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THE GENERAL ASSEMBLY OF PENNSYLVANIA

SENATE BILL

No. 878 Session of 2013

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

REFERRED TO BANKING AND INSURANCE, APRIL 24, 2013

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 providing for conflict.

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

Section 1. Sections 711(d), 712(c)(2), (d) and (e)(3) and 745 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:

(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, and each calendar year thereafter, 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 policies issued or renewed in calendar

year [2006] 2019 and each calendar year thereafter 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 policies issued or renewed three calendar years after the increase in coverage limits required by paragraph (3) and for each calendar 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 712. Medical Care Availability and Reduction of Error Fund.

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(c) Fund liability limits.--

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(2) [The] Subject to section 711(d)(3) and (4), 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, 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, 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, the limit of liability of the fund shall be zero.

(d) Assessments.--

(1) For calendar year 2003 [and for each year thereafter] <u>through 2013</u>, 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 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).

<u>(1.1) For calendar year 2014 and for each calendar year thereafter, 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.</u>

The assessment shall be based on the prevailing primary premium for each participating health care provider and shall, in the aggregate, produce an amount equal to the sum of the following amounts minus the projected fund balance at the close of the calendar year preceding the assessment year:

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

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

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

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

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

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

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

department.

(e) Discount on surcharges and assessments.--

* * *

(3) For calendar years [2005] 2019 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).

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Section 745. Actuarial data.

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

(1) [No later than April 1, 2005] Between January 1, 2018, and April 1, 2018, 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] After the filing under paragraph (1) and before July 2, 2018, the commissioner shall [conduct] complete and present a study regarding the availability of additional basic insurance coverage capacity to the chairman and minority chairman of the Banking and Insurance Committee of the Senate and to the chairman and minority chairman of 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:

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

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

(b) Additional study.--[The] If additional basic insurance coverage capacity is found under subsection (a) and limits are increased under section 711(d)(3), 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] complete and present a study regarding the availability of additional basic insurance coverage capacity to the chairman and minority chairman of the Banking and Insurance Committee of the Senate and to the chairman and minority chairman of 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:

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

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

Section 2. The act is amended by adding a section to read:

Section 749. Conflict.

This chapter does not affect any other statutory provision which:

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

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

Section 3. This act shall take effect as follows:

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

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