**SELECTED PARTS OF**

**ACT NO. 13**

**HOUSE BILL NO. 1802**

**2002 Pa. ALS 13; 2002 Pa. Laws 13; 2001 Pa. HB 1802**

**TABLE OF CONTENTS**

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

## CHAPTER 1

## PRELIMINARY PROVISIONS

**Section 101. Short title.**

This act shall be known and may be cited as the Medical Care Availability and Reduction of Error (Mcare) Act.

**Section 102. Declaration of policy.** The General Assembly finds and declares as follows:

(1) It is the purpose of this act to ensure that medical care is available in this Commonwealth through a comprehensive and high-quality health care system.

(2) Access to a full spectrum of hospital services and to highly trained physicians in all specialties must be available across this Commonwealth.

(3) To maintain this system, medical professional liability insurance has to be obtainable at an affordable and reasonable cost in every geographic region of this Commonwealth.

(4) A person who has sustained injury or death as a result of medical negligence by a health care provider must be afforded a prompt determination and fair compensation.

(5) Every effort must be made to reduce and eliminate medical errors by identifying problems and implementing solutions that promote patient safety.

(6) Recognition and furtherance of all of these elements is essential to the public health, safety and welfare of all the citizens of Pennsylvania.

**Section 103. Definitions.**

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

"Birth center." An entity licensed as a birth center under the act of July 19, 1979 (P.L.130, No. 48), known as the Health Care Facilities Act.

"Claimant." A patient, including a patient's immediate family, guardian, personal representative or estate.

"Commissioner." The Insurance Commissioner of the Commonwealth.

"Guardian." A fiduciary who has the care and management of the estate or person of a minor or an incapacitated person.

"Health care provider." A primary health care center or a person, including a corporation, university or other educational institution licensed or approved by the Commonwealth to provide health care or professional medical services as a physician, a certified nurse midwife, a podiatrist, hospital, nursing home, birth center, and except as to section 711(a), an officer, employee or agent of any of them acting in the course and scope of employment.

"Hospital." An entity licensed as a hospital under the act of June 13, 1967 (P.L.31, No. 21), known as the Public Welfare Code, or the act of July 19, 1979 (P.L.130, No. 48), known as the Health Care Facilities Act.

"Immediate family." A parent, a spouse, a child or an adult sibling residing in the same household.

"Medical professional liability action." any proceeding in which a medical professional liability claim is asserted, including an action in a court of law or an arbitration proceeding.

"Medical professional liability claim." any claim seeking the recovery of damages or loss from a health care provider arising out of any tort or breach of contract causing injury or death resulting from the furnishing of health care services which were or should have been provided.

"Nursing home." An entity licensed as a nursing home under the act of July 19, 1979 (P.L.130, No. 48), known as the Health Care Facilities Act.

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

"Personal representative." An executor or administrator of a patient's estate.

"Primary health center." 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.

**Section 104. Liability of nonqualifying health care providers.**

Any person rendering services normally rendered by a health care provider who fails to qualify as a health care provider under this act is subject to liability under the law without regard to the provisions of this act.

**Section 105. Provider not a warrantor or guarantor.**

In the absence of a special contract in writing, a health care provider is neither a warrantor nor a guarantor of a cure.

# CHAPTER 7

# INSURANCE

## SUBCHAPTER A

## PRELIMINARY PROVISIONS

### Section 701. Scope.

This chapter relates to medical professional liability insurance.

### 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:

"Basic insurance coverage." The limits of medical professional liability insurance required under section 711(d).

"Claims made." Medical professional liability insurance that insures those claims made or reported during a period which is insured and excludes coverage for a claim reported subsequent to the period even if the claim resulted from an occurrence during the period which was insured.

"Claims period." The period from September 1 to the following August 31.

"Deficit." A joint underwriting association loss which exceeds the sum of earned premiums collected by the joint underwriting association and investment income.

"Department." The Insurance Department of the Commonwealth.

"Fund." The Medical Care Availability and Reduction of Error (Mcare) Fund established in section 712.

"Fund coverage limits." The coverage provided by the Medical Care Availability and Reduction of Error Fund under section 712.

"Government." 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 business or practice." The number of patients to whom health care services are rendered by a health care provider within an annual period.

"Health care provider." A participating health care provider or nonparticipating health care provider.

