PRINTER'S NO. 187

THE GENERAL ASSEMBLY OF PENNSYLVANIA

SENATE BILL

No. 219 Session of 2011

INTRODUCED BY FOLMER, ALLOWAY, D. WHITE, MENSCH, EARLL, PICCOLA AND M. WHITE, JANUARY 21, 2011

REFERRED TO BANKING AND INSURANCE, JANUARY 21, 2011

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 the Medical Care Availability and Reduction of Error Fund; and establishing the Health Care Provider Rate Stabilization Fund.

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

Section 1. Section 711(d)(3) and (4) of the act of March 20, 2002 (P.L.154, No.13), known as the Medical Care Availability and Reduction of Error (Mcare) Act, are 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:

* * *

(3) [Unless the commissioner finds pursuant to section 745(a) that additional basic insurance coverage capacity is not available, for] For policies issued or renewed in calendar [year 2006 and each year thereafter] years 2011, 2012, 2013 and 2014 subject to paragraph (4), 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 year 2015 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.]

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Section 2. Section 712(d) is amended by adding a paragraph to read:

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

* * *

(d) Assessments.--

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(4) For calendar year 2015 and for each calendar year thereafter, all assessments shall cease and the fund shall be funded in accordance with section 5102.1.

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Section 3. The act is amended by adding a section to read:

Section 5102.1. Health Care Provider Rate Stabilization Fund.

(a) Declaration of policy.--The General Assembly finds and declares as follows:

(1) Adequate numbers of health care providers for access to quality health care must be available.

(2) Health care providers must be encouraged to practice in this Commonwealth.

(3) The maintenance of a health care medical malpractice marketplace is essential to these goals.

(4) The financial impact to health care providers as a result of the transition to a private medical malpractice marketplace must be mitigated.

(b) Establishment.--Effective January 1, 2011, the Health Care Provider Rate Stabilization Fund is established in the State Treasury. Money in the fund shall be used for the following purposes:

(1) Payment of any obligations as described under this chapter.

(2) Effective January 1, 2015, payment of claims against any participating providers for losses or damages awarded in medical liability actions against them in accordance with section 712(c).

(3) Payment of premiums and assessments for insurance coverage as required under sections 711(d) and 712(c) in effect for calendar year 2011 and each year thereafter until all liabilities of the fund have been eliminated, to the degree that the premiums and assessments are greater than 110% of the premiums and assessments in effect during the

previous calendar year. The commissioner shall determine the amount available for this purpose.

(4) Payment of the patient safety discount as established under section 312. The amount available for this purpose shall be determined by the commissioner and shall only be authorized if there are sufficient funds available after satisfying the obligations under paragraphs (1), (2) and (3).

(c) Responsibilities of commissioner.--In order to carry out this section, the commissioner shall:

(1) Certify classes of health care providers by specialty, subspecialty or type of health care provider within a geographic classification, whose average medical malpractice premium, as a class, on or after January 1, 2011, is in excess of an amount per year as determined by the commissioner in accordance with subsection (b)(3).

(2) Establish a methodology and procedures for determining eligibility for and providing payments from the fund in accordance with subsection (b)(3).

(3) Upon certification of eligibility, the commission shall notify and send to the applicable health care provider's insurance carrier or self-insured program the appropriate amount from the fund, and the insurance carrier or self-insured provider shall provide a rebate or credit equal to the payment.

(4) Take all necessary action to recover the cost of the subsidy provided to a health care provider that the commissioner determines to have been incorrectly provided.

(d) Requirements of health care providers.--

(1) A health care provider that fails to comply with the

provisions of this section shall be required to repay to the commissioner the amount of the subsidy, in whole or in part, as determined by the commissioner.

(2) A health care provider who has been subject to a disciplinary action or civil penalty by the practitioner's respective licensing board is not eligible for a subsidy from the fund.

(e) Transfer of assets--The money in the Tobacco Settlement Fund is transferred to the fund effective January 1, 2012.

Section 4. This act shall take effect immediately.