PRINTER'S NO. 66

THE GENERAL ASSEMBLY OF PENNSYLVANIA

SENATE BILL

No. 76

Session of 2005

INTRODUCED BY GREENLEAF, ORIE AND BOSCOLA, JANUARY 31, 2005

REFERRED TO BANKING AND INSURANCE, JANUARY 31, 2005

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 actuarial data.

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

Section 1. Section 711(d) 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 and the section is amended by adding subsections 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, 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 $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.]

(d.1) Experience rating.--

(1) For the calendar year 2006, and each year thereafter, a health care provider, other than a hospital, shall insure or self-insure its professional liability in the amount mandated by the department's experience rating system, which shall not be more than $1,000,000 and less than $250,000.

(2) The department shall establish an experience rating system which shall be utilized by insurers in determining the amount of medical professional liability insurance a health care provider must obtain in order to provide health care in this Commonwealth. The system shall include, but not be limited to, the following criteria: number of years free from serious and valid claims, frequency and severity of claims, payout level of any settlements or jury verdicts, any suspensions or disciplinary actions by a State licensing board or hospital and degree of fault.

(3) If the commissioner finds pursuant to section 745(a) that additional basic insurance coverage capacity is

available, the commissioner shall, to the extent possible, increase the percentage of basic insurance coverage and decrease the percentage of fund coverage that comprises a health care provider's total mandated medical professional liability coverage level based on the health care provider's experience rating. The commissioner shall conduct a study every two years similar to the initial study required under section 745(a).

(d.2) Disclosure of coverage.--A health care provider shall, upon implementation of the department's experience rating system under subsection (d.1), provide notice to the health care provider's patients of the level of medical professional liability coverage the health care provider is required to maintain. The notice shall be printed on any consent form that the patients must sign for a medical procedure.

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Section 2. Section 712(c) of the act is amended 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.]

(3) The limit of liability of the fund for each participating health care provider for calendar years 2003, 2004 and 2005 shall be $500,000 for each occurrence and $1,500,000 per annual aggregate.

* * *

Section 3. Section 745(b) of the act is repealed.

Section 4. This act shall take effect in 60 days.