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THE GENERAL ASSEMBLY OF PENNSYLVANIA

HOUSE BILL

No. 1877 Session of 1997

INTRODUCED BY ROHRER, LAUGHLIN, HUTCHINSON, FARGO, WILT, LYNCH, ALLEN, STERN, HERSHEY, LEH, BIRMELIN, SAYLOR, ARMSTRONG, CLYMER, MILLER, PETRARCA, SHANER, CONTI, STEIL, SEYFERT, SAINATO, BROWN, TRELLO, M. N. WRIGHT, OLASZ, BAKER, COLAIZZO, CORRIGAN, PLATTS, TULLI, EGOLF, McNAUGHTON, CHADWICK, STABACK, DERMODY, HERMAN, J. TAYLOR, WALKO, READSHAW, BENNINGHOFF, WOJNAROSKI, PISTELLA, E. Z. TAYLOR, BARD, GIGLIOTTI, ARGALL, D. W. SNYDER AND PETRONE, NOVEMBER 3, 1997

REFERRED TO COMMITTEE ON INSURANCE, NOVEMBER 3, 1997

AN ACT

Amending the act of October 15, 1975 (P.L.390, No.111), entitled "An act relating to medical and health related malpractice insurance, prescribing the powers and duties of the Insurance Department; providing for a joint underwriting plan; the Arbitration Panels for Health Care, compulsory screening of claims; collateral sources requirement; limitation on contingent fee compensation; establishing a Catastrophe Loss Fund; and prescribing penalties," abolishing the Catastrophic Loss Fund, creating a temporary assessment procedure to pay off existing claims; repealing mandatory liability insurance; imposing additional powers and duties upon the Insurance Commissioner and the Department of Revenue; and providing penalties.

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

Section 1. The definitions of "fund," "fund coverage limits" and "health care provider" in section 103 of the act of October 15, 1975 (P.L.390, No.111), known as the Health Care Services Malpractice Act, are amended and the section is amended by adding definitions to read:

Section 103. Definitions.--As used in this act:

* * *

Department" means the Department of Revenue.

"Fund" means the former Medical Professional Liability Catastrophe Loss Fund.

"Fund coverage limits" means the coverage provided by the Medical Professional Liability Catastrophe Loss Fund under former section 701(a).

* * *

"Gross income" means gross income as defined in section 61 of the Internal Revenue Code of 1954 (68A Stat. 3, 26 U.S.C. § 1 et seq.), or any successor provision, and the implementing regulations of the Internal Revenue Service.

"Health care provider" means a primary health center or a person, corporation, university or other educational institution, facility, institution or other entity licensed or approved by the Commonwealth to provide health care or professional medical services as a physician, a certified nurse midwife, a podiatrist, hospital, nursing home, birth center, and except as to section [701(a)] 701.1, an officer, employee or agent of any of them acting in the course and scope of employment and, for purposes of Article VII, any licensed HMO doing business in this Commonwealth.

* * *

"HMO" or "health maintenance organization" means any health maintenance organization organized and operating under the provisions of the act of December 29, 1972 (P.L.1701, No.364), known as the "Health Maintenance Organization Act."

* * *

"Phaseout fund" means the Medical Professional Liability

Catastrophe Loss Phaseout Fund.

Section 2. Section 605 of the act, amended November 26, 1996 (P.L.776, No.135), is amended to read:

Section 605. Statute of Limitations.--All claims for recovery pursuant to this act must be commenced within the existing applicable statutes of limitation. In the event that any claim is made against a health care provider subject to the provisions of Article VII more than four years after the breach of contract or tort occurred which is filed within the statute of limitations, such claim shall be defended and paid by the phaseout fund if the former fund or phaseout fund has received a written request for indemnity and defense within 180 days of the date on which notice of the claim is given to the health care provider or his insurer. Where multiple treatments or consultations took place less than four years before the date on which the health care provider or his insurer received notice of the claim, the claim shall be deemed, for purposes of this section, to have occurred less than four years prior to the date of notice and shall be defended by the insurer pursuant to section 702(d). If such claim is made after four years because of the willful concealment by the health care provider or his insurer, the phaseout fund shall have the right of full indemnity including defense costs from such health care provider or his insurer. A filing pursuant to section 401 shall toll the running of the limitations contained herein.

Section 3. Section 701 of the act is repealed.

Section 4. The act is amended by adding sections to read:

Section 701.1 Phaseout Fund.--(a) The Medical Professional Liability Catastrophe Loss Phaseout Fund is hereby established to cover any liability arising from claims made against the

former Medical Professional Liability Catastrophe Loss Fund on or before the effective date of this section or from claims which thereafter may be made against this fund to cover any liability arising from any health care provider services performed on or before the effective date of this section.

