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THE GENERAL ASSEMBLY OF PENNSYLVANIA

SENATE BILL

No. 679 Session of 1977

INTRODUCED BY HANKINS, CIANFRANI, HAGER, LYNCH, COPPERSMITH, HESS, HILL, SMITH AND MELLOW, MARCH 30, 1977

SENATOR HANKINS, INSURANCE, AS AMENDED, JULY 28, 1977

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," PROVIDING ADDITIONAL PROCEDURES TO CONTROL THE MALPRACTICE OF HEALTH CARE SERVICES AND authorizing certain professional corporations to obtain insurance coverage from certain sources. <—

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

SECTION 1. THE DEFINITIONS OF "GOVERNMENT" AND "HEALTH CARE PROVIDER" IN SECTION 103 AND THE INTRODUCTORY PARAGRAPH AND PARAGRAPHS (4) AND (5) OF SUBSECTION (A) OF SECTION 701, ACT OF OCTOBER 15, 1975 (P.L.390, NO.111), KNOWN AS THE "HEALTH CARE SERVICES MALPRACTICE ACT," AMENDED JULY 15, 1976 (P.L.1028, NO.207), ARE AMENDED AND DEFINITIONS ARE ADDED TO SECTION 103 TO READ: <—

SECTION 103. DEFINITIONS.--AS USED IN THIS ACT:

"ACT" MEANS THE ACT OF OCTOBER 15, 1975 (P.L.390, NO.111),

KNOWN AS THE "HEALTH CARE SERVICES MALPRACTICE ACT," UNLESS OTHERWISE STATED.

* * *

"GOVERNMENT" MEANS THE GOVERNMENT OF THE UNITED STATES, THE COMMONWEALTH OF PENNSYLVANIA, ANY STATE, ANY POLITICAL SUBDIVISION OF A STATE, ANY INSTRUMENTALITY OF ONE OR MORE STATES, OR ANY AGENCY, SUBDIVISION, OR DEPARTMENT OF ANY SUCH GOVERNMENT, INCLUDING ANY CORPORATION OR OTHER ASSOCIATION ORGANIZED BY A GOVERNMENT FOR THE EXECUTION OF A GOVERNMENT PROGRAM AND SUBJECT TO CONTROL BY A GOVERNMENT, OR ANY CORPORATION OR AGENCY ESTABLISHED UNDER AN INTERSTATE COMPACT OR INTERNATIONAL TREATY.

"HEALTH CARE PROVIDER" MEANS A PRIMARY HEALTH CENTER OR A PERSON, CORPORATION, FACILITY INSTITUTION OR OTHER ENTITY LICENSED OR APPROVED BY THE COMMONWEALTH TO PROVIDE HEALTH CARE OR PROFESSIONAL MEDICAL SERVICES AS A PHYSICIAN, [AN OSTEOPATHIC PHYSICIAN OR SURGEON,] A PODIATRIST, HOSPITAL, NURSING HOME, AND EXCEPT AS TO SECTION 701(A), AN OFFICER, EMPLOYEE OR AGENT OF ANY OF THEM ACTING IN THE COURSE AND SCOPE OF HIS EMPLOYMENT.

"HEALTH CARE PROFESSIONAL" MEANS THOSE PERSONS OR ENTITIES ACTIVELY ENGAGED IN PROVIDING OR RENDERING HEALTH SERVICES AS DETERMINED BY THE COMMISSIONER IN ACCORD WITH SECTION 804.

* * *

"PLAN OF RISK MANAGEMENT" MEANS A PROGRAM ESTABLISHED AND MAINTAINED FOR THE PURPOSES OF REDUCING THE FREQUENCY OR SEVERITY OF PERSONAL INJURIES OR DEATH ARISING OUT OF THE RENDITION OF OR FAILURE TO RENDER PROFESSIONAL SERVICES BY A HEALTH CARE PROVIDER OR HEALTH CARE PROFESSIONAL AS DEFINED IN THE ACT, THROUGH LOSS PREVENTION, LOSS REDUCTION AND OTHER GENERALLY ACCEPTED RISK MANAGEMENT TECHNIQUES.

* * *

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 WITH AN INSURANCE COMPANY EITHER LICENSED OR APPROVED IN THE COMMONWEALTH OF PENNSYLVANIA OR PROVIDE PROOF OF SELF-INSURANCE IN ACCORDANCE WITH THIS SECTION.

