PRIOR PRINTER'S NO. 1488 PRINTER'S NO. 1491

THE GENERAL ASSEMBLY OF PENNSYLVANIA

SENATE BILL

No. 1137 Session of 2007

INTRODUCED BY D. WHITE, RAFFERTY, PILEGGI, ORIE, SCARNATI, ROBBINS, ERICKSON, GORDNER, C. WILLIAMS AND FONTANA, OCTOBER 23, 2007

SENATOR D. WHITE, BANKING AND INSURANCE, AS AMENDED, OCTOBER 24, 2007

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 and for the Medical Care Availability and Reduction of Error Fund; providing for the Medical Care Availability and Reduction of Error (Mcare) Reserve Fund; and further providing for abatement program, for the Health Care Provider Retention Account and for expiration.

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

Section 1. Sections 711 and 712 of the act of March 20, 2002 (P.L.154, No.13), known as the Medical Care Availability and Reduction of Error (Mcare) Act, are amended to read:

Section 711. Medical professional liability insurance.

(a) Requirement.--A health care provider providing health care services in this Commonwealth shall:

(1) purchase medical professional liability insurance from an insurer which is licensed or approved by the department; or

(2) provide self-insurance.

(b) Proof of insurance.--A health care provider required by subsection (a) to purchase medical professional liability insurance or provide self-insurance shall submit proof of insurance or self-insurance to the department within 60 days of the policy being issued.

(c) Failure to provide proof of insurance.--If a health care provider fails to submit the proof of insurance or self-insurance required by subsection (b), the department shall, after providing the health care provider with notice, notify the health care provider's licensing authority. A health care provider's license shall be suspended or revoked by its licensure board or agency if the health care provider fails to comply with any of the provisions of this chapter.

(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) Up to $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) Up to $1,000,000 per occurrence or claim and $3,000,000 per annual aggregate for a nonparticipating health care provider.

(iii) Up to $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] year 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] two years after the increase in coverage limits required by paragraph (3) and for each year thereafter, the basic insurance coverage shall be:

(i) Up to $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) Up to $1,000,000 per occurrence or claim and $3,000,000 per annual aggregate for a nonparticipating health care provider.

(iii) Up to $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] year 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.

(5) THE AMOUNT OF BASIC INSURANCE COVERAGE PER OCCURRENCE OR CLAIM UNDER PARAGRAPHS (3) AND (4) SHALL BE NO LESS THAN $500,000 AND SHALL BE SET IN $50,000 INCREMENTS. <—

(e) Fund participation.--A participating health care provider shall be required to participate in the fund.

(f) Self-insurance.--

(1) If a health care provider self-insures its medical professional liability, the health care provider shall submit its self-insurance plan, such additional information as the department may require and the examination fee to the department for approval.

(2) The department shall approve the plan if it determines that the plan constitutes protection equivalent to the insurance required of a health care provider under subsection (d).

(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) unless the health care provider's medical professional liability insurance policy or self-insurance plan provides for a higher limit.

(2) If a claim 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 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 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.

(i) Governmental entities.--A governmental entity may satisfy its obligations under this chapter, as well as the obligations of its employees to the extent of their employment, by either purchasing medical professional liability insurance or assuming an obligation as a self-insurer, and paying the assessments under this chapter.

(j) Exemptions.--The following participating health care providers shall be exempt from this chapter:

(1) A physician who exclusively practices the specialty of forensic pathology.

(2) A participating health care provider who is a member of the Pennsylvania military forces while in the performance of the member's assigned duty in the Pennsylvania military forces under orders.

(3) A retired licensed participating health care provider who provides care only to the provider or the provider's immediate family members.

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 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 for the administration of the fund.

(b) Transfer of assets and liabilities.--

(1) (i) The money in the Medical Professional Liability Catastrophe Loss Fund established under section 701(d) of the former act of October 15, 1975 (P.L.390, No.111), known as the Health Care Services Malpractice Act, is transferred to the fund.

(ii) The rights of the Medical Professional Liability Catastrophe Loss Fund established under section 701(d) of the former Health Care Services Malpractice Act are transferred to and assumed by the fund.

