SENATE AMENDED
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THE GENERAL ASSEMBLY OF PENNSYLVANIA

HOUSE BILL

No. 2210 Session of 1995

INTRODUCED BY ADOLPH, MICOZZIE, COLAFELLA, FLEAGLE, COLAIZZO, DRUCE, WALKO, GLADECK, MASLAND, FAJT, MARSICO, FEESE, D. W. SNYDER, SEMMEL, CORNELL, STABACK, TIGUE, GODSHALL, CLYMER, CLARK, DENT, BAKER, LaGROTTA, GRUPPO, M. N. WRIGHT, BROWN, VANCE, MAJOR, CAPPABIANCA, CIVERA, BATTISTO, SANTONI, GANNON, RUBLEY, PHILLIPS, GORDNER, LEVDANSKY, PETTIT, BARD, McCALL, SCHRODER, STISH, KREBS, CONTI, CHADWICK, HALUSKA, MICHLOVIC, DiGIROLAMO, LEH, SAYLOR, NICKOL, PLATTS, O'BRIEN, S. H. SMITH, TULLI, SHANER, ITKIN, MERRY, TRELLO, FARMER, ALLEN, KING, TANGRETTI, ZUG, FARGO, HENNESSEY, STURLA, YOUNGBLOOD, SERAFINI, BROWNE, BOSCOLA, RAYMOND, ROONEY, MELIO, E. Z. TAYLOR, KAISER, DURHAM AND BOYES, NOVEMBER 14, 1995

AS AMENDED ON THIRD CONSIDERATION, IN SENATE, NOVEMBER 19, 1996

AN ACT

~~Amending the act of October 15, 1975 (P.L.390, No.111), entitled "An act relating to medical and health related malpractice insurance, prescribing the powers and duties of the Insurance Department; providing for a joint underwriting plan; the Arbitration Panels for Health Care, compulsory screening of claims; collateral sources requirement; limitation on contingent fee compensation; establishing a Catastrophe Loss Fund; and prescribing penalties," further providing for liability insurance and the Medical Professional Liability Catastrophe Loss Fund.~~ <

AMENDING THE ACT OF OCTOBER 15, 1975 (P.L.390, NO.111), ENTITLED "AN ACT RELATING TO MEDICAL AND HEALTH RELATED MALPRACTICE INSURANCE, PRESCRIBING THE POWERS AND DUTIES OF THE INSURANCE DEPARTMENT; PROVIDING FOR A JOINT UNDERWRITING PLAN; THE ARBITRATION PANELS FOR HEALTH CARE, COMPULSORY SCREENING OF CLAIMS; COLLATERAL SOURCES REQUIREMENT; LIMITATION ON CONTINGENT FEE COMPENSATION; ESTABLISHING A CATASTROPHE LOSS FUND; AND PRESCRIBING PENALTIES," FURTHER PROVIDING FOR DEFINITIONS, FOR STATUTES OF LIMITATION, FOR PROFESSIONAL LIABILITY INSURANCE AND THE MEDICAL PROFESSIONAL LIABILITY CATASTROPHE LOSS FUND, FOR ADMINISTRATION OF THAT FUND AND FOR LIABILITY OF EXCESS CARRIERS; PROVIDING FOR A MEDICAL <

PROFESSIONAL INSURANCE FUND ADVISORY BOARD AND FOR SURCHARGE LIMITS; AND FURTHER PROVIDING FOR PLAN OPERATION AND RATES, FOR REPORTS TO THE INSURANCE COMMISSIONER, FOR FORMS OF DOING BUSINESS AND FOR THE JOINT STUDY COMMITTEE.

The General Assembly of the Commonwealth of Pennsylvania hereby enacts as follows:

~~Section 1. Section 701(e) of the act of October 15, 1975 (P.L.390, No.111), known as the Health Care Services Malpractice Act, amended October 15, 1980 (P.L.971, No.165), is amended to read:~~ <

~~Section 701. Professional Liability Insurance and Fund.--* * *~~

~~(e) (1) The fund shall be funded by the levying of an annual surcharge on or after January 1 of every year on all health care providers entitled to participate in the fund. The surcharge shall be determined by the director appointed pursuant to section 702 and subject to the prior approval of the commissioner. The surcharge shall be based on the cost to each health care provider for maintenance of professional liability insurance and shall be the appropriate percentage thereof, necessary to produce an amount sufficient to reimburse the fund for the payment of all claims paid and expenses incurred during the preceding calendar year and to provide an amount necessary to maintain an additional $15,000,000.~~

~~(2) Health care providers having approved self-insurance plans shall be surcharged an amount equal to the surcharge imposed on a health care provider of like class, size, risk and kind as determined by the director. The fund and all income from the fund shall be held in trust, deposited in a segregated account, invested and reinvested by the director, and shall not become a part of the General Fund of the Commonwealth. All~~

~~claims shall be computed on August 31, 1981 for all claims which become final between January 1, 1981 and August 31, 1981 and annually thereafter on August 31 for all claims which became final between that date and September 1 of the preceding year. All such claims shall be paid on or before December 31 following the August 31 by which they became final, as provided above. All claims which become final between January 1, 1980 and the effective date of this amendatory act shall be computed on the effective date of this amendatory act and shall be paid on or before December 31, 1980.~~

~~(3) Notwithstanding the above provisions relating to an annual surcharge, the commissioner shall have the authority, during September 1981 and during September of each year thereafter, if the fund would be exhausted by the payment in full of all claims which have become final and the expenses of the office of the director, to determine and levy an emergency surcharge on all health care providers then entitled to participate in the fund. Such emergency surcharge shall be the appropriate percentage of the cost to each health care provider for maintenance of professional liability insurance necessary to produce an amount sufficient to allow the fund to pay in full all claims determined to be final as of August 31, 1981 and August 31 of each year thereafter and the expenses of the office of the director, as of December 31, 1980 and December 31 of each year thereafter.~~

~~(4) The annual and emergency surcharges on health care providers and any income realized by investment or reinvestment shall constitute the sole and exclusive sources of funding for the fund. No claims or expenses against the fund shall be deemed to constitute a debt of the Commonwealth or a charge against the~~

~~General Fund of the Commonwealth. The director shall issue rules and regulations consistent with this section regarding the establishment and operation of the fund including all procedures and the levying, payment and collection of the surcharges except that the commissioner shall issue rules and regulations regarding the imposition of the emergency surcharge. A fee shall be charged by the director to all self-insurers for examination and approval of their plans.~~

~~(5) A health care provider may elect to pay the annual surcharge in equal installments, not exceeding four, if the health care provider informs the primary carrier of the option to pay in installments and the entire annual surcharge is collected and remitted to the fund by December 10, with four equal installments commencing 60 days from the date of policy inception or renewal with payment due each 60 days thereafter until the full remittance is paid. This paragraph shall expire January 1, 1997 JANUARY 1, 1998.~~ <—

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~~Section 2. The addition of section 701(e)(5) of the act shall apply to surcharges for 1996 1997.~~ <—

~~Section 3. This act shall take effect immediately.~~

SECTION 1. SECTION 103 OF THE ACT OF OCTOBER 15, 1975 <—
(P.L.390, NO.111), KNOWN AS THE HEALTH CARE SERVICES MALPRACTICE ACT, AMENDED JULY 15, 1976 (P.L.1028, NO.207) AND NOVEMBER 6, 1985 (P.L.311, NO.78) AND REPEALED IN PART FEBRUARY 23, 1996 (P.L.27, NO.10), IS AMENDED TO READ:

SECTION 103. DEFINITIONS.--AS USED IN THIS ACT:

"CLAIMS MADE" MEANS A POLICY OF PROFESSIONAL LIABILITY INSURANCE THAT WOULD LIMIT OR RESTRICT THE LIABILITY OF THE INSURER UNDER THE POLICY TO ONLY THOSE CLAIMS MADE OR REPORTED

DURING THE CURRENCY OF THE POLICY PERIOD AND WOULD EXCLUDE COVERAGE FOR CLAIMS REPORTED SUBSEQUENT TO THE TERMINATION EVEN WHEN SUCH CLAIMS RESULTED FROM OCCURRENCES DURING THE CURRENCY OF THE POLICY PERIOD.