"Joint underwriting association." The Pennsylvania Professional Liability Joint Underwriting Association established in section 731.

"Joint underwriting association loss." The sum of the administrative expenses, taxes, losses, loss adjustment expenses, unearned premiums and reserves, including reserves for losses incurred and losses incurred but not reported, of the joint underwriting association.

"Licensure authority." The State Board of Medicine, the State Board of Osteopathic Medicine, the State Board of Podiatry, the Department of Public Welfare and the Department of Health.

"Medical professional liability insurance." 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.

"Nonparticipating health care provider." A health care provider as defined in section 103 that conducts 20% or less of its health care business or practice within this Commonwealth.

"Participating health care provider." A health care provider as defined in section 103 that conducts more than 20% of its health care business or practice within this Commonwealth or a nonparticipating health care provider who chooses to participate in the fund.

"Prevailing primary premium." The schedule of occurrence rates approved by the commissioner for the joint underwriting association.

## SUBCHAPTER B

## FUND

### 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) $ 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. -- 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) 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.

(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).

(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. Section 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. Section 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. Section 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 713. Administration of fund.**

(a) General rule. -- The fund shall be administered by the department. The department shall contract with an entity or entities for the administration of claims against the fund in accordance with 62 Pa.C.S. (relating to procurement) and, to the fullest extent practicable, the department shall contract with entities that:

(1) Are not writing, underwriting or brokering medical professional liability insurance for participating health care providers, however, the department may contract with a subsidiary or affiliate of any writer, underwriter or broker of medical professional liability insurance.

(2) Are not trade organizations or associations representing the interests of participating health care providers in this Commonwealth.

(3) Have demonstrable knowledge of and experience in the handling and adjusting of professional liability or other catastrophic claims.

(4) Have developed, instituted and utilized best practice standards and systems for the handling and adjusting of professional liability or other catastrophic claims.

(5) Have demonstrable knowledge of and experience with the professional liability marketplace and the judicial systems of this Commonwealth.

(b) Reinsurance. -- The department may purchase, on behalf of and in the name of the fund, as much insurance or reinsurance as is necessary to preserve the fund or retire the liabilities of the fund.

(c) Transfers. -- The Governor may transfer to the fund from the Catastrophic Loss Benefits Continuation Fund, or such other funds as may be appropriate, such money as is necessary in order to pay the liabilities of the fund until sufficient revenues are realized by the fund. Any transfer made under this subsection shall be repaid with interest pursuant to section 2 of the act of August 22, 1961 (P.L. 1049, No. 479), entitled"An act authorizing the State Treasurer under certain conditions to transfer sums of money between the General Fund and certain funds and subsequent transfers of equal sums between such funds, and making appropriations necessary to effect such transfers."

(d) Confidentiality. -- Information provided to the department or maintained by the department regarding a claim or adjustments to an individual participating health care provider's assessment shall be confidential, notwithstanding the act of June 21, 1957 (P.L.390, No. 212), referred to as the Right-to-Know Law, or 65 Pa.C.S. Ch. 7 (relating to open meetings).

**Section 714. Medical professional liability claims.**

(a) Notification. -- A basic coverage insurer or self-insured participating health care provider shall promptly notify the department in writing of any medical professional liability claim.

(b) Failure to notify. -- If a basic coverage insurer or self-insured participating health care provider fails to notify the department as required under subsection (a) and the department has been prejudiced by the failure of notice, the insurer or provider shall be solely responsible for the payment of the entire award or verdict that results from the medical professional liability claim.

(c) Defense. -- A basic coverage insurer or self-insured participating health care provider shall provide a defense to a medical professional liability claim, including a defense of any potential liability of the fund, except as provided for in section 715. The department may join in the defense and be represented by counsel.

(d) Responsibilities. -- In accordance with section 713, the department may defend, litigate, settle or compromise any medical professional liability claim payable by the fund.

(e) Releases. -- In the event that a basic coverage insurer or self-insured participating health care provider enters into a settlement with a claimant to the full extent of its liability as provided in this chapter, it may obtain a release from the claimant to the extent of its payment, which payment shall have no effect upon any claim against the fund or its duty to continue the defense of the claim.

(f) Adjustment. -- The department may adjust claims.

