State Treasurer
38 and the General Assembly.

39 (g) The Insurance Commissioner shall adopt regulations, in
40 accordance with chapter 54 of the general statutes, to establish a plan
41 of operation for the fund.

42 Sec. 2. (NEW) (*Effective from passage*) (a) Not later than ____, and
43 annually thereafter, the Insurance Commissioner shall determine the
44 amount necessary to maintain solvency of the Healthy Connecticut
45 Fund established in section 1 of this act.

46 (b) Each medical malpractice insurer, health insurer, health care

47 center, provider and attorney licensed in this state and each
48 pharmaceutical company or manufacturer of medical equipment ____
49 shall annually pay to the Insurance Commissioner, for deposit in the
50 Healthy Connecticut Fund, an amount assessed by the commissioner
51 pursuant to this section. ____ per cent of each medical malpractice
52 award or settlement shall be paid into the fund. Not later than ____,
53 the commissioner shall determine the assessment amount for the fiscal
54 year ending June 30, 2005. Not later than ____, and annually thereafter,
55 the commissioner shall determine the assessment amount for the next
56 fiscal year. Not later than ____, and annually thereafter, the
57 commissioner shall submit a statement to each person subject to
58 assessment that includes the proposed assessment amount.

59 (c) Any person aggrieved by an assessment levied under this section
60 may appeal therefrom in the same manner as provided for appeals
61 under section 38a-52 of the general statutes.

62 Sec. 3. (NEW) (*Effective from passage*) The Insurance Commissioner
63 may approve professional liability insurance policies for providers
64 who participate in the Healthy Connecticut Fund established pursuant
65 to section 1 of this act that contain a deductible that does not exceed (1)
66 fifty thousand dollars with respect to a medical professional, and (2)
67 one hundred thousand dollars with respect to a medical entity,
68 including, but not limited to, a hospital. Such policies shall be subject
69 to title 38a of the general statutes.

70 Sec. 4. (NEW) (*Effective from passage*) (a) As used in this section and
71 section 5 of this act: (1) "Licensed health care provider" or "provider"
72 means a physician or surgeon; director, officer or trustee of a hospital
73 or nursing home; nurse; oral surgeon; dentist; pharmacist;
74 chiropractor; optometrist; podiatrist; hospital or nursing home; (2)
75 "fund" means the Patients' Compensation Fund; and (3)
76 "commissioner" means the Insurance Commissioner.

77 (b) There is established a Patients' Compensation Fund for the
78 purpose of paying any portion of a medical malpractice claim,

79 settlement or judgment that exceeds the greater of (1) ____ hundred
80 thousand dollars for one person, per occurrence, or ____ hundred
81 thousand dollars in the aggregate for one year, or (2) the maximum
82 liability limit for which the health care provider is insured. The fund
83 shall be liable only for (A) payment of claims, settlements or
84 judgments against licensed health care providers who comply with the
85 provisions of this section where the claim, settlement or judgment
86 arises from an event that occurs on or after the effective date of the first
87 plan of operation established pursuant to this section, and (B)
88 reasonable and necessary expenses incurred in payment of such
89 claims, settlements or judgments and the fund's administrative
90 expenses. The fund may contain any moneys required by law to be
91 deposited in the fund and shall be held by the State Treasurer separate
92 and apart from all other moneys, funds and accounts. The interest
93 derived from the investment of the fund shall be credited to the fund.
94 Amounts in the fund may be expended only pursuant to the direction
95 of the board or commissioner in accordance with this section. Any
96 balance remaining in the fund at the end of any fiscal year shall be
97 carried forward in the fund for the fiscal year next succeeding.

98 (c) A board of governors is established to manage and operate the
99 fund. The board shall consist of the following members:

100 (1) One physician and one attorney appointed by the speaker of the
101 House of Representatives;

102 (2) One physician and one attorney appointed by the president pro
103 tempore of the Senate;

104 (3) One representative of the insurance industry appointed by the
105 majority leader of the House of Representatives;

106 (4) One representative of the insurance industry appointed by the
107 majority leader of the Senate;

108 (5) One member of the general public unaffiliated with the medical,

109 legal or insurance industry appointed by the minority leader of the
110 House of Representatives;

111 (6) One member of the general public unaffiliated with the medical,
112 legal or insurance industry appointed by the minority leader of the
113 Senate;

114 (7) The Insurance Commissioner, or the commissioner's designee;

115 (8) The Commissioner of Public Health, or the commissioner's
116 designee; and

117 (9) One member appointed by the Governor.