"CLAIMS PERIOD" MEANS THE PERIOD FROM SEPTEMBER 1 TO THE FOLLOWING AUGUST 31.

"COMMISSIONER" MEANS THE INSURANCE COMMISSIONER OF THIS COMMONWEALTH.

"FUND" MEANS THE MEDICAL PROFESSIONAL LIABILITY CATASTROPHE LOSS FUND CREATED IN ARTICLE VII.

"GOVERNMENT" MEANS THE GOVERNMENT OF THE UNITED STATES, ANY STATE, ANY POLITICAL SUBDIVISION OF A STATE, ANY INSTRUMENTALITY OF ONE OR MORE STATES, OR ANY AGENCY, SUBDIVISION, OR DEPARTMENT OF ANY SUCH GOVERNMENT, INCLUDING ANY CORPORATION OR OTHER ASSOCIATION ORGANIZED BY A GOVERNMENT FOR THE EXECUTION OF A GOVERNMENT PROGRAM AND SUBJECT TO CONTROL BY A GOVERNMENT, OR ANY CORPORATION OR AGENCY ESTABLISHED UNDER AN INTERSTATE COMPACT OR INTERNATIONAL TREATY.

"HEALTH CARE PROVIDER" MEANS A PRIMARY HEALTH CENTER OR A PERSON, CORPORATION, UNIVERSITY OR OTHER EDUCATIONAL INSTITUTION, FACILITY, INSTITUTION OR OTHER ENTITY LICENSED OR APPROVED BY THE COMMONWEALTH TO PROVIDE HEALTH CARE OR PROFESSIONAL MEDICAL SERVICES AS A PHYSICIAN, AN OSTEOPATHIC PHYSICIAN OR SURGEON, A CERTIFIED NURSE MIDWIFE, A PODIATRIST, HOSPITAL, NURSING HOME, BIRTH CENTER, AND EXCEPT AS TO SECTION 701(A), AN OFFICER, EMPLOYEE OR AGENT OF ANY OF THEM ACTING IN THE COURSE AND SCOPE OF HIS EMPLOYMENT.

"INFORMED CONSENT" MEANS FOR THE PURPOSES OF THIS ACT AND OF ANY PROCEEDINGS ARISING UNDER THE PROVISIONS OF THIS ACT, THE CONSENT OF A PATIENT TO THE PERFORMANCE OF HEALTH CARE SERVICES

BY A PHYSICIAN OR PODIATRIST: PROVIDED, THAT PRIOR TO THE CONSENT HAVING BEEN GIVEN, THE PHYSICIAN OR PODIATRIST HAS INFORMED THE PATIENT OF THE NATURE OF THE PROPOSED PROCEDURE OR TREATMENT AND OF THOSE RISKS AND ALTERNATIVES TO TREATMENT OR DIAGNOSIS THAT A REASONABLE PATIENT WOULD CONSIDER MATERIAL TO THE DECISION WHETHER OR NOT TO UNDERGO TREATMENT OR DIAGNOSIS. NO PHYSICIAN OR PODIATRIST SHALL BE LIABLE FOR A FAILURE TO OBTAIN AN INFORMED CONSENT IN THE EVENT OF AN EMERGENCY WHICH PREVENTS CONSULTING THE PATIENT. NO PHYSICIAN OR PODIATRIST SHALL BE LIABLE FOR FAILURE TO OBTAIN AN INFORMED CONSENT IF IT IS ESTABLISHED BY A PREPONDERANCE OF THE EVIDENCE THAT FURNISHING THE INFORMATION IN QUESTION TO THE PATIENT WOULD HAVE RESULTED IN A SERIOUSLY ADVERSE EFFECT ON THE PATIENT OR ON THE THERAPEUTIC PROCESS TO THE MATERIAL DETRIMENT OF THE PATIENT'S HEALTH.

"INTEREST" MEANS INTEREST AT THE RATE PRESCRIBED IN SECTION 806 OF THE ACT OF APRIL 9, 1929 (P.L.343, NO.176), KNOWN AS "THE FISCAL CODE."

"LICENSURE BOARD" MEANS THE STATE BOARD OF [MEDICAL EDUCATION AND LICENSURE] MEDICINE, THE STATE BOARD OF OSTEOPATHIC [EXAMINERS] MEDICINE, THE STATE BOARD OF PODIATRY [EXAMINERS], THE DEPARTMENT OF PUBLIC WELFARE AND THE DEPARTMENT OF HEALTH.

"PATIENT" MEANS A NATURAL PERSON WHO RECEIVES OR SHOULD HAVE RECEIVED HEALTH CARE FROM A LICENSED HEALTH CARE PROVIDER.

"PREVAILING PRIMARY PREMIUM" MEANS THE SCHEDULE OF OCCURRENCE RATES APPROVED BY THE INSURANCE COMMISSIONER FOR THE JOINT UNDERWRITING ASSOCIATION.

"PRIMARY HEALTH CENTER" MEANS A COMMUNITY-BASED NONPROFIT CORPORATION MEETING STANDARDS PRESCRIBED BY THE DEPARTMENT OF HEALTH, WHICH PROVIDES PREVENTIVE, DIAGNOSTIC, THERAPEUTIC, AND

BASIC EMERGENCY HEALTH CARE BY LICENSED PRACTITIONERS WHO ARE EMPLOYEES OF THE CORPORATION OR UNDER CONTRACT TO THE CORPORATION.

"PROFESSIONAL LIABILITY INSURANCE" MEANS INSURANCE AGAINST LIABILITY ON THE PART OF A HEALTH CARE PROVIDER ARISING OUT OF ANY TORT OR BREACH OF CONTRACT CAUSING INJURY OR DEATH RESULTING FROM THE FURNISHING OF MEDICAL SERVICES WHICH WERE OR SHOULD HAVE BEEN PROVIDED.

SECTION 2. SECTION 605 OF THE ACT, AMENDED JULY 15, 1976 (P.L.1028, NO.207), IS AMENDED TO READ:

SECTION 605. STATUTE OF LIMITATIONS.--ALL CLAIMS FOR RECOVERY PURSUANT TO THIS ACT MUST BE COMMENCED WITHIN THE EXISTING APPLICABLE STATUTES OF LIMITATION. IN THE EVENT THAT ANY CLAIM IS MADE AGAINST A HEALTH CARE PROVIDER SUBJECT TO THE PROVISIONS OF ARTICLE VII MORE THAN FOUR YEARS AFTER THE BREACH OF CONTRACT OR TORT OCCURRED WHICH IS FILED WITHIN THE STATUTE OF LIMITATIONS, SUCH CLAIM SHALL BE DEFENDED AND PAID BY THE [MEDICAL PROFESSIONAL LIABILITY CATASTROPHE LOSS FUND ESTABLISHED PURSUANT TO SECTION 701.] FUND, IF THE FUND HAS RECEIVED A WRITTEN REQUEST FOR INDEMNITY AND DEFENSE WITHIN 180 DAYS OF THE DATE ON WHICH NOTICE OF THE CLAIM IS GIVEN TO THE HEALTH CARE PROVIDER OR HIS INSURER. WHERE MULTIPLE TREATMENTS OR CONSULTATIONS TOOK PLACE LESS THAN FOUR YEARS BEFORE THE DATE ON WHICH THE HEALTH CARE PROVIDER OR HIS INSURER RECEIVED NOTICE OF THE CLAIM, THE CLAIM SHALL BE DEEMED, FOR PURPOSES OF THIS SECTION, TO HAVE OCCURRED LESS THAN FOUR YEARS PRIOR TO THE DATE OF NOTICE AND SHALL BE DEFENDED BY THE INSURER PURSUANT TO SECTION 702(D). IF SUCH CLAIM IS MADE AFTER FOUR YEARS BECAUSE OF THE WILLFUL CONCEALMENT BY THE HEALTH CARE PROVIDER OR HIS INSURER, THE FUND SHALL HAVE THE RIGHT OF FULL INDEMNITY

INCLUDING DEFENSE COSTS FROM SUCH HEALTH CARE PROVIDER OR HIS INSURER. A FILING PURSUANT TO SECTION 401 SHALL TOLL THE RUNNING OF THE LIMITATIONS CONTAINED HEREIN.