(g) Mediation. -- Upon the request of a party to a medical professional liability claim within the fund coverage limits, the department may provide for a mediator in instances where multiple carriers disagree on the disposition or settlement of a case. Upon the consent of all parties, the mediation shall be binding. Proceedings conducted and information provided in accordance with 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 or 65 Pa.C.S. Ch. 7 (relating to open meetings).

(h) Delay damages and postjudgment interest. -- Delay damages and postjudgment interest applicable to the fund's liability on a medical professional liability claim shall be paid by the fund and shall not be charged against the participating health care provider's annual aggregate limits. The basic coverage insurer or self-insured participating health care provider shall be responsible for its proportionate share of delay damages and postjudgment interest.

**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, 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.

(b) Payment. -- If a health care provider is found liable for a claim defended by the department in accordance with subsection (a), the claim shall be paid by the fund. The limit of liability of the fund for a claim defended by the department under subsection (a) shall be $1,000,000 per occurrence.

(c) Concealment. -- If a claim is defended by the department under subsection (a) or paid under subsection (b), and the claim is made after four years because of the willful concealment by the health care provider or its insurer, the fund shall have the right to full indemnity including the department's defense costs from the health care provider or its insurer.

(d) Extended coverage required. -- Notwithstanding subsections (a), (b) and (c), all medical professional liability insurance policies issued on or after January 1, 2006, shall provide indemnity and defense for claims asserted against a health care provider for a breach of contract or tort which occurs four or more years after the breach of contract or tort occurred and after December 31, 2005.

**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 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.

## SUBCHAPTER C

## JOINT UNDERWRITING ASSOCIATION

### Section 731. Joint underwriting association.

(a) Establishment. -- There is established a nonprofit joint underwriting association to be known as the Pennsylvania Professional Liability Joint Underwriting Association. The joint underwriting association shall consist of all insurers authorized to write insurance in accordance with section 202(c)(4) and (11) of the act of May 17, 1921 (P.L. 682, No. 284), known as The Insurance Company Law of 1921, and shall be supervised by the department. The powers and duties of the joint underwriting association shall be vested in and exercised by a board of directors.

(b) Duties. -- The joint underwriting association shall do all of the following:

(1) Submit a plan of operation to the commissioner for approval.

(2) Submit rates and any rate modification to the department for approval in accordance with the act of June 11, 1947 (P.L.538, No. 246), known as The Casualty and Surety Rate Regulatory Act.

(3) Offer medical professional liability insurance to health care providers in accordance with section 732.

(4) File with the department the information required in section 712.

(c) Liabilities. -- A claim against or a liability of the joint underwriting association shall not be deemed to constitute a debt or liability of the Commonwealth or a charge against the General Fund.

### Section 732. Medical professional liability insurance.

(a) Insurance. -- The joint underwriting association shall offer medical professional liability insurance to health care providers and professional corporations, professional associations and partnerships which are entirely owned by health care providers who cannot conveniently obtain medical professional liability insurance through ordinary methods at rates not in excess of those applicable to similarly situated health care providers, professional corporations, professional associations or partnerships.

(b) Requirements. -- The joint underwriting association shall ensure that the medical professional liability insurance it offers does all of the following:

(1) Is conveniently and expeditiously available to all health care providers required to be insured under section 711.

(2) Is subject only to the payment or provisions for payment of the premium.

(3) Provides reasonable means for the health care providers it insures to transfer to the ordinary insurance market.

(4) Provides sufficient coverage for a health care provider to satisfy its insurance requirements under section 711 on reasonable and not unfairly discriminatory terms.

(5) Permits a health care provider to finance its premium or allows installment payment of premiums subject to customary terms and conditions.

**Section 733. Deficit.**

(a) Filing. -- In the event the joint underwriting association experiences a deficit in any calendar year, the board of directors shall file with the commissioner the deficit.

(b) Approval. -- Within 30 days of receipt of the filing, the commissioner shall approve or deny the filing. If approved, the joint underwriting association is authorized to borrow funds sufficient to satisfy the deficit.

(c) Rate filing. -- Within 30 days of receiving approval of its filing in accordance with subsection (b), the joint underwriting association shall file a rate filing with the department. The commissioner shall approve the filing if the premiums generate sufficient income for the joint underwriting association to avoid a deficit during the following 12 months and to repay principal and interest on the money borrowed in accordance with subsection (b).