(b) The phaseout fund shall be composed of funds transferred from the former Medical Professional Liability Catastrophe Loss Fund, funds contributed by assessments under subsection (g), and funds earned by the investment and reinvestment of the fund.

(c) The phaseout fund shall be held in trust, be deposited into a separate account and be the sole and exclusive source of funds for payment of claims filed under former section 701 and this section and for the administration of the Medical Professional Liability Catastrophe Loss Benefits Continuation Fund.

(d) The phaseout fund and all income earned by the phaseout fund shall not become part of the General Fund. No obligation of or expense of or claim against the former fund or the phaseout fund shall constitute a debt of the Commonwealth or a charge against the General Fund of the Commonwealth.

(e) To ensure the administration of the phaseout fund and the payment of awards to eligible claimants, all powers and duties previously imposed on the director under former section 702 are transferred to the Insurance Commissioner.

(f) Beginning one year after the effective date of this section, the commissioner shall submit an annual report to the Governor and the General Assembly on the actuarial soundness of the phaseout fund which shall include an estimate regarding the time period for paying all claims provided for under this act.

(g) The phaseout fund shall be financed by the levying of an

annual assessment on or after January 1 of every year on all health care providers as defined in section 103. The department shall communicate the assessment to all health care providers. Each health care provider shall be required to pay an annual assessment equal to 1% of the gross income received from patients or from third-party payors on behalf of patients which such provider derived from its health care practice within the Commonwealth during the preceding calendar year. A health care provider may elect to pay the annual assessment in equal assessments not exceeding four, if the health care provider informs the department of the option to pay in installments. No physician or other individual health care provider shall be assessed on gross income derived from such individual's health care practice within this Commonwealth to the extent that a health care provider entity, other than an HMO, pays an assessment with respect to the same income. The assessment levied against each HMO shall be in addition to the assessment levied against any health care provider under contract with such HMO.

(h) The commissioner shall issue rules and regulations consistent with this section regarding the establishment and operation of the phaseout fund, and the department shall issue rules and regulations regarding the time for payment, the calculation, the verification and the collection and responsibility for payment of the assessments under this section and section 701.2. The commissioner and the department shall promulgate temporary regulations which shall not be subject to the provisions of the act of June 25, 1982 (P.L.633, No.181), known as the "Regulatory Review Act." Such temporary regulations shall expire two years after the effective date of this section

or upon the adoption of regulations pursuant to the "Regulatory Review Act," whichever first occurs.

(i) The phaseout fund shall not make any payments with respect to any claim which is based upon any health care provider services performed after the effective date of this section.

(j) The annual assessment on health care providers, the assessment prescribed in section 701.2 and any income realized by investment or reinvestment shall constitute the sole and exclusive sources of funding for the phaseout fund.

Section 701.2. Termination of Phaseout Fund.--(a) In addition to the annual assessment provided for in section 701.1, the department, upon the request of the commissioner, shall levy a one-time special assessment upon each health care provider for the sole purpose of purchasing insurance sufficient to cover the unfunded liability of the phaseout fund at that point in time that the one-time cost of purchasing such insurance would enable the phaseout fund to make such purchase by levying an assessment at a rate which is equal to or lesser than the rate for the annual assessment payable by each provider in the same calendar year in which the special assessment is levied. The special assessment authorized by this section shall be imposed in accordance with the same criteria that govern the annual assessment authorized under section 701.1.

(b) Upon the purchase of the insurance specified in subsection (a) and the payment of all claims submitted during the same calendar year, no further assessments shall be levied against health care providers pursuant to this section or section 701.1, and the commissioner shall terminate the existence of the phaseout fund as soon as feasible thereafter.

(c) The commissioner shall make an annual determination regarding the feasibility of purchasing the insurance specified in subsection (a).

Section 701.3. Assessment Procedure.--(a) On or before the date when the assessment is due, an assessment return shall be made and filed by or for every health care provider having income for the calendar year. The assessment return shall be signed in accordance with the instructions from the department. The making or filing of any return or related document or copy thereof required to be made or filed pursuant to this article shall constitute a certification by the person making or filing such return or other document or copy thereof that the statements contained therein are true and that any copy filed is a true copy. The department may, upon application, grant a reasonable extension of time for filing any assessment return or related document required pursuant to this article on such terms and conditions as it may require. No such extension for filing any return or other document shall exceed six months.

