
THE GENERAL ASSEMBLY OF PENNSYLVANIA

SENATE BILL

No. 1018 Session of
2009

INTRODUCED BY ERICKSON, RAFFERTY, O'PAKE, BOSCOLA, GREENLEAF,
ROBBINS, STACK, ORIE, WOZNIAK, PIPPY, M. WHITE, BRUBAKER,
BAKER, PICCOLA, TOMLINSON, FERLO AND YAW, JULY 10, 2009

REFERRED TO BANKING AND INSURANCE, JULY 10, 2009

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," further providing for medical
16 professional liability insurance, for Medical Care
17 Availability and Reduction of Error Fund and for actuarial
18 data; and making repeals.

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

21 Section 1. Section 711(d) of the act of March 20, 2002
22 (P.L.154, No.13), known as the Medical Care Availability and
23 Reduction of Error (Mcare) Act, is amended to read:

24 Section 711. Medical professional liability insurance.

25 * * *

1 (d) Basic coverage limits.--A health care provider shall
2 insure or self-insure medical professional liability in
3 accordance with the following:

4 (1) For policies issued or renewed in the calendar year
5 2002, the basic insurance coverage shall be:

6 (i) \$500,000 per occurrence or claim and \$1,500,000
7 per annual aggregate for a health care provider who
8 conducts more than 50% of its health care business or
9 practice within this Commonwealth and that is not a
10 hospital.

11 (ii) \$500,000 per occurrence or claim and \$1,500,000
12 per annual aggregate for a health care provider who
13 conducts 50% or less of its health care business or
14 practice within this Commonwealth.

15 (iii) \$500,000 per occurrence or claim and
16 \$2,500,000 per annual aggregate for a hospital.

17 (2) For policies issued or renewed in the calendar years
18 2003[, 2004 and 2005] through 2009, the basic insurance
19 coverage shall be:

20 (i) \$500,000 per occurrence or claim and \$1,500,000
21 per annual aggregate for a participating health care
22 provider that is not a hospital.

23 (ii) \$1,000,000 per occurrence or claim and
24 \$3,000,000 per annual aggregate for a nonparticipating
25 health care provider.

26 (iii) \$500,000 per occurrence or claim and
27 \$2,500,000 per annual aggregate for a hospital.

28 (3) [Unless the commissioner finds pursuant to section
29 745(a) that additional basic insurance coverage capacity is
30 not available, for] For policies issued or renewed in

1 calendar [year 2006 and each year thereafter subject to
2 paragraph (4)] years 2010, 2011 and 2012, the basic insurance
3 coverage shall be:

4 (i) \$750,000 per occurrence or claim and \$2,250,000
5 per annual aggregate for a participating health care
6 provider that is not a hospital.

7 (ii) \$1,000,000 per occurrence or claim and
8 \$3,000,000 per annual aggregate for a nonparticipating
9 health care provider.

10 (iii) \$750,000 per occurrence or claim and
11 \$3,750,000 per annual aggregate for a hospital.

12 [If the commissioner finds pursuant to section 745(a) that
13 additional basic insurance coverage capacity is not
14 available, the basic insurance coverage requirements shall
15 remain at the level required by paragraph (2); and the
16 commissioner shall conduct a study every two years until the
17 commissioner finds that additional basic insurance coverage
18 capacity is available, at which time the commissioner shall
19 increase the required basic insurance coverage in accordance
20 with this paragraph.]

21 (4) [Unless the commissioner finds pursuant to section
22 745(b) that additional basic insurance coverage capacity is
23 not available, for] For policies issued or renewed [three
24 years after the increase in coverage limits required by
25 paragraph (3)] in calendar year 2013 and for each year
26 thereafter, the basic insurance coverage shall be:

27 (i) \$1,000,000 per occurrence or claim and
28 \$3,000,000 per annual aggregate for a participating
29 health care provider that is not a hospital.

30 (ii) \$1,000,000 per occurrence or claim and

1 \$3,000,000 per annual aggregate for a nonparticipating
2 health care provider.

3 (iii) \$1,000,000 per occurrence or claim and
4 \$4,500,000 per annual aggregate for a hospital.