118 (d) (1) Members of the board shall serve for four-year terms which
119 shall commence on October first, except that members first appointed
120 shall have the following terms: The Governor, majority leader of the
121 House of Representatives and majority leader of the Senate shall each
122 appoint one member for a term of three years; the minority leader of
123 the House of Representatives, the president pro tempore of the Senate
124 and the speaker of the House of Representatives shall each appoint one
125 member for a term of two years; the minority leader of the Senate,
126 president pro tempore of the Senate and the speaker of the House of
127 Representatives shall each appoint one member for a term of four
128 years.

129 (2) Any vacancy on the board shall be filled for the unexpired
130 portion of the term by the appointing authority having the power to
131 make the original appointment. Any vacancy occurring on the board
132 shall be filled within thirty days.

133 (3) The board shall elect a chairperson from among its members
134 who shall preside at meetings of the board and a vice-chairperson to
135 preside in the absence of the chairperson. ____ members of the board
136 shall constitute a quorum and a majority vote of the quorum shall be
137 required for action by the board. The board shall meet at least
138 monthly, except that the chairperson, commissioner or any four

139 members may call a meeting at any time.

140 (4) The board shall not be construed to be a board or commission
141 within the meaning of section 4-9a of the general statutes, as amended.

142 (5) The members of the board shall serve without compensation
143 except for necessary expenses incurred in the performance of their
144 duties.

145 (e) (1) The board shall be within the Insurance Department and shall
146 submit to the commissioner a plan of operation and any amendments
147 to the plan necessary or suitable to assure the fair, reasonable and
148 equitable administration of the fund. The plan of operation may
149 contain other provisions including, but not limited to, assessment of all
150 members for expenses, deficits, losses, commissions arrangements,
151 reasonable underwriting standards, acceptance and cession of
152 reinsurance, appointment of servicing carriers, participation
153 requirements for self-insured individuals and procedures for
154 determining the amounts of insurance to be provided by the
155 association. The fund may not grant retroactive coverage.

156 (2) The plan of operation and any amendments shall become
157 effective upon approval, in writing, by the commissioner. If the board
158 fails to submit a suitable plan of operation by ____, or if at any time
159 thereafter the board fails to submit suitable amendments to the plan,
160 the commissioner shall, after notice and hearing, adopt such
161 reasonable regulations, in accordance with chapter 54 of the general
162 statutes, as are necessary or advisable to effectuate the provisions of
163 this section. Such regulations shall continue in force until modified by
164 the commissioner or superseded by a plan submitted by the board and
165 approved by the commissioner.

166 (f) (1) Any Connecticut-licensed health care provider may
167 participate in the fund and maintain participation by remitting to the
168 board the appropriate membership fees and assessments as are
169 required by the board on or before the provider's membership

170 anniversary date.

171 (2) Each fund member shall pay annual membership fees set by the
172 board, annual assessments as determined by the Insurance
173 Commissioner and deficit assessments upon the determination by the
174 board that insufficient money is available to meet the fund's liabilities.
175 Membership in the fund is contingent upon the member making
176 timely payment of all membership fees and assessments.

177 (3) Self-insured individuals may participate in the fund upon
178 compliance with the requirements established in the plan of operation
179 and shall pay the same membership fees and assessments as the other
180 members.

181 (g) Any deficit in the fund shall be paid by the members of the fund
182 or by assessment pursuant to section 5 of this act. The state shall not be
183 responsible for any costs, expenses, liabilities, judgments, or other
184 obligations of the fund.

185 (h) All books, records and audits of the fund shall be public records,
186 as defined in section 1-200 of the general statutes, except that any
187 medical-record information, as defined in section 38a-976 of the
188 general statutes, shall be confidential unless all individually
189 identifiable information is removed.

190 (i) On or before December thirty-first of each year the Auditors of
191 Public Accounts shall audit the records of the fund and shall furnish an
192 audited financial report to the board, commissioner, State Treasurer
193 and the General Assembly.

194 (j) A licensed health care provider participating in the fund may
195 withdraw upon written notice of thirty days prior to the date of
196 withdrawal except that the provider shall remain subject to any
197 assessment pertaining to any year in which the provider participated
198 in the fund. A provider who withdraws during any year shall be
199 entitled to a pro rata return of any paid annual membership fee.

