Cascadrill

Regulatory Analysis Form

This space for use by IRRC

(1) Agency

Medical Professional Liability Catastrophe Loss Fund

(2) I.D. Number (Governor's Office Use)

IRRC Number: 1880

(3) Short Title

(4) PA Code Cite

31 Pa. Code §§241 et seq.

(5) Agency Contacts & Telephone Numbers

Primary Contact: Arthur F. McNulty (717)733-3770

Secondary Contact: Kenneth J. Serafin

(6) Type of Rulemaking (Check One)

XX Proposed Rulemaking
___ Final Order Adopting Regulation
___ Final Order, Proposed Rulemaking Omitted

(7) Is a 120-Day Emergency Certification Attached?

___ No
___ Yes: By the Attorney General
___ Yes: By the Governor

(8) Briefly explain the regulation in clear and nontechnical language.

The regulations are intended to implement the changes brought about by Act 135 of 1996, and to update regulations that have not been amended since 1984. Specifically, these regulations would:

(1) Insert into the existing regulations, amendments prompted by the reforms brought about by Act 135 of 1996;

(2) Add technical changes to the process by which primary carriers collect, remit and report the Fund surcharge to the Fund;

(3) Provide uniform procedures to be used in conducting voluntary mediation among basic insurance carriers and the Fund.

(9) State the statutory authority for the regulation and any relevant state or federal court decisions.

40 P.S. §1301.701 et seq.

Regulatory Analysis Form

(10) Is the regulation mandated by any federal or state law or court order, or federal regulation? If yes, cite the specific law, case or regulation, and any deadlines for action.

Amendments are warranted by Act 135 of 1996.

(11) Explain the compelling public interest that justifies the regulation. What is the problem it addresses?

(12) State the public health, safety, environmental or general welfare risks associated with non-regulation.

(13) Describe who will benefit from the regulation. (Quantify the benefits as completely as possible and approximate the number of people who will benefit.)

Basic insurance carriers, health care providers, the Fund and, ultimately, the parties to medical malpractice litigation.

Regulatory Analysis Form

(14) Describe who will be adversely affected by the regulation. (Quantify the adverse effects as completely as possible and approximate the number of people who will be adversely affected.)

(15) List the persons, groups or entities that will be required to comply with the regulation. (Approximate the number of people who will be required to comply.)

(16) Describe the communications with and input from the public in the development and drafting of the regulation. List the persons and/or groups who were involved, if applicable.

The proposed mediation regulations were drafted with specific reference to Common Rules established by the American Arbitration Association.

(17) Provide a specific estimate of the costs and/or savings to the regulated community associated with compliance, including any legal, accounting or consulting procedures which may be required.

(18) Provide a specific estimate of the costs and/or savings to local governments associated with compliance, including any legal, accounting or consulting procedures which may be required.

(19) Provide a specific estimate of the costs and/or savings to state government associated with the implementation of the regulation, including any legal, accounting, or consulting procedures which may be required.

Regulatory Analysis Form

(20) In the table below, provide an estimate of the fiscal savings and costs associated with implementation and compliance for the regulated community, local government, and state government for the current year and five subsequent years.

	Current FY Year	FY +1 Year	FY +2 Year	FY +3 Year	FY +4 Year	FY +5 Year
SAVINGS:	$	$	$	$	$	$
Regulated Community						
Local Government						
State Government						
Total Savings						
COSTS:						
Regulated Community						
Local Government						
State Government						
Total Costs						
REVENUE LOSSES:						
Regulated Community						
Local Government						
State Government						
Total Revenue Losses						

(20a) Explain how the cost estimates listed above were derived.

Regulatory Analysis Form

(20b) Provide the past three year expenditure history for programs affected by the regulation.

Program	FY -3	FY -2	FY -1	Current FY

(21) Using the cost-benefit information provided above, explain how the benefits of the regulation outweigh the adverse effects and costs.

(22) Describe the nonregulatory alternatives considered and the costs associated with those alternatives. Provide the reasons for their dismissal.

(23) Describe alternative regulatory schemes considered and the costs associated with those schemes. Provide the reasons for their dismissal.

(24) Are there any provisions that are more stringent than federal standards? If yes, identify the specific provisions and the compelling Pennsylvania interest that demands stronger regulation.