SECTION 3. SECTION 701 OF THE ACT, AMENDED OCTOBER 15, 1980 (P.L.971, NO.165), IS AMENDED TO READ:

SECTION 701. PROFESSIONAL LIABILITY INSURANCE AND FUND.--(A) EVERY HEALTH CARE PROVIDER AS DEFINED IN THIS ACT, PRACTICING MEDICINE OR PODIATRY OR OTHERWISE PROVIDING HEALTH CARE SERVICES IN THE COMMONWEALTH SHALL INSURE HIS PROFESSIONAL LIABILITY ONLY WITH AN INSURER LICENSED OR APPROVED BY THE COMMONWEALTH OF PENNSYLVANIA, OR PROVIDE PROOF OF SELF-INSURANCE IN ACCORDANCE WITH THIS SECTION.

(1) (I) [A] FOR POLICIES ISSUED OR RENEWED IN THE CALENDAR YEARS 1997 THROUGH 1998, A HEALTH CARE PROVIDER, OTHER THAN HOSPITALS, WHO CONDUCTS MORE THAN 50% OF [HIS] ITS HEALTH CARE BUSINESS OR PRACTICE WITHIN THE COMMONWEALTH OF PENNSYLVANIA SHALL ANNUALLY INSURE OR SELF-INSURE [HIS] ITS PROFESSIONAL LIABILITY IN THE AMOUNT OF [$100,000] $300,000 PER OCCURRENCE AND [$300,000] $900,000 PER ANNUAL AGGREGATE, AND HOSPITALS LOCATED IN THE COMMONWEALTH SHALL INSURE OR SELF-INSURE THEIR PROFESSIONAL LIABILITY IN THE AMOUNT OF [$100,000] $300,000 PER OCCURRENCE, AND [$1,000,000] $1,500,000 PER ANNUAL AGGREGATE, HEREINAFTER KNOWN AS "BASIC COVERAGE INSURANCE" AND THEY SHALL BE ENTITLED TO PARTICIPATE IN THE FUND. [IN THE EVENT THAT AMOUNTS WHICH SHALL BECOME PAYABLE BY THE FUND SHALL EXCEED THE AMOUNT OF $20,000,000 IN ANY YEAR FOLLOWING CALENDAR YEAR 1980, BASIC COVERAGE INSURANCE COMMENCING IN THE ENSUING YEAR SHALL BECOME $150,000 PER OCCURRENCE AND $450,000 PER ANNUAL AGGREGATE FOR HEALTH CARE PROVIDERS OTHER THAN HOSPITALS FOR WHICH BASIC COVERAGE INSURANCE SHALL BECOME $150,000 PER OCCURRENCE AND

$1,000,000 PER ANNUAL AGGREGATE.

(II) IN THE EVENT THAT AMOUNTS WHICH SHALL BECOME PAYABLE BY THE FUND SHALL EXCEED THE AMOUNT OF $30,000,000 IN ANY YEAR FOLLOWING CALENDAR YEAR 1982, BASIC COVERAGE INSURANCE COMMENCING IN THE ENSUING YEAR SHALL BECOME $200,000 PER OCCURRENCE AND $600,000 PER ANNUAL AGGREGATE FOR HEALTH CARE PROVIDERS OTHER THAN HOSPITALS FOR WHICH BASIC COVERAGE INSURANCE SHALL BECOME $200,000 PER OCCURRENCE AND $1,000,000 PER ANNUAL AGGREGATE.]

(II) FOR POLICIES ISSUED OR RENEWED IN THE CALENDAR YEARS 1999 THROUGH 2000, A HEALTH CARE PROVIDER, OTHER THAN HOSPITALS, WHO CONDUCTS MORE THAN 50% OF ITS HEALTH CARE BUSINESS OR PRACTICE WITHIN THIS COMMONWEALTH SHALL ANNUALLY INSURE OR SELF-INSURE ITS PROFESSIONAL LIABILITY IN THE AMOUNT OF $400,000 PER OCCURRENCE AND $1,200,000 PER ANNUAL AGGREGATE, AND HOSPITALS LOCATED IN THIS COMMONWEALTH SHALL INSURE OR SELF-INSURE THEIR PROFESSIONAL LIABILITY IN THE AMOUNT OF $400,000 PER OCCURRENCE AND $2,000,000 PER ANNUAL AGGREGATE.

(III) FOR POLICIES ISSUED OR RENEWED IN THE CALENDAR YEAR 2001, AND EACH YEAR THEREAFTER, A HEALTH CARE PROVIDER, OTHER THAN HOSPITALS, WHO CONDUCTS MORE THAN 50% OF ITS HEALTH CARE, BUSINESS OR PRACTICE WITHIN THIS COMMONWEALTH SHALL ANNUALLY INSURE OR SELF-INSURE ITS PROFESSIONAL LIABILITY IN THE AMOUNT OF $500,000 PER OCCURRENCE AND $1,500,000 PER ANNUAL AGGREGATE, AND HOSPITALS LOCATED IN THIS COMMONWEALTH SHALL INSURE OR SELF-INSURE THEIR PROFESSIONAL LIABILITY IN THE AMOUNT OF $500,000 PER OCCURRENCE AND $2,500,000 PER ANNUAL AGGREGATE.

(2) (I) A HEALTH CARE PROVIDER WHO CONDUCTS 50% OR LESS OF [HIS] ITS HEALTH CARE BUSINESS OR PRACTICE WITHIN THE COMMONWEALTH SHALL INSURE OR SELF-INSURE [HIS] ITS PROFESSIONAL

LIABILITY IN THE [AMOUNT OF $200,000 PER OCCURRENCE AND $600,000 PER ANNUAL AGGREGATE] AMOUNTS LISTED IN SUBPARAGRAPHS (II), (III) AND (IV) AND SHALL NOT BE REQUIRED TO CONTRIBUTE TO OR BE ENTITLED TO PARTICIPATE IN THE FUND SET FORTH IN ARTICLE VII OF THIS ACT OR THE PLAN SET FORTH IN ARTICLE VIII OF THIS ACT.

(II) FOR CALENDAR YEARS 1997 THROUGH 1998, BASIC INSURANCE COVERAGE SHALL, ON AN ANNUAL BASIS, BE IN THE AMOUNT OF $300,000 PER OCCURRENCE AND $900,000 PER ANNUAL AGGREGATE.

(III) FOR CALENDAR YEARS 1999 THROUGH 2000, BASIC INSURANCE COVERAGE SHALL, ON AN ANNUAL BASIS, BE IN THE AMOUNT OF $400,000 PER OCCURRENCE AND $1,200,000 PER ANNUAL AGGREGATE.

(IV) FOR CALENDAR YEAR 2001, AND EACH YEAR THEREAFTER, BASIC INSURANCE COVERAGE SHALL, ON AN ANNUAL BASIS, BE IN THE AMOUNT OF $500,000 PER OCCURRENCE AND $1,500,000 PER ANNUAL AGGREGATE.

(3) FOR THE PURPOSES OF THIS SECTION, "HEALTH CARE BUSINESS OR PRACTICE" SHALL MEAN THE NUMBER OF PATIENTS TO WHOM HEALTH CARE SERVICES ARE RENDERED BY A HEALTH CARE PROVIDER WITHIN AN ANNUAL PERIOD.

(4) ALL SELF-INSURANCE PLANS SHALL BE SUBMITTED WITH SUCH INFORMATION AS THE COMMISSIONER SHALL REQUIRE FOR APPROVAL AND SHALL BE APPROVED BY THE COMMISSIONER UPON HIS FINDING THAT THE PLAN CONSTITUTES PROTECTION EQUIVALENT TO THE INSURANCE REQUIREMENTS OF A HEALTH CARE PROVIDER.

(5) A FEE SHALL BE CHARGED BY THE INSURANCE DEPARTMENT TO ALL SELF-INSURERS FOR EXAMINATION AND APPROVAL OF THEIR PLANS.

(6) SELF-INSURED HEALTH CARE PROVIDERS AND HOSPITALS IF EXEMPT FROM THIS ACT SHALL SUBMIT THE INFORMATION REQUIRED UNDER SECTION 809 TO THE COMMISSIONER.

