

THE GENERAL ASSEMBLY OF PENNSYLVANIA

SENATE BILL

No. 1280 Session of
2010

INTRODUCED BY RAFFERTY, ERICKSON, ORIE, WARD, ARGALL, KASUNIC,
WASHINGTON, ALLOWAY, GREENLEAF, LEACH, TOMLINSON, PIPPY,
MENSCH, BOSCOLA, O'PAKE, BAKER, STACK, LOGAN, FONTANA AND
DINNIMAN, MARCH 19, 2010

SENATOR CORMAN, APPROPRIATIONS, RE-REPORTED AS AMENDED,
SEPTEMBER 28, 2010

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 PROVIDING FOR CONFLICT. ←

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

21 Section 1. Sections 711(d), 712(c)(2), (D) and (e)(3) and ←
22 745 of the act of March 20, 2002 (P.L.154, No.13), known as the
23 Medical Care Availability and Reduction of Error (Mcare) Act,
24 are amended to read:

1 Section 711. Medical professional liability insurance.

2 * * *

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

6 (1) For policies issued or renewed in the calendar year
7 2002, the basic insurance coverage shall be:

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

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

17 (iii) \$500,000 per occurrence or claim and
18 \$2,500,000 per annual aggregate for a hospital.

19 (2) For policies issued or renewed in the calendar years
20 2003, 2004 and 2005, and each year thereafter, the basic
21 insurance coverage shall be:

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

25 (ii) \$1,000,000 per occurrence or claim and
26 \$3,000,000 per annual aggregate for a nonparticipating
27 health care provider.

28 (iii) \$500,000 per occurrence or claim and
29 \$2,500,000 per annual aggregate for a hospital.

30 †(3) Unless the commissioner finds pursuant to section



1 745(a) that additional basic insurance coverage capacity is
2 not available, for policies issued or renewed in calendar
3 year [2006] 2018 and each year thereafter subject to
4 paragraph (4), the basic insurance coverage shall be:

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

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

11 (iii) \$750,000 per occurrence or claim and
12 \$3,750,000 per annual aggregate for a hospital.

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

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

28 (i) \$1,000,000 per occurrence or claim and
29 \$3,000,000 per annual aggregate for a participating
30 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 712. Medical Care Availability and Reduction of Error
Fund.

* * *

(c) Fund liability limits.--

* * *

(2) 【The】 SUBJECT TO SECTION 711(D) (3) AND (4), 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

1 requirement, the limit of liability of the fund shall be
2 \$250,000 for each occurrence and \$750,000 per annual
3 aggregate.

4 (iii) If the basic insurance coverage requirement is
5 increased in accordance with section 711(d)(4) and,
6 notwithstanding subparagraphs (i) and (ii), for each
7 calendar year following the increase in the basic
8 insurance coverage requirement, the limit of liability of
9 the fund shall be zero.†

10 * * *

11 (D) ASSESSMENTS.--

12 (1) FOR CALENDAR YEAR 2003 [AND FOR EACH YEAR
13 THEREAFTER] THROUGH 2010, THE FUND SHALL BE FUNDED BY AN
14 ASSESSMENT ON EACH PARTICIPATING HEALTH CARE PROVIDER.
15 ASSESSMENTS SHALL BE LEVIED BY THE DEPARTMENT ON OR AFTER
16 JANUARY 1 OF EACH YEAR. THE ASSESSMENT SHALL BE BASED ON THE
17 PREVAILING PRIMARY PREMIUM FOR EACH PARTICIPATING HEALTH CARE
18 PROVIDER AND SHALL, IN THE AGGREGATE, PRODUCE AN AMOUNT
19 SUFFICIENT TO DO ALL OF THE FOLLOWING:

20 (I) REIMBURSE THE FUND FOR THE PAYMENT OF REPORTED
21 CLAIMS WHICH BECAME FINAL DURING THE PRECEDING CLAIMS
22 PERIOD.

23 (II) PAY EXPENSES OF THE FUND INCURRED DURING THE
24 PRECEDING CLAIMS PERIOD.

25 (III) PAY PRINCIPAL AND INTEREST ON MONEYS
26 TRANSFERRED INTO THE FUND IN ACCORDANCE WITH SECTION
27 713(C).

28 (IV) PROVIDE A RESERVE THAT SHALL BE 10% OF THE SUM
29 OF SUBPARAGRAPHS (I), (II) AND (III).

30 (1.1) FOR CALENDAR YEAR 2011 AND EACH YEAR THEREAFTER,

1 THE FUND SHALL BE FUNDED BY AN ASSESSMENT ON EACH
2 PARTICIPATING HEALTH CARE PROVIDER. ASSESSMENTS SHALL BE
3 LEVIED BY THE DEPARTMENT ON OR AFTER JANUARY 1 OF EACH YEAR.
4 THE ASSESSMENT SHALL BE BASED ON THE PREVAILING PRIMARY
5 PREMIUM FOR EACH PARTICIPATING HEALTH CARE PROVIDER AND
6 SHALL, IN THE AGGREGATE, PRODUCE AN AMOUNT EQUAL TO THE SUM
7 OF THE FOLLOWING AMOUNTS MINUS THE PROJECTED FUND BALANCE AT
8 THE CLOSE OF THE CALENDAR YEAR PRECEDING THE ASSESSMENT YEAR:

9 (I) THE REPORTED CLAIMS WHICH BECAME FINAL DURING
10 THE PRECEDING CLAIMS PERIOD.

11 (II) THE EXPENSES OF THE FUND INCURRED DURING THE
12 PRECEDING CLAIMS PERIOD.

13 (III) THE OUTSTANDING PRINCIPAL AND INTEREST ON
14 MONEYS TRANSFERRED INTO THE FUND IN ACCORDANCE WITH
15 SECTION 713(C).