(25) How does this regulation compare with those of other states? Will the regulation put Pennsylvania at a competitive disadvantage with other states?

(26) Will the regulation affect existing or proposed regulations of the promulgating agency or other state agencies? If yes, explain and provide specific citations.

(27) Will any public hearings or informational meetings be scheduled? Please provide the dates, times, and locations, if available.

Regulatory Analysis Form

(28) Will the regulation change existing reporting, record keeping, or other paperwork requirements? Describe the changes and attach copies of forms or reports which will be required as a result of implementation, if available.

(29) Please list any special provisions which have been developed to meet the particular needs of affected groups or persons including, but not limited to, minorities, elderly, small businesses, and farmers.

(30) What is the anticipated effective date of the regulation; the date by which compliance with the regulation will be required; and the date by which any required permits, licenses or other approvals must be obtained?

(31) Provide the schedule for continual review of the regulation.

CDL-1

FACE SHEET
FOR FILING DOCUMENTS
WITH THE LEGISLATIVE REFERENCE BUREAU

(Pursuant to Commonwealth Documents Law)

DO NOT WRITE IN THIS SPACE

Copy below is hereby approved as to form and legality. Attorney General

(DEPUTY ATTORNEY GENERAL)

DATE OF APPROVAL

Check if applicable
Copy not approved. Objections attached.

Copy below is hereby certified to be a true and correct copy of a document issued, prescribed or promulgated by:

Pennsylvania Medical Professional Liability Catastrophe Loss Fund
(AGENCY)

DOCUMENT/FISCAL NOTE NO. 20-1

DATE OF ADOPTION:

BY: John H. Reed

TITLE: John H. Reed, Director
(EXECUTIVE OFFICER, CHAIRMAN OR SECRETARY)

Copy below is hereby approved as to form and legality. Executive or Independent Agencies.

BY:

6/16/97
DATE OF APPROVAL

(Deputy General Counsel)
~~(Chief Counsel, Independent Agency)~~
(Strike inapplicable title)

☐ Check if applicable. No Attorney General approval or objection within 30 days after submission.

Notice of Proposed Regulations
Pennsylvania Medical Professional Liability
Catastrophe Loss Fund

31 Pa. Code Chapters 242 and 246 (New)

Notice is hereby given that the Pennsylvania Medical Professional Liability Catastrophe Loss Fund, under the authority of the Health Care Services Malpractice Act, 40 P.S. §1301.101-1301.1006, intends to adopt the regulations set forth in Annex A to this notice.

BACKGROUND:

On November 26, 1996, Governor Tom Ridge signed into law Act 135 of 1996. This legislation amends the Health Care Services Malpractice Act, (40 P.S. §1301.101, et seq.), (hereinafter "Act") and constitutes the first substantive changes to the Act in over 14 years. The Medical Professional Liability Catastrophe Loss Fund (hereinafter "the Fund") was first established under the Act in 1976, and its purpose is to provide professional liability insurance to Pennsylvania's health care providers, as defined in the Act, at a reasonable cost and ensure just compensation to the victims of alleged professional negligence. (40 P.S. §1301.103). The recent amendments to the Act alter the professional liability insurance marketplace, the Fund's role in the marketplace, and certain of the procedures and processes governing professional liability malpractice litigation in this Commonwealth.

The purpose of these regulations is to provide uniform procedures and forms to enable insurance companies and self-insurers to comply with the liability insurance provisions of the Act, to promulgate guidelines and requirements governing the purchase of insurance by health care providers as mandated by the Act and to issue regulations necessary to properly effectuate the administrative and financial operations of the Fund. In addition, the proposed rulemaking embodied in Chapter 246 implements Section 701(I) of the Act by providing uniform procedures to be used in conducting mediation where primary medical malpractice insurance carrier(s) and self-insureds disagree in a case involving the Fund. The mediation provisions create a system whereby mediation can be used to resolve differences, rather than litigation.

SUMMARY:

General Amended Provisions
Chapter 242

Purpose (Section 242.1) There are no changes to this Section.

Definitions (Section 242.2) This Section deletes definitions that refer to the prior method of calculating the Fund surcharge. Added to this Section are definitions of the Prevailing Primary Premium, which is now the basis upon which the Fund surcharge is calculated, pursuant to the Act and the definition of the term Interest.

Notice and Amount of Surcharge (Section 242.3) The amendments to this Section clarify the notice requirements regarding any change in the amount of

surcharge and the applicability of such change.