(B) (1) NO INSURER PROVIDING PROFESSIONAL LIABILITY INSURANCE SHALL BE LIABLE FOR PAYMENT OF ANY CLAIM AGAINST A

HEALTH CARE PROVIDER FOR ANY LOSS OR DAMAGES AWARDED IN A PROFESSIONAL LIABILITY ACTION IN EXCESS OF THE BASIC COVERAGE INSURANCE, AS PROVIDED IN SUBSECTION (A)(1) FOR EACH HEALTH CARE PROVIDER AGAINST WHOM AN AWARD IS MADE UNLESS THE HEALTH CARE PROVIDER'S PROFESSIONAL LIABILITY POLICY OR SELF-INSURANCE PLAN PROVIDES FOR A HIGHER ANNUAL AGGREGATE LIMIT.

(2) IF A CLAIM EXCEEDS THE AGGREGATE LIMITS OF AN INSURER OR A SELF-INSURANCE PLAN, THE FUND SHALL BE RESPONSIBLE FOR THE PAYMENT OF THE CLAIM UP TO THE FUND COVERAGE LIMITS.

(C) A GOVERNMENT MAY SATISFY ITS OBLIGATIONS PURSUANT TO THIS ACT, AS WELL AS THE OBLIGATIONS OF ITS EMPLOYEES TO THE EXTENT OF THEIR EMPLOYMENT, BY EITHER PURCHASING INSURANCE OR ASSUMING SUCH OBLIGATION AS A SELF-INSURER AND INCLUDING THE PAYMENT OF ALL SURCHARGES UNDER THIS ACT.

(D) THERE IS HEREBY CREATED A CONTINGENCY FUND FOR THE PURPOSE OF PAYING ALL AWARDS, JUDGMENTS AND SETTLEMENTS FOR LOSS OR DAMAGES AGAINST A HEALTH CARE PROVIDER ENTITLED TO PARTICIPATE IN THE FUND AS A CONSEQUENCE OF ANY CLAIM FOR PROFESSIONAL LIABILITY BROUGHT AGAINST SUCH HEALTH CARE PROVIDER AS A DEFENDANT OR AN ADDITIONAL DEFENDANT TO THE EXTENT SUCH HEALTH CARE PROVIDER'S SHARE EXCEEDS [HIS] ITS BASIC COVERAGE INSURANCE IN EFFECT AT THE TIME OF OCCURRENCE AS PROVIDED IN SUBSECTION (A)(1). [SUCH FUND SHALL BE KNOWN AS THE "MEDICAL PROFESSIONAL LIABILITY CATASTROPHE LOSS FUND," IN THIS ARTICLE VII CALLED THE "FUND."] THE LIMIT OF LIABILITY OF THE FUND SHALL BE [$1,000,000 FOR EACH OCCURRENCE FOR EACH HEALTH CARE PROVIDER AND $3,000,000 PER ANNUAL AGGREGATE FOR EACH HEALTH CARE PROVIDER.] AS FOLLOWS:

(1) FOR CALENDAR YEARS 1997 THROUGH 1998, THE LIMIT OF LIABILITY OF THE FUND SHALL BE $900,000 FOR EACH OCCURRENCE FOR

EACH HEALTH CARE PROVIDER AND $2,700,000 PER ANNUAL AGGREGATE FOR EACH HEALTH CARE PROVIDER.

(2) FOR CALENDAR YEARS 1999 THROUGH 2000, THE LIMIT OF LIABILITY OF THE FUND SHALL BE $800,000 FOR EACH OCCURRENCE FOR EACH HEALTH CARE PROVIDER AND $2,400,000 PER ANNUAL AGGREGATE FOR EACH HEALTH CARE PROVIDER.

(3) FOR CALENDAR YEAR 2001, AND EACH YEAR THEREAFTER, THE LIMIT OF LIABILITY OF THE FUND SHALL BE $700,000 FOR EACH OCCURRENCE FOR EACH HEALTH CARE PROVIDER AND $2,100,000 PER ANNUAL AGGREGATE FOR EACH HEALTH CARE PROVIDER.

(E) (1) [THE] AFTER DECEMBER 31, 1996, THE FUND SHALL BE FUNDED BY THE LEVYING OF AN ANNUAL SURCHARGE ON OR AFTER JANUARY 1 OF EVERY YEAR ON ALL HEALTH CARE PROVIDERS ENTITLED TO PARTICIPATE IN THE FUND. THE SURCHARGE SHALL BE DETERMINED BY THE [DIRECTOR APPOINTED PURSUANT TO SECTION 702 AND SUBJECT TO THE PRIOR APPROVAL OF THE COMMISSIONER] FUND, FILED WITH THE COMMISSIONER AND COMMUNICATED TO ALL BASIC INSURANCE COVERAGE CARRIERS AND SELF-INSURED PROVIDERS. THE SURCHARGE SHALL BE BASED ON THE [COST TO] PREVAILING PRIMARY PREMIUM FOR EACH HEALTH CARE PROVIDER FOR MAINTENANCE OF PROFESSIONAL LIABILITY INSURANCE AND SHALL BE THE APPROPRIATE PERCENTAGE THEREOF, NECESSARY TO PRODUCE AN AMOUNT SUFFICIENT TO REIMBURSE THE FUND FOR THE PAYMENT OF [ALL CLAIMS PAID] FINAL CLAIMS AND EXPENSES INCURRED DURING THE PRECEDING [CALENDAR YEAR] CLAIMS PERIOD AND TO PROVIDE AN AMOUNT NECESSARY TO MAINTAIN AN ADDITIONAL [$15,000,000.] 15% OF THE FINAL CLAIMS AND EXPENSES INCURRED DURING THE PRECEDING CLAIMS PERIOD.

(2) THE JOINT UNDERWRITING ASSOCIATION SHALL FILE UPDATED RATES FOR ALL HEALTH CARE PROVIDERS WITH THE COMMISSIONER BY MAY 1 OF EACH YEAR.

(3) THE FUND SHALL REVIEW AND MAY ADJUST THE PREVAILING PRIMARY PREMIUM IN LINE WITH ANY APPLICABLE CHANGES TO THE PREVAILING PRIMARY PREMIUM MADE IN FILINGS BY THE JOINT UNDERWRITING ASSOCIATION AND APPROVED BY THE COMMISSIONER.

(4) THE FUND MAY ADJUST THE APPLICABLE PREVAILING PRIMARY PREMIUM OF ANY HOSPITAL, INCLUDING A HOSPITAL ASSOCIATED WITH A UNIVERSITY OR OTHER EDUCATION INSTITUTION, THROUGH AN INCREASE OR DECREASE IN THE INDIVIDUAL HOSPITAL'S PREVAILING PRIMARY PREMIUM NOT TO EXCEED 20%. ANY SUCH ADJUSTMENT SHALL BE BASED UPON THE FREQUENCY AND SEVERITY OF CLAIMS PAID BY THE FUND ON BEHALF OF OTHER HOSPITALS OF SIMILAR CLASS, SIZE, RISK AND KIND WITHIN THE SAME DEFINED REGION DURING THE PAST FIVE MOST RECENT CLAIMS PERIODS. ALL PREMIUM ADJUSTMENTS PURSUANT TO THIS SUBSECTION SHALL REQUIRE THE APPROVAL OF THE COMMISSIONER.

(5) FOR HEALTH CARE PROVIDERS THAT DO NOT ENGAGE IN DIRECT CLINICAL PRACTICE ON A FULL-TIME BASIS, THE PREVAILING PRIMARY PREMIUM RATE SHALL BE ADJUSTED BY THE FUND TO REFLECT THE LOWER RISK ASSOCIATED WITH THE LESS THAN FULL-TIME DIRECT CLINICAL PRACTICE.

(6) THE SURCHARGE PROVIDED IN PARAGRAPH (1) SHALL BE REVIEWED BY THE COMMISSIONER WITHIN 30 DAYS OF SUBMISSION. AFTER REVIEW, THE COMMISSIONER MAY ONLY DISAPPROVE A SURCHARGE IF IT IS INADEQUATE OR EXCESSIVE. IF SO DISAPPROVED, THE FUND SHALL MAKE AN ADJUSTMENT TO THE NEXT SURCHARGE CALCULATION TO REFLECT THE APPROPRIATE INCREASE OR DECREASE.

