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THE GENERAL ASSEMBLY OF PENNSYLVANIA

# HOUSE BILL

## No. 1913 Session of 2009

INTRODUCED BY MICOZZIE, DeLUCA, BOYD, GRELL, PICKETT, MENSCH, QUINN, BEYER, FAIRCHILD, GEIST, GEORGE, HARHART, HARPER, HORNAMAN, LONGIETTI, MILLER, MILNE, MOUL, RAPP, SCAVELLO AND VULAKOVICH, AUGUST 7, 2009

REFERRED TO COMMITTEE ON INSURANCE, AUGUST 7, 2009

AN ACT

Amending the act of March 20, 2002 (P.L.154, No.13), entitled "An act reforming the law on medical professional liability; providing for patient safety and reporting; establishing the Patient Safety Authority and the Patient Safety Trust Fund; abrogating regulations; providing for medical professional liability informed consent, damages, expert qualifications, limitations of actions and medical records; establishing the Interbranch Commission on Venue; providing for medical professional liability insurance; establishing the Medical Care Availability and Reduction of Error Fund; providing for medical professional liability claims; establishing the Joint Underwriting Association; regulating medical professional liability insurance; providing for medical licensure regulation; providing for administration; imposing penalties; and making repeals," further providing for medical professional liability insurance, for Medical Care Availability and Reduction of Error Fund and for actuarial data; and making repeals.

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

Section 1. Section 711(d) of the act of March 20, 2002 (P.L.154, No.13), known as the Medical Care Availability and Reduction of Error (Mcare) Act, is amended to read:

Section 711. Medical professional liability insurance.

* * *

(d) Basic coverage limits.--A health care provider shall insure or self-insure medical professional liability in accordance with the following:

(1) For policies issued or renewed in the calendar year 2002, the basic insurance coverage shall be:

(i) $500,000 per occurrence or claim and $1,500,000 per annual aggregate for a health care provider who conducts more than 50% of its health care business or practice within this Commonwealth and that is not a hospital.

(ii) $500,000 per occurrence or claim and $1,500,000 per annual aggregate for a health care provider who conducts 50% or less of its health care business or practice within this Commonwealth.

(iii) $500,000 per occurrence or claim and $2,500,000 per annual aggregate for a hospital.

(2) For policies issued or renewed in the calendar years 2003[, 2004 and 2005] <u>through 2009</u>, the basic insurance coverage shall be:

(i) $500,000 per occurrence or claim and $1,500,000 per annual aggregate for a participating health care provider that is not a hospital.

(ii) $1,000,000 per occurrence or claim and $3,000,000 per annual aggregate for a nonparticipating health care provider.

(iii) $500,000 per occurrence or claim and $2,500,000 per annual aggregate for a hospital.

(3) [Unless the commissioner finds pursuant to section 745(a) that additional basic insurance coverage capacity is not available, for] <u>For</u> policies issued or renewed in

calendar [year 2006 and each year thereafter subject to paragraph (4)] years 2010, 2011 and 2012, the basic insurance coverage shall be:

(i) $750,000 per occurrence or claim and $2,250,000 per annual aggregate for a participating health care provider that is not a hospital.

(ii) $1,000,000 per occurrence or claim and $3,000,000 per annual aggregate for a nonparticipating health care provider.

(iii) $750,000 per occurrence or claim and $3,750,000 per annual aggregate for a hospital.

[If the commissioner finds pursuant to section 745(a) that additional basic insurance coverage capacity is not available, the basic insurance coverage requirements shall remain at the level required by paragraph (2); and the commissioner shall conduct a study every two years until the commissioner finds that additional basic insurance coverage capacity is available, at which time the commissioner shall increase the required basic insurance coverage in accordance with this paragraph.]

(4) [Unless the commissioner finds pursuant to section 745(b) that additional basic insurance coverage capacity is not available, for] For policies issued or renewed [three years after the increase in coverage limits required by paragraph (3)] in calendar year 2013 and for each year thereafter, the basic insurance coverage shall be:

(i) $1,000,000 per occurrence or claim and $3,000,000 per annual aggregate for a participating health care provider that is not a hospital.

(ii) $1,000,000 per occurrence or claim and

$3,000,000 per annual aggregate for a nonparticipating health care provider.