## SUBCHAPTER D

## REGULATION OF MEDICAL PROFESSIONAL LIABILITY INSURANCE

**Section 741. Approval.**

In order for an insurer to issue a policy of medical professional liability insurance to a health care provider or to a professional corporation, professional association or partnership which is entirely owned by health care providers, the insurer must be authorized to write medical professional liability insurance in accordance with the act of May 17, 1921 (P.L. 682, No. 284), known as The Insurance Company Law of 1921.

**Section 742. Approval of policies on “claims made” basis.**

The commissioner shall not approve a medical professional liability insurance policy written on a “claims made” basis by any insurer doing business in this Commonwealth unless the insurer shall guarantee to the commissioner the continued availability of suitable liability protection for a health care provider subsequent to the discontinuance of professional practice by the health care provider or the termination of the insurance policy by the insurer or the health

care provider for so long as there is a reasonable probability of a claim for injury for which the health care provider may be held liable.

**Section 743. Reports to commissioner and claims information.**

(a) Duty to report. -- By October 15 of each year, basic insurance coverage insurers and self-insured participating health care providers shall report to the department the claims information specified in subsection (b).

(b) Department report. -- Sixty days after the end of each calendar year, the department shall prepare a report. The report shall contain the total amount of claims paid and expenses incurred during the preceding calendar year, the total amount of reserve set aside for future claims, the date and place in which each claim arose, the amounts paid, if any, and the disposition of each claim, judgment of court, settlement or otherwise. For final claims at the end of any calendar year, the report shall include details by basic insurance coverage insurers and self-insured participating health care providers of the amount of assessment collected, the number of reimbursements paid and the amount of reimbursements paid.

(c) Submission of report. -- A copy of the report prepared pursuant to this section shall be submitted to the chairman and minority chairman of the Banking and Insurance Committee of the Senate and the chairman and minority chairman of the Insurance Committee of the House of Representatives.

**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 be required to participate in the fund and, upon payment of the assessment required by section 712, be entitled to coverage from the fund.

**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.

(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 746. Mandatory reporting.**

(a) General provisions. -- Each medical professional liability insurer and each self-insured health care provider, including the fund established by this chapter, which makes payment in settlement, or in partial settlement of, or in satisfaction of a judgment in a medical professional liability action or claim shall provide to the appropriate licensure board a true and correct copy of the report required to be filed with the Federal Government by section 421 of the Health Care Quality Improvement Act of 1986 (Public Law 99-660, 42 U.S.C. Section 11131). The copy of the report required by this section shall be filed simultaneously with the report required by section 421 of the Health Care Quality Improvement Act of 1986. The department shall monitor and enforce compliance with this section. The Bureau of Professional and Occupational Affairs and the licensure boards shall have access to information pertaining to compliance.

(b) Immunity. -- A medical professional liability insurer or person who reports under subsection (a) in good faith and without malice shall be immune from civil or criminal liability arising from the report.

(c) Public information. -- Information received under this section shall not be considered public information for the purposes of the act of June 21, 1957 (P.L.390, No. 212), referred to as the Right-to-Know Law or 65 Pa.C.S. Ch. 7 (relating to open meetings), until used in a formal disciplinary proceeding.

**Section 747. Cancellation of insurance policy.**

A termination of a medical professional liability insurance policy by cancellation, except for suspension or revocation of the insured's license or for reason of nonpayment of premium, is not effective against the insured, unless notice of cancellation was given within 60 days after the issuance of the policy to the insured and no cancellation shall take effect unless a written notice stating the reasons for the cancellation and the date and time upon which the termination becomes effective has been received by the commissioner. Mailing of the notice to the commissioner at the commissioner's principal office address shall constitute notice to the commissioner.

**Section 748. Regulations.**

The commissioner may promulgate regulations to implement and administer this chapter.

## CHAPTER 51

## MISCELLANEOUS PROVISIONS

**Section 5101. Oversight.**

(a) General rule. -- The department has the authority and shall assume oversight of the Medical Professional Liability Catastrophe Loss Fund established in section 701(d) of the act of October 15, 1975 (P.L.390, No. 111), known as the Health Care Services Malpractice Act. As part of its responsibilities, the department shall do all of the following:

(1) Make all administrative decisions, including staffing requirements, on behalf of that fund.

