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THE GENERAL ASSEMBLY OF PENNSYLVANIA

SENATE BILL

No. 1122 Session of 1995

INTRODUCED BY HOLL, SALVATORE, JONES, HELFRICK, WENGER, HART, CORMAN, AFFLERBACH, HECKLER, O'PAKE, JUBELIRER AND LEMMOND, JUNE 21, 1995

SENATOR HOLL, BANKING AND INSURANCE, AS AMENDED, OCTOBER 17, 1995

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 definitions, for statutes of limitation, for professional liability insurance and the Medical Professional Liability Catastrophe Loss Fund, for administration of that fund, for liability of excess carriers, for plan operation and rates, for reports to the Insurance Commissioner, for forms of doing business and for the Joint Study Committee.

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

Section 1. Section 103 of the 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) and November 6, 1985 (P.L.311, No.78), is amended to read:

Section 103. Definitions.--As used in this act:

"Administrator" means the office of Administrator for Arbitration Panels for Health Care.

"Arbitration panel" means Arbitration Panels for Health Care.

"Board" means the Board of Directors responsible for administering the Medical Professional Liability Catastrophe Loss Fund under section 702.

"Claims made" means a policy of professional liability insurance that would limit or restrict the liability of the insurer under the policy to only those claims made or reported during the currency of the policy period and would exclude coverage for claims reported subsequent to the termination even when such claims resulted from occurrences during the currency of the policy period.

"Claims period" means the six-month period:

(1) beginning March 1 and ending August 31; or

(2) beginning September 1 and ending on the last day of February.

"Commissioner" means the Insurance Commissioner of this Commonwealth.

"Final claim" means any of the following:

(1) A payment made by the fund directly to a claimant.

(2) A payment made by the fund to a basic insurance carrier or self-insured provider to reimburse it for a payment made from the fund coverage limits.

(3) A payment the fund is obligated by this act to make to a basic insurance carrier of self-insured provider for a payment, made from the fund coverage limits to a claimant, which is not reimbursed, including interest, due to a lack of surcharge receipts. In no event shall a payment or obligation to pay be included in more than one claims period for the purposes of surcharge calculation.

"Fund" means the Medical Professional Liability Catastrophe

Loss Fund established under section 701(d).

"Fund coverage limits" means the coverage provided by the Medical Professional Liability Catastrophe Loss Fund under section 701(d).

"Government" means the Government of the United States, 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 practice entity" means a professional corporation, restricted limited liability corporation, professional association, partnership or limited liability partnership which:

(1) provides professional services; and

(2) is, as determined by the Medical Professional Liability Catastrophe Loss Fund, owned entirely by health care providers.

"Health care provider" means a primary health center or a person, corporation, UNIVERSITY OR OTHER EDUCATIONAL INSTITUTION, 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 certified nurse midwife, a podiatrist, hospital, nursing home, birth center, 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.

"Informed consent" means for the purposes of this act and of any proceedings arising under the provisions of this act, the

consent of a patient to the performance of health care services by a physician or podiatrist: Provided, That prior to the consent having been given, the physician or podiatrist has informed the patient of the nature of the proposed procedure or treatment and of those risks and alternatives to treatment or diagnosis that a reasonable patient would consider material to the decision whether or not to undergo treatment or diagnosis. No physician or podiatrist shall be liable for a failure to obtain an informed consent in the event of an emergency which prevents consulting the patient. No physician or podiatrist shall be liable for failure to obtain an informed consent if it is established by a preponderance of the evidence that furnishing the information in question to the patient would have resulted in a seriously adverse effect on the patient or on the therapeutic process to the material detriment of the patient's health.

"Interest" means interest at the rate prescribed in section 806 of the act of April 9, 1929 (P.L.343, No.176), known as "The Fiscal Code."

"Licensure Board" means the State Board of [Medical Education and Licensure] Medicine, the State Board of Osteopathic [Examiners] Medicine, the State Board of Podiatry [Examiners], the Department of Public Welfare and the Department of Health.

"Patient" means a natural person who receives or should have received health care from a licensed health care provider.

"Prevailing primary rate" means a schedule of professional liability insurance premium rates for health care providers of similar class, size, risk and kind within defined regions as determined by the Medical Professional Liability Catastrophe Loss Fund under section 701(e)(2).

"Primary health center" means a community-based nonprofit corporation meeting standards prescribed by the Department of Health, which provides preventive, diagnostic, therapeutic, and basic emergency health care by licensed practitioners who are employees of the corporation or under contract to the corporation.

