AMENDMENTS TO HOUSE BILL NO. 489

Sponsor: SENATOR HUGHES

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Amend Sec. 1, page 2, line 19, by striking out "712(C)" and inserting

712(c) and (d)

Amend Sec. 1 (Sec. 712), page 6, by inserting between lines 22 and 23

(d) Assessments.--

(1) For calendar year 2003 and for each 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. 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).

(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. All basic insurance coverage insurers, self-insured participating health care providers and Risk Retention Groups hereinafter in this subparagraph designated as "RRGs" shall bill, collect and remit the fund assessment to the fund within 60 days of the inception or renewal date of the primary professional liability policy. All basic insurance coverage insurers, self-insured participating health care providers and RRGs will be subject to the following:

(i) For assessments remitted to the fund 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 RRG shall pay the fund 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 fund.

(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 RRG 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 RRG receives the assessment from a health care provider, professional corporation or professional association with less than 30 days to make a timely remittance, the basic insurance coverage insurer, self-insurer or RRG remittance period will be extended by 30 days from the date of receipt upon providing reasonable evidence to the fund regarding the date of receipt and will not be subject to the penalties provided under subparagraph (i).

(iv) If the basic insurance coverage insurer, self-insurer or RRG 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 RRG will not be subject to the penalties provided for under subparagraph (i). Remittances to the fund beyond the 30-day extension shall be subject to the penalties provided under subparagraph (i).

(v) 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 fund assessment is paid to the basic insurance coverage insurer, self-insurer or RRG within 60 days of the inception or renewal date of the primary professional liability policy. A health care provider or professional corporation, professional association or partnership failing to pay the billed fund assessment to its basic insurance coverage insurer, self-insurer or RRG within 60 days of the policy inception or renewal and before receiving notice of a claim will not have fund coverage for that claim. If, however, a health care provider or professional corporation, professional association or partnership is billed by the basic insurance coverage insurer, self-insurer or RRG 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 RRG within 30 days from the date of receipt of the bill and the basic insurance coverage insurer, self-insurer or RRG carrier remits the assessment to the fund within 30 days from the date of receipt, then the health care provider will be provided fund coverage as of the inception or renewal

date of the primary policy. Fund coverage will 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) Except as to provisions in conflict with this paragraph, nothing in this paragraph shall affect existing regulations saved under section 5107(a) and all existing regulations shall remain in full force and effect.

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