(b) If any amount of assessment imposed by this article is not paid on or before the last date prescribed for payment, interest on such amount at the rate established pursuant to section 806 of the act of April 9, 1929 (P.L.343, No.176), known as "The Fiscal Code," shall be paid for the period from such last date to the date paid. The last date prescribed for payment shall be determined without regard to any extension of time for filing the return.

(c) The department, or any agent authorized in writing by it, is hereby authorized to examine the books, papers and records of any health care provider in order to verify the accuracy of any assessment return made, or if no assessment

return was made, to ascertain and assess the assessment imposed by this act. Every such health care provider is hereby directed and required to give to the department or its duly authorized agent the means, facilities and opportunity for such examinations and investigations as are hereby provided and authorized. The department is hereby authorized to examine any person under oath concerning any income which was or should have been returned for assessment, and to this end may compel the production of books, papers and records and the attendance of all persons, whether as parties or witnesses, whom it believes to have knowledge of such income. The procedure for such hearing or examination shall be the same as that provided by "The Fiscal Code" relating to inquisitorial powers of fiscal officers.

(d) The department shall deposit all revenues derived from the assessments paid pursuant to this act in the phaseout fund.

Section 701.4. Penalties.--(a) Any person who willfully attempts in any manner to evade or defeat any assessment imposed by this article or the payment thereof shall, in addition to other penalties provided by law, be guilty of a misdemeanor and shall, upon conviction, be sentenced to pay a fine not exceeding $25,000 or to undergo imprisonment not exceeding two years, or both.

(b) Any person required under this act to collect, account for and pay over any assessment imposed by this act who willfully fails to collect or truthfully account for and pay over such assessment shall, in addition to other penalties provided by law, be guilty of a misdemeanor and shall, upon conviction, be sentenced to pay a fine not exceeding $25,000 or to undergo imprisonment not exceeding two years, or both.

(c) Any person required under this article to pay any

assessment or to make a return, keep any records or supply any information, who willfully fails to pay such assessment or make such return, keep such records or supply such information at the time or times required by law or regulations shall, in addition to other penalties provided by law, be guilty of a misdemeanor and shall, upon conviction, be sentenced to pay a fine not exceeding $5,000 or to undergo imprisonment not exceeding two years, or both.

(d) Any person who willfully makes and subscribes any assessment return, or other document required under this article which contains or is verified by a written declaration that it is made under the penalties of perjury and which he does not believe to be true and correct as to every material matter, or willfully aids or assists in, or procures, counsels or advises the preparation or presentation, in connection with any matter arising under this article, of a return, affidavit, claim or other document which is fraudulent or is false as to any material matter, whether or not such falsity or fraud is with the knowledge or consent of the person authorized or required to present such return, affidavit, claim or document shall be guilty of a misdemeanor and shall, upon conviction, be sentenced to pay a fine not exceeding $5,000 or to undergo imprisonment not exceeding two years, or both.

(e) Any person who willfully delivers or discloses to the commissioner any assessment, return, or other document, required under this article, known by him to be fraudulent or to be false as to any material matter shall be guilty of a misdemeanor and shall, upon conviction, be sentenced to pay a fine not exceeding $5,000 or to undergo imprisonment not exceeding two years, or both.

(f) It shall be unlawful for any officer, agent or employee of the Commonwealth to divulge or to make known in any manner whatever, not provided by law, except for official purposes, to any person, the amount or source of income, or any particular thereof or other information set forth or disclosed in any assessment return, or other document required under this article, or to permit any return or copy thereof or any book containing any abstract or particulars thereof, to be seen or examined by any person except as provided by law; and it shall be unlawful for any person to print or publish in any manner whatsoever not provided by law any return or any part thereof or source of income or other information appearing in any return, and any person committing an offense against the foregoing provisions shall be guilty of a misdemeanor and, upon conviction thereof, shall be fined not more than $1,000 or imprisoned for not more than one year, or both, together with the costs of prosecution and if the offender be an officer or employee of the Commonwealth, he shall be dismissed from office or discharged from employment.

(g) In case of failure to file any assessment return required under this act on the date prescribed therefor, determined with regard to any extension of time for filing, unless it is shown that such failure is due to reasonable cause and not due to willful neglect, there shall be added to the amount required to be shown as tax on such return 10% of the amount of such assessment if the failure is for not more than one month, with an additional 5% for each additional month or fraction thereof during which such failure continues, not exceeding 20%.

(h) Notwithstanding anything in this section or any other

law to the contrary, the department may conduct or authorize the conduct of studies of data and information submitted to the department which relates to the assessment program and may distribute the results of the studies, provided such studies do not contain any identifiable information regarding any health care provider.

