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THE GENERAL ASSEMBLY OF PENNSYLVANIA

HOUSE BILL

No. 980 Session of 2003

INTRODUCED BY BARD, GODSHALL, SCHRODER, LEWIS, CRAHALLA, REICHLEY, WATSON, CAPPELLI, CREIGHTON AND BENNINGHOFF, APRIL 29, 2003

REFERRED TO COMMITTEE ON INSURANCE, APRIL 29, 2003

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 medical professional liability insurance, for Medical Care Availability and Reduction of Error Fund and for extended claims; providing for filing of rates; and further providing for actuarial data.

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

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

(1.1) For policies issued or renewed in the calendar year 2003, the basic insurance coverage shall be:

(i) $500,000 per occurrence or claim and $1,500,000 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 per occurrence or claim and $1,250,000 per annual aggregate for a hospital.

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

(i) $500,000 per occurrence or claim and $1,500,000

per annual aggregate for a participating health care provider that is not a hospital.

(ii) [$1,000,000] $500,000 per occurrence or claim and [$3,000,000] $1,500,000 per annual aggregate for a nonparticipating health care provider.

(iii) $500,000 per occurrence or claim and $2,500,000 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.]

* * *

Section 2. Section 712(c), (d), (e) and (m) of the act are amended and the section is amended by adding a subsection to read:

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

* * *

(c) Fund liability limits.--

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

[(2) 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 requirement, the limit of liability of the fund shall be $250,000 for each occurrence and $750,000 per annual aggregate.

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

(2) For calendar year 2003, the limit of liability of the fund shall be $500,000 for each occurrence and $1,500,000 per annual aggregate.

(c.1) Coverage elimination.--The commissioner shall eliminate the liability coverage provided by the fund to health

care providers as defined in section 702 no later than December 31, 2003. Upon this action by the commissioner, the limit of liability of the fund shall thereafter be zero for any claims that occur after December 31, 2003.

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

* * *

(m) Supplemental funding.--

[Notwithstanding the provisions of 75 Pa.C.S. § 6506(b) (relating to surcharge) to the contrary, beginning January 1, 2004, and for a period of nine calendar years thereafter, all surcharges levied and collected under 75 Pa.C.S. § 6506(a) by any division of the unified judicial system shall be remitted to the Commonwealth for deposit in the Medical Care Availability and Restriction of Error Fund. These funds shall be used to reduce surcharges and assessments in accordance with subsection (e). Beginning January 1, 2014, and each year thereafter, the surcharges levied and collected under 75 Pa.C.S. § 6506(a) shall be deposited into the General Fund.]

Revenue collected under section 1206 of the act of March 4, 1971 (P.L.6, No.2), known as the Tax Reform Code of 1971, in excess of $.05 per cigarette shall be deposited in the fund. These funds shall be used to reduce surcharges and assessments for calendar year 2003 and thereafter. This subsection shall expire when the fund terminates under subsection (k).

* * *

Section 3. Sections 715(a) and 745 of the act are amended to

read:

Section 715. Extended claims.

(a) General rule.--If a medical professional liability claim against a health care provider who was required to participate in the Medical Professional Liability Catastrophe Loss Fund under section 701(d) of the act of October 15, 1975 (P.L.390, No.111), known as the Health Care Services Malpractice Act, is made more than four years after the breach of contract or tort occurred and if the claim is filed within the applicable statute of limitations and statute of repose, the claim shall be defended by the department if the department received a written request for indemnity and defense within 180 days of the date on which notice of the claim is first given to the participating health care provider or its insurer. Where multiple treatments or consultations took place less than four years before the date on which the health care provider or its insurer received notice of the claim, the claim shall be deemed for purposes of this section to have occurred less than four years prior to the date of notice and shall be defended by the insurer in accordance with this chapter.

* * *

Section 745. Actuarial data.

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

(1)] No later than April 1, 2005, 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] section.

[(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 4. This act shall take effect in 60 days.