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THE GENERAL ASSEMBLY OF PENNSYLVANIA

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SENATE BILL

No. 878 Session of  
2013

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INTRODUCED BY RAFFERTY, GREENLEAF AND MENSCH, APRIL 24, 2013

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REFERRED TO BANKING AND INSURANCE, APRIL 24, 2013

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AN ACT

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

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

21 Section 1. Sections 711(d), 712(c)(2), (d) and (e)(3) and  
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 \* \* \*

1 (d) Basic coverage limits.--A health care provider shall  
2 insure or self-insure medical professional liability in  
3 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.

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

15 (iii) \$500,000 per occurrence or claim and  
16 \$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, and each calendar year thereafter, 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.

28 (3) Unless the commissioner finds pursuant to section  
29 745(a) that additional basic insurance coverage capacity is  
30 not available, for policies issued or renewed in calendar

1 year [2006] 2019 and each calendar 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 (iii) \$750,000 per occurrence or claim and  
10 \$3,750,000 per annual aggregate for a hospital.

11 If the commissioner finds pursuant to section 745(a) that  
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  
16 commissioner finds that additional basic insurance coverage  
17 capacity is available, at which time the commissioner shall  
18 increase the required basic insurance coverage in accordance  
19 with this paragraph.

20 (4) Unless the commissioner finds pursuant to section  
21 745(b) that additional basic insurance coverage capacity is  
22 not available, for policies issued or renewed three calendar  
23 years after the increase in coverage limits required by  
24 paragraph (3) and for each calendar year thereafter, the  
25 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

1 health care provider.

2 (iii) \$1,000,000 per occurrence or claim and  
3 \$4,500,000 per annual aggregate for a hospital.

4 If the commissioner finds pursuant to section 745(b) that  
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 (2) [The] Subject to section 711(d)(3) and (4), the  
20 limit of liability of the fund for each participating health  
21 care provider shall be as follows:

22 (i) For calendar year 2003 and each year thereafter,  
23 the limit of liability of the fund shall be \$500,000 for  
24 each occurrence and \$1,500,000 per annual aggregate.

25 (ii) If the basic insurance coverage requirement is  
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

1 aggregate.

2 (iii) If the basic insurance coverage requirement is  
3 increased in accordance with section 711(d)(4) and,  
4 notwithstanding subparagraphs (i) and (ii), for each  
5 calendar year following the increase in the basic  
6 insurance coverage requirement, the limit of liability of  
7 the fund shall be zero.

8 (d) Assessments.--

9 (1) For calendar year 2003 [and for each year  
10 thereafter] through 2013, the fund shall be funded by an  
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  
16 sufficient to do all of the following:

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 the  
21 preceding claims period.

22 (iii) Pay principal and interest on moneys  
23 transferred into the fund in accordance with section  
24 713(c).

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

27 (1.1) For calendar year 2014 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.

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 minus the projected fund balance at  
5 the close of the calendar year preceding the assessment year:

6 (i) The reported claims which became final during  
7 the preceding claims period.

8 (ii) The expenses of the fund incurred during the  
9 preceding claims period.

10 (iii) The outstanding principal and interest on  
11 moneys transferred into the fund in accordance with  
12 section 713(c).

13 (iv) Ten percent of the sum of subparagraphs (i),  
14 (ii) and (iii).

15 (1.2) No assessment receipts or fund balances of the  
16 fund may be transferred from the fund for other purposes.  
17 Fund assessment receipts and fund balances may only be used  
18 to pay claims against the fund, administrative costs of the  
19 fund or assessment credits provided in paragraph (1.1).

20 (1.3) Paragraph (1.1) shall not be construed to validate  
21 or refute any position advanced by any party in proceedings  
22 challenging any assessment prior to the effective date of  
23 this paragraph. The outcome of those proceedings shall be  
24 based upon the statutory language in effect on the day before  
25 the effective date of this paragraph.

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

30 (3) Any appeal of the assessment shall be filed with the

1 department.

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

3 \* \* \*

4 (3) For calendar years [2005] 2019 and thereafter, if  
5 the basic insurance coverage requirement is increased in  
6 accordance with section 711(d) (3) or (4), the department may  
7 discount the aggregate assessment imposed under subsection  
8 (d) by an amount not to exceed the aggregate sum to be  
9 deposited in the fund in accordance with subsection (m).

10 \* \* \*

11 Section 745. Actuarial data.

12 (a) [Initial study] Study.--The following shall apply:

13 (1) [No later than April 1, 2005] Between January 1,  
14 2018, and April 1, 2018, each insurer providing medical  
15 professional liability insurance in this Commonwealth shall  
16 file loss data as required by the commissioner. For failure  
17 to comply, the commissioner shall impose an administrative  
18 penalty of \$1,000 for every day that this data is not  
19 provided in accordance with this paragraph.

20 (2) [By July 1, 2005] After the filing under paragraph  
21 (1) and before July 2, 2018, the commissioner shall [conduct]  
22 complete and present a study regarding the availability of  
23 additional basic insurance coverage capacity to the chairman  
24 and minority chairman of the Banking and Insurance Committee  
25 of the Senate and to the chairman and minority chairman of  
26 the Insurance Committee of the House of Representatives. The  
27 study shall include an estimate of the total change in  
28 medical professional liability insurance loss-cost resulting  
29 from implementation of this act prepared by an independent  
30 actuary. The fee for the independent actuary shall be borne

1 by the fund. In developing the estimate, the independent  
2 actuary shall consider all of the following:

3 (i) The most recent [accident year] claim and  
4 ratemaking data available.

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

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

11 (1) Three years following the increase of the basic  
12 insurance coverage requirement in accordance with section  
13 711(d)(3), each insurer providing medical professional  
14 liability insurance in this Commonwealth shall file loss data  
15 with the commissioner upon request. For failure to comply,  
16 the commissioner shall impose an administrative penalty of  
17 \$1,000 for every day that this data is not provided in  
18 accordance with this paragraph.

19 (2) Three months following the request made under  
20 paragraph (1), the commissioner shall [conduct] complete and  
21 present a study regarding the availability of additional  
22 basic insurance coverage capacity to the chairman and  
23 minority chairman of the Banking and Insurance Committee of  
24 the Senate and to the chairman and minority chairman of the  
25 Insurance Committee of the House of Representatives. The  
26 study shall include an estimate of the total change in  
27 medical professional liability insurance loss-cost resulting  
28 from implementation of this act prepared by an independent  
29 actuary. The fee for the independent actuary shall be borne  
30 by the fund. In developing the estimate, the independent



1       actuary shall consider all of the following:

2               (i)   The most recent [accident year] claim and  
3       ratemaking data available.

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

7       Section 2.  The act is amended by adding a section to read:  
8       Section 749.  Conflict.

9       This chapter does not affect any other statutory provision  
10      which:

11              (1)  relates to the participation of a health care  
12      provider in the fund; and

13              (2)  is in effect on the effective date of this section.

14      Section 3.  This act shall take effect as follows:

15              (1)  The amendment of section 712(d) of the act shall  
16      take effect immediately.

17              (2)  The remainder of this act shall take effect in 60  
18      days.