(i) No health care provider shall be subject to the penalty prescribed in subsection (g) or to any criminal penalty prescribed by this section if the health care provider submits evidence satisfactory to the department that the failure to pay all or part of an assessment on a timely basis is due to severe financial hardship as defined by regulation of the commissioner. In such cases the department may fix the amounts and times of payment of installments on the principal and interest owed.

Section 5. Sections 702 and 705 of the act, amended November 26, 1996 (P.L.776, No.135), are amended to read:

Section 702. [Director and] Administration of Phaseout Fund.--(a) The phaseout fund shall be administered by [a director who shall be appointed by the Governor and whose salary shall be fixed by the Executive Board. The director may employ and fix the compensation of such clerical and other assistants as may be deemed necessary and may promulgate rules and regulations relating to procedures for the reporting of claims to the fund.

(b) The director shall be provided with adequate offices in which the records shall be kept and official business shall be transacted, and the director shall also be provided with necessary office furniture and other supplies] the commissioner.

(c) The basic coverage insurance carrier or self-insured provider shall promptly notify the [director] commissioner of

any case where it reasonably believes that the value of the claim exceeds the basic insurer's coverage or self-insurance plan or falls under section 605. Such information, including the phaseout fund's claim file, shall be confidential, notwithstanding the act of June 21, 1957 (P.L.390, No.212), referred to as the Right To Know Law, and the act of July 3, 1986 (P.L.388, No.84), known as the "Sunshine Act." Failure to so notify the [director] commissioner shall make the basic coverage insurance carrier or self-insured provider responsible for the payment of the entire award or verdict, provided that the phaseout fund has been prejudiced by the failure of notice.

(d) The basic coverage insurance carrier or self-insured provider shall be responsible to provide a defense to the claim, including defense of the phaseout fund, except as provided for in section 605. In such instances where the [director] commissioner has been notified in accordance with subsection (c), the [director] commissioner may join in the defense and be represented by counsel.

(e) In the event that the basic coverage insurance carrier or self-insured provider enters into a settlement with the claimant to the full extent of its liability as provided above, it may obtain a release from the claimant to the extent of its payment, which payment shall have no effect upon any excess claim against the phaseout fund or its duty to continue the defense of the claim.

(f) The [director] commissioner is authorized to defend, litigate, settle or compromise any claim payable by the phaseout fund. A health care provider's basic insurance coverage carrier shall have the right to approve any settlement entered into by the [director] commissioner on behalf of its insured health care

provider. If the basic insurance coverage carrier does not disapprove a settlement prior to execution by the [director] commissioner, it shall be deemed approved by the basic insurance coverage carrier. In the event that more than one health care provider defendant is party to a settlement, the health care provider's basic insurance coverage carrier shall have the right to approve only that portion of the settlement which is contributed on behalf of its insured health care provider.

(g) The [director] commissioner is hereby empowered to purchase, on behalf of the phaseout fund, as much insurance or re-insurance as is necessary to preserve the phaseout fund.

(h) Nothing in this act shall preclude the [director] commissioner from adjusting or paying for the adjustment of claims.

(i) Upon the request of a party to a case within the phaseout fund coverage limits, the phaseout fund may provide for a mediator in instances where multiple carriers disagree on a case. Upon the consent of all parties to any proceeding hereunder that mediation shall be binding, the parties shall be bound by the conclusions of the mediator. The phaseout fund shall promulgate such rules and regulations as are necessary to implement this provision. Proceedings conducted under this section shall be confidential and shall not be considered public information subject to disclosure under the Right-to-Know Law and the "Sunshine Act."

(j) Delay damages and postjudgment interest applicable to the phaseout fund's liability in a case shall be paid by the phaseout fund and shall not be charged against the insured's annual aggregate limits. The basic insurance carrier or self-insurer shall be responsible for its proportionate share of

delay damages and post-judgment interest.

(k) The phaseout fund shall have the authority to borrow money for periods of less than two years in order to pay claims and expenses until sufficient revenues are realized by the fund.

Section 705. Liability of Excess Carriers.--(a) No insurer providing excess professional liability insurance to any health care provider eligible for coverage under the phaseout fund shall be liable for payment of any claim against a health care provider for any loss or damages except those in excess of the phaseout fund coverage limits.

(b) No carrier providing excess professional liability insurance for a health care provider covered by the phaseout fund shall be liable for any loss resulting from the insolvency or dissolution of the phaseout fund.