200 (k) In an action for damages arising out of the rendering of medical
201 services against a licensed health care provider covered under the fund
202 the provider shall give written notice to the board of the action not
203 later than five days after the provider receives such a complaint. If,
204 after reviewing the facts upon which the action is based, it appears that
205 the claim will exceed ____ hundred thousand dollars, the board may
206 appear and actively defend the fund. In so defending, the board may
207 retain counsel and pay out of the fund attorney's fees and expenses
208 including court costs incurred in defending the fund. Any judgment
209 affecting the fund may be appealed.

210 (l) Each insurer providing insurance for a licensed health care
211 provider who is also covered by the fund and each self-insured
212 provider covered by the fund shall remain responsible for providing
213 an adequate defense on any claim filed that potentially affects the fund
214 with respect to the insurance contract or the self-insured's liability. The
215 insurers or self-insured providers shall have a fiduciary relationship
216 with respect to any claim affecting the fund. No insurer, provider or
217 self-insured individual may agree to a settlement exceeding ____
218 hundred thousand dollars per incident, or ____ hundred thousand
219 dollars in the aggregate for one year, without prior written approval of
220 the board.

221 (m) Any person who has recovered a final judgment or a settlement
222 approved by the board against a provider covered by the fund may file
223 a claim with the board to recover that portion of the judgment or
224 settlement which is in excess of ____ hundred thousand dollars or ____
225 hundred thousand dollars in the aggregate for one year. If the fund
226 incurs liability exceeding ____ hundred thousand dollars to any person
227 under a single occurrence, the fund may not pay more than ____
228 hundred thousand dollars per year until the claim has been paid in
229 full, except that the board may pay an amount in excess of ____
230 hundred thousand dollars to avoid the payment of interest.

231 (n) Claims filed against the fund shall be paid in the order received

232 not later than ninety days after the date filed unless the judgment is
233 appealed. If the fund does not have sufficient moneys to pay all of the
234 claims, claims received after the funds are exhausted shall be
235 immediately payable the following year in the order in which they
236 were received.

237 (o) Any person aggrieved by a final decision of the board may
238 appeal therefrom in accordance with section 4-183 of the general
239 statutes.

240 Sec. 5. (NEW) (*Effective from passage*) (a) Not later than January 1,
241 2005, and annually thereafter, the board of governors established in
242 section 4 of this act shall (1) determine the amount necessary to
243 maintain solvency of the Patients' Compensation Fund established in
244 section 4 of this act, and (2) inform the Insurance Commissioner of the
245 amount and its findings. The board shall consider the following factors
246 when establishing the amount:

247 (A) The past and prospective loss and expense experience in
248 different types of practice;

249 (B) The past and prospective loss and expense experience of the
250 fund;

251 (C) The loss and expense experience of each provider which
252 resulted in the payment of money, from the fund or other sources, for
253 damages arising out of the rendering of medical care by the provider;
254 and

255 (D) The risk factors for providers who are semiretired or employed
256 on a part-time basis.

257 (b) Each provider that participates in the fund and each ____
258 licensed in this state shall annually pay to the Insurance
259 Commissioner, for deposit in the Patients' Compensation Fund, an
260 amount assessed by the Insurance Commissioner pursuant to this
261 section. Not later than ____, the Insurance Commissioner shall

262 determine the assessment amount for the fiscal year ending June 30,
263 2005. Not later than ____, and annually thereafter, the Insurance
264 Commissioner shall determine the assessment amount for the next
265 fiscal year. Not later than ____, and annually thereafter, the Insurance
266 Commissioner shall submit a statement to each such provider and ____
267 that includes the proposed assessment amount.

268 (c) Any person aggrieved by an assessment levied under this section
269 may appeal therefrom in the same manner as provided for appeals
270 under section 38a-52 of the general statutes.

271 Sec. 6. (NEW) (*Effective from passage*) (a) As used in this section:

272 (1) "Association" means the Connecticut Medical Malpractice
273 Reinsurance Association established pursuant to this section.

274 (2) "Commissioner" means the Insurance Commissioner.

275 (3) "Insurer" means an insurer admitted and licensed in this state to
276 write liability insurance which has been qualified by the board of
277 directors of the association and has not been disqualified by the
278 commissioner.

279 (4) "Licensed health care provider" or "provider" means a physician
280 or surgeon; director, officer or trustee of a hospital or nursing home;
281 nurse; oral surgeon; dentist; pharmacist; chiropractor; optometrist;
282 podiatrist; hospital or nursing home.

