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THE GENERAL ASSEMBLY OF PENNSYLVANIA

HOUSE BILL

No. 2645 Session of 2002

INTRODUCED BY TANGRETTI, DeLUCA, BLAUM, CURRY, DALEY, FREEMAN, GEORGE, GRUCELA, HORSEY, JOSEPHS, LEVDANSKY, MELIO, MICHLOVIC, PALLONE, PISTELLA, SHANER, SOLOBAY, STABACK, STEELMAN, THOMAS, TIGUE, TRICH, WANSACZ AND J. WILLIAMS, MAY 8, 2002

REFERRED TO COMMITTEE ON INSURANCE, MAY 8, 2002

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 definitions, for medical professional liability insurance, for the Medical Care Availability and Reduction of Error Fund, for podiatrist liability, for business combinations and for actuarial data; and authorizing the Medical Care Availability and Reduction of Error Fund to write malpractice insurance.

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

Section 1. Section 702 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 by adding a

definition to read:

Section 702. Definitions.

The following words and phrases when used in this chapter shall have the meanings given to them in this section unless the context clearly indicates otherwise:

* * *

"Subscriber." A health care provider or hospital that purchases insurance from the fund under Subchapter E.

Section 2. Sections 711(d), (e), (g) and (h), 712(a), (d), (e), (k) and (l), 716, 744 and 745 of the act are amended to read:

Section 711. Medical professional liability insurance.

* * *

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

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

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

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

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

(2) For policies issued or renewed in the calendar years

2003[, 2004 and 2005] and thereafter, the basic insurance coverage shall be:

(i) [$500,000] $1,000,000 per occurrence or claim and [$1,500,000] $3,000,000 per annual aggregate for a [participating] 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) [$500,000] $1,000,000 per occurrence or claim and [$2,500,000] $4,500,000 per annual aggregate for a hospital.

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

(i) $750,000 per occurrence or claim and $2,250,000 per annual aggregate for a participating 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) $750,000 per occurrence or claim and $3,750,000 per annual aggregate for a hospital.

If the commissioner finds pursuant to section 745(a) that additional basic insurance coverage capacity is not available, the basic insurance coverage requirements shall remain at the level required by paragraph (2); 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.

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

(i) $1,000,000 per occurrence or claim and $3,000,000 per annual aggregate for a participating 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.]

(e) Fund participation.--

(1) A participating health care provider shall be required to participate in the fund. This paragraph shall expire January 1, 2003.

(2) A participating health care provider and a subscriber shall be subject to assessment by the fund.

* * *

(g) Basic insurance liability.--

(1) An insurer providing medical professional liability insurance shall not be liable for payment of a claim against a health care provider for any loss or damages awarded in a medical professional liability action in excess of the basic insurance coverage required by subsection [(d)] (d)(1) unless the health care provider's medical professional liability insurance policy or self-insurance plan provides for a higher limit.

(2) If a claim under a policy referred to in subsection (d)(1) exceeds the limits of a participating health care provider's basic insurance coverage or self-insurance plan, the fund shall be responsible for payment of the claim against the participating health care provider up to the fund liability limits.

(h) Excess insurance.--

(1) No insurer providing medical professional liability insurance with liability limits under subsection (d)(1) in excess of the fund's liability limits to a participating health care provider shall be liable for payment of a claim against the participating health care provider for a loss or damages in a medical professional liability action, except the losses and damages in excess of the fund coverage limits.

(2) No insurer providing medical professional liability insurance with liability limits under subsection (d)(1) in excess of the fund's liability limits to a participating health care provider shall be liable for any loss resulting

from the insolvency or dissolution of the fund.

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:

(1) pay claims against subscribers;

(2) 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] 711(d)(1);

(3) pay for the administration of the fund.

* * *

(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, by premiums under Subchapter E and by earnings on the premiums. 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.

(3) Any appeal of the assessment shall be filed with the department.

(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, if assessments are being imposed, 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)] assessments are being imposed, the department may discount the aggregate assessment imposed under subsection [(d)] (d)(1) by an amount not to exceed the aggregate sum to be deposited in the fund in accordance with subsection (m).

* * *

(k) Termination.--Upon satisfaction of all liabilities of the fund under section 711(g), the fund shall [terminate] operate only under Subchapter E. [Any] Upon satisfaction under this subsection, any balance remaining in the fund [upon such termination] derived from assessments and earnings on

assessments 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) and Subchapter E, 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.

* * *

Section 716. Podiatrist liability.

Within two years of the effective date of this chapter, the department shall calculate the amount necessary to arrange for the separate retirement of the fund's liabilities under section 711(g) associated with podiatrists. Any arrangement shall be on terms and conditions proportionate to the individual liability of the class of health care provider. The arrangement may result in assessments for podiatrists different from the assessments for other health care providers. Upon satisfaction of the arrangement, podiatrists shall not be required to contribute to or be entitled to participate in the fund. In cases where the class rejects an arrangement, the department shall present to the provider class new term arrangements at least once in every two-year period. All costs and expenses associated with the

completion and implementation of the arrangement shall be paid by podiatrists and may be charged in the form of an addition to the assessment.

Section 744. Professional corporations, professional associations and partnerships.

A professional corporation, professional association or partnership which is entirely owned by health care providers and which elects to purchase basic insurance coverage in accordance with section 711 from the joint underwriting association or from an insurer licensed or approved by the department shall:

(1) before January 1, 2003, be required to participate in the fund and, upon payment of the assessment required by section 712, be entitled to coverage from the fund; and

(2) after December 31, 2002, not be required to participate in the fund but be subject to assessment by the fund under section 712.

Section 745. Actuarial data.

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

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

[(2) By July 1, 2005, the commissioner shall conduct a study regarding the availability of additional basic insurance coverage capacity. The study shall include an estimate of the total change in medical professional liability insurance loss-cost resulting from implementation

of this act prepared by an independent actuary. The fee for the independent actuary shall be borne by the fund. In developing the estimate, the independent actuary shall consider all of the following:

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

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

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

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

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

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

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

Section 3. Chapter 7 of the act is amended by adding a subchapter to read:

SUBCHAPTER E

MCARE FUND BASIC COVERAGE

Section 751. Basic insurance coverage.

The department shall utilize the fund to provide basic insurance coverage as required under section 711(d)(2) to subscribers.

Section 752. Underwriting.

For insurance under section 751, the department has the following powers and duties:

(1) Determine whether to issue a policy and the amount of premium in accordance with the following:

(i) The nature of the subscriber's practice.

(ii) The subscriber's claims record and risk history.

(2) Permit self-insurance in an amount of not more than $100,000, in accordance with the following:

(i) A subscriber must submit a plan as required by the department.

(ii) A subscriber must submit an application fee set by the department.

(iii) The plan must be acceptable to the department.

(3) Include in the premium charge, an applicable assessment under section 711(e).

(4) Maintain capital in an amount sufficient to do all of the following:

(i) Pay estimated claims. The amount under this subparagraph shall not be less than $750,000.

(ii) Maintain a minimum surplus of $350,000.

(iii) Meet any solvency requirements that are required by State law for similar insurance companies.

Section 4. This act shall take effect as follows:

(1) The addition of Subchapter E of Chapter 7 of the act shall take effect January 1, 2003.

(2) This section shall take effect immediately.

(3) The remainder of this act shall take effect in 60 days.