(7) WHEN A HEALTH CARE PROVIDER CHANGES THE TERM OF ITS PROFESSIONAL LIABILITY COVERAGE, THE SURCHARGE SHALL BE CALCULATED ON AN ANNUAL BASE AND SHALL REFLECT THE SURCHARGE PERCENTAGES IN EFFECT FOR ALL THE SURCHARGE PERIODS OVER WHICH THE POLICY IS IN EFFECT.

[(2)] (8) HEALTH CARE PROVIDERS HAVING APPROVED SELF-INSURANCE PLANS SHALL BE SURCHARGED AN AMOUNT EQUAL TO THE SURCHARGE IMPOSED ON A HEALTH CARE PROVIDER OF LIKE CLASS, SIZE, RISK AND KIND AS DETERMINED BY THE DIRECTOR. THE FUND AND ALL INCOME FROM THE FUND SHALL BE HELD IN TRUST, DEPOSITED IN A SEGREGATED ACCOUNT, INVESTED AND REINVESTED BY THE DIRECTOR, AND SHALL NOT BECOME A PART OF THE GENERAL FUND OF THE COMMONWEALTH. ALL CLAIMS SHALL BE COMPUTED ON [AUGUST 31, 1981 FOR ALL CLAIMS WHICH BECOME FINAL BETWEEN JANUARY 1, 1981 AND AUGUST 31, 1981 AND ANNUALLY THEREAFTER ON] AUGUST 31 FOR ALL CLAIMS WHICH BECAME FINAL BETWEEN THAT DATE AND SEPTEMBER 1 OF THE PRECEDING YEAR. ALL SUCH CLAIMS SHALL BE PAID ON OR BEFORE DECEMBER 31 FOLLOWING THE AUGUST 31 BY WHICH THEY BECAME FINAL, AS PROVIDED ABOVE. [ALL CLAIMS WHICH BECOME FINAL BETWEEN JANUARY 1, 1980 AND THE EFFECTIVE DATE OF THIS AMENDATORY ACT SHALL BE COMPUTED ON THE EFFECTIVE DATE OF THIS AMENDATORY ACT AND SHALL BE PAID ON OR BEFORE DECEMBER 31, 1980.

(3)] (9) NOTWITHSTANDING THE ABOVE PROVISIONS RELATING TO AN ANNUAL SURCHARGE, THE COMMISSIONER SHALL HAVE THE AUTHORITY, DURING SEPTEMBER 1981 AND DURING SEPTEMBER OF EACH YEAR THEREAFTER, IF THE FUND WOULD BE EXHAUSTED BY THE PAYMENT IN FULL OF ALL CLAIMS WHICH HAVE BECOME FINAL AND THE EXPENSES OF THE OFFICE OF THE DIRECTOR, TO DETERMINE AND LEVY AN EMERGENCY SURCHARGE ON ALL HEALTH CARE PROVIDERS THEN ENTITLED TO PARTICIPATE IN THE FUND. SUCH EMERGENCY SURCHARGE SHALL BE THE APPROPRIATE PERCENTAGE OF THE COST TO EACH HEALTH CARE PROVIDER FOR MAINTENANCE OF PROFESSIONAL LIABILITY INSURANCE NECESSARY TO PRODUCE AN AMOUNT SUFFICIENT TO ALLOW THE FUND TO PAY IN FULL ALL CLAIMS DETERMINED TO BE FINAL AS OF [AUGUST 31, 1981 AND] AUGUST 31 OF EACH YEAR [THEREAFTER] AND THE EXPENSES OF THE

[OFFICE OF THE DIRECTOR, AS OF DECEMBER 31, 1980 AND] FUND AS OF DECEMBER 31 OF EACH YEAR [THEREAFTER].

[(4)] (10) THE ANNUAL AND EMERGENCY SURCHARGES ON HEALTH CARE PROVIDERS AND ANY INCOME REALIZED BY INVESTMENT OR REINVESTMENT SHALL CONSTITUTE THE SOLE AND EXCLUSIVE SOURCES OF FUNDING FOR THE FUND. NO CLAIMS OR EXPENSES AGAINST THE FUND SHALL BE DEEMED TO CONSTITUTE A DEBT OF THE COMMONWEALTH OR A CHARGE AGAINST THE GENERAL FUND OF THE COMMONWEALTH.

(11) THE DIRECTOR SHALL ISSUE RULES AND REGULATIONS CONSISTENT WITH THIS SECTION REGARDING THE ESTABLISHMENT AND OPERATION OF THE FUND INCLUDING ALL PROCEDURES AND THE LEVYING, PAYMENT AND COLLECTION OF THE SURCHARGES EXCEPT THAT THE COMMISSIONER SHALL ISSUE RULES AND REGULATIONS REGARDING THE IMPOSITION OF THE EMERGENCY SURCHARGE. [A FEE SHALL BE CHARGED BY THE DIRECTOR TO ALL SELF-INSURERS FOR EXAMINATION AND APPROVAL OF THEIR PLANS.]

(12) UPON THE EFFECTIVE DATE OF THIS SECTION, THE FUND SHALL IMMEDIATELY NOTIFY ALL INSURERS WRITING PROFESSIONAL LIABILITY INSURANCE OF THE SCHEDULE OF OCCURRENCE RATES APPROVED BY THE COMMISSIONER AND IN EFFECT FOR THE JOINT UNDERWRITING ASSOCIATION.

(13) WITHIN 20 DAYS OF THE EFFECTIVE DATE OF THIS SECTION, THE FUND SHALL RECALCULATE THE SURCHARGE FOR HEALTH CARE PROVIDERS FOR THE SURCHARGE PERIOD BEGINNING JANUARY 1, 1997, BASED UPON THE PREVAILING PRIMARY PREMIUM.

(14) A HEALTH CARE PROVIDER MAY ELECT TO PAY THE ANNUAL SURCHARGE IN EQUAL INSTALLMENTS, NOT EXCEEDING FOUR, IF THE HEALTH CARE PROVIDER INFORMS THE PRIMARY CARRIER OF THE OPTION TO PAY IN INSTALLMENTS AND THE ENTIRE ANNUAL SURCHARGE IS COLLECTED AND REMITTED TO THE FUND BY DECEMBER 10, WITH FOUR

EQUAL INSTALLMENTS COMMENCING 60 DAYS FROM THE DATE OF POLICY INCEPTION OR RENEWAL WITH PAYMENT DUE EACH 60 DAYS THEREAFTER UNTIL THE FULL REMITTANCE IS PAID. THIS PARAGRAPH SHALL APPLY TO SURCHARGES FOR 1997. THIS PARAGRAPH SHALL EXPIRE JANUARY 1, 1998.

(F) THE FAILURE OF ANY HEALTH CARE PROVIDER TO COMPLY WITH ANY OF THE PROVISIONS OF THIS SECTION OR ANY OF THE RULES AND REGULATIONS ISSUED BY THE DIRECTOR SHALL RESULT IN THE SUSPENSION OR REVOCATION OF THE HEALTH CARE PROVIDER'S LICENSE BY THE LICENSURE BOARD.

(G) ANY PHYSICIAN WHO EXCLUSIVELY PRACTICES THE SPECIALTY OF FORENSIC PATHOLOGY SHALL BE EXEMPT FROM THE PROVISIONS OF THIS ACT.

(H) ALL HEALTH CARE PROVIDERS WHO ARE MEMBERS OF THE PENNSYLVANIA MILITARY FORCES ARE EXEMPT FROM THE PROVISIONS OF THIS ACT WHILE IN THE PERFORMANCE OF THEIR ASSIGNED DUTY IN THE PENNSYLVANIA MILITARY FORCES UNDER ORDERS.

SECTION 4. SECTION 702 OF THE ACT, AMENDED JULY 15, 1976 (P.L.1028, NO.207) AND OCTOBER 15, 1980 (P.L.971, NO.165), IS AMENDED TO READ:

SECTION 702. DIRECTOR AND ADMINISTRATION OF FUND.--(A) THE FUND SHALL BE ADMINISTERED BY A DIRECTOR WHO SHALL BE APPOINTED BY THE GOVERNOR AND WHOSE SALARY SHALL BE FIXED BY THE EXECUTIVE BOARD. THE DIRECTOR MAY EMPLOY AND FIX THE COMPENSATION OF SUCH CLERICAL AND OTHER ASSISTANTS AS MAY BE DEEMED NECESSARY AND MAY PROMULGATE RULES AND REGULATIONS RELATING TO PROCEDURES FOR THE REPORTING OF CLAIMS TO THE FUND.