"Professional liability insurance" means insurance against liability on the part of a health care provider arising out of any tort or breach of contract causing injury or death resulting from the furnishing of medical services which were or should have been provided.

"Surcharge period" means the six-month period:

(1) beginning January 1 and ending June 30; or

(2) beginning July 1 and ending December 31.

Section 2. Section 605 of the act, amended July 15, 1976 (P.L.1028, No.207), is amended to read:

Section 605. Statute of Limitations~~[.--] and Defense.--(a)~~ <—

.--(A) All claims for recovery pursuant to this act must be <—

commenced within the existing applicable statutes of limitation. In the event that any claim is made against a health care provider subject to the provisions of Article VII more than four years after the breach of contract or tort occurred which is filed within the statute of limitations, such claim shall be defended and paid by the [Medical Professional Liability Catastrophe Loss Fund established pursuant to section 701] fund. If such claim is made after four years because of the willful concealment by the health care provider or his insurer, the fund shall have the right of full indemnity including defense costs from such health care provider or his insurer. A filing pursuant to section 401 shall toll the running of the limitations

contained herein.

(b) ~~Basic insurance coverage carriers and self-insured providers may, at their discretion, undertake the defense of cases under this section.~~ The fund coverage limits for cases under this section reported on or after the effective date of this subsection shall be $1,200,000.

~~(c) Upon the conclusion of a claim under this section in which the basic insurance coverage carrier or self-insured provider has provided a defense, the basic insurance coverage carrier or self-insured provider shall be reimbursed from the fund:~~

~~(1) upon request, reasonable costs incurred up to $15,000; and~~

~~(2) upon request and approval by the fund, reasonable costs incurred in excess of $15,000.~~

Section 3. Section 701(b), (C), (e) and (f) of the act, amended October 15, 1980 (P.L.971, No.165), is amended to read:

Section 701. Professional Liability Insurance and Fund.--~~(a)~~

* * *

(b) **[**No**]** (1) EXCEPT AS PROVIDED IN SECTION 702(G), NO insurer or self-insurance plan providing professional liability insurance shall be liable for the defense or 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 limits of an insurer or

a self-insurance plan, the fund shall be responsible for the payment of the claim and any related expense up to the fund coverage limits.

(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.

* * *

(e) (1) [The] After December 31, 1995, the fund shall be funded by the levying of [an annual surcharge on or after January 1 of every year] a semiannual surcharge on all health care providers entitled to participate in the fund. [The] Within 30 days following the end of a claims period, the surcharge shall be determined by the [director appointed pursuant to section 702 and subject to the prior approval of the commissioner.] fund, filed with the commissioner and communicated to all basic insurance coverage carriers and self-insured providers. The surcharge shall be based on the [cost to] prevailing primary rate 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 [all claims paid] final claims and expenses incurred during the preceding [calendar year] claims period and to provide an amount necessary to maintain an additional **[**$15,000,000.**]** 15% OF THE FINAL CLAIMS AND EXPENSES INCURRED DURING THE PRECEDING CLAIMS PERIOD. The surcharge shall be exempt from approval by the commissioner prior to imposition. If, after imposition, a surcharge is disapproved by the commissioner due to the surcharge being

inadequate or excessive, the fund shall make an adjustment to the next surcharge calculation to reflect the appropriate increase or decrease.

(2) [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, 1981 for all claims which become final between January 1, 1981 and August 31, 1981 and annually thereafter 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. All claims which become final between January 1, 1980 and the effective date of this amendatory act shall be computed on the effective date of this amendatory act and shall be paid on or before December 31, 1980.] The prevailing primary rate shall be determined by the fund based on the average of the basic insurance coverage rates filed with and approved by the commissioner by June 30 of the year in which the prevailing primary rate is determined by three nursing home insurers, three hospital insurers and three insurers for other health care providers, that have the largest share of their respective markets in this Commonwealth. The market share shall be determined by the fund based on total surcharges collected by the primary coverage carriers in the preceding calendar year. The fund shall determine the prevailing primary rate by August

31 every two years.