283 (5) "Medical malpractice liability insurance" means professional
284 liability insurance coverage against the legal liability of the insured
285 against loss, damage or expense incident to a claim arising out of the
286 death or injury of any person as the result of negligence or malpractice
287 in rendering professional service by any licensed health care provider
288 or a claim arising out of the ownership, operation or maintenance of
289 the provider's business premises. "Medical malpractice liability
290 insurance" includes primary and excess coverages.

291 (6) "Net direct premium written" means direct written liability
292 insurance, excluding workers' compensation insurance and employer's
293 liability insurance written in connection with workers' compensation
294 insurance, less policyholder dividends and return premiums for the
295 unused portion of premium deposits and excluding premiums ceded
296 to or written by the association.

297 (7) "Person" means a person, as defined in section 38a-1 of the
298 general statutes, as amended.

299 (8) "Plan of operation" means the plan of operation of the association
300 approved by the commissioner pursuant to this section.

301 (b) There is established the Connecticut Medical Malpractice
302 Reinsurance Association. Each insurer authorized to write, and
303 engaged in writing within this state, on a direct basis, liability
304 insurance, except any insurer that writes only workers' compensation
305 insurance or employer's liability insurance written in connection with
306 workers' compensation insurance, shall be a member of the association
307 and shall be bound by the plan of operation as a condition of the
308 insurer's authority to continue to transact such insurance in this state.
309 All funds and reserves of the association shall be separately held and
310 invested. The association shall maintain complete accounts of all
311 moneys received including investment income and all losses and
312 expenses incurred in connection with its operation. No part of the net
313 earnings of the association shall inure to the benefit of any member
314 insurer.

315 (c) The association may:

316 (1) Assume or cede one hundred per cent reinsurance or a lesser
317 percentage on any policy of insurance or binder subject to this section;

318 (2) Provide separate accounts for categories and subcategories of
319 insureds reinsured or insured by the association;

320 (3) Maintain relevant loss, expense and premium data relative to all

321 risks reinsured in or insured by the association and require each
322 member to furnish statistics in connection with insurance ceded to the
323 association at such times and in such form and detail as may be
324 deemed necessary;

325 (4) Establish fair and reasonable procedures to assess members
326 whenever the assets of the association and the Connecticut Medical
327 Malpractice Reinsurance Recovery Fund are insufficient to pay
328 claimants as required by this section for their appropriate shares in
329 accordance with participation ratios to be established in the plan of
330 operation on the basis of the ratio that the members' net direct
331 premiums written bears to the total net direct premium written by all
332 members in this state on insurance against liability for damages to
333 persons or property, excluding workers' compensation insurance or
334 employer's liability insurance written in connection with workers'
335 compensation insurance;

336 (5) Receive and distribute all sums required for the operation of the
337 association;

338 (6) Establish procedures for reviewing claims procedures and
339 practices of insurers and in the event that the claims procedures or
340 practices of any insurer are considered inadequate to properly service
341 the risks ceded by it to the association, the association may establish a
342 claims program that will undertake to adjust or assist in the
343 adjustment of claims for the insurer on risks ceded by it, and in such
344 event shall charge such insurer a reasonable fee for establishing and
345 operating such claim program;

346 (7) Audit the operations of member companies to such extent as the
347 board of directors determines to be necessary to assure compliance
348 with this section in a reasonable manner and at such reasonable time
349 as prescribed by the board of directors;

350 (8) Sue and be sued provided no judgment against the association
351 shall create any direct liability in the individual member companies

352 and the association may provide for the indemnification of its member
353 companies, members of the board of directors and officers and
354 employees and such other persons acting on behalf of the association
355 to the extent permitted by law;

356 (9) Review the market in this state for insurance subject to this
357 section to make certain that eligible risks can readily obtain such
358 insurance, provide in the plan of operation a reasonable means for
359 achieving such purpose by requiring all members, in a fair and
360 equitable manner, to discharge their responsibilities under this section
361 and establish limits of liability for medical malpractice liability
362 insurance for each category or subcategory of insureds;

363 (10) Prepare and file rates, rating plans, rules, classifications and
364 policy forms to be used by the association in writing medical
365 malpractice liability insurance on a direct basis; and

366 (11) Issue binders or policies of medical malpractice liability
367 insurance in accordance with this section and adjust and pay losses
368 with respect to the binders and policies or appoint persons to perform
369 those functions.

