THE GENERAL ASSEMBLY OF PENNSYLVANIA

SENATE BILL No. 811 Session of 2011

INTRODUCED BY RAFFERTY, ORIE, PIPPY, MENSCH, STACK, ARGALL, TOMLINSON, GREENLEAF AND BOSCOLA, MARCH 8, 2011

REFERRED TO BANKING AND INSURANCE, MARCH 8, 2011

AN ACT

Amending the act of March 20, 2002 (P.L.154, No.13), entitled 1 "An act reforming the law on medical professional liability; 2 providing for patient safety and reporting; establishing the 3 Patient Safety Authority and the Patient Safety Trust Fund; 4 abrogating regulations; providing for medical professional 5 liability informed consent, damages, expert qualifications, 6 limitations of actions and medical records; establishing the 7 Interbranch Commission on Venue; providing for medical 8 professional liability insurance; establishing the Medical 9 Care Availability and Reduction of Error Fund; providing for 10 medical professional liability claims; establishing the Joint 11 Underwriting Association; regulating medical professional 12 liability insurance; providing for medical licensure 13 regulation; providing for administration; imposing penalties; 14 and making repeals," further providing for medical 15 16 professional liability insurance, for Medical Care 17 Availability and Reduction of Error Fund and for actuarial data; and providing for conflict. 18 19 The General Assembly of the Commonwealth of Pennsylvania 20 hereby enacts as follows: 21 Sections 711(d), 712(c)(2), (d) and (e)(3) and Section 1. 22 745 of the act of March 20, 2002 (P.L.154, No.13), known as the 23 Medical Care Availability and Reduction of Error (Mcare) Act, 24 are amended to read: 25 Section 711. Medical professional liability insurance. 26 * * *

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

4 (1) For policies issued or renewed in the calendar year 5 2002, the basic insurance coverage shall be:

6 (i) \$500,000 per occurrence or claim and \$1,500,000 7 per annual aggregate for a health care provider who 8 conducts more than 50% of its health care business or 9 practice within this Commonwealth and that is not a 10 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.

17 (2) For policies issued or renewed in the calendar years
18 2003, 2004 and 2005, <u>and each calendar year thereafter</u>, the
19 basic insurance coverage shall be:

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

23 (ii) \$1,000,000 per occurrence or claim and
24 \$3,000,000 per annual aggregate for a nonparticipating
25 health care provider.

26 (iii) \$500,000 per occurrence or claim and
27 \$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 policies issued or renewed in calendar

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1 year [2006] 2016 and each <u>calendar</u> year thereafter subject to 2 paragraph (4), the basic insurance coverage shall be:

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

6 (ii) \$1,000,000 per occurrence or claim and
7 \$3,000,000 per annual aggregate for a nonparticipating
8 health care provider.

9 \$750,000 per occurrence or claim and (iii) 10 \$3,750,000 per annual aggregate for a hospital. If the commissioner finds pursuant to section 745(a) that 11 12 additional basic insurance coverage capacity is not 13 available, the basic insurance coverage requirements shall 14 remain at the level required by paragraph (2); and the 15 commissioner shall conduct a study every two years until the commissioner finds that additional basic insurance coverage 16 17 capacity is available, at which time the commissioner shall 18 increase the required basic insurance coverage in accordance 19 with this paragraph.

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

26 (i) \$1,000,000 per occurrence or claim and
27 \$3,000,000 per annual aggregate for a participating
28 health care provider that is not a hospital.

29 (ii) \$1,000,000 per occurrence or claim and
30 \$3,000,000 per annual aggregate for a nonparticipating

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health care provider.

2 (iii) \$1,000,000 per occurrence or claim and 3 \$4,500,000 per annual aggregate for a hospital. If the commissioner finds pursuant to section 745(b) that 4 5 additional basic insurance coverage capacity is not 6 available, the basic insurance coverage requirements shall 7 remain at the level required by paragraph (3); and the 8 commissioner shall conduct a study every two years until the 9 commissioner finds that additional basic insurance coverage 10 capacity is available, at which time the commissioner shall 11 increase the required basic insurance coverage in accordance 12 with this paragraph. * * * 13 14 Section 712. Medical Care Availability and Reduction of Error 15 Fund. * * 16 17 (c) Fund liability limits.--* * * 18 19 [The] Subject to section 711(d)(3) and (4), the (2)20 limit of liability of the fund for each participating health 21 care provider shall be as follows: 22 For calendar year 2003 and each year thereafter, (i) 23 the limit of liability of the fund shall be \$500,000 for 24 each occurrence and \$1,500,000 per annual aggregate. 25 If the basic insurance coverage requirement is (ii) 26 increased in accordance with section 711(d)(3) and, 27 notwithstanding subparagraph (i), for each calendar year 28 following the increase in the basic insurance coverage 29 requirement, the limit of liability of the fund shall be 30 \$250,000 for each occurrence and \$750,000 per annual

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1 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, the limit of liability of
the fund shall be zero.

8 (d) Assessments.--

9 For calendar year 2003 [and for each year (1)thereafter] through 2010, the fund shall be funded by an 10 11 assessment on each participating health care provider. 12 Assessments shall be levied by the department on or after 13 January 1 of each year. The assessment shall be based on the 14 prevailing primary premium for each participating health care 15 provider and shall, in the aggregate, produce an amount sufficient to do all of the following: 16

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

20 (ii) Pay expenses of the fund incurred during the21 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).