(2) The liabilities and obligations of the Medical Professional Liability Catastrophe Loss Fund established under section 701(d) of the former Health Care Services Malpractice Act are transferred to and assumed by the 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) or (4) 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] $1,000,000 per occurrence and $3,000,000 per annual aggregate, except hospitals which shall be $1,000,000 per occurrence and $4,500,000 per annual aggregate, minus the amount the commissioner determines for basic insurance coverage under section 711(d)(3) and (4).

(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. <u>The department shall bill and collect the assessment from all participating health care providers.</u>

(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).

(f) Updated rates.--The joint underwriting association shall file updated rates for all health care providers with the commissioner by May 1 of each year. The department shall review and may adjust the prevailing primary premium in line with any applicable changes which have been approved by the commissioner.

(g) Additional adjustments of the prevailing primary premium.--The department shall adjust the applicable prevailing primary premium of each participating health care provider in accordance with the following:

(1) The applicable prevailing primary premium of a participating health care provider which is not a hospital may be adjusted through an increase in the individual participating health care provider's prevailing primary premium not to exceed 20%. Any adjustment shall be based upon the frequency of claims paid by the fund on behalf of the individual participating health care provider during the past five most recent claims periods and shall be in accordance with the following:

(i) If three claims have been paid during the past five most recent claims periods by the fund, a 10% increase shall be charged.

(ii) If four or more claims have been paid during the past five most recent claims periods by the fund, a 20% increase shall be charged.

(2) The applicable prevailing primary premium of a participating health care provider which is not a hospital and which has not had an adjustment under paragraph (1) may be adjusted through an increase in the individual

participating health care provider's prevailing primary premium not to exceed 20%. Any adjustment shall be based upon the severity of at least two claims paid by the fund on behalf of the individual participating health care provider during the past five most recent claims periods.

(3) The applicable prevailing primary premium of a participating health care provider not engaged in direct clinical practice on a full-time basis may be adjusted through a decrease in the individual participating health care provider's prevailing primary premium not to exceed 10%. Any adjustment shall be based upon the lower risk associated with the less-than-full-time direct clinical practice.

(4) The applicable prevailing primary premium of a hospital may be adjusted through an increase or decrease in the individual hospital's prevailing primary premium not to exceed 20%. Any adjustment shall be based upon the frequency and severity of claims paid by the fund on behalf of other hospitals of similar class, size, risk and kind within the same defined region during the past five most recent claims periods.

(h) Self-insured health care providers.--A participating health care provider that has an approved self-insurance plan shall be assessed an amount equal to the assessment imposed on a participating health care provider of like class, size, risk and kind as determined by the department.

(i) Change in basic insurance coverage.--If a participating health care provider changes the term of its medical professional liability insurance coverage, the assessment shall be calculated on an annual basis and shall reflect the assessment percentages in effect for the period over which the

policies are in effect.

(j) Payment of claims.--Claims which became final during the preceding claims period shall be paid on or before December 31 following the August 31 on which they became final.

(k) Termination.--Upon satisfaction of all liabilities of the fund, the fund shall terminate. Any balance remaining in the fund upon such termination 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), 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.

(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.

(n) Waiver of right to consent to settlement.--A participating health care provider may maintain the right to consent to a settlement in a basic insurance coverage policy for medical professional liability insurance upon the payment of an additional premium amount.

Section 2. Chapter 7 of the act is amended by adding subchapters to read:

SUBCHAPTER E

MEDICAL CARE AVAILABILITY AND REDUCTION OF ERROR (MCARE) RESERVE FUND

Section 751. Establishment.

There is established within the State Treasury a special fund to be known as the Medical Care Availability and Reduction of Error (Mcare) Reserve Fund.

Section 752. Allocation.

Money in the Medical Care Availability and Reduction of Error (Mcare) Reserve Fund shall be allocated annually as follows:

(1) Fifty percent of the total amount in the Medical Care Availability and Reduction of Error (Mcare) Reserve Fund shall remain in the Medical Care Availability and Reduction of Error (Mcare) Reserve Fund for the sole purpose of reducing the unfunded liability of the fund.