5 [If the commissioner finds pursuant to section 745(b) that
6 additional basic insurance coverage capacity is not
7 available, the basic insurance coverage requirements shall
8 remain at the level required by paragraph (3); and the
9 commissioner shall conduct a study every two years until the
10 commissioner finds that additional basic insurance coverage
11 capacity is available, at which time the commissioner shall
12 increase the required basic insurance coverage in accordance
13 with this paragraph.]

14 * * *

15 Section 2. Section 712(c), (d), (e), (j), (k), (l) and (m)
16 of the act are amended and the section is amended by adding
17 subsections to read:

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

20 * * *

21 (c) Fund liability limits.--

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

29 (2) The limit of liability of the fund for each
30 participating health care provider shall be as follows:

1 (i) For calendar [year 2003 and each year
2 thereafter] years 2003 through 2009, the limit of
3 liability of the fund shall be \$500,000 for each
4 occurrence and \$1,500,000 per annual aggregate.

5 (ii) [If the basic insurance coverage requirement is
6 increased in accordance with section 711(d)(3) and,
7 notwithstanding subparagraph (i), for each calendar year
8 following the increase in the basic insurance coverage
9 requirement] For calendar years 2010, 2011 and 2012, the
10 limit of liability of the fund shall be \$250,000 for each
11 occurrence and \$750,000 per annual aggregate.

12 (iii) [If the basic insurance coverage requirement
13 is increased in accordance with section 711(d)(4) and,
14 notwithstanding subparagraphs (i) and (ii), for each
15 calendar year following the increase in the basic
16 insurance coverage requirement] For 2013 and each
17 calendar year thereafter, the limit of liability of the
18 fund shall be zero.

19 (3) A policy period of less than 12 months shall result
20 in a pro rata reduction in the fund annual aggregation
21 limits.

22 (d) Assessments.--

23 (1) For calendar [year 2003 and for each year
24 thereafter] years 2003 through 2012, the fund shall be funded
25 by an assessment on each participating health care provider.
26 Assessments shall be levied by the department on or after
27 January 1 of each year. The assessment shall be based on the
28 prevailing primary premium for each participating health care
29 provider [and]. Except as provided in subsection (d)(1.1),
30 the assessment shall, in the aggregate, produce an amount

1 sufficient to do all of the following:

2 (i) Reimburse the fund for the payment of reported
3 claims which became final during the preceding claims
4 period.

5 (ii) Pay expenses of the fund incurred during the
6 preceding claims period.

7 (iii) Pay principal and interest on moneys
8 transferred into the fund in accordance with section
9 713(c).

10 (iv) Provide a reserve that shall be 10% of the sum
11 of subparagraphs (i), (ii) and (iii).

12 (1.1) The assessments for calendar years 2010, 2011 and
13 2012 shall be reduced to 40% of the amount otherwise
14 determined by the formula in paragraph (d)(1) to coincide
15 with the change in coverage limits in section 701(c)(3).

16 (2) The department shall notify all basic insurance
17 coverage insurers and self-insured participating health care
18 providers of the assessment by November 1 for the succeeding
19 calendar year.

20 (3) The assessment will apply to medical professional
21 liability policies providing basic insurance coverage with an
22 effective or renewal date during each calendar year in which
23 there is an assessment.

24 (4) Any appeal of the assessment shall be filed with the
25 department.

26 (5) For calendar year 2013 and each year thereafter, no
27 assessment shall be levied against any participating health
28 care provider and all claims and expenses of the fund shall
29 be paid from the funds set forth in subsection (m.1).

30 (6) A health care provider or professional corporation,

1 professional association or partnership shall not be liable
2 in any medical professional liability action against the
3 provider or entity for any portion of a settlement or a
4 judgment within Mcare coverage under this act.

5 [(e) Discount on surcharges and assessments.--

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

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

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

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

25 (2) For calendar years 2003 and 2004, the department
26 shall discount the aggregate assessment imposed under
27 subsection (d) for each calendar year by 10% of the aggregate
28 surcharge imposed under section 701(e)(1) of the former
29 Health Care Services Malpractice Act for calendar year 2001
30 in accordance with the following:

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

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

9 (3) For calendar years 2005 and thereafter, if the basic
10 insurance coverage requirement is increased in accordance
11 with section 711(d)(3) or (4), the department may discount
12 the aggregate assessment imposed under subsection (d) by an
13 amount not to exceed the aggregate sum to be deposited in the
14 fund in accordance with subsection (m).]

