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THE GENERAL ASSEMBLY OF PENNSYLVANIA

HOUSE BILL

No. 954 Session of 1999

INTRODUCED BY MICOZZIE, DEMPSEY, WRIGHT, ADOLPH, SCHRODER, CIVERA, BARD, BARRAR, BENNINGHOFF, DRUCE, FARGO, FLICK, GEIST, GORDNER, HARHAI, HENNESSEY, HERMAN, HERSHEY, McNAUGHTON, S. MILLER, MUNDY, NICKOL, PLATTS, PRESTON, ROSS, SCHULER, SEYFERT, STEELMAN, STEIL, STERN, E. Z. TAYLOR, TRELLO AND YOUNGBLOOD, MARCH 22, 1999

REFERRED TO COMMITTEE ON INSURANCE, MARCH 22, 1999

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," further providing for the transfer of the Medical Professional Liability Catastrophe Loss Fund coverage to the private sector.

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

Section 1. Section 605 of the act of October 15, 1975 (P.L.390, No.111), known as the Health Care Services Malpractice Act, is repealed.

Section 2. Section 701 of the act, amended November 26, 1996 (P.L.776, No 135), is amended to read:

Section 701. Professional Liability Insurance and Fund.--(a) Every health care provider as defined in this act, practicing medicine or podiatry or otherwise providing health care services

in the Commonwealth shall insure his professional liability only with an insurer licensed or approved by the Commonwealth of Pennsylvania, or provide proof of self-insurance in accordance with this section.

(1) (i) For policies issued or renewed in the calendar years 1997 through 1998, a health care provider, other than hospitals, who conducts more than 50% of its health care business or practice within the Commonwealth of Pennsylvania shall annually insure or self-insure its professional liability in the amount of $300,000 per occurrence and $900,000 per annual aggregate, and hospitals located in the Commonwealth shall insure or self-insure their professional liability in the amount of $300,000 per occurrence, and $1,500,000 per annual aggregate, hereinafter known as "basic coverage insurance" and they shall be entitled to participate in the fund.

(ii) For policies issued or renewed in the calendar [years 1999 through 2000] <u>year 1999</u>, a health care provider, other than hospitals, who conducts more than 50% of its health care business or practice within this Commonwealth shall annually insure or self-insure its professional liability in the amount of $400,000 per occurrence and $1,200,000 per annual aggregate, and hospitals located in this Commonwealth shall insure or self-insure their professional liability in the amount of $400,000 per occurrence and $2,000,000 per annual aggregate.

(iii) For policies issued or renewed in the calendar year [2001] <u>2000</u>, and each year thereafter, a health care provider, other than hospitals, who conducts more than 50% of its health care, business or practice within this Commonwealth shall annually insure or self-insure its professional liability in the amount of [$500,000] <u>$1,2000,000</u> per occurrence and [$1,500,000]

$3,6000,000 per annual aggregate, and hospitals located in this Commonwealth shall insure or self-insure their professional liability in the amount of [$500,000] $1,200,000 per occurrence and [$2,500,000] $4,000,000 per annual aggregate.

(2) (i) A health care provider who conducts 50% or less of its health care business or practice within the Commonwealth shall insure or self-insure its professional liability in the amounts listed in subparagraphs (ii), (iii) and (iv) and shall not be required to contribute to or be entitled to participate in the fund set forth in Article VII of this act or the plan set forth in Article VIII of this act.

(ii) For calendar years 1997 through 1998, basic insurance coverage shall, on an annual basis, be in the amount of $300,000 per occurrence and $900,000 per annual aggregate.

(iii) For calendar [years 1999 through 2000] year 1999, basic insurance coverage shall, on an annual basis, be in the amount of $400,000 per occurrence and $1,200,000 per annual aggregate.

(iv) For calendar year [2001] 2000, and each year thereafter, basic insurance coverage shall, on an annual basis, be in the amount of [$500,000] $1,200,000 per occurrence and [$1,500,000] $3,600,000 per annual aggregate.

(v) Every health care provider shall insure or self-insure its professional liability for those claims falling within the funds limits of liability set forth in paragraph (d) below, which occurred prior to December 31, 1999, but not reported to the fund on or before December 31, 1999.

(3) For the purposes of this section, "health care business or practice" shall mean the number of patients to whom health care services are rendered by a health care provider within an

annual period.