(3) [Notwithstanding the above provisions relating to an annual surcharge, the commissioner shall have the authority, during September 1981 and during September of each year thereafter, if the fund would be exhausted by the payment in full of all claims which have become final and the expenses of the office of the director, 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, 1981 and August 31 of each year thereafter and the expenses of the office of the director, as of December 31, 1980 and December 31 of each year thereafter.] In addition to the surcharge calculation in ~~paragraph (1), the following shall apply:~~ <—

~~(i) For the surcharge period beginning January 1, 1996, the fund is authorized to include in the surcharge calculation an amount sufficient to allow the fund to pay in full all final claims as of August 31, 1995, taking into account existing surcharge receipts.~~

~~(ii) For the surcharge period beginning July 1, 1996, the~~ PARAGRAPH (1), FOR THE SURCHARGE PERIOD BEGINNING JANUARY 1, <— 1996, THE fund is authorized to include in the surcharge calculation an amount sufficient to allow the fund to pay in full all final claims as of December 31, 1995, taking into account existing surcharge receipts.

(3.1) Surcharges shall be due 20 days following commencement of the applicable surcharge period. Late remittance by carriers

of surcharges collected from health care providers and late remittance of surcharges due from self-insured providers shall include interest.

(3.2) The annual surcharge of 102% of the cost to each health care provider for maintenance of professional liability insurance levied by the fund in 1994 shall continue to be in force for all policies renewed in 1995. Prorated credit for the 1995 annual surcharge applicable beyond December 31, 1995, shall be credited against the semiannual surcharges levied under this subsection.

(3.3) The fund and all income from the fund shall be held in trust, deposited in a segregated account and invested and reinvested by the fund and shall not become a part of the General Fund.

(3.4) Claims shall be paid as follows:

(i) Final claims as of August 31, 1995, shall be paid by January 20, 1996.

(ii) Final claims ~~after~~ AS OF December 31, 1995, shall be paid by July 20, 1996. <——

~~(iii) For final claims as of December 31, 1995, basic coverage insurance carriers or self-insured providers shall make payment to plaintiffs for the basic coverage and the fund coverage limits at the same time. The fund shall, within 30 days of submission of payment information, reimburse basic coverage insurance carriers and self-insured providers for the fund's portion of payments made to plaintiffs. Late reimbursement by the fund shall include interest.~~ <——

(III) FINAL CLAIMS AFTER DECEMBER 31, 1995, SHALL BE PAID TO THE PLAINTIFF WITHIN 90 DAYS OF NOTIFICATION OF SETTLEMENT OR VERDICT. LATE PAYMENTS SHALL INCLUDE INTEREST. <——

(4) 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. 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. A fee shall be charged by the director to all self-insurers for examination and approval of their plans].

(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] <u>fund</u> shall result in the suspension or revocation of the health care provider's license by the licensure board.

* * *

Section 4. Section 702 of the act, amended July 15, 1976 (P.L.1028, No.207) and October 15, 1980 (P.L.971, No.165), is amended to read:

Section 702. Director and Administration of Fund.--(a) The fund shall be <u>supervised and</u> administered by a [director who shall be appointed by the Governor and whose salary shall be fixed by the Executive Board.] <u>Board of Directors.</u>

<u>(1) The board shall consist of seven members appointed by the Governor in accordance with the following:</u>

<u>(i) One physician shall be appointed for a three-year term, and one physician shall be appointed for a one-year term.</u>

(ii) One representative of a hospital shall be appointed for a three-year term, and one representative of a hospital shall be appointed for a one-year term.

(iii) One representative of the public at large shall be appointed for a two-year term.

(iv) One representative of a casualty insurer with a 1% or less share of the medical malpractice insurance market in this Commonwealth shall be appointed for a two-year term.

(v) One podiatrist or one representative of a nursing home shall be appointed for a three-year term. The podiatrist and the representative of a nursing home shall alternate terms.

(vi) After the initial terms under this paragraph have been completed, all terms shall be for a period of three years.

(2) No member of the board may serve more than two successive terms.

(3) Board members may be reimbursed by the fund for reasonable expenses incurred in the performance of duties of office.

(4) The [director] board may employ a director and [fix the compensation of such clerical and other assistants] staff as [may be deemed] necessary [and].

(a.1) The fund may promulgate rules and regulations [relating to] consistent with this act regarding the establishment and operation of the fund, including procedures [for] related to the payment of surcharges and the reporting of claims to the fund.

(b) The [director] fund shall be provided with adequate offices in which the records shall be kept and official business shall be transacted, and the [director] fund shall also be provided with necessary office furniture and other supplies.