(2) Twenty-five percent of the total amount in the Medical Care Availability and Reduction of Error (Mcare) Reserve Fund shall be transferred to the Patient Safety Trust Fund for use by the Department of Public Welfare for implementing section 407.

(3) Twenty-five percent of the total amount in the

Medical Care Availability and Reduction of Error (Mcare) Reserve Fund shall be transferred to the Medical Safety Automation Fund.

SUBCHAPTER F

MEDICAL SAFETY AUTOMATION FUND

Section 762. Medical Safety Automation Fund established.

There is established within the State Treasury a special fund to be known as the Medical Safety Automation Fund. No money in the Medical Safety Automation Fund shall be used until legislation is enacted for the purpose of providing medical safety automation system grants to health care providers under the act of July 19, 1979 (P.L.130, No.48), known as the Health Care Facilities Act, a group practice or a community-based health care provider.

Section 3. Section 1102 of the act, amended October 27, 2006 (P.L.1198, No.128), is amended to read:

Section 1102. Abatement program.

(a) Establishment.--There is hereby established within the Insurance Department a program to be known as the Health Care Provider Retention Program. The Insurance Department, in conjunction with the Department of Public Welfare, shall administer the program. The program shall provide assistance in the form of assessment abatements to health care providers for calendar years 2003, 2004, 2005, 2006 [and], 2007 and 2008, except that licensed podiatrists shall not be eligible for calendar years 2003 and 2004, and nursing homes shall not be eligible for calendar years 2003, 2004 and 2005.

(b) Other abatement.--Emergency physicians not employed full time by a trauma center or working under an exclusive contract with a trauma center shall retain eligibility for an abatement

pursuant to section 1104(b)(2) for calendar years 2003, 2004, 2005 and 2006. Commencing in calendar year 2007, these emergency physicians shall be eligible for an abatement pursuant to section 1104(b)(1).

Section 4. Section 1112 of the act, added December 22, 2005 (P.L.458, No.88), is amended to read:

Section 1112. Health Care Provider Retention Account.

(a) Fund established.--There is established within the General Fund a special account to be known as the Health Care Provider Retention Account. Funds in the account shall be subject to an annual appropriation by the General Assembly to the Department of Public Welfare. The Department of Public Welfare shall administer funds appropriated under this section consistent with its duties under section 201(1) of the act of June 13, 1967 (P.L.31, No.21), known as the Public Welfare Code.

(b) Transfers from Mcare Fund.--By December 31 of each year, the Secretary of the Budget may transfer from the Medical Care Availability and Reduction of Error (Mcare) Fund established in section 712(a) to the account an amount equal to the difference between the amount deposited under section 712(m) and the amount granted as discounts under section 712(e)(2) for that calendar year.

(c) Transfers from account.--The Secretary of the Budget may annually transfer from the account to the Medical Care Availability and Reduction of Error (MCARE) Fund an amount up to the aggregate amount of abatements granted by the Insurance Department under section 1104(b).

(c.1) Transfers to the Medical Care Availability and Reduction of Error (Mcare) Reserve Fund.--If the Secretary of the Budget makes a transfer from the account under subsection

(c), the remaining funds in the account shall be transferred to the Medical Care Availability and Reduction of Error (Mcare) Reserve Fund. If the Secretary of the Budget does not make a transfer from the account under subsection (c), all of the funds in the account shall be transferred to the Medical Care Availability and Reduction of Error (Mcare) Reserve Fund.

(d) Other deposits.--The Department of Public Welfare may deposit any other funds received by the department which it deems appropriate in the account.

(e) Administration assistance.--The Insurance Department shall provide assistance to the Department of Public Welfare in administering the account.

Section 5. Section 1115 of the act, amended October 27, 2006 (P.L.1198, No.128), is amended to read:

Section 1115. Expiration.

The Health Care Provider Retention Program established under this chapter shall expire December 31, [2008] 2009.

Section 6. Section 5106 of the act is amended to read:

Section 5106. Expiration.

Section 312 shall expire on December 31, [2007] 2008.

Section 7. This act shall take effect in 60 days.