370 (d) A board of governors is established to manage and operate the
371 association. The board shall consist of the following members:

372 (1) Two appointed by the speaker of the House of Representatives;

373 (2) Two appointed by the president pro tempore of the Senate;

374 (3) One representative of the insurance industry appointed by the
375 majority leader of the House of Representatives;

376 (4) One representative of the insurance industry appointed by the
377 majority leader of the Senate;

378 (5) One appointed by the minority leader of the House of
379 Representatives;

380 (6) One appointed by the minority leader of the Senate;

381 (7) The Insurance Commissioner, or the commissioner's designee;

382 (8) The Commissioner of Public Health, or the commissioner's
383 designee; and

384 (9) One member appointed by the Governor.

385 (e) (1) Members of the board shall serve for four-year terms which
386 shall commence on October first, except that members first appointed
387 shall have the following terms: The Governor, majority leader of the
388 House of Representatives and majority leader of the Senate shall each
389 appoint one member for a term of three years; the minority leader of
390 the House of Representatives, the president pro tempore of the Senate
391 and the speaker of the House of Representatives shall each appoint one
392 member for a term of two years; the minority leader of the Senate,
393 president pro tempore of the Senate and the speaker of the House of
394 Representatives shall each appoint one member for a term of four
395 years.

396 (2) Any vacancy on the board shall be filled for the unexpired
397 portion of the term by the appointing authority having the power to
398 make the original appointment. Any vacancy occurring on the board
399 shall be filled within thirty days.

400 (3) The board shall elect a chairperson from among its members
401 who shall preside at meetings of the board and a vice-chairperson to
402 preside in the absence of the chairperson. ____ members of the board
403 shall constitute a quorum and a majority vote of the quorum shall be
404 required for action by the board. The board shall meet at least
405 monthly, except that the chairperson, commissioner or any four
406 members may call a meeting at any time.

407 (4) The board shall not be construed to be a board or commission
408 within the meaning of section 4-9a of the general statutes, as amended.

409 (5) The members of the board shall serve without compensation
410 except for necessary expenses incurred in the performance of their
411 duties.

412 (f) (1) The board shall be within the Insurance Department and shall
413 submit to the commissioner a plan of operation and any amendments
414 to the plan necessary or suitable to assure the fair, reasonable and
415 equitable administration of the fund. The plan of operation may
416 contain other provisions including, but not limited to, assessment of all
417 members for expenses, deficits, losses, commissions arrangements,
418 reasonable underwriting standards, acceptance and cession of
419 reinsurance, appointment of servicing carriers, participation
420 requirements for self-insured individuals and procedures for
421 determining the amounts of reinsurance to be provided by the
422 association. The association may not grant retroactive coverage.

423 (2) The plan of operation and any amendments shall become
424 effective upon approval, in writing, by the commissioner. If the board
425 fails to submit a suitable plan of operation by ____, or if at any time
426 thereafter the board fails to submit suitable amendments to the plan,
427 the commissioner shall, after notice and hearing, adopt such
428 reasonable regulations, in accordance with chapter 54 of the general
429 statutes, as are necessary or advisable to effectuate the provisions of
430 this section. Such regulations shall continue in force until modified by
431 the commissioner or superseded by a plan submitted by the board and
432 approved by the commissioner.

433 (g) Except as may be delegated to others in the plan of operation or
434 reserved to the members, the board of directors shall have full power
435 and responsibility for the operation of the association.

436 (h) The commissioner (1) may review the plan of operation
437 whenever the commissioner deems expedient, (2) shall review the plan
438 at least once a year, and (3) may amend the plan after consultation
439 with the board and upon certification to the board of such amendment.

440 (i) On and after the date that reinsurance is available from the
441 association:

442 (1) The commissioner, after a hearing, may make a finding that
443 medical malpractice liability insurance is not readily available for any
444 category or subcategory of insureds to which this section applies and
445 after such a finding shall activate the association with respect to such
446 category or subcategory.

447 (2) Upon such activation, the board shall identify the members of
448 the association that have written in the United States the type of
449 medical malpractice liability insurance applicable to such category or
450 subcategory during the preceding twenty-four months and the board
451 shall invite such members to become qualified insurers in this state. If
452 the board qualifies no company as an insurer or if the commissioner
453 determines after a hearing and on the basis of facts developed at such
454 hearing that the company or companies were not properly qualified
455 the commissioner shall order the association to write medical
456 malpractice liability insurance on a direct basis and not later than
457 thirty days after the date of the order, the association shall file said
458 rates, rating plans, rules and classifications for the category or
459 subcategory of insureds for which the association will be writing
460 insurance on a direct basis. If the association does not submit such a
461 filing within said thirty days or during any extension granted by the
462 commissioner the commissioner shall adopt and certify the rates,
463 rating plans, rules and classifications and order the association to
464 insure eligible risks in accordance with the terms of the commissioner's
465 order. Qualified insurers shall be compensated in accordance with the
466 plan of operation.