* * *

(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 AND PROVIDE FOR A PLAN OF RISK MANAGEMENT ACCEPTABLE TO THE COMMISSIONER.

(5) A FEE SHALL BE CHARGED BY THE INSURANCE DEPARTMENT TO ALL SELF-INSURERS FOR EXAMINATION ,RE-EXAMINATION AND APPROVAL OF THEIR PLANS EQUAL TO THE ACTUAL COSTS INCURRED BY THE INSURANCE DEPARTMENT. ALL SELF-INSURERS SHALL PAY THE FEE FOR THIS EXAMINATION, RE-EXAMINATION AND APPROVAL DIRECTLY TO THE INSURANCE DEPARTMENT. THE FUNDS COLLECTED FOR THE EXAMINATION, RE-EXAMINATION AND APPROVAL FOR THESE SELF-INSURANCE PLANS SHALL BE FOR THE SOLE AND EXCLUSIVE USE OF THE INSURANCE DEPARTMENT FOR REIMBURSEMENT IN CARRYING OUT THE PROVISIONS OF THIS ACT. AT ANY TIME DURING THE REVIEW OF SELF-INSURANCE PLANS, THE COMMISSIONER AT HIS DISCRETION MAY DELEGATE THE EXAMINATION OF SELF-INSURANCE PLANS TO ANY QUALIFIED PERSON OR ORGANIZATION NOT EMPLOYED BY THE INSURANCE DEPARTMENT OR AFFILIATED WITH THE SELF-INSURER. IN THIS INSTANCE THE REASONABLE FEE FOR THIS SERVICE SHALL BE PAID DIRECTLY TO THE EXAMINING PERSON OR

ORGANIZATION AND NOT THE INSURANCE DEPARTMENT.

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SECTION 2. SUBSECTION (B) OF SECTION 803, SECTION 804 AND SECTION 808 OF THE ACT ARE AMENDED TO READ:

SECTION 803. PLAN OPERATION, RATES AND DEFICITS.-- * * *

(B) IN THE EVENT THAT THE JOINT UNDERWRITING ASSOCIATION SUFFERS A DEFICIT IN ANY CALENDAR YEAR, THE BOARD OF DIRECTORS OF THE JOINT UNDERWRITING ASSOCIATION SHALL SO CERTIFY TO [THE DIRECTOR OF THE CATASTROPHE LOSS FUND AND] THE INSURANCE COMMISSIONER. SUCH CERTIFICATION SHALL BE SUBJECT TO THE REVIEW AND APPROVAL OF THE INSURANCE COMMISSIONER. WITHIN 60 DAYS FOLLOWING SUCH CERTIFICATION AND APPROVAL [THE DIRECTOR OF THE FUND SHALL MAKE SUFFICIENT PAYMENT TO THE JOINT UNDERWRITING ASSOCIATION TO COMPENSATE FOR SAID DEFICIT] THE PLAN SHALL ASSESS MEMBER INSURERS ON AN EQUITABLE APPORTIONMENT BASIS SUFFICIENT FUNDS TO COMPENSATE THE JOINT UNDERWRITING ASSOCIATION FOR SAID DEFICIT. THIS ASSESSMENT SHALL BE MADE RETROACTIVE TO JANUARY 13, 1976. A DEFICIT SHALL EXIST WHENEVER THE SUM OF THE EARNED PREMIUMS COLLECTED BY THE JOINT UNDERWRITING ASSOCIATION AND THE INVESTMENT INCOME THEREFROM IS EXHAUSTED BY VIRTUE OF PAYMENT OF OR ALLOCATION FOR THE JOINT UNDERWRITING ASSOCIATION'S NECESSARY ADMINISTRATIVE EXPENSES, TAXES, LOSSES, LOST ADJUSTMENT EXPENSES AND RESERVES, INCLUDING RESERVES FOR: (1) LOSSES INCURRED, EXCLUDING INCURRED BUT NOT REPORTED LOSSES EXCEPT TO THE EXTENT THAT A RESERVE MAY BE ESTABLISHED FOR A REPORTED INCIDENT WHICH REASONABLY MAY RESULT IN A CLAIM, (2) [LOSSES INCURRED BUT NOT REPORTED, (3)] LOSS ADJUSTMENT EXPENSES, [(4)](3) UNEARNED PREMIUMS.

