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THE GENERAL ASSEMBLY OF PENNSYLVANIA

SENATE BILL

No. 1242 Session of 2008

INTRODUCED BY HUGHES, COSTA, FONTANA, TARTAGLIONE, O'PAKE, C. WILLIAMS, STACK, FUMO AND KITCHEN, JANUARY 15, 2008

REFERRED TO BANKING AND INSURANCE, JANUARY 15, 2008

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 the Medical Care Availability and Reduction of Error Fund; providing for the Medical Care Availability for Pennsylvanians (MCAP) Reserve Fund; and further providing for the Health Care Provider Retention Account and for expiration.

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

Section 1. Section 712 of the act of March 20, 2002 (P.L.154, No.13), known as the Medical Care Availability and Reduction of Error (Mcare) Act, is amended to read:

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

(a) Establishment.--There is hereby established within the State Treasury a special fund to be known as the Medical Care Availability and Reduction of Error Fund. Money in the fund shall be used to pay claims against participating health care providers for losses or damages awarded in medical professional liability actions against them in excess of the basic insurance coverage required by section 711(d), liabilities transferred in accordance with subsection (b) and for the administration of the fund.

(b) Transfer of assets and liabilities.--

(1) (i) The money in the Medical Professional Liability Catastrophe Loss Fund established under section 701(d) of the former act of October 15, 1975 (P.L.390, No.111), known as the Health Care Services Malpractice Act, is transferred to the fund.

(ii) The rights of the Medical Professional Liability Catastrophe Loss Fund established under section 701(d) of the former Health Care Services Malpractice Act are transferred to and assumed by the fund.

(2) The liabilities and obligations of the Medical Professional Liability Catastrophe Loss Fund established under section 701(d) of the former Health Care Services Malpractice Act are transferred to and assumed by the fund.

(c) Fund liability limits.--

(1) For calendar year 2002, the limit of liability of the fund created in section 701(d) of the former Health Care Services Malpractice Act for each health care provider that conducts more than 50% of its health care business or practice within this Commonwealth and for each hospital shall be $700,000 for each occurrence and $2,100,000 per annual

aggregate.

(2) 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, 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.

(4) For calendar year beginning January 1, 2008, the department may delay or suspend the collection of assessments until the requirements under section 752(b) are met.

(e) Discount on surcharges and assessments.--

(1) For calendar year 2002, the department shall discount the aggregate surcharge imposed under section 701(e)(1) of the Health Care Services Malpractice Act by 5% of the aggregate surcharge imposed under that section for calendar year 2001 in accordance with the following:

(i) Fifty percent of the aggregate discount shall be granted equally to hospitals and to participating health care providers that were surcharged as members of one of the four highest rate classes of the prevailing primary premium.

(ii) Notwithstanding subparagraph (i), 50% of the aggregate discount shall be granted equally to all participating health care providers.

(iii) The department shall issue a credit to a participating health care provider who, prior to the effective date of this section, has paid the surcharge imposed under section 701(e)(1) of the former Health Care Services Malpractice Act for calendar year 2002 prior to the effective date of this section.

(2) For calendar years 2003 and 2004, the department shall discount the aggregate assessment imposed under subsection (d) for each calendar year by 10% of the aggregate

surcharge imposed under section 701(e)(1) of the former Health Care Services Malpractice Act for calendar year 2001 in accordance with the following:

(i) Fifty percent of the aggregate discount shall be granted equally to hospitals and to participating health care providers that were assessed as members of one of the four highest rate classes of the prevailing primary premium.

(ii) Notwithstanding subparagraph (i), 50% of the aggregate discount shall be granted equally to all participating health care providers.

(3) For calendar years 2005 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).

(f) Updated rates.--The joint underwriting association shall file updated rates for all health care providers with the commissioner by May 1 of each year. The department shall review and may adjust the prevailing primary premium in line with any applicable changes which have been approved by the commissioner.

(g) Additional adjustments of the prevailing primary premium.--The department shall adjust the applicable prevailing primary premium of each participating health care provider in accordance with the following:

(1) The applicable prevailing primary premium of a participating health care provider which is not a hospital may be adjusted through an increase in the individual participating health care provider's prevailing primary

premium not to exceed 20%. Any adjustment shall be based upon the frequency of claims paid by the fund on behalf of the individual participating health care provider during the past five most recent claims periods and shall be in accordance with the following:

(i) If three claims have been paid during the past five most recent claims periods by the fund, a 10% increase shall be charged.

(ii) If four or more claims have been paid during the past five most recent claims periods by the fund, a 20% increase shall be charged.

(2) The applicable prevailing primary premium of a participating health care provider which is not a hospital and which has not had an adjustment under paragraph (1) may be adjusted through an increase in the individual participating health care provider's prevailing primary premium not to exceed 20%. Any adjustment shall be based upon the severity of at least two claims paid by the fund on behalf of the individual participating health care provider during the past five most recent claims periods.

(3) The applicable prevailing primary premium of a participating health care provider not engaged in direct clinical practice on a full-time basis may be adjusted through a decrease in the individual participating health care provider's prevailing primary premium not to exceed 10%. Any adjustment shall be based upon the lower risk associated with the less-than-full-time direct clinical practice.