(4) All self-insurance plans shall be submitted with such information as the commissioner shall require for approval and shall be approved by the commissioner upon his finding that the plan constitutes protection equivalent to the insurance requirements of a health care provider.

(5) A fee shall be charged by the Insurance Department to all self-insurers for examination and approval of their plans.

(6) Self-insured health care providers and hospitals if exempt from this act shall submit the information required under section 809 to the commissioner.

(b) (1) No insurer providing professional liability insurance shall be liable for payment of any claim against a health care provider for any loss or damages awarded in a professional liability action in excess of the basic coverage insurance, as provided in subsection (a)(1) for each health care provider against whom an award is made unless the health care provider's professional liability policy or self-insurance plan provides for a higher [annual aggregate] limit.

(2) If a claim exceeds the [aggregate] basic coverage insurance limits of an insurer or a self-insurance plan and is reported to the fund on or before December 31, 1999, the fund shall be responsible for the payment of the claim [up to] within the fund coverage limits. Within 180 days following the effective date of this act, the fund shall evaluate each claim reported to the fund on or before December 31, 1999 and shall determine an estimated value of each claim. The total number of claims and the total estimated value of these claims shall be reported to the Advisory Board.

(3) The fund is hereby released from any responsibility for

payment of any claim reported on or after January 1, 2000.

(c) A government may satisfy its obligations pursuant to this act, as well as the obligations of its employees to the extent of their employment, by either purchasing insurance or assuming such obligation as a self-insurer and including the payment of all surcharges under this act.

(d) There is hereby created a contingency fund for the purpose of paying all awards, judgments and settlements for loss or damages arising from claims reported to the fund on or before December 31, 1999, against a health care provider entitled to participate in the fund as a consequence of any claim for professional liability brought against such health care provider as a defendant or an additional defendant to the extent such health care provider's share exceeds its basic coverage insurance in effect at the time of occurrence as provided in subsection (a)(1). For purposes of this subsection, a health care provider or its insurer may report, and the fund shall accept, any and all suits, expressed demands for damages and incidents of injury or death resulting from the furnishing of medical services which may result in an award, judgment or settlement in excess of the basic insurance coverage. The limit of liability of the fund shall be as follows:

(1) For calendar years 1997 through 1998, the limit of liability of the fund shall be $900,000 for each occurrence, reported to the fund on or before December 31, 1999, for each health care provider and $2,700,000 per annual aggregate for each health care provider.

(2) For calendar [years 1999 through 2000] year 1999, the limit of liability of the fund shall be $800,000 for each occurrence, reported to the fund on or before December 31, 1999,

for each health care provider and $2,400,000 per annual aggregate for each health care provider.

(3) For calendar year [2001] 2000, and each year thereafter, the limit of liability of the fund shall be [$700,000] $0 for each occurrence for each health care provider and [$2,100,000] $0 per annual aggregate for each health care provider.

(e) (1) After December 31, 1996, the fund shall be funded by the levying of an annual surcharge on or after January 1 of every year on all health care providers entitled to participate in the fund. The surcharge shall be determined by the fund, filed with the commissioner and communicated to all basic insurance coverage carriers and self-insured providers. The surcharge shall be based on the prevailing primary premium for each health care provider for maintenance of professional liability insurance and shall be the appropriate percentage thereof, necessary to produce an amount sufficient to reimburse the fund for the payment of final claims and expenses incurred during the preceding claims period and to provide an amount necessary to maintain up to an additional 15% of the final claims and expenses incurred during the preceding claims period.

(2) The Joint Underwriting Association shall file updated rates for all health care providers with the commissioner by May 1 of each year.

(3) The fund shall review and may adjust the prevailing primary premium in line with any applicable changes to the prevailing primary premium made in filings by the Joint Underwriting Association and approved by the commissioner.

(4) The fund [may] shall adjust the applicable prevailing primary premium of any hospital, including a hospital associated with a university or other education institution, through an

increase or decrease in the individual hospital's prevailing primary premium not to exceed 20%. Any such adjustment shall be based upon the frequency and severity of claims paid by the fund on behalf of other hospitals of similar class, size, risk and kind within the same defined region during the past five most recent [claims] claim periods. All premium adjustments pursuant to this subsection shall require the approval of the commissioner.

(5) For health care providers that do not engage in direct clinical practice on a full-time basis, the prevailing primary premium rate shall be adjusted by the fund to reflect the lower risk associated with the less-than-full-time direct clinical practice.