15 * * *

16 (j) Payment of claims.--Claims which became final during the
17 preceding claims period shall be paid on [or before] December 31
18 or the last business day of the year following the August 31 on
19 which they became final.

20 (k) Termination.--Upon satisfaction of all liabilities of
21 the fund, the fund shall terminate. Any balance remaining in the
22 fund upon such termination shall be [returned] transferred by
23 the department to the [participating health care providers who
24 participated in the fund in proportion to their assessments in
25 the preceding calendar year] General Fund.

26 (l) Sole and exclusive source of funding.--Except as
27 provided in subsection (m), section 713(c) and any
28 appropriations to the fund, the surcharges imposed under section
29 701(e)(1) of the Health Care Services Malpractice Act and
30 assessments on participating health care providers and any

1 income realized by investment or reinvestment shall constitute
2 the sole and exclusive sources of funding for the fund. Nothing
3 in this subsection shall prohibit the fund from accepting
4 contributions from nongovernmental sources. A claim against or a
5 liability of the fund shall not be deemed to constitute a debt
6 or liability of the Commonwealth or a charge against the General
7 Fund.

8 (m) Supplemental funding.--Notwithstanding the provisions of
9 75 Pa.C.S. § 6506(b) (relating to surcharge) to the contrary,
10 for the period beginning January 1, 2004, [and for a period of
11 nine calendar years thereafter] through December 31, 2027, all
12 surcharges levied and collected under 75 Pa.C.S. § 6506(a) by
13 any division of the unified judicial system shall be remitted to
14 the Commonwealth for deposit in the Medical Care Availability
15 and [Restriction] Reduction of Error Fund. [These funds shall be
16 used to reduce surcharges and assessments in accordance with
17 subsection (e).] Beginning January 1, [2014] 2028, and each year
18 thereafter, [the] all surcharges levied and collected under 75
19 Pa.C.S. § 6506(a) shall be deposited into the General Fund.

20 (m.1) Fund balance.--The balance of the fund as of July 1,
21 2009, assessments levied for calendar years 2009 through 2012,
22 supplemental funding provided under subsection (m), any
23 appropriations to the fund and other fund revenue, including any
24 interest or other investment income earned thereon, shall be
25 held in trust for the exclusive purpose of paying the fund's
26 share of settlements and judgments, the fund's operating
27 expenses and the fund's obligations under section 713(c) and
28 shall not be used for any other purpose.

29 (m.2) Penalties.--By March 15 of each year beginning in 2013
30 and continuing until termination of the fund under subsection

1 (k), the commissioner shall report to the General Assembly on
2 the financial solvency of the fund. The report shall include the
3 current balance of the fund and projections as to the fund's
4 future liabilities and revenue by year as certified by an
5 independent actuary using generally accepted actuarial practices
6 and methods.

7 * * *

8 (o) Coverage of claims in relation to payment of certain
9 late assessments.--

10 (1) All basic insurance coverage insurers, self-insured
11 participating health care providers and risk retention groups
12 shall bill, collect and remit the assessment to the
13 department within 60 days of the inception or renewal date of
14 the primary professional liability policy.

15 (2) All basic insurance coverage insurers, self-insured
16 participating health care providers and risk retention groups
17 shall be subject to the following:

18 (i) For assessments remitted to the department in
19 excess of 60 days after the inception or renewal date of
20 the primary policy, the basic insurance coverage insurer,
21 self-insured participating health care provider or risk
22 retention group shall pay to the department a penalty
23 equal to 10% per annum of each untimely assessment
24 accruing from the 61st day after the inception or renewal
25 date of the primary policy until the remittance is
26 received by the department.

27 (ii) In addition to the provisions of subparagraph
28 (i), if the department finds that there has been a
29 pattern or practice of not complying with this section,
30 the basic insurance coverage insurer, self-insured

1 participating health care provider or risk retention
2 group shall be subject to the penalties and process set
3 forth in the act of July 22, 1974 (P.L.589, No.205),
4 known as the Unfair Insurance Practices Act.

5 (iii) If the basic insurance coverage insurer, self-
6 insurer or risk retention group receives the assessment
7 from a health care provider, professional corporation or
8 professional association with less than 30 days to make
9 the remittance timely as provided under this subsection,
10 the basic insurance coverage insurer, self-insurer or
11 risk retention group remittance period shall be extended
12 by 30 days from the date of receipt upon providing
13 reasonable evidence to the department regarding the date
14 of receipt and shall not be subject to the penalties
15 provided for under this section.