(4) The applicable prevailing primary premium of a hospital may be adjusted through an increase or decrease in the individual hospital's prevailing primary premium not to

exceed 20%. Any 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 periods.

(h) Self-insured health care providers.--A participating health care provider that has an approved self-insurance plan shall be assessed an amount equal to the assessment imposed on a participating health care provider of like class, size, risk and kind as determined by the department.

(i) Change in basic insurance coverage.--If a participating health care provider changes the term of its medical professional liability insurance coverage, the assessment shall be calculated on an annual basis and shall reflect the assessment percentages in effect for the period over which the policies are in effect.

(j) Payment of claims.--Claims which became final during the preceding claims period shall be paid on or before December 31 following the August 31 on which they became final.

(k) Termination.--Upon satisfaction of all liabilities of the fund, the fund shall terminate. Any balance remaining in the fund upon such termination shall be returned by the department to the participating health care providers who participated in the fund in proportion to their assessments in the preceding calendar year.

(l) Sole and exclusive source of funding.--Except as provided in subsection (m), the surcharges imposed under section 701(e)(1) of the Health Care Services Malpractice Act and assessments on participating health care providers and any income realized by investment or reinvestment shall constitute

the sole and exclusive sources of funding for the fund. Nothing in this subsection shall prohibit the fund from accepting contributions from nongovernmental sources. A claim against or a liability of the fund shall not be deemed to constitute a debt or liability of the Commonwealth or a charge against the General Fund.

(m) Supplemental funding.--Notwithstanding the provisions of 75 Pa.C.S. § 6506(b) (relating to surcharge) to the contrary, beginning January 1, 2004, and for a period of nine calendar years thereafter, all surcharges levied and collected under 75 Pa.C.S. § 6506(a) by any division of the unified judicial system shall be remitted to the Commonwealth for deposit in the Medical Care Availability and Restriction of Error Fund. These funds shall be used to reduce surcharges and assessments in accordance with subsection (e). Beginning January 1, 2014, and each year thereafter, the surcharges levied and collected under 75 Pa.C.S. § 6506(a) shall be deposited into the General Fund.

(n) Waiver of right to consent to settlement.--A participating health care provider may maintain the right to consent to a settlement in a basic insurance coverage policy for medical professional liability insurance upon the payment of an additional premium amount.

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

SUBCHAPTER E

MEDICAL CARE AVAILABILITY FOR PENNSYLVANIANS

(MCAP) RESERVE FUND

Section 751. Establishment.

There is established within the State Treasury a special fund to be known as the Medical Care Availability for Pennsylvanians

(MCAP) Reserve Fund.

Section 752. Allocation.

(a) Annual allocation.--Money in the Medical Care Availability for Pennsylvanians (MCAP) Reserve Fund shall be allocated annually as follows:

(1) Fifty percent of the total amount in the Medical Care Availability for Pennsylvanians (MCAP) Reserve Fund shall remain in the Medical Care Availability for Pennsylvanians (MCAP) Reserve Fund for the sole purpose of reducing the unfunded liability of the fund.

(2) Fifty percent of the total amount in the Medical Care Availability for Pennsylvanians (MCAP) Reserve Fund shall be dedicated to funding the program established under subsection (b).

(b) Enactment of legislation.--No money in the Medical Care Availability for Pennsylvanians (MCAP) Reserve Fund shall be used until legislation is enacted that provides both assistance to certain small business employers in covering their low wage uninsured and access to affordable health insurance coverage for uninsured low-income adult Pennsylvanians that shall include all of the following:

(1) Subsidies and tax credits for small business health savings accounts.

(2) Subsidies and tax credits for incentives for disease management programs.

(3) Subsidies and tax credits for wellness and healthy living programs.

(4) Funding for low-income health care access to community-based health providers.

(5) Collection and disclosure of health care costs by

various providers and insurers throughout the health care continuum.

(6) Implementation of cost containment measures that expand access while maintaining quality and patient safety.

Section 3. Section 1112 of the act is amended by adding a subsection to read:

Section 1112. Health Care Provider Retention Account.

* * *

(c.1) Transfers to the Medical Care Availability for Pennsylvanians (MCAP) Reserve Fund.--If the Secretary of the Budget makes a transfer from the account under subsection (c), the remaining funds in the account shall be transferred to the Medical Care Availability for Pennsylvanians (MCAP) Reserve Fund. If the Secretary of the Budget does not make a transfer from the account under subsection (c), all of the funds in the account shall be transferred to the Medical Care Availability for Pennsylvanians (MCAP) Reserve Fund.

* * *

Section 4. If the requirements of section 752(b) of the act are not satisfied by June 30, 2008, sections 711, 712(d), (e), (g), (h) and (i) of the act shall expire June 30, 2008. If these sections expire on June 30, 2008, the fund shall continue to be responsible for payment of claims against participating health care providers as of June 30, 2008, up to the fund liability limits as of June 30, 2008, to the extent the fund would have been responsible for payment of such claims if sections 711, 712(d), (e), (g), (h) and (i) of the act did not expire June 30, 2008.

Section 5. This act shall take effect in 60 days.