Computation of Surcharge (Section 242.4) The amendment to this Section mandates that basic insurance carriers shall obtain statements from health care providers as to their addresses and specialties, and that the primary insurer must accurately compute the insurance premium and Fund surcharge. The amendments to this Section are necessitated by the General Assembly's adoption of the Prevailing Primary Premium to calculate Fund surcharge.

Adjustment of Surcharge. (Section 242.5) The amendments to this Section provide that primary insurers must submit the Fund surcharge within twenty (20) days after the date on which the policy is written or renewed, or the effective date of the policy. Late remittance by the insurer or self-insurance plan shall result in the payment of interest by said party. Also, a refund check shall not be issued to a carrier or health care provider unless unusual circumstances arise which indicate that such a refund shall be made.

Reporting Forms and Procedures (Section 242.6) The amendments to this Section attempt to clarify the procedures and forms used by insurers and self-insured plans when reporting to the Fund. Specifically, the original Form 5116 or Declarations Page is to be mailed to the health care provider within twenty (20) days of the effective date of the policy or self-insurance. A Declarations Page, indicating acknowledgment of insurance and surcharge paid shall be submitted to the Fund at its Harrisburg, Pennsylvania office, and shall contain all of the information requested on the Form 5116. The Form 2116 Remittance Advice, summarizing all surcharges collected, payable and refundable, accompanied by a check, shall be received in the Director's Office within twenty (20) days from the effective date of the policy. In amended Section 242.6 (a)(3), there are additional requirements regarding information that must be contained on the Form 2116 in order to assist the Fund in verifying coverage.

Discontinuation of Basic Coverage Insurance and Notices of Noncompliance (Section 242.7) The amendments to this Section contain requirements applicable in the event the health care provider changes the term of his or her professional liability coverage. In such circumstances, the surcharge shall be calculated on an annual basis and shall reflect the surcharge percentages in effect for all calendar years over which the policy is in effect. Additional payments necessitated by such change shall be remitted within twenty (20) days of the effective date of the annual surcharge. Cancellations are to be reported on Form 2116 by indicating the unused portion of the policy. These dates, the return premium and the return surcharge shall be recorded in parenthesis.

New Acknowledgment (Section 242.8) There are no changes to this Section.

Overpayments, Credits and Duplicate Payments (Section 242.9) The amendments to this Section state that in the event of overpayments made by insureds, agents or insurers, such overpayments shall be recovered by offsets against amounts due from companies to the Fund. Also, the amendments mandate that refunds shall be paid directly to the health care provider by the agent or insurer, and upon showing of proof of payment, the Fund will then issue the appropriate credit to the agent or insurer.

Self-Insurers (Section 242.10) The amendments to this Section make clear that the provisions of this Chapter apply to approved and accepted self-insurance plans and self-insurers, and that they shall pay the surcharge to the Fund, accompanied by reporting forms required under Section 242.6, within twenty (20) days of the effective date of the self-insurance plan and on an annual basis thereafter within twenty (20) days of the inception of the annual self-insurance.

Sections (242.11 to 242.16) There are no changes or amendments to these Sections.

Compliance (Section 242.17) The amendments to this Section provide that the health care provider who fails to pay the surcharge or emergency surcharge within the prescribed time limits shall be responsible for the payment of interest, and will not be covered by the Fund in the event of loss for the period of time in which any delinquencies exists. Also, late remittances by insurance carriers of surcharges collected from health care providers and late remittance of surcharges due from self-insurance providers shall include interest.

Effective Date (Section 242.18) The amendment to this Section makes clear that the effective date of Chapter 242 as well as the commencement date for using the prescribed forms shall be November 26, 1996.

Sections (242.19 and 242.20) There are no changes or amendments to these Sections.

Corrections (Section 242.21) This new Section provides that any corrections to previously submitted Form 216 shall be clearly marked "Correction." Any Correction Form 216 shall be separate from other reporting forms and shall identify the original Form 216 being corrected, and shall contain only the health care provider(s) erroneously submitted. The insurer or the self-insurer shall respond with a Correction Form 216 within twenty (20) days after being notified of an erroneous submission.

Chapter 246. Mediation

Purpose (Section 246.1) This Section identifies the purpose of Chapter 246 pertaining to mediation of disputes between insurers, self-insurers or the Fund in

medical malpractice actions.