1 ~~{~~(c) The basic coverage insurance carrier or self-insured <——
2 provider shall promptly notify the **[**director of any case where <——
3 it reasonably believes that the value of the claim exceeds the
4 basic insurer's coverage or self-insurance plan or falls under
5 section 605. Such information shall be confidential,
6 notwithstanding the act of July 19, 1974 (P.L.486, No.175)
7 referred to as the Public Agency Open Meeting Law, and act of
8 June 21, 1957 (P.L.390, No.212) referred to as the Right To Know
9 Law**]** FUND. Failure to so notify the **[**director**]** FUND shall make <——
10 the basic coverage insurance carrier or self-insured provider
11 responsible for the payment of the entire award or verdict,
12 provided that the fund has been prejudiced by the failure of
13 notice.~~}~~ <——
14 (d) The basic coverage insurance carrier or self-insured
15 provider shall be responsible to provide a defense to the claim,
16 including defense of the fund, except as provided for in section
17 605. [In such instances where the director has been notified in
18 accordance with subsection (c), the director may, at his option,
19 join in the defense and be represented by counsel.]
20 (e) [In the event that the basic coverage insurance carrier
21 or self-insured provider enters into a settlement with the
22 claimant to the full extent of its liability as provided above,
23 it may obtain a release from the claimant to the extent of its
24 payment, which payment shall have no effect upon any excess
25 claim against the fund or its duty to continue the defense of
26 the claim.] Until December 31, 1995, the fund has the
27 responsibility to settle or compromise claims payable by the
28 fund, subject to concurrence by the basic coverage insurance
29 carrier or self-insured provider.
30 (f) [The director is authorized] After December 31, 1995,

the basic coverage insurance carrier or self-insured provider shall be responsible to defend, litigate, settle or compromise any claim payable by the fund. [A health care provider's basic insurance coverage carrier shall have the right to approve any settlement entered into by the director on behalf of its insured health care provider. If the basic insurance coverage carrier does not disapprove a settlement prior to execution by the director, it shall be deemed approved by the basic insurance coverage carrier. In the event that more than one health care provider defendant is party to a settlement, the health care provider's basic insurance coverage carrier shall have the right to approve only that portion of the settlement which is contributed on behalf of its insured health care provider.]

(g) The [director] fund is hereby empowered to purchase, on behalf of the fund, as much insurance or re-insurance as is necessary to preserve the fund.

[(h) Nothing in this act shall preclude the director from adjusting or paying for the adjustment of claims.]

~~(i) The basic insurance carrier and the fund are liable for any act committed in bad faith and are liable for payment of the entire award on verdict in such instances.~~ <—

~~(j) Upon the request of a party to a case within the fund coverage limits, and with the agreement of the other parties to the case, the fund may provide for a mediator in instances where multiple carriers disagree on a case.~~

(I) THE FUND SHALL BE LIABLE FOR ANY ACTIONS TAKEN, COMMITTED OR OMITTED, IN BAD FAITH UNDER THIS ACT AND IS LIABLE FOR PAYMENT OF THE ENTIRE AWARD ON VERDICT IN SUCH INSTANCES. IF AND TO THE EXTENT THAT A BASIC INSURANCE CARRIER OR SELF-INSURED PROVIDER ACTS FOR OR ON BEHALF OF THE FUND UNDER THIS ACT, <—

WHETHER AS AN AGENT OR DELEGATEE, THE BASIC INSURANCE CARRIER OR SELF-INSURED PROVIDER, AS APPLICABLE, SHALL BE LIABLE UNDER THIS SUBSECTION.

(J) UPON THE REQUEST OF A PARTY TO A CASE WITHIN THE FUND COVERAGE LIMITS, THE FUND MAY PROVIDE FOR A MEDIATOR IN INSTANCES WHERE MULTIPLE CARRIERS DISAGREE ON A CASE. UPON THE CONSENT OF ALL PARTIES TO ANY PROCEEDING HEREUNDER THAT MEDIATION SHALL BE BINDING, THE PARTIES SHALL BE BOUND BY THE CONCLUSIONS OF THE MEDIATOR. THE FUND SHALL PROMULGATE SUCH RULES AND REGULATIONS AS ARE NECESSARY TO IMPLEMENT THIS PROVISION. PROCEEDINGS CONDUCTED UNDER THIS SECTION SHALL BE CONFIDENTIAL AND SHALL NOT BE CONSIDERED PUBLIC INFORMATION SUBJECT TO DISCLOSURE UNDER THE ACT OF JUNE 21, 1957 (P.L.390, NO.212), REFERRED TO AS THE RIGHT-TO-KNOW LAW, AND THE ACT OF JULY 3, 1986 (P.L.388, NO.84), KNOWN AS THE "SUNSHINE ACT."