467 (3) No member of the association qualified as an insurer in
468 accordance with this section shall refuse to issue to any eligible risk a
469 policy of insurance of the type normally afforded by such insurer to
470 the public utilizing the rates, rating plans, rules and classification
471 systems in effect for such insurer, except that (A) the coverages and

472 coverage limits to be afforded may be ceded to the association, and (B)
473 nothing in this section shall require an insurer to accept any risk if such
474 insurer's policy forms or rates do not apply to such risk.

475 (4) No licensed insurance agent or producer of a qualified insurer
476 shall (A) refuse to furnish to any eligible risk quotations of premiums
477 for such insurer with whom such agent or producer regularly places
478 medical malpractice liability insurance policies, or (B) fail to submit
479 any eligible risk to such insurer.

480 (5) No insurer shall (A) terminate any agent or producer or restrict
481 the authority of an agent or producer, directly or indirectly, solely by
482 reason of the volume of such agent's or producer's business ceded to
483 the association or the experience produced by such ceded business, or
484 (B) make any distinction in remuneration to an agent or producer
485 between business retained and business ceded, or use any promise of
486 reward or threat of penalty, related to certain classes of risks or other
487 classes of business, which would tend to induce the agent or producer
488 to avoid writing business for certain classes or types of risks.

489 (j) There is established a Medical Malpractice Reinsurance Recovery
490 Fund for the purpose of providing financial backup for the plan of
491 operation of the association and reimbursing the association for any
492 deficit sustained in the operation of the association. A deficit in the
493 fund shall exist whenever the sum of the earned premiums collected
494 by the association and the investment income therefrom is exhausted
495 by virtue of payment of, or allocation for (1) the association's necessary
496 administrative expenses, (2) reimbursements to members for
497 assessments levied as a result of the members' participation in the
498 association, (3) losses, loss adjustment expenses and reserves,
499 including, but not limited to, reserves for losses incurred, (4) losses
500 incurred but not reported, and (5) loss adjustment expenses. The
501 recovery fund shall consist of all payments made to it by insurers of
502 securities acquired by and through the use of moneys belonging to the
503 recovery fund, moneys appropriated to the recovery fund, together

504 with interest and earnings on such payments or investments. The fund
505 shall be liable only for (A) payments in accordance with this section,
506 and (B) reasonable and necessary expenses incurred in such payments
507 and the fund's administrative expenses. The fund may contain any
508 moneys required by law to be deposited in the fund and shall be held
509 by the State Treasurer separate and apart from all other moneys, funds
510 and accounts. The interest derived from the investment of the fund
511 shall be credited to the fund. Amounts in the fund may be expended
512 only pursuant to the direction of the board or commissioner in
513 accordance with this section. Any balance remaining in the fund at the
514 end of any fiscal year shall be carried forward in the fund for the fiscal
515 year next succeeding.

516 (k) For the purpose of providing moneys necessary to establish the
517 recovery fund in an amount sufficient to meet the requirements of this
518 section, the commissioner shall establish reasonable additional
519 premium charges for policies of the various categories and
520 subcategories of medical malpractice liability insurance. Such charges
521 may vary by category or subcategory of risk in reasonable relationship
522 to the past and prospective loss experience of the association and its
523 members attributable to such category or subcategory.

524 (l) The commissioner may adopt regulations, in accordance with
525 chapter 54 of the general statutes, to implement this section, and may
526 suspend or revoke, after reasonable notice and a hearing, the certificate
527 of authority to transact insurance in this state of any insurer which fails
528 to comply with this section, such regulations or any plan of operation.

This act shall take effect as follows:	
Section 1	<i>from passage</i>
Sec. 2	<i>from passage</i>
Sec. 3	<i>from passage</i>
Sec. 4	<i>from passage</i>
Sec. 5	<i>from passage</i>
Sec. 6	<i>from passage</i>

Statement of Purpose:

To establish (1) a Healthy Connecticut Fund to pay deductibles due after a medical malpractice award or settlement, (2) a Patient Compensation Fund for the payment of awards that exceed certain limits, and (3) a Reinsurance Fund for medical malpractice insurance.

[Proposed deletions are enclosed in brackets. Proposed additions are indicated by underline, except that when the entire text of a bill or resolution or a section of a bill or resolution is new, it is not underlined.]