Definitions (Section 246.2) This Section defines terms used in Chapter 246 of the regulations.

Agreement of Parties (Section 246.3) This Section provides that where multiple insurers and/or the Fund disagree on a case, the Fund may provide for a mediator upon the request of any party, as defined in Section 246.2. Whenever any of the parties agree to mediation, the provisions of Chapter 246 apply.

Administration and Delegation of Duties (Section 246.4) This Section provides that upon the request of a party to a case within Fund coverage limits, the Fund may, in its discretion, provide for a mediator. Special mediation sessions may be held to determine each defendant's proportionate share of liability. Selected mediators shall immediately disclose any circumstances creating a presumption of bias or interest in the outcome of the proceedings, or any circumstances that may prevent prompt meeting with the parties. If any party thereafter objects to such a mediator on the basis of identifiable bias, interest or unavailability, a new mediator will be selected who is agreeable to all participants.

Binding Mediation (Section 246.5) This Section provides that if all parties agree to binding mediation, all parties shall be bound by the conclusions of the mediator. If parties cannot agree to binding mediation, they should utilize the assistance of an impartial mediator in a good faith attempt to work toward a mutually satisfactory solution.

Date, Time and Location of the Mediation Proceedings (Section 246.6) This Section provides that a mediator will immediately work with the parties to establish a date and time of the mediation session and that notice of a mediation session must be provided to all parties at least three (3) working days in advance of such session. At the discretion of the mediator, her or she may meet with or request information from one or more parties.

Mediation Session (Section 246.7) This Section states that the manner in which mediation sessions shall be conducted must expeditiously permit full production of all relevant information, including written materials and a description of the testimony of each witness, if necessary. Materials or information for complex cases, as designated by the Fund, may be requested by the mediator in advance of a mediation session. Documents provided to the mediator shall also be provided to every other party to the mediation. Mediators will conduct orderly settlement negotiations at mediation sessions, considering the facts, issues and arguments of the parties, and parties will be represented by person(s) with authority to resolve and/or settle disputes.

Mediation by Document Submission (Section 246.8) This Section permits parties

to agree that a dispute will be decided on the basis of document submission, and specifies the procedures to be followed in such circumstance.

Conclusions of the Mediator (Section 246.9) The mediator shall issue and distribute his or her decision no later than two (2) business days from the date of closing of the final mediation session or complete submission of documents. The decision shall specify the remedy, if any, shall be in writing and signed by the mediator, and there will be no formal opinion unless all parties agree.

Expenses (Section 246.10) This Section provides that witness expenses shall be paid by the party producing such witness and that all of their expenses of the mediation, and including mediator expenses and the expenses of any witness and the cost of any proof produced at the direct request of the mediator, shall be borne equally by all parties, unless they agree otherwise.

Confidentially (Section 246.11) This Section makes clear that statements made and items of proof admitted at mediation sessions are inadmissable in any litigation or arbitration, to the extent allowed by law. Also, this Section provides that the parties agree not to subpoena or otherwise require the mediator to testify or produce records, notes or work product in any future proceedings. In addition, no record will be made of the mediation session(s). The conclusion of the mediator in binding mediation shall have the force and effect of a settlement.

Effective Date (Section 246.12) The effective date of Chapter 246 shall be November 26, 1996.

EFFECTED ORGANIZATIONS AND INDIVIDUALS

These regulations will have positive effect on all basic coverage insurers, self-insurers, plaintiffs and all defendants in medical malpractice litigation involving the Fund in that the regulations will provide clarification of uniform procedures and forms to enable insurance companies and self-insures to comply with the liability insurance provisions of the Act. The regulations will properly effectuate the administrative and financial operations of the Fund and provisions will be in place to provide uniform procedures to be used in conducting mediation where there is disagreement on a case involving the Fund.

ACCOMPLISHMENTS/BENEFITS

The amended regulations in Chapter 242 and the regulations in Chapter 246 will ensure dissemination of proper administrative procedures and requirements and a means by which disagreements on medical malpractice litigation involving the Fund can be resolved without resort to costly litigation.

FISCAL IMPACT

PUBLIC SECTOR

With respect to Chapter 242, the regulations require more timely remittance of Fund surcharges by insurers, and also provide for payment of interest to the Fund on any overdue amounts. Chapter 246, Mediation will provide fiscal benefit to the Commonwealth in that mediation provides a means by which to avoid costly litigation.