(iii) $1,000,000 per occurrence or claim and $4,500,000 per annual aggregate for a hospital.

[If the commissioner finds pursuant to section 745(b) that additional basic insurance coverage capacity is not available, the basic insurance coverage requirements shall remain at the level required by paragraph (3); and the commissioner shall conduct a study every two years until the commissioner finds that additional basic insurance coverage capacity is available, at which time the commissioner shall increase the required basic insurance coverage in accordance with this paragraph.]

* * *

Section 2. Section 712(c), (d), (e), (j), (k), (l) and (m) of the act are amended and the section is amended by adding subsections to read:

Section 712. Medical Care Availability and Reduction of Error Fund.

* * *

(c) Fund liability limits.--

(1) For calendar year 2002, the limit of liability of the fund created in section 701(d) of the former Health Care Services Malpractice Act for each health care provider that conducts more than 50% of its health care business or practice within this Commonwealth and for each hospital shall be $700,000 for each occurrence and $2,100,000 per annual aggregate.

(2) The limit of liability of the fund for each participating health care provider shall be as follows:

(i) For calendar [year 2003 and each year thereafter] years 2003 through 2009, the limit of liability of the fund shall be $500,000 for each occurrence and $1,500,000 per annual aggregate.

(ii) [If the basic insurance coverage requirement is increased in accordance with section 711(d)(3) and, notwithstanding subparagraph (i), for each calendar year following the increase in the basic insurance coverage requirement] For calendar years 2010, 2011 and 2012, the limit of liability of the fund shall be $250,000 for each occurrence and $750,000 per annual aggregate.

(iii) [If the basic insurance coverage requirement is increased in accordance with section 711(d)(4) and, notwithstanding subparagraphs (i) and (ii), for each calendar year following the increase in the basic insurance coverage requirement] For 2013 and each calendar year thereafter, the limit of liability of the fund shall be zero.

(3) A policy period of less than 12 months shall result in a pro rata reduction in the fund annual aggregation limits.

(d) Assessments.--

(1) For calendar [year 2003 and for each year thereafter] years 2003 through 2012, the fund shall be funded by an assessment on each participating health care provider. Assessments shall be levied by the department on or after January 1 of each year. The assessment shall be based on the prevailing primary premium for each participating health care provider [and]. Except as provided in subsection (d)(1.1), the assessment shall, in the aggregate, produce an amount

sufficient to do all of the following:

(i) Reimburse the fund for the payment of reported claims which became final during the preceding claims period.

(ii) Pay expenses of the fund incurred during the preceding claims period.

(iii) Pay principal and interest on moneys transferred into the fund in accordance with section 713(c).

(iv) Provide a reserve that shall be 10% of the sum of subparagraphs (i), (ii) and (iii).

(1.1) The assessments for calendar years 2010, 2011 and 2012 shall be reduced to 40% of the amount otherwise determined by the formula in paragraph (d)(1) to coincide with the change in coverage limits in section 701(c)(3).

(2) The department shall notify all basic insurance coverage insurers and self-insured participating health care providers of the assessment by November 1 for the succeeding calendar year.

(3) The assessment will apply to medical professional liability policies providing basic insurance coverage with an effective or renewal date during each calendar year in which there is an assessment.

(4) Any appeal of the assessment shall be filed with the department.

(5) For calendar year 2013 and each year thereafter, no assessment shall be levied against any participating health care provider and all claims and expenses of the fund shall be paid from the funds set forth in subsection (m.1).

(6) A health care provider or professional corporation,

professional association or partnership shall not be responsible for any portion of a judgment or settlement which is the responsibility of the fund under this section.

[(e) Discount on surcharges and assessments.--

(1) For calendar year 2002, the department shall discount the aggregate surcharge imposed under section 701(e)(1) of the Health Care Services Malpractice Act by 5% of the aggregate surcharge imposed under that section for calendar year 2001 in accordance with the following:

(i) Fifty percent of the aggregate discount shall be granted equally to hospitals and to participating health care providers that were surcharged as members of one of the four highest rate classes of the prevailing primary premium.

(ii) Notwithstanding subparagraph (i), 50% of the aggregate discount shall be granted equally to all participating health care providers.