(6) The surcharge provided in paragraph (1) shall be reviewed by the commissioner within 30 days of submission. After review, the commissioner may only disapprove a surcharge if it is inadequate or excessive. If so disapproved, the fund shall make an adjustment to the next surcharge calculation to reflect the appropriate increase or decrease.

(7) When a health care provider changes the term of its professional liability coverage, the surcharge shall be calculated on an annual base and shall reflect the surcharge percentages in effect for all the surcharge periods over which the policy is in effect.

(8) Health care providers having approved self-insurance plans shall be surcharged an amount equal to the surcharge imposed on a health care provider of like class, size, risk and kind as determined by the director. The fund and all income from the fund shall be held in trust, deposited in a segregated account, invested and reinvested by the director, and shall not

become a part of the General Fund of the Commonwealth. All claims shall be computed on August 31 for all claims which became final between that date and September 1 of the preceding year. All such claims shall be paid on or before December 31 following the August 31 by which they became final, as provided above.

(9) Notwithstanding the above provisions relating to an annual surcharge, the commissioner shall have the authority, during September of each year, if the fund would be exhausted by the payment in full of all claims which have become final and the expenses of the fund, to determine and levy an emergency surcharge on all health care providers then entitled to participate in the fund. Such emergency surcharge shall be the appropriate percentage of the cost to each health care provider for maintenance of professional liability insurance necessary to produce an amount sufficient to allow the fund to pay in full all claims determined to be final as of August 31 of each year and the expenses of the fund as of December 31 of each year.

(10) The annual and emergency surcharges on health care providers and any income realized by investment or reinvestment shall constitute the sole and exclusive sources of funding for the fund. No claims or expenses against the fund shall be deemed to constitute a debt of the Commonwealth or a charge against the General Fund of the Commonwealth.

(11) The director shall issue rules and regulations consistent with this section regarding the establishment and operation of the fund including all procedures and the levying, payment and collection of the surcharges except that the commissioner shall issue rules and regulations regarding the imposition of the emergency surcharge.

(12) Upon the effective date of this section, the fund shall immediately notify all insurers writing professional liability insurance of the schedule of occurrence rates approved by the commissioner and in effect for the Joint Underwriting Association.

(13) Within 20 days of the effective date of this section, the fund shall recalculate the surcharge for health care providers for the surcharge period beginning January 1, 1997, based upon the prevailing primary premium.

(14) A health care provider may elect to pay the annual surcharge in equal installments, not exceeding four, if the health care provider informs the primary carrier of the option to pay in installments and the entire annual surcharge is collected and remitted to the fund by December 10, with four equal installments commencing 60 days from the date of policy inception or renewal with payment due each 60 days thereafter until the full remittance is paid. This paragraph shall apply to surcharges for 1997. This paragraph shall expire January 1, 1998.

(15) Consistent with the purposes of this act to close-out the fund, the fund shall undertake its best efforts to transfer liability for and the management of its claims to a private entity within 24 months of the effective date of this paragraph. During that 24-month period, the fund shall report to the advisory board at least quarterly on the progress of transferring its claims. If at the end of 18 months, the fund has been unsuccessful in completing such transfer, the advisory board shall submit a report to the General Assembly summarizing the efforts made by the fund to transfer its claims and providing further recommendations for closing out the fund. The

fund shall be dissolved following the resolution of all claims covered by the fund pursuant to this act.

(f) The failure of any health care provider to comply with any of the provisions of this section or any of the rules and regulations issued by the director shall result in the suspension or revocation of the health care provider's license by the licensure board.

(g) Any physician who exclusively practices the specialty of forensic pathology shall be exempt from the provisions of this act.

(h) All health care providers who are members of the Pennsylvania military forces are exempt from the provisions of this act while in the performance of their assigned duty in the Pennsylvania military forces under orders.

Section 3. Article VII of the act is repealed.

Section 4. This act shall take effect as follows:

(1) The repeal of section 605 of the act shall take effect December 31, 1999.

(2) The repeal of Article VII shall take effect upon publication in the Pennsylvania Bulletin by the Insurance Department of a notice that the transfer of all liability and management of the Medical Professional Liability Catastrophe Loss Fund's claims have been completed.

(3) This section and the remainder of this act shall take effect immediately.