Section 6. Section 706 of the act is repealed.

Section 7. The act is amended by adding a section to read:

Section 801.1. Liability Insurance not Mandatory.--(a) Nothing in this act or any other law or regulation shall require that any health care provider carry or be covered by any professional liability insurance policy.

(b) No health care provider shall be subject to a license revocation or suspension or to any disciplinary action by the commissioner or by any licensing board because such health care provider does not carry or is not covered by any professional liability insurance policy.

Section 8. Sections 803(c), 809, 811 and 841-A(a) of the act, amended or added November 26, 1996 (P.L.776, No.135), are amended to read:

Section 803. Plan Operation, Rates and Deficits.--* * *

(c) Within 60 days following the certification that the

Joint Underwriting Association has suffered a deficit, as set forth in subsection (b), the board of directors of the Joint Underwriting Association shall file with the commissioner. The commissioner shall approve a premium increase sufficient to generate the requisite income to[:

(1) reimburse the fund for any payment made by the fund to compensate for said deficit; and

(2) increase premiums to a level actuarially sufficient to avoid an operating deficit by the Joint Underwriting Association during the following 12 months. The Joint Underwriting Association shall reimburse the fund with interest at a rate equal to that earned by the fund on its invested assets within one year of any payment made by the fund as compensation for any deficit incurred by the Joint Underwriting Association.]

increase premiums to a level actuarially sufficient to avoid an operating deficit by the Joint Underwriting Association during the following 12 months.

* * *

Section 809. Reports to Commissioner and Claims Information.--(a) By October 15 of each year, basic coverage insurance carriers and self-insured providers shall report to the phaseout fund the claims information specified in subsection (b).

(b) Sixty days after the end of any calendar year, the phaseout fund shall prepare a report for the commissioner. The report shall contain the total amount of claims paid and expenses incurred therewith, the total amount of reserve set aside for future claims, the date and place in which each claim arose, the amounts paid, if any, and the disposition of each claim, judgment of court, settlement or otherwise, and such

additional information as the commissioner shall require. For final claims at the end of any calendar year, the report shall include details by basic coverage insurance carriers and self-insured providers of the amount of surcharge collected, the number of reimbursements paid and the amount of reimbursements paid.

(c) A copy of any report prepared pursuant to this section shall be submitted to the chairman and minority chairman of the Banking and Insurance Committee of the Senate and the chairman and minority chairman of the Insurance Committee of the House of Representatives.

Section 811. Professional Corporations, Professional Associations and Partnerships.--(a) The Joint Underwriting Association shall offer basic coverage insurance to such professional corporations, professional associations and partnerships entirely owned by health care providers who cannot conveniently obtain insurance through ordinary methods at rates not in excess of those applicable to similarly situated professional corporations, professional associations and partnerships.

(b) In the event that a professional corporation, professional association or partnership entirely owned by health care providers elects to be covered by basic coverage insurance and upon payment of the annual [surcharge] <u>assessment</u> as required by section [701(e)] <u>701.1</u>, the professional corporation, professional association or partnership shall be entitled to such excess coverage from the <u>phaseout</u> fund as is provided in this act.

(c) Any professional corporation, professional association, or partnership which acquires basic coverage insurance from the

Joint Underwriting Association pursuant to subsection (a) or from an insurer licensed or approved by the Commonwealth of Pennsylvania shall be required to participate in and contribute to the phaseout fund as provided in this act.

(d) Any professional corporation, professional association or partnership which participates in or contributes to the phaseout fund shall be subject to all other provisions of this act.

Section 841-A. Mandatory Reporting.--(a) Each malpractice insurer, including the Medical Professional Liability Catastrophe Loss Fund established by this act and the phaseout fund, which makes payment under a policy of insurance in settlement, or in partial settlement of, or in satisfaction of a judgment in a medical malpractice action or claim shall provide to the appropriate licensure board a true and correct copy of the report required to be filed with the Federal Government by section 421 of the Health Care Quality Improvement Act of 1986 (Public Law 99-660, 42 U.S.C. § 11131). The copy of the report required by this section shall be filed simultaneously with the report required by section 421 of the Health Care Quality Improvement Act of 1986. The Insurance Department shall monitor and enforce compliance with this section. The Bureau of Professional and Occupational Affairs and the licensure boards shall have access to information pertaining to compliance.

* * *

Section 9. This act shall take effect as follows:

(1) The amendment of section 701.1(f) and (h) of the act shall take effect immediately.

(2) This section shall take effect immediately.

(3) The remainder of this act shall take effect December

31, 1997.