(iii) The department shall issue a credit to a participating health care provider who, prior to the effective date of this section, has paid the surcharge imposed under section 701(e)(1) of the former Health Care Services Malpractice Act for calendar year 2002 prior to the effective date of this section.

(2) For calendar years 2003 and 2004, the department shall discount the aggregate assessment imposed under subsection (d) for each calendar year by 10% of the aggregate surcharge imposed under section 701(e)(1) of the former Health Care Services Malpractice Act for calendar year 2001 in accordance with the following:

(i) Fifty percent of the aggregate discount shall be

granted equally to hospitals and to participating health care providers that were assessed as members of one of the four highest rate classes of the prevailing primary premium.

(ii) Notwithstanding subparagraph (i), 50% of the aggregate discount shall be granted equally to all participating health care providers.

(3) For calendar years 2005 and thereafter, if the basic insurance coverage requirement is increased in accordance with section 711(d)(3) or (4), the department may discount the aggregate assessment imposed under subsection (d) by an amount not to exceed the aggregate sum to be deposited in the fund in accordance with subsection (m).]

* * *

(j) Payment of claims.--Claims which became final during the preceding claims period shall be paid on [or before] December 31 <u>or the last business day of the year</u> following the August 31 on which they became final.

(k) Termination.--Upon satisfaction of all liabilities of the fund, the fund shall terminate. Any balance remaining in the fund upon such termination shall be [returned] <u>transferred</u> by the department to the [participating health care providers who participated in the fund in proportion to their assessments in the preceding calendar year] <u>General Fund</u>.

(l) Sole and exclusive source of funding.--Except as provided in subsection (m), <u>section 713(c) and any appropriations to the fund,</u> the surcharges imposed under section 701(e)(1) of the Health Care Services Malpractice Act and assessments on participating health care providers and any income realized by investment or reinvestment shall constitute

the sole and exclusive sources of funding for the fund. Nothing in this subsection shall prohibit the fund from accepting contributions from nongovernmental sources. A claim against or a liability of the fund shall not be deemed to constitute a debt or liability of the Commonwealth or a charge against the General Fund.

(m) Supplemental funding.--Notwithstanding the provisions of 75 Pa.C.S. § 6506(b) (relating to surcharge) to the contrary, for the period beginning January 1, 2004, [and for a period of nine calendar years thereafter] through December 31, 2023, all surcharges levied and collected under 75 Pa.C.S. § 6506(a) by any division of the unified judicial system shall be remitted to the Commonwealth for deposit in the Medical Care Availability and [Restriction] Reduction of Error Fund. [These funds shall be used to reduce surcharges and assessments in accordance with subsection (e).] Beginning January 1, [2014] 2024, and each year thereafter, [the] all surcharges levied and collected under 75 Pa.C.S. § 6506(a) shall be deposited into the General Fund.

(m.1) Fund balance.--The balance of the fund as of July 1, 2009, assessments levied for calendar years 2009 through 2012, supplemental funding provided under subsection (m), any appropriations to the fund and other fund revenue, including any interest or other investment income earned thereon, shall be held in trust for the exclusive purpose of paying the fund's share of settlements and judgments, the fund's operating expenses and the fund's obligations under section 713(c) and shall not be used for any other purpose.

(m.2) Penalties.--By March 15 of each year beginning in 2013 and continuing until termination of the fund under subsection (k), the commissioner shall report to the General Assembly on

the financial solvency of the fund. The report shall include the current balance of the fund and projections as to the fund's future liabilities and revenue by year as certified by an independent actuary using generally accepted actuarial practices and methods.

* * *

(o) Coverage of claims in relation to payment of certain late assessments.--

(1) All basic insurance coverage insurers, self-insured participating health care providers and risk retention groups shall bill, collect and remit the assessment to the department within 60 days of the inception or renewal date of the primary professional liability policy.

(2) All basic insurance coverage insurers, self-insured participating health care providers and risk retention groups shall be subject to the following:

(i) For assessments remitted to the department in excess of 60 days after the inception or renewal date of the primary policy, the basic insurance coverage insurer, self-insured participating health care provider or risk retention group shall pay to the department a penalty equal to 10% per annum of each untimely assessment accruing from the 61st day after the inception or renewal date of the primary policy until the remittance is received by the department.