SECTION 804. AUTHORITY OF INSURANCE COMMISSIONER.--TO CARRY OUT THE OBJECTIVES OF THIS ARTICLE, THE COMMISSIONER MAY ADOPT

RULES, MAKE ORDERS, ENTER INTO AGREEMENTS WITH OTHER GOVERNMENTAL OR PRIVATE ENTITIES AND INDIVIDUALS AND FORM AND OPERATE OR AUTHORIZE THE FORMATION AND OPERATION OF BUREAUS AND OTHER LEGAL ENTITIES. WHENEVER THE COMMISSIONER FINDS AFTER REVIEW OF THE PROFESSIONAL LIABILITY INSURANCE MARKET THAT HEALTH CARE PROFESSIONALS CANNOT CONVENIENTLY OBTAIN PROFESSIONAL LIABILITY INSURANCE THROUGH ORDINARY METHODS AT RATES NOT IN EXCESS OF THOSE APPLICABLE TO SIMILARLY SITUATED HEALTH CARE PROVIDERS UNDER THE PLAN, HE MAY DIRECT THE PLAN TO PROVIDE BASIC LIMITS PROFESSIONAL LIABILITY INSURANCE COVERAGE IN THE AMOUNT OF $100,000 PER OCCURRENCE AND $300,000 PER ANNUAL AGGREGATE OR IN OTHER AMOUNTS AS HE MAY DEEM APPROPRIATE. FOR THE PURPOSES OF THIS SECTION, OTHER HEALTH CARE PROFESSIONALS SHALL INCLUDE BUT ARE NOT LIMITED TO LICENSED OR APPROVED PROVIDERS OF HEALTH CARE SERVICES OF ANY NATURE AND THOSE PROVIDERS OF HEALTH CARE SERVICES WHICH ARE NOT LICENSED BUT WHICH IN THE COMMISSIONER'S JUDGMENT CONTRIBUTE SUBSTANTIALLY TO THE PUBLIC WELFARE THROUGH THE DELIVERY OF HEALTH CARE SERVICES.

SECTION 808. WHEN PLAN EXCLUSIVE SOURCE OF INSURANCE.--IF THE PRIVATE INSURANCE MARKET UNFAIRLY DISCRIMINATES AGAINST [HIGHER RISK PHYSICIANS BY DENYING PROFESSIONAL LIABILITY INSURANCE COVERAGE TO 50% OR MORE OF ALL PHYSICIANS IN INSURANCE RATING CLASSES 3, 4 OR 5, OR THEIR EQUIVALENTS] ANY CLASS OF HEALTH CARE PROVIDER OR HEALTH CARE PROFESSIONAL DEFINED UNDER THIS ACT OR INCLUDED BY THE COMMISSIONER'S ACTION UNDER SECTION 804 BY DENYING PROFESSIONAL LIABILITY INSURANCE COVERAGE TO 50% OR MORE OF A CLASS OF HEALTH CARE PROVIDER OR HEALTH CARE PROFESSIONAL EITHER BY RATING CLASS OR BY HEALTH CARE PROVIDER OR HEALTH CARE PROFESSIONAL DEFINITION, THE COMMISSIONER, AFTER NOTICE IN THE PENNSYLVANIA BULLETIN AND PUBLIC HEARINGS, MAY