PRIVATE SECTOR

There will be no added cost to basic coverage insurers, self-insurers, plaintiffs and defendants in medical malpractice litigation involving the Fund. In addition, there will be no cost to the general public.

PAPERWORK REQUIREMENTS

Chapter 242 of the regulations provides for no additional paperwork requirements, other than minor changes in the collection and reporting of certain relevant data and its inclusion on already existing forms that are submitted to the Fund.

EFFECTIVE DATE

The regulations will become effective retroactively to November 26, 1996, after they are published in the *Pennsylvania Bulletin* in final form.

SUNSET DATE

There is no sunset date for these regulations.

PUBLIC HEARING

There are currently no plans to hold public hearings.

PUBLIC COMMENT

Interested persons are invited to submit suggestions or objections regarding the proposed regulations to Arthur F. McNulty, Chief Counsel, Pennsylvania Medical Professional Liability Catastrophe Loss Fund, 10th Floor, Suite 1000, 30 N. Third Street, P.O. Box 12030, Harrisburg, PA 17108, telephone (717) 783-3770, within thirty (30) days after the date of publication of this Notice in the *Pennsylvania Bulletin*. All comments received within thirty (30) calendar days will be reviewed and considered in the preparation of the final regulations. Comments received after the thirty-day comment period will be considered for any subsequent revisions of this regulation.

REGULATORY REVIEW ACT (Legislative Oversight)

Under Section 5(a) of the Regulatory Review Act, the Act of June 30, 1989 (P.L. ____, No. 19) (71 P.S. Section 745.1-745.15), the agency submitted a copy of this proposed regulation on to the Independent Regulatory Review Commission and to the Chairman of the House Committee on Health and Welfare and the Senate Committee on Public Health and Welfare. In addition to submitting the regulation, the agency has provided the Commission and the Committees with a copy of a detailed Regulatory Analysis Form prepared by the agency in compliance with Executive Order 1982-2, "Improving Government Regulations." A copy of this material is available to the public upon request.

If the Commission has any objections to any portion of the proposed regulation, it will notify the agency by 30 days after the close of the public comment period. Such notification shall specify the regulatory review criteria which have not been met by that portion. The Act specifies detailed procedures for review, prior to final publication of the regulation, by the agency, the General Assembly and the Governor of objections raised.

PART IX. MEDICAL CATASTROPHE LOSS FUND

CHAPTER 242. MEDICAL PROFESSIONAL LIABILITY CATASTROPHE LOSS FUND

Sec.

Source

The provisions of this Chapter 242 adopted October 15, 1976, effective October 16, 1976, 6 Pa.B. 2565; renumbered February 9, 1979, 9 Pa.B. 489, unless otherwise noted.

§242.1. Purpose.

The purpose of this chapter is to provide uniform procedures and forms to enable insurance companies and self-insurers to comply with the liability insurance provisions of the act, to promulgate guidelines and requirements governing the purchase of insurance by health care providers as mandated by the act, and to issue regulations necessary to properly effectuate the administrative and financial operations of the Fund.

Source

The provisions of this § 242.1 adopted October 15, 1976, effective October 16, 1976, 6 Pa.B. 2565; amended October 7, 1977, effective October 8, 1977, 7 Pa.B. 2893; renumbered February 9, 1979, 9 Pa.B. 489. Immediately preceding text appears at serial page (30245).

Notes of Decisions

These provisions provide for resolution of complaints of adverse agency action, and as such, do not provide adequate remedy or preclude litigant from seeking relief in court, where issue is Cat Fund's failure to pay share of malpractice claim settlement, which places Fund in position of defendant, as opposed to its designed position of participant and/or arbiter. Ohio Gas Group of Insurance Companies v. Argonaut Insurance Co., 525 A.2d 1195, 1197 (Pa. 1987).

§242.2. Definitions.

The following words and terms, when used in this chapter, shall have the following meanings, unless the context clearly indicates otherwise:

Act — The Health Care Services Malpractice Act (40 P.S. §§ 1301.101 — 1301.1006).