(B) THE DIRECTOR SHALL BE PROVIDED WITH ADEQUATE OFFICES IN WHICH THE RECORDS SHALL BE KEPT AND OFFICIAL BUSINESS SHALL BE TRANSACTED, AND THE DIRECTOR SHALL ALSO BE PROVIDED WITH

NECESSARY OFFICE FURNITURE AND OTHER SUPPLIES.

(C) THE BASIC COVERAGE INSURANCE CARRIER OR SELF-INSURED PROVIDER SHALL PROMPTLY NOTIFY THE DIRECTOR OF ANY CASE WHERE IT REASONABLY BELIEVES THAT THE VALUE OF THE CLAIM EXCEEDS THE BASIC INSURER'S COVERAGE OR SELF-INSURANCE PLAN OR FALLS UNDER SECTION 605. SUCH INFORMATION, INCLUDING THE FUND'S CLAIM FILE, SHALL BE CONFIDENTIAL, NOTWITHSTANDING THE [ACT OF JULY 19, 1974 (P.L.486, NO.175) REFERRED TO AS THE PUBLIC AGENCY OPEN MEETING LAW, AND] ACT OF JUNE 21, 1957 (P.L.390, NO.212) REFERRED TO AS THE RIGHT TO KNOW LAW[.] AND THE ACT OF JULY 3, 1986 (P.L.388, NO.84), KNOWN AS THE "SUNSHINE ACT." FAILURE TO SO NOTIFY THE DIRECTOR SHALL MAKE THE BASIC COVERAGE INSURANCE CARRIER OR SELF-INSURED PROVIDER RESPONSIBLE FOR THE PAYMENT OF THE ENTIRE AWARD OR VERDICT, PROVIDED THAT THE FUND HAS BEEN PREJUDICED BY THE FAILURE OF NOTICE.

(D) THE BASIC COVERAGE INSURANCE CARRIER OR SELF-INSURED PROVIDER SHALL BE RESPONSIBLE TO PROVIDE A DEFENSE TO THE CLAIM, INCLUDING DEFENSE OF THE FUND, EXCEPT AS PROVIDED FOR IN SECTION 605. IN SUCH INSTANCES WHERE THE DIRECTOR HAS BEEN NOTIFIED IN ACCORDANCE WITH SUBSECTION (C), THE DIRECTOR MAY[, AT HIS OPTION,] JOIN IN THE DEFENSE AND BE REPRESENTED BY COUNSEL.

(E) IN THE EVENT THAT THE BASIC COVERAGE INSURANCE CARRIER OR SELF-INSURED PROVIDER ENTERS INTO A SETTLEMENT WITH THE CLAIMANT TO THE FULL EXTENT OF ITS LIABILITY AS PROVIDED ABOVE, IT MAY OBTAIN A RELEASE FROM THE CLAIMANT TO THE EXTENT OF ITS PAYMENT, WHICH PAYMENT SHALL HAVE NO EFFECT UPON ANY EXCESS CLAIM AGAINST THE FUND OR ITS DUTY TO CONTINUE THE DEFENSE OF THE CLAIM.

(F) THE DIRECTOR IS AUTHORIZED TO DEFEND, LITIGATE, SETTLE OR COMPROMISE ANY CLAIM PAYABLE BY THE FUND. A HEALTH CARE

PROVIDER'S BASIC INSURANCE COVERAGE CARRIER SHALL HAVE THE RIGHT TO APPROVE ANY SETTLEMENT ENTERED INTO BY THE DIRECTOR ON BEHALF OF ITS INSURED HEALTH CARE PROVIDER. IF THE BASIC INSURANCE COVERAGE CARRIER DOES NOT DISAPPROVE A SETTLEMENT PRIOR TO EXECUTION BY THE DIRECTOR, IT SHALL BE DEEMED APPROVED BY THE BASIC INSURANCE COVERAGE CARRIER. IN THE EVENT THAT MORE THAN ONE HEALTH CARE PROVIDER DEFENDANT IS PARTY TO A SETTLEMENT, THE HEALTH CARE PROVIDER'S BASIC INSURANCE COVERAGE CARRIER SHALL HAVE THE RIGHT TO APPROVE ONLY THAT PORTION OF THE SETTLEMENT WHICH IS CONTRIBUTED ON BEHALF OF ITS INSURED HEALTH CARE PROVIDER.

(G) THE DIRECTOR IS HEREBY EMPOWERED TO PURCHASE, ON BEHALF OF THE FUND, AS MUCH INSURANCE OR RE-INSURANCE AS IS NECESSARY TO PRESERVE THE FUND.

(H) NOTHING IN THIS ACT SHALL PRECLUDE THE DIRECTOR FROM ADJUSTING OR PAYING FOR THE ADJUSTMENT OF CLAIMS.

(I) UPON THE REQUEST OF A PARTY TO A CASE WITHIN THE FUND COVERAGE LIMITS, THE FUND MAY PROVIDE FOR A MEDIATOR IN INSTANCES WHERE MULTIPLE CARRIERS DISAGREE ON A CASE. UPON THE CONSENT OF ALL PARTIES TO ANY PROCEEDING HEREUNDER THAT MEDIATION SHALL BE BINDING, THE PARTIES SHALL BE BOUND BY THE CONCLUSIONS OF THE MEDIATOR. THE FUND SHALL PROMULGATE SUCH RULES AND REGULATIONS AS ARE NECESSARY TO IMPLEMENT THIS PROVISION. PROCEEDINGS CONDUCTED UNDER THIS SECTION SHALL BE CONFIDENTIAL AND SHALL NOT BE CONSIDERED PUBLIC INFORMATION SUBJECT TO DISCLOSURE UNDER THE RIGHT-TO-KNOW LAW AND THE "SUNSHINE ACT."

(J) DELAY DAMAGES AND POSTJUDGMENT INTEREST APPLICABLE TO THE FUND'S LIABILITY IN A CASE SHALL BE PAID BY THE FUND AND SHALL NOT BE CHARGED AGAINST THE INSURED'S ANNUAL AGGREGATE

LIMITS. THE BASIC INSURANCE CARRIER OR SELF-INSURER SHALL BE RESPONSIBLE FOR ITS PROPORTIONATE SHARE OF DELAY DAMAGES AND POST-JUDGMENT INTEREST.

(K) THE FUND SHALL HAVE THE AUTHORITY TO BORROW MONEY FOR PERIODS OF LESS THAN TWO YEARS IN ORDER TO PAY CLAIMS AND EXPENSES UNTIL SUFFICIENT REVENUES ARE REALIZED BY THE FUND.

SECTION 5. SECTION 705 OF THE ACT, ADDED JULY 15, 1976 (P.L.1028, NO.207), IS AMENDED TO READ:

SECTION 705. LIABILITY OF EXCESS CARRIERS.--(A) NO INSURER PROVIDING EXCESS PROFESSIONAL LIABILITY INSURANCE TO ANY HEALTH CARE PROVIDER ELIGIBLE FOR COVERAGE UNDER THE [MEDICAL PROFESSIONAL LIABILITY CATASTROPHE LOSS FUND] FUND SHALL BE LIABLE FOR PAYMENT OF ANY CLAIM AGAINST A HEALTH CARE PROVIDER FOR ANY LOSS OR DAMAGES EXCEPT THOSE IN EXCESS OF THE FUND COVERAGE LIMITS [OF LIABILITY PROVIDED BY THE MEDICAL PROFESSIONAL LIABILITY CATASTROPHE LOSS FUND].

(B) NO CARRIER PROVIDING EXCESS PROFESSIONAL LIABILITY INSURANCE FOR A HEALTH CARE PROVIDER COVERED BY THE [MEDICAL PROFESSIONAL CATASTROPHE LOSS FUND] FUND SHALL BE LIABLE FOR ANY LOSS RESULTING FROM THE INSOLVENCY OR DISSOLUTION OF THE [CATASTROPHE LOSS] FUND.