(ii) In addition to the provisions of subparagraph (i), if the department finds that there has been a pattern or practice of not complying with this section, the basic insurance coverage insurer, self-insured participating health care provider or risk retention

group shall be subject to the penalties and process set forth in the act of July 22, 1974 (P.L.589, No.205), known as the Unfair Insurance Practices Act.

(iii) If the basic insurance coverage insurer, self-insurer or risk retention group receives the assessment from a health care provider, professional corporation or professional association with less than 30 days to make the remittance timely as provided under this subsection, the basic insurance coverage insurer, self-insurer or risk retention group remittance period shall be extended by 30 days from the date of receipt upon providing reasonable evidence to the department regarding the date of receipt and shall not be subject to the penalties provided for under this section.

(iv) If the basic insurance coverage insurer, self-insurer or risk retention group receives an assessment after 60 days of the inception or renewal date of the primary professional liability policy and remits the assessment within 30 days from the date of receipt, the basic insurance coverage insurer, self-insurer or risk retention group shall not be subject to the penalties provided for under this section. Remittances to the department beyond the 30-day period shall be subject to the penalties provided for under this section.

(v) (A) A health care provider or professional corporation, professional association or partnership shall be provided fund coverage from the inception or renewal date of the primary professional liability policy if the billed assessment is paid to the basic insurance coverage insurer, self-insurer or risk

retention group within 60 days of the inception or renewal date of the primary professional liability policy.

(B) Except as provided in clause (C), a health care provider or professional corporation, professional association or partnership that fails to pay the billed assessment to its basic insurance coverage insurer, self-insurer or risk retention group within 60 days of policy inception or renewal date and before receiving notice of a claim shall not have fund coverage for that claim.

(C) If a health care provider or professional corporation, professional association or partnership is billed by the basic insurance coverage insurer, self-insurer or risk retention group no later than 30 days after the policy inception or renewal date and the health care provider or professional corporation, professional association or partnership pays the basic insurance coverage insurer, self-insurer or risk retention group within 30 days from the date of receipt of the bill, the health care provider shall be provided fund coverage as of the inception or renewal date of the primary policy. Fund coverage shall also be provided to the health care provider or professional corporation, professional association or partnership for all professional liability claims made after payment of the assessment.

(vi) Notwithstanding any provisions to the contrary, nothing in this section shall be construed to affect existing regulations saved by section 5107(a), and all

existing regulations shall remain in full force and effect.

Section 3. Section 745 of the act is amended to read:

[Section 745. Actuarial data.

(a) Initial study.--The following shall apply:

(1) No later than April 1, 2005, each insurer providing medical professional liability insurance in this Commonwealth shall file loss data as required by the commissioner. For failure to comply, the commissioner shall impose an administrative penalty of $1,000 for every day that this data is not provided in accordance with this paragraph.

(2) By July 1, 2005, the commissioner shall conduct a study regarding the availability of additional basic insurance coverage capacity. The study shall include an estimate of the total change in medical professional liability insurance loss-cost resulting from implementation of this act prepared by an independent actuary. The fee for the independent actuary shall be borne by the fund. In developing the estimate, the independent actuary shall consider all of the following:

(i) The most recent accident year and ratemaking data available.

(ii) Any other relevant factors within or outside this Commonwealth in accordance with sound actuarial principles.

(b) Additional study.--The following shall apply:

(1) Three years following the increase of the basic insurance coverage requirement in accordance with section 711(d)(3), each insurer providing medical professional liability insurance in this Commonwealth shall file loss data

with the commissioner upon request. For failure to comply, the commissioner shall impose an administrative penalty of $1,000 for every day that this data is not provided in accordance with this paragraph.

(2) Three months following the request made under paragraph (1), the commissioner shall conduct a study regarding the availability of additional basic insurance coverage capacity. The study shall include an estimate of the total change in medical professional liability insurance loss-cost resulting from implementation of this act prepared by an independent actuary. The fee for the independent actuary shall be borne by the fund. In developing the estimate, the independent actuary shall consider all of the following:

(i) The most recent accident year and ratemaking data available.

(ii) Any other relevant factors within or outside this Commonwealth in accordance with sound actuarial principles.]

Section 4. All acts and parts of acts are repealed insofar as they are inconsistent with this act.

Section 5. This act shall take effect in 30 days.