(2) Approve the adjustment, defense, litigation, settlement or compromise of any claim payable by that fund.

(3) Collect the surcharges imposed in accordance with section 701(e)(1) of the Health Care Services Malpractice Act.

(b) Expiration. -- This section shall expire October 1, 2002.

**Section 5102. Prior fund.**

(a) Administration. -- Employees of the Medical Professional Liability Catastrophe Loss Fund on the effective date of this section shall continue to administer that fund subject to the authority and oversight of the department. This subsection shall expire October 1, 2002.

(b) Employees. -- If an employee of that fund on the effective date of this section is subsequently furloughed and the employee held a position not covered by a collective bargaining agreement, the employee shall be given priority consideration for employment to fill vacancies with executive agencies under the Governor's jurisdiction.

**Section 5103. Notice.**

When the authority has established a Statewide reporting system, the notice shall be transmitted to the Legislative Reference Bureau for publication in the Pennsylvania Bulletin.

**Section 5104. Repeals.**

(a) Specific. --

(1) Section 6506(c) of Title 75 of the Pennsylvania Consolidated Statutes is repealed.

(2) Except as set forth in paragraphs (3), (4) and (5), the act of October 15, 1975 (P.L.390, No. 111), known as the Health Care Services Malpractice Act, is repealed.

(3) Section 103 of the Health Care Services Malpractice Act is repealed.

(4) Except as provided in paragraph (5), Article VII of the Health Care Services Malpractice Act is repealed.

(5) Section 701(e)(1) of the Health Care Services Malpractice Act is repealed.

(b) Inconsistent. --

(1) Section 6506(b) of Title 75 of the Pennsylvania Consolidated Statutes is repealed insofar as it is inconsistent with section 712(m).

(2) All other acts and parts of acts are repealed insofar as they are inconsistent with this act.

**Section 5105. Applicability.**

(a) Patient safety discount. -- Section 312 shall apply to policies issued or renewed after December 31, 2002.

(b) Actions. -- sections 504(d)(2), 505(e), 508, 509, 510, 513 and 516 shall apply to causes of action which arise on or after the effective date of this section.

**Section 5106. Expiration.**

Section 312 shall expire on December 31, 2007.

**Section 5107. Continuation.**

(a) Orders and regulations. -- Orders and regulations which were issued or promulgated under the former act of October 15, 1975 (P.L.390, No. 111), known as the Health Care Services Malpractice Act, and which are in effect on the effective date of this section shall remain applicable and in full force and effect until modified under this act.

(b) Administration and construction. -- To the extent possible under Subchapter C of Chapter 7, the joint underwriting association is authorized to administer Subchapter C of Chapter 7 as a continuation of the former Article VIII of the Health Care Services Malpractice Act.

**Section 5108. Effective date.**

This act shall take effect as follows:

(1) The following provisions shall take effect immediately:

(i) Chapter 1.

(ii) Section 501.

(iii) Section 502.

(iv) Section 503.

(v) Section 504.

(vi) Section 505.

(vii) Section 506.

(viii) Section 507.

(ix) Section 508.

(x) Section 509.

(xi) Section 510.

(xii) Section 513.

(xiii) Section 514.

(xiv) Section 515.

(xv) Section 516.

(xvi) Except as provided in paragraph (3)(i), Chapter 7.

(xvii) Section 5101.

(xviii) Section 5102.

(xix) Section 5103.

(xx) Section 5104(a)(1) and (2) and (b)(2).

(xxi) Section 5105.

(xxii) Section 5106.

(xxiii) Section 5107.

(xxiv) This section.

(2) The following provisions shall take effect 30 days after publication of the notice under section 5103:

(i) Section 313.

(ii) Section 314.

(3) The following provisions shall take effect October 1, 2002:

(i) Section 712(b) and (c)(1).

(ii) Section 5104(a)(4).

(4) Section 5104(a) (3) and (5) and (b)(1) shall take effect January 1, 2004.

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

**HISTORY:**
Approved March 20, 2002

**SPONSOR:** Micozzie

**NOTES:**
SENATE AMENDMENTS TO HOUSE AMENDMENTS, MARCH 13, 2002

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