SECTION 6. THE ACT IS AMENDED BY ADDING A SECTION TO READ:

SECTION 706. ADVISORY BOARD.--(A) THERE IS HEREBY ESTABLISHED AN ADVISORY BOARD OF ELEVEN MEMBERS TO BE KNOWN AS THE MEDICAL PROFESSIONAL LIABILITY INSURANCE CATASTROPHE LOSS FUND ADVISORY BOARD.

(B) THE BOARD SHALL BE COMPRISED OF THE FOLLOWING PERSONS:

(1) THE INSURANCE COMMISSIONER.

(2) FOUR MEMBERS, ONE EACH TO BE APPOINTED BY THE PRESIDENT PRO TEMPORE OF THE SENATE, THE MINORITY LEADER OF THE SENATE,

THE SPEAKER OF THE HOUSE OF REPRESENTATIVES AND THE MINORITY LEADER OF THE HOUSE OF REPRESENTATIVES. THESE MEMBERS SHALL HAVE EXPERIENCE IN THE AREAS OF LAW, HEALTH CARE, LIABILITY INSURANCE, FINANCE OR ACTUARIAL ANALYSIS.

(3) SIX MEMBERS APPOINTED BY THE GOVERNOR AS FOLLOWS:

(I) ONE PHYSICIAN, WHO SHALL BE APPOINTED FOR A THREE-YEAR TERM.

(II) ONE REPRESENTATIVE OF A HOSPITAL PROVIDER, WHO SHALL BE APPOINTED FOR A THREE-YEAR TERM.

(III) ONE REPRESENTATIVE OF A CASUALTY INSURER WITH 1% OR LESS SHARE OF THE MEDICAL PROFESSIONAL LIABILITY INSURANCE MARKET IN THIS COMMONWEALTH, WHO SHALL BE APPOINTED FOR A TWO-YEAR TERM.

(IV) ONE PODIATRIST OR ONE REPRESENTATIVE OF A NURSING HOME, WHO SHALL BE APPOINTED FOR A THREE-YEAR TERM. THE PODIATRIST AND THE REPRESENTATIVE OF A NURSING HOME SHALL ALTERNATE TERMS.

(V) TWO REPRESENTATIVES OF THE PUBLIC-AT-LARGE, ONE OF WHOM SHALL BE APPOINTED FOR A TWO-YEAR TERM AND THE OTHER FOR A ONE-YEAR TERM.

(C) AFTER THE INITIAL TERMS UNDER THIS PARAGRAPH HAVE BEEN COMPLETED, ALL TERMS SHALL BE FOR A PERIOD OF THREE YEARS.

(D) THE MEMBERS OF THE BOARD SHALL SERVE WITHOUT COMPENSATION, BUT SHALL BE REIMBURSED FOR THEIR ACTUAL AND NECESSARY TRAVELING AND OTHER EXPENSES IN CONNECTION WITH ATTENDANCE AT MEETINGS.

(E) THE MEMBERS OF THE BOARD SHALL HAVE THE FOLLOWING POWERS AND DUTIES:

(1) TO REVIEW PROCEDURES AND OPERATIONS OF THE FUND.

(2) TO COMMISSION AUDITS TO BE PAID FOR BY THE FUND, NOT TO EXCEED MORE THAN ONE EVERY TWO YEARS.

(3) TO ADOPT REASONABLE STANDARDS FOR PROMPT INVESTIGATION AND SETTLEMENT OF CLAIMS ARISING UNDER THIS ACT TO INCLUDE, BUT NOT BE LIMITED TO:

(I) PROMPT ACKNOWLEDGMENT OF PERTINENT COMMUNICATIONS WITH RESPECT TO CLAIMS.

(II) REASONABLE STANDARDS FOR PROMPT INVESTIGATION AND SETTLEMENT OF CLAIMS.

(III) PROMPT AND REASONABLE SETTLEMENT OF CLAIMS IN WHICH LIABILITY HAS BECOME REASONABLY CLEAR.

(IV) FAIR SETTLEMENT OF ALL CLAIMS.

(V) PREVENTION OF DUPLICATION IN FORMAL PROOF OF LOSS AND SUBSEQUENT VERIFICATION.

(VI) PROVISION OF REASONABLE AND ACCURATE EXPLANATIONS OF BASIS FOR CLAIMS DENIALS OR SETTLEMENT OFFERS.

(F) THE BOARD SHALL MAKE ANNUAL REPORTS TO THE GOVERNOR AND THE GENERAL ASSEMBLY WHICH SHALL INCLUDE RECOMMENDATIONS REGARDING MANAGEMENT AND LEGISLATIVE CHANGES.

(G) THE BOARD SHALL UNDERTAKE A STUDY OF THE OPERATIONS AND STRUCTURE OF THE FUND AND SHALL REPORT TO THE GOVERNOR AND THE GENERAL ASSEMBLY, NOT LATER THAN SEPTEMBER 1, 1997, ITS RECOMMENDATIONS CONCERNING THE FUTURE OF THE FUND, INCLUDING, BUT NOT LIMITED TO, AN OPT-OUT PROVISION FOR DOCTORS AND HOSPITALS, TOTAL ELIMINATION OR PHASEOUT OF THE FUND AND OTHER PROVISIONS FOR PROVIDING ADEQUATE MEDICAL PROFESSIONAL LIABILITY INSURANCE, INCLUDING EVALUATION OF THE UNFUNDED LIABILITY AND FINANCING OPTIONS TO RETIRE ANY UNFUNDED LIABILITIES. THE REPORT SHALL RECOMMEND MEASURES TO BE TAKEN BY THE GENERAL ASSEMBLY.

(H) AS USED IN THIS SECTION, THE TERM "BOARD" MEANS THE MEDICAL PROFESSIONAL LIABILITY INSURANCE CATASTROPHE LOSS FUND ADVISORY BOARD.

SECTION 7. SECTION 803 OF THE ACT, AMENDED OCTOBER 15, 1980 (P.L.971, NO.165), IS AMENDED TO READ:

SECTION 803. PLAN OPERATION, RATES AND DEFICITS.--(A) SUBJECT TO THE SUPERVISION AND APPROVAL OF THE COMMISSIONER, INSURERS MAY CONSULT AND AGREE WITH EACH OTHER AND WITH OTHER APPROPRIATE PERSONS AS TO THE ORGANIZATION, ADMINISTRATION AND OPERATION OF THE PLAN AND AS TO RATES AND RATE MODIFICATIONS FOR INSURANCE COVERAGES PROVIDED UNDER THE PLAN. RATES AND RATE MODIFICATIONS ADOPTED OR CHANGED FOR INSURANCE COVERAGES PROVIDED UNDER THE PLAN SHALL BE APPROVED BY THE COMMISSIONER IN ACCORDANCE WITH THE ACT OF JUNE 11, 1947 (P.L.538, NO.246), KNOWN AS "THE CASUALTY AND SURETY RATE REGULATORY ACT," EXCEPT AS MAY BE INCONSISTENT WITH SUBSECTION (C).

(B) IN THE EVENT THAT THE JOINT UNDERWRITING ASSOCIATION SUFFERS A DEFICIT IN ANY CALENDAR YEAR, THE BOARD OF DIRECTORS OF THE JOINT UNDERWRITING ASSOCIATION SHALL SO CERTIFY TO THE DIRECTOR OF THE [CATASTROPHE LOSS FUND AND THE INSURANCE COMMISSIONER] <u>FUND AND THE COMMISSIONER</u>. SUCH CERTIFICATION SHALL BE SUBJECT TO THE REVIEW AND APPROVAL OF THE [INSURANCE COMMISSIONER] <u>COMMISSIONER</u>. WITHIN 60 DAYS FOLLOWING SUCH CERTIFICATION AND APPROVAL THE DIRECTOR OF THE FUND SHALL MAKE SUFFICIENT PAYMENT TO THE JOINT UNDERWRITING ASSOCIATION TO COMPENSATE FOR SAID DEFICIT. A DEFICIT SHALL EXIST WHENEVER THE SUM OF THE EARNED PREMIUMS COLLECTED BY THE JOINT UNDERWRITING ASSOCIATION AND THE INVESTMENT INCOME THEREFROM IS EXHAUSTED BY VIRTUE OF PAYMENT OF OR ALLOCATION FOR THE JOINT UNDERWRITING ASSOCIATION'S NECESSARY ADMINISTRATIVE EXPENSES, TAXES, LOSSES, LOSS ADJUSTMENT EXPENSES AND RESERVES, INCLUDING RESERVES FOR: (1) LOSSES INCURRED, (2) LOSSES INCURRED BUT NOT REPORTED, (3) LOSS ADJUSTMENT EXPENSES, (4) UNEARNED PREMIUMS.