DECLARE THAT THE PLAN ESTABLISHED UNDER THIS ARTICLE SHALL BE THE SOLE AND EXCLUSIVE SOURCE OF PROFESSIONAL LIABILITY INSURANCE FOR [HEALTH CARE PROVIDERS WITHIN THIS COMMONWEALTH. THE COMMISSIONER MAY DISSOLVE THE PLAN IF HE DETERMINES THAT IT IS NO LONGER NECESSARY AND THAT AN ADEQUATE MARKET WILL BE MAINTAINED FOR PROFESSIONAL LIABILITY INSURANCE FOR HEALTH CARE PROVIDERS BY THE PRIVATE INSURANCE MARKET. THE COMMISSIONER MAY REESTABLISH THE PLAN IF HE SHALL FIND THAT THE PRIVATE INDUSTRY HAS FAILED TO PROVIDE AN ADEQUATE MARKET FOR PROFESSIONAL LIABILITY INSURANCE BY DENYING PROFESSIONAL LIABILITY INSURANCE COVERAGE TO 50% OR MORE OF ALL RATING CLASSES 3, 4 OR 5, OR THEIR EQUIVALENTS, AND MAY DECLARE IT THE SOLE AND EXCLUSIVE SOURCE OF SUCH INSURANCE UNDER THE PROCEDURE SET FORTH IN THIS SECTION.] THAT CLASS OF HEALTH CARE PROVIDER OR HEALTH CARE PROFESSIONAL WITHIN THE COMMONWEALTH. WHENEVER THE COMMISSIONER DETERMINES THAT AN ADEQUATE MARKET WILL BE MAINTAINED FOR PROFESSIONAL LIABILITY FOR THAT CLASS OF HEALTH CARE PROVIDER OR HEALTH CARE PROFESSIONAL BY THE PRIVATE INSURANCE MARKET, HE MAY DISSOLVE THE PLAN OR REVOKE THE PLAN'S EXCLUSIVE UNDERWRITING AUTHORITY.

Section ~~1~~ 3. The act ~~of October 15, 1975 (P.L.390, No.111), known as the "Health Care Services Malpractice Act,"~~ is amended by adding a section to read:

Section 811. Professional Corporations.--(a) The Joint Underwriting Association shall offer basic coverage insurance to such professional corporations 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.

(b) In the event that a professional corporation entirely

owned by health care providers elected to be covered by professional liability insurance and upon payment of the annual surcharge as required by section 701(e), the professional corporation shall be entitled to such excess coverage from the Medical Professional Liability Catastrophe Loss Fund as is provided in this act.

SECTION 4. SECTION 1002 OF THE ACT, AMENDED JULY 15, 1976 (P.L.1028, NO.207) IS AMENDED TO READ: <—

SECTION 1002. [CANCELLATION] TERMINATION OF INSURANCE POLICY.--(A) ANY TERMINATION OF A PROFESSIONAL LIABILITY INSURANCE POLICY BY CANCELLATION, EXCEPT FOR SUSPENSION OR REVOCATION OF THE INSURED'S LICENSE OR APPROVAL BY THE COMMONWEALTH TO PROVIDE HEALTH CARE SERVICES OR FOR REASON OF NONPAYMENT OF PREMIUM, IS NOT EFFECTIVE AGAINST THE INSURED COVERED THEREBY, UNLESS NOTICE OF [CANCELLATION] TERMINATION SHALL HAVE BEEN GIVEN WITHIN 60 DAYS AFTER THE ISSUANCE OF SUCH CONTRACT OF INSURANCE [AGAINST] TO THE INSURED COVERED THEREUNDER AND NO [CANCELLATION] TERMINATION SHALL TAKE EFFECT UNLESS A WRITTEN NOTICE [STATING THE REASONS FOR THE CANCELLATION AND THE DATE AND TIME UPON WHICH TERMINATION BECOMES EFFECTIVE HAS BEEN RECEIVED BY THE COMMISSIONER AT HIS OFFICE. MAILING OF SUCH NOTICE TO THE COMMISSIONER AT HIS PRINCIPAL OFFICE ADDRESS SHALL CONSTITUTE NOTICE TO THE COMMISSIONER] HAS BEEN MAILED TO THE INSURED AND THE COMMISSIONER. SUCH NOTICE SHALL:

(1) STATE THE TIME AND DATE THAT THE TERMINATION BECOMES EFFECTIVE.

(2) STATE THE SPECIFIC REASON OR REASONS OF THE INSURER FOR TERMINATION.

(B) IN THE EVENT OF TERMINATION BY NONRENEWAL, THE INSURER

MUST MAIL WRITTEN NOTICE TO THE INSURED AND THE COMMISSIONER WHICH SHALL:

(1) STATE THE SPECIFIC REASON OR REASONS FOR NONRENEWAL.

(2) STATE THE DATE AND TIME UPON WHICH THE NONRENEWAL BECOMES EFFECTIVE.

(C) THE NOTICE OF NONRENEWAL MUST BE MAILED TO THE INSURED AND THE COMMISSIONER 60 DAYS PRIOR TO NONRENEWAL OF THE POLICY.

Section ~~2~~ 5. This act shall take effect immediately, and shall be retroactive to January 13, 1976. <——