INTRODUCED BY FOLMER, MENSCH, MARTIN AND STEFANO, SEPTEMBER 26, 2017

REFERRED TO BANKING AND INSURANCE, SEPTEMBER 26, 2017

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," in insurance, further providing for
16 medical professional liability insurance and for the Medical
17 Care Availability and Reduction of Error Fund; and, in
18 miscellaneous provisions, establishing the Health Care
19 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.

* * *
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 years 2006 and each year thereafter years 2017, 2018, 2019 and 2020 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

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years after the increase in coverage limits required by paragraph (3) in year 2021 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.]

* * *

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

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

* * *

(d) Assessments.--

* * *

(4) For calendar year 2021 and for each calendar year thereafter, all assessments shall cease and the fund shall be
funded in accordance with section 5102.1.

* * *

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.--Beginning January 1, 2018, 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) Beginning January 1, 2018, 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 2017 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.
(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, 2017,
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 beginning January 1, 2018.

Section 4. This act shall take effect immediately.