Basic insurance coverage — Insurance or self-insurance with limits of liability which comply with the occurrence-based requirements of the act in section 701 of the act (40 P.S. § 1301.701). In the case of a claims made policy permitted under sections 103 and 807 of the act (40 P.S. §§ 1301.103 and 1301.807), the insurance requirements of the act require purchase of the reporting endorsement (that is, tail coverage) or prior acts coverage or its substantial equivalent by the health care provider, upon cancellation or termination of the claims made policy.

[*Cost to each health care provider* — The gross premium, including experience and schedule rating for basic coverage professional liability insurance.]

Department — The Insurance Department of the Commonwealth.

Director — The Office of the Director of the Medical Professional Liability Catastrophe Loss Fund.

Emergency surcharge — A surcharge levied by the Insurance Commissioner under section 701(e) of the act (40 P.S. § 1301.701(e)).

Fund — The Medical Professional Liability Catastrophe Loss Fund established by section 701 of the act (40 P.S. § 1301.701.)

[*Gross premium* — The entire premium charged the insured, including, but not limited to, binder charges and policy fees, as is generated to secure an occurrence-based policy. In the case of a claims made policy, the gross premium shall be computed as the sum of all the premiums charged for the claims made policy including the reporting endorsement (that is, tail coverage) or prior acts coverage or its substantial equivalent. Payment of the surcharge shall be made at the time that the respective premium is collected subject to the limitation of §242.6(a)(3) (relating to reporting forms and procedures).]

Health care provider - Health care provider as defined by the act.

Insurer - The insurance company providing basic coverage insurance.

Interest - The rate prescribed in section 506 of the act of April 9, 1929 (P.L. 345, No. 176), known as "The Fiscal Code."

Prevailing Primary Premium - The schedule of rates approved by the Insurance Commissioner and in use by the Joint Underwriting Association as of January 1, 1996.

Authority

The provisions of this § 242.2 issued under sections 206 and 506 of the act of April 9, 1929 (P.L. 177, No. 175)(71 P.S. §§ 66 and 186); and sections 701(e)(4) and 702(a) of the act of October 15, 1975 (P.L. 390, No. 111) (40 P.S. §§ 1301.701(e)(4) and 1301.702(a)).

Source

The provisions of this § 242.2 adopted October 15, 1976, effective October 16, 1976, 6 Pa.B. 2565; amended October 7, 1977, effective October 8, 1977, 7 Pa.B. 2893; renumbered February 9, 1979, 9 Pa.B. 498; amended August 29, 1980, effective August 30, 1980, 10 Pa.B. 3514; amended September 30, 1983, effective October 1, 19883, 13 Pa.B. 2969; amended through April 27, 1984, effective April 28, 1984, 14 Pa.B. 1453. Immediately preceding text appears at serial pages (85378) to (85379).

Notes of Decisions

These provisions provide for resolution of complaints of adverse agency action, and as such, do not provide adequate remedy or preclude litigant from seeking relief in court, where issue is Cat Fund's failure to pay share of malpractice claim settlement, which places Fund in position of defendant, as opposed to its designed position of participant and/or arbiter. *Ohio Gas Group of Insurance Companies v. Argonaut Insurance Co.*, 525 A.2d 1195, 1197 (Pa. 1987).

§242.3. Notice of and amount of surcharge.

(a) The Director, with the prior approval of the Insurance Commissioner, will publish, prior to December 1, in the *Pennsylvania Bulletin*, notice of [a] any change in the amount of surcharge applicable to health care providers and collectible during the following calendar year.

(b) The effective date of [a] any change in the amount of surcharge shall be January 1 and shall be applicable to all policies of basic coverage insurance or plans of self-insurance [having new or renewal dates occurring on or after January 1].

Source

The provisions of this § 242.3 adopted October 15, 1976, effective October 16, 1976, 6 Pa.B. 2565; amended January 20, 1978, effective January 21, 1978, 8 Pa.B. 755; renumbered February 9, 1979, 9 Pa.B. 498. Immediately preceding text appears at serial page (32045).

Notes of Decisions

These provisions provide for resolution of complaints of adverse agency action, and as such, do not provide adequate remedy or preclude litigant from seeking relief in court, where issue is Cat Fund's failure to pay share of malpractice claim settlement, which places Fund in position of defendant, as opposed to its designed position of participant and/or arbiter. *Ohio Gas Group of Insurance Companies v. Argonaut Insurance Co.*, 525 A.2d 1195, 