(C) WITHIN 60 DAYS FOLLOWING THE CERTIFICATION THAT THE JOINT UNDERWRITING ASSOCIATION HAS SUFFERED A DEFICIT, AS SET FORTH IN SUBSECTION (B), THE BOARD OF DIRECTORS OF THE JOINT UNDERWRITING ASSOCIATION SHALL FILE WITH THE [INSURANCE COMMISSIONER AND THE INSURANCE COMMISSIONER] COMMISSIONER. THE COMMISSIONER SHALL APPROVE A PREMIUM INCREASE SUFFICIENT TO GENERATE THE REQUISITE INCOME TO:

(1) REIMBURSE THE FUND FOR ANY PAYMENT MADE BY THE FUND TO COMPENSATE FOR SAID DEFICIT; AND

(2) INCREASE PREMIUMS TO A LEVEL ACTUARIALLY SUFFICIENT TO AVOID AN OPERATING DEFICIT BY THE JOINT UNDERWRITING ASSOCIATION DURING THE FOLLOWING 12 MONTHS.

THE JOINT UNDERWRITING ASSOCIATION SHALL REIMBURSE THE FUND WITH INTEREST AT A RATE EQUAL TO THAT EARNED BY THE FUND ON ITS INVESTED ASSETS WITHIN ONE YEAR OF ANY PAYMENT MADE BY THE FUND AS COMPENSATION FOR ANY DEFICIT INCURRED BY THE JOINT UNDERWRITING ASSOCIATION.

SECTION 8. SECTION 809 OF THE ACT IS AMENDED TO READ:

SECTION 809. [ANNUAL REPORTS TO INSURANCE COMMISSIONER.--THE PLAN SHALL REPORT TO THE COMMISSIONER ANNUALLY ON A DATE AND, ON A FORM PRESCRIBED BY THE COMMISSIONER THE TOTAL AMOUNT OF PREMIUM DOLLARS COLLECTED, THE TOTAL AMOUNT OF CLAIMS PAID AND EXPENSES INCURRED THEREWITH, THE TOTAL AMOUNT OF RESERVE SET ASIDE FOR FUTURE CLAIMS, THE NATURE AND SUBSTANCE OF EACH CLAIM, THE DATE AND PLACE IN WHICH EACH CLAIM AROSE, THE AMOUNTS PAID, IF ANY, AND THE DISPOSITION OF EACH CLAIM (JUDGMENT OF ARBITRATION PANEL, JUDGMENT OF COURT, SETTLEMENT OR OTHERWISE), AND SUCH ADDITIONAL INFORMATION AS THE COMMISSIONER SHALL REQUIRE.] REPORTS TO COMMISSIONER AND CLAIMS INFORMATION.--(A) BY OCTOBER 15 OF EACH YEAR, BASIC COVERAGE INSURANCE CARRIERS

AND SELF-INSURED PROVIDERS SHALL REPORT TO THE FUND THE CLAIMS INFORMATION SPECIFIED IN SUBSECTION (B).

(B) SIXTY DAYS AFTER THE END OF ANY CALENDAR YEAR, THE FUND SHALL PREPARE A REPORT FOR THE COMMISSIONER. THE REPORT SHALL CONTAIN THE TOTAL AMOUNT OF CLAIMS PAID AND EXPENSES INCURRED THEREWITH, THE TOTAL AMOUNT OF RESERVE SET ASIDE FOR FUTURE CLAIMS, THE DATE AND PLACE IN WHICH EACH CLAIM AROSE, THE AMOUNTS PAID, IF ANY, AND THE DISPOSITION OF EACH CLAIM, JUDGMENT OF COURT, SETTLEMENT OR OTHERWISE, AND SUCH ADDITIONAL INFORMATION AS THE COMMISSIONER SHALL REQUIRE. FOR FINAL CLAIMS AT THE END OF ANY CALENDAR YEAR, THE REPORT SHALL INCLUDE DETAILS BY BASIC COVERAGE INSURANCE CARRIERS AND SELF-INSURED PROVIDERS OF THE AMOUNT OF SURCHARGE COLLECTED, THE NUMBER OF REIMBURSEMENTS PAID AND THE AMOUNT OF REIMBURSEMENTS PAID.

(C) A COPY OF ANY REPORT PREPARED PURSUANT TO THIS SECTION SHALL BE SUBMITTED TO THE CHAIRMAN AND MINORITY CHAIRMAN OF THE BANKING AND INSURANCE COMMITTEE OF THE SENATE AND THE CHAIRMAN AND MINORITY CHAIRMAN OF THE INSURANCE COMMITTEE OF THE HOUSE OF REPRESENTATIVES.

SECTION 9. SECTION 811 OF THE ACT, ADDED NOVEMBER 26, 1978 (P.L.1324, NO.320), IS AMENDED TO READ:

SECTION 811. PROFESSIONAL CORPORATIONS, PROFESSIONAL ASSOCIATIONS AND PARTNERSHIPS.--(A) THE JOINT UNDERWRITING ASSOCIATION SHALL OFFER BASIC COVERAGE INSURANCE TO SUCH PROFESSIONAL CORPORATIONS, PROFESSIONAL ASSOCIATIONS AND PARTNERSHIPS ENTIRELY OWNED BY HEALTH CARE PROVIDERS WHO CANNOT CONVENIENTLY OBTAIN INSURANCE THROUGH ORDINARY METHODS AT RATES NOT IN EXCESS OF THOSE APPLICABLE TO SIMILARLY SITUATED PROFESSIONAL CORPORATIONS, PROFESSIONAL ASSOCIATIONS AND PARTNERSHIPS.

(B) IN THE EVENT THAT A PROFESSIONAL CORPORATION, PROFESSIONAL ASSOCIATION OR PARTNERSHIP ENTIRELY OWNED BY HEALTH CARE PROVIDERS ELECTS TO BE COVERED BY BASIC COVERAGE INSURANCE AND UPON PAYMENT OF THE ANNUAL SURCHARGE AS REQUIRED BY SECTION 701(E), THE PROFESSIONAL CORPORATION, PROFESSIONAL ASSOCIATION OR PARTNERSHIP SHALL BE ENTITLED TO SUCH EXCESS COVERAGE FROM THE [MEDICAL PROFESSIONAL LIABILITY CATASTROPHE LOSS FUND] FUND AS IS PROVIDED IN THIS ACT.

(C) ANY PROFESSIONAL CORPORATION, PROFESSIONAL ASSOCIATION, OR PARTNERSHIP WHICH ACQUIRES BASIC COVERAGE INSURANCE FROM THE JOINT UNDERWRITING ASSOCIATION PURSUANT TO SUBSECTION (A) OR FROM AN INSURER LICENSED OR APPROVED BY THE COMMONWEALTH OF PENNSYLVANIA SHALL BE REQUIRED TO PARTICIPATE IN AND CONTRIBUTE TO THE [MEDICAL PROFESSIONAL LIABILITY CATASTROPHE LOSS FUND] FUND AS PROVIDED IN THIS ACT.

(D) ANY PROFESSIONAL CORPORATION, PROFESSIONAL ASSOCIATION OR PARTNERSHIP WHICH PARTICIPATES IN OR CONTRIBUTES TO THE [MEDICAL PROFESSIONAL LIABILITY CATASTROPHE LOSS FUND] FUND SHALL BE SUBJECT TO ALL OTHER PROVISIONS OF THIS ACT.

SECTION 10. SECTION 1006 OF THE ACT IS REPEALED.

SECTION 11. THIS ACT SHALL TAKE EFFECT IMMEDIATELY.