(k) Delay damages and postjudgment interest applicable to the fund's liability in a case shall be paid by the fund and shall not be charged against the insured's annual aggregate limits.

(l) The fund coverage limits shall be exempt from requirements to furnish appeal bonds.

(m) The fund shall determine who is a health care provider for the purpose of having access to the liability coverage provided by the fund.

(N) THE FUND SHALL HAVE THE AUTHORITY TO BORROW MONEY FOR <—— PERIODS OF LESS THAN ONE YEAR IN ORDER TO PAY CLAIMS AND EXPENSES UNTIL SUFFICIENT REVENUES ARE REALIZED BY THE FUND THROUGH THE SEMIANNUAL SURCHARGES.

Section 5. Section 705 of the act, added July 15, 1976 (P.L.1028, No.207), is amended to read:

Section 705. Liability of Excess Carriers.--(a) No insurer providing excess professional liability insurance to any health care provider eligible for coverage under the [Medical Professional Liability Catastrophe Loss Fund] fund shall be liable for payment of any claim against a health care provider for any loss or damages except those in excess of the fund coverage limits [of liability provided by the Medical Professional Liability Catastrophe Loss Fund].

(b) No carrier providing excess professional liability insurance for a health care provider covered by the [Medical Professional Catastrophe Loss Fund] fund shall be liable for any loss resulting from the insolvency or dissolution of the [catastrophe loss] fund.

Section 6. Section 803 of the act, amended October 15, 1980 (P.L.971, No.165), is amended to read:

Section 803. Plan Operation, Rates and Deficits.--(a) Subject to the supervision and approval of the commissioner, insurers may consult and agree with each other and with other appropriate persons as to the organization, administration and operation of the plan and as to rates and rate modifications for insurance coverages provided under the plan. Rates and rate modifications adopted or changed for insurance coverages provided under the plan shall be approved by the commissioner in accordance with the act of June 11, 1947 (P.L.538, No.246), known as "The Casualty and Surety Rate Regulatory Act," except as may be inconsistent with subsection (c).

(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] fund and the commissioner. Such certification shall be subject to the review and approval of the [Insurance Commissioner] 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. 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, loss adjustment expenses and reserves, including reserves for: (1) losses incurred, (2) losses incurred but not reported, (3) loss adjustment expenses, (4) unearned premiums.

(c) Within 60 days following the certification that the Joint Underwriting Association has suffered a deficit, as set forth in subsection (b), the board of directors of the Joint Underwriting Association shall file with the [Insurance Commissioner and the Insurance Commissioner] commissioner and the commissioner shall approve a premium increase sufficient to generate the requisite income to:

(1) reimburse the fund for any payment made by the fund to compensate for said deficit; and

(2) increase premiums to a level actuarially sufficient to avoid an operating deficit by the Joint Underwriting Association during the following 12 months.

The Joint Underwriting Association shall reimburse the fund with interest at a rate equal to that earned by the fund on its invested assets within one year of any payment made by the fund as compensation for any deficit incurred by the Joint Underwriting Association.

Section 7. Section 809 of the act is amended to read:

Section 809. [Annual Reports to Insurance Commissioner.--The plan shall report to the commissioner annually on a date and, on a form prescribed by the commissioner the total amount of premium dollars collected,] Reports to Commissioner and Claims Information.--(a) Ten days after the close of a claims period, basic coverage insurance carriers and self-insured providers shall report to the fund the claims information specified in subsection (b).

(b) Thirty days after the close of a claims period, the fund shall prepare a report for the commissioner. The report shall contain the total amount of claims paid and expenses incurred therewith, the total amount of reserve set aside for future claims, the nature and substance of each claim, the date and place in which each claim arose, the amounts paid, if any, and the disposition of each claim (judgment of arbitration panel, judgment of court, settlement or otherwise)[, and such additional information as the commissioner shall require]. For final claims during the claims period, the report shall include details by basic coverage insurance carriers and self-insured providers of the amount of surcharge collected, the number of reimbursements paid and the amount of reimbursements paid.