27 (1.1) For calendar year 2011 and for each calendar year
 28 thereafter, the fund shall be funded by an assessment on each
 29 participating health care provider. Assessments shall be

30 levied by the department on or after January 1 of each year.

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1	The assessment shall be based on the prevailing primary
2	premium for each participating health care provider and
3	shall, in the aggregate, produce an amount equal to the sum
4	of the following amounts:
5	(i) The reported claims which became final during
6	the preceding claims period.
7	(ii) The expenses of the fund incurred during the
8	preceding claims period.
9	(iii) The outstanding principal and interest on
10	moneys transferred into the fund in accordance with
11	section 713(c).
12	(iv) If the fund balance projected as of the close
13	of business on December 31 of the year prior to the
14	assessment is less than \$50 million, 10% of the sum of
15	subparagraphs (i), (ii) and (iii).
16	If the fund balance projected as of the close of business on
17	December 31 of the year prior to the assessment is greater
18	than \$50 million, the fund balance in excess of \$50 million
19	shall be credited against the aggregate amount of the
20	assessment.
21	(1.2) No assessment receipts or fund balances of the
22	fund may be transferred from the fund for other purposes.
23	Fund assessment receipts and fund balances may only be used
24	to pay claims against the fund, administrative costs of the
25	fund or assessment credits provided in paragraph (1.1).
26	(1.3) Paragraph (1.1) shall not be construed to validate
27	or refute any position advanced by any party in proceedings
28	challenging any assessment prior to the effective date of
29	this paragraph. The outcome of those proceedings shall be
30	based upon the statutory language in effect on the day before

1 <u>the effective date of this paragraph.</u>

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

6 (3) Any appeal of the assessment shall be filed with the 7 department.

(e) Discount on surcharges and assessments.--

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10 (3) For calendar years [2005] <u>2016</u> and thereafter, if 11 the basic insurance coverage requirement is increased in 12 accordance with section 711(d)(3) or (4), the department may 13 discount the aggregate assessment imposed under subsection 14 (d) by an amount not to exceed the aggregate sum to be 15 deposited in the fund in accordance with subsection (m). 16 * * *

17 Section 745. Actuarial data.

* * *

18 (a) [Initial study] <u>Study</u>.--The following shall apply: 19 No later than April 1, [2005] 2015, each insurer (1)20 providing medical professional liability insurance in this 21 Commonwealth shall file loss data as required by the 22 commissioner. For failure to comply, the commissioner shall 23 impose an administrative penalty of \$1,000 for every day that 24 this data is not provided in accordance with this paragraph.

(2) [By July 1, 2005] <u>After the filing under paragraph</u>
(1) and before July 2, 2015, the commissioner shall [conduct]
<u>complete and present</u> a study regarding the availability of
additional basic insurance coverage capacity <u>to the chairman</u>
<u>and minority chairman of the Banking and Insurance Committee</u>
<u>of the Senate and to the chairman and minority chairman of</u>

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the Insurance Committee of the House of Representatives. 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:

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(i) The most recent [accident year] <u>claim</u> and ratemaking data available.

10 (ii) Any other relevant factors within or outside 11 this Commonwealth in accordance with sound actuarial 12 principles.

(b) Additional study.--[The] <u>If additional basic insurance</u>
<u>coverage capacity is found under subsection (a) and limits are</u>
<u>increased under section 711(d)(3)</u>, the following shall apply:

16 Three years following the increase of the basic (1)17 insurance coverage requirement in accordance with section 18 711(d)(3), each insurer providing medical professional 19 liability insurance in this Commonwealth shall file loss data 20 with the commissioner upon request. For failure to comply, 21 the commissioner shall impose an administrative penalty of 22 \$1,000 for every day that this data is not provided in 23 accordance with this paragraph.

(2) Three months following the request made under
paragraph (1), the commissioner shall [conduct] <u>complete and</u>
<u>present</u> a study regarding the availability of additional
basic insurance coverage capacity <u>to the chairman and</u>
<u>minority chairman of the Banking and Insurance Committee of</u>
<u>the Senate and to the chairman and minority chairman of the</u>
<u>Insurance Committee of the House of Representatives</u>. The

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1 study shall include an estimate of the total change in 2 medical professional liability insurance loss-cost resulting 3 from implementation of this act prepared by an independent actuary. The fee for the independent actuary shall be borne 4 5 by the fund. In developing the estimate, the independent actuary shall consider all of the following: 6 The most recent [accident year] claim and 7 (i) 8 ratemaking data available. 9 Any other relevant factors within or outside (ii) 10 this Commonwealth in accordance with sound actuarial 11 principles. 12 Section 2. The act is amended by adding a section to read: 13 Section 749. Conflict. 14 This chapter does not affect any other statutory provision 15 which: 16 (1) relates to the participation of a health care 17 provider in the fund; and 18 (2) is in effect on the effective date of this section. 19 Section 3. This act shall take effect as follows: 20 The amendment of section 712(d) of the act shall (1)21 take effect immediately. 22 The remainder of this act shall take effect in 60 (2)23 days.

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