16 (iv) If the basic insurance coverage insurer, self-
17 insurer or risk retention group receives an assessment
18 after 60 days of the inception or renewal date of the
19 primary professional liability policy and remits the
20 assessment within 30 days from the date of receipt, the
21 basic insurance coverage insurer, self-insurer or risk
22 retention group shall not be subject to the penalties
23 provided for under this section. Remittances to the
24 department beyond the 30-day period shall be subject to
25 the penalties provided for under this section.

26 (v) (A) A health care provider or professional
27 corporation, professional association or partnership
28 shall be provided fund coverage from the inception or
29 renewal date of the primary professional liability
30 policy if the billed assessment is paid to the basic

1 insurance coverage insurer, self-insurer or risk
2 retention group within 60 days of the inception or
3 renewal date of the primary professional liability
4 policy.

5 (B) Except as provided in clause (C), a health
6 care provider or professional corporation,
7 professional association or partnership that fails to
8 pay the billed assessment to its basic insurance
9 coverage insurer, self-insurer or risk retention
10 group within 60 days of policy inception or renewal
11 date and before receiving notice of a claim shall not
12 have fund coverage for that claim.

13 (C) If a health care provider or professional
14 corporation, professional association or partnership
15 is billed by the basic insurance coverage insurer,
16 self-insurer or risk retention group no later than 30
17 days after the policy inception or renewal date and
18 the health care provider or professional corporation,
19 professional association or partnership pays the
20 basic insurance coverage insurer, self-insurer or
21 risk retention group within 30 days from the date of
22 receipt of the bill, the health care provider shall
23 be provided fund coverage as of the inception or
24 renewal date of the primary policy. Fund coverage
25 shall also be provided to the health care provider or
26 professional corporation, professional association or
27 partnership for all professional liability claims
28 made after payment of the assessment.

29 (vi) Notwithstanding any provisions to the contrary,
30 nothing in this section shall be construed to affect

1 existing regulations saved by section 5107(a), and all
2 existing regulations shall remain in full force and
3 effect.

4 Section 3. Section 745 of the act is amended to read:

5 [Section 745. Actuarial data.

6 (a) Initial study.--The following shall apply:

7 (1) No later than April 1, 2005, each insurer providing
8 medical professional liability insurance in this Commonwealth
9 shall file loss data as required by the commissioner. For
10 failure to comply, the commissioner shall impose an
11 administrative penalty of \$1,000 for every day that this data
12 is not provided in accordance with this paragraph.

13 (2) By July 1, 2005, the commissioner shall conduct a
14 study regarding the availability of additional basic
15 insurance coverage capacity. The study shall include an
16 estimate of the total change in medical professional
17 liability insurance loss-cost resulting from implementation
18 of this act prepared by an independent actuary. The fee for
19 the independent actuary shall be borne by the fund. In
20 developing the estimate, the independent actuary shall
21 consider all of the following:

22 (i) The most recent accident year and ratemaking
23 data available.

24 (ii) Any other relevant factors within or outside
25 this Commonwealth in accordance with sound actuarial
26 principles.

27 (b) Additional study.--The following shall apply:

28 (1) Three years following the increase of the basic
29 insurance coverage requirement in accordance with section
30 711(d)(3), each insurer providing medical professional

1 liability insurance in this Commonwealth shall file loss data
2 with the commissioner upon request. For failure to comply,
3 the commissioner shall impose an administrative penalty of
4 \$1,000 for every day that this data is not provided in
5 accordance with this paragraph.

6 (2) Three months following the request made under
7 paragraph (1), the commissioner shall conduct a study
8 regarding the availability of additional basic insurance
9 coverage capacity. The study shall include an estimate of the
10 total change in medical professional liability insurance
11 loss-cost resulting from implementation of this act prepared
12 by an independent actuary. The fee for the independent
13 actuary shall be borne by the fund. In developing the
14 estimate, the independent actuary shall consider all of the
15 following:

16 (i) The most recent accident year and ratemaking
17 data available.

18 (ii) Any other relevant factors within or outside
19 this Commonwealth in accordance with sound actuarial
20 principles.]

21 Section 4. All acts and parts of acts are repealed insofar
22 as they are inconsistent with this act.

23 Section 5. This act shall take effect in 30 days.