16 (IV) TEN PERCENT OF THE SUM OF SUBPARAGRAPHS (I),
17 (II) AND (III).

18 (1.2) PARAGRAPH (1.1) IS NOT INTENDED TO VALIDATE OR
19 REFUTE ANY POSITION ADVANCED BY ANY PARTY IN PROCEEDINGS
20 CHALLENGING ANY ASSESSMENT PRIOR TO THE EFFECTIVE DATE OF
21 THIS PARAGRAPH. THE OUTCOME OF THOSE PROCEEDINGS SHALL BE
22 BASED UPON THE STATUTORY LANGUAGE IN EFFECT ON THE DAY BEFORE
23 THE EFFECTIVE DATE OF THIS PARAGRAPH.

24 (2) THE DEPARTMENT SHALL NOTIFY ALL BASIC INSURANCE
25 COVERAGE INSURERS AND SELF-INSURED PARTICIPATING HEALTH CARE
26 PROVIDERS OF THE ASSESSMENT BY NOVEMBER 1 FOR THE SUCCEEDING
27 CALENDAR YEAR.

28 (3) ANY APPEAL OF THE ASSESSMENT SHALL BE FILED WITH THE
29 DEPARTMENT.

30 (e) Discount on surcharges and assessments.--

1 * * *

2 †(3) For calendar years [2005] 2018 and thereafter, if ←
3 the basic insurance coverage requirement is increased in
4 accordance with section 711(d)(3) or (4), the department may
5 discount the aggregate assessment imposed under subsection
6 (d) by an amount not to exceed the aggregate sum to be
7 deposited in the fund in accordance with subsection (m).† ←

8 * * *

9 †Section 745. Actuarial data. ←

10 (a) [Initial study] STUDY.--The following shall apply: ←

11 (1) No later than April 1, [2005] 2017, each insurer ←
12 providing medical professional liability insurance in this
13 Commonwealth shall file loss data as required by the
14 commissioner. For failure to comply, the commissioner shall
15 impose an administrative penalty of \$1,000 for every day that
16 this data is not provided in accordance with this paragraph.

17 (2) [By July 1, 2005] AFTER THE FILING UNDER PARAGRAPH ←
18 (1) AND BEFORE JULY 2, 2017, the commissioner shall [conduct] ←
19 COMPLETE AND PRESENT a study regarding the availability of
20 additional basic insurance coverage capacity TO THE CHAIRMAN ←
21 AND MINORITY CHAIRMAN OF THE BANKING AND INSURANCE COMMITTEE
22 OF THE SENATE AND TO THE CHAIRMAN AND MINORITY CHAIRMAN OF
23 THE INSURANCE COMMITTEE OF THE HOUSE OF REPRESENTATIVES. The
24 study shall include an estimate of the total change in
25 medical professional liability insurance loss-cost resulting
26 from implementation of this act prepared by an independent
27 actuary. The fee for the independent actuary shall be borne
28 by the fund. In developing the estimate, the independent
29 actuary shall consider all of the following:

30 (i) The most recent [accident year] CLAIM and ←

1 ratemaking data available.

2 (ii) Any other relevant factors within or outside
3 this Commonwealth in accordance with sound actuarial
4 principles.

5 (b) Additional study.--[The] IF ADDITIONAL BASIC INSURANCE ←
6 COVERAGE CAPACITY IS FOUND UNDER SUBSECTION (A) AND LIMITS ARE
7 INCREASED UNDER SECTION 711(D)(3), THE following shall apply:

8 (1) Three years following the increase of the basic
9 insurance coverage requirement in accordance with section
10 711(d)(3), each insurer providing medical professional
11 liability insurance in this Commonwealth shall file loss data
12 with the commissioner upon request. For failure to comply,
13 the commissioner shall impose an administrative penalty of
14 \$1,000 for every day that this data is not provided in
15 accordance with this paragraph.

16 (2) Three months following the request made under
17 paragraph (1), the commissioner shall [conduct] COMPLETE AND ←
18 PRESENT a study regarding the availability of additional
19 basic insurance coverage capacity TO THE CHAIRMAN AND ←
20 MINORITY CHAIRMAN OF THE BANKING AND INSURANCE COMMITTEE OF
21 THE SENATE AND TO THE CHAIRMAN AND MINORITY CHAIRMAN OF THE
22 INSURANCE COMMITTEE OF THE HOUSE OF REPRESENTATIVES. The
23 study shall include an estimate of the total change in
24 medical professional liability insurance loss-cost resulting
25 from implementation of this act prepared by an independent
26 actuary. The fee for the independent actuary shall be borne
27 by the fund. In developing the estimate, the independent
28 actuary shall consider all of the following:

29 (i) The most recent [accident year] CLAIM and ←
30 ratemaking data available.

1 (ii) Any other relevant factors within or outside
2 this Commonwealth in accordance with sound actuarial
3 principles.†

4 SECTION 1.1. THE ACT IS AMENDED BY ADDING A SECTION TO READ:

5 SECTION 749. CONFLICT.

6 THIS CHAPTER DOES NOT AFFECT ANY OTHER STATUTORY PROVISION
7 WHICH:

8 (1) RELATES TO THE PARTICIPATION OF A HEALTH CARE
9 PROVIDER IN THE FUND; AND

10 (2) IS IN EFFECT ON THE EFFECTIVE DATE OF THIS SECTION.

11 Section 2. This act shall take effect ~~in 60 days.~~ AS
12 FOLLOWS:

13 (1) THE AMENDMENT OF SECTION 712(D) OF THE ACT SHALL
14 TAKE EFFECT IMMEDIATELY.

15 (2) THE REMAINDER OF THIS ACT SHALL TAKE EFFECT IN 60
16 DAYS.