(c) If, in two consecutive claims periods, a basic coverage insurance carrier or self-insured provider receives reimbursement proportionately higher than the amount of surcharges collected from them, the board shall investigate the reasons for this occurrence. If more than one basic coverage insurance carrier or self-insured provider receives reimbursement proportionately higher than the amount remitted to the fund, the board's investigation shall be limited to the two

basic coverage insurance carriers or self-insured providers with the proportionately highest ratios. The board shall consider pre-1995 ratios of reimbursement to surcharge remitted by the basic coverage insurance carrier or self-insured provider in its investigation. If the board finds, in an adjudication, that a basic coverage insurance carrier or self-insured provider is not administering claims in a manner consistent with the adequate protection of the assets of the fund, the board may require the basic coverage insurance carrier or self-insured provider to seek and obtain prior approval of the fund before committing the fund coverage limits to the settlement of a claim for a stated period of time, known as a probationary period, not to exceed one year. Adjudications under this subsection are subject to 2 Pa.C.S. Ch. 5 Subch. A (relating to practice and procedure of Commonwealth agencies) and Ch. 7 Subch. A (relating to judicial review of Commonwealth agency action).

(d) During the probationary period under subsection (c), the following shall apply:

(1) The basic coverage insurance carrier or self-insured provider shall promptly notify the fund of any case where it reasonably believes that the value of the claim exceeds the basic insurer's coverage or self-insurance plan or falls under section 605. Upon failure to notify under this paragraph, the basic coverage insurance carrier or self-insured provider shall be responsible for the payment of the entire award or verdict if the fund has been prejudiced by the failure.

(2) The fund must approve any settlement which represents a liability of the fund entered into by the basic coverage insurance carrier or self-insured provider on behalf of its insured health care provider.

(e) Claim information shall be confidential and shall not be considered public information subject to disclosure under the act of June 21, 1957 (P.L.390, No.212), referred to as the Right-to-Know Law, or the act of July 3, 1986 (P.L.388, No.84), known as the "Sunshine Act."

Section 8. Sections 811 and 1006 of the act, amended or added November 26, 1978 (P.L.1324, No.320), are amended to read:

Section 811. [Professional Corporations, Professional Associations and Partnerships] Health Care Practice Entities.--

(a) The Joint Underwriting Association shall offer basic coverage insurance to [such professional corporations, professional associations and partnerships entirely owned by health care providers] health care practice entities who cannot conveniently obtain insurance through ordinary methods at rates not in excess of those applicable to similarly situated [professional corporations, professional associations and partnerships.] health care practice entities.

(b) In the event that a [professional corporation, professional association or partnership entirely owned by health care providers] health care practice entity elects to be covered by basic coverage insurance and upon payment of the [annual] surcharge as required by section 701(e), the [professional corporation, professional association or partnership] health care practice entity shall be entitled to such excess coverage from the [Medical Professional Liability Catastrophe Loss Fund] fund as is provided in this act.

(c) Any [professional corporation, professional association, or partnership] health care practice entity which acquires basic coverage insurance from the Joint Underwriting Association pursuant to subsection (a) or from an insurer licensed or

approved by the Commonwealth of Pennsylvania shall be required to participate in and contribute to the [Medical Professional Liability Catastrophe Loss Fund] fund as provided in this act.

(d) Any [professional corporation, professional association or partnership] health care practice entity which participates in or contributes to the [Medical Professional Liability Catastrophe Loss Fund] fund shall be subject to all other provisions of this act. The fund is responsible for making the determination of whether a health care practice entity is entitled to fund coverage.

Section 1006. Joint Committee.--There is hereby created a committee to consist of the commissioner as chairman, the Secretary of Health and two members of the Senate, one member of each party, to be appointed by the President pro tempore and two members of the House of Representatives, one member of each party, to be appointed by the Speaker of the House of Representatives. The committee shall study the distribution of professional liability insurance costs as among the various classes of physicians and health care providers and shall report its findings and recommendations to the General Assembly within one year of the effective date of this act. The committee shall also study all phases and the financial impact of the operations of the [Medical Professional Liability Catastrophe Loss Fund] fund and shall report its findings and recommendations to the General Assembly on or before July 1, 1977. This committee shall also study actual or potential problems of conflicts of interest which exist or may exist among members of the arbitration panel with each other and with other persons appearing before the arbitration panel or having their interests represented before the arbitration panel. The committee shall promulgate a proposed

Code of Ethics with suggested legal sanctions to deal with any violators of the Code of Ethics on or before July 1, 1976. This committee shall study the act, its application and operation to determine if any changes in the present act are necessary or advisable. This study shall include consideration of the advisability and potential effect of the application of the act to mental health/mental retardation facilities. The committee shall report on this study on or before July 1, 1979 and each year thereafter.

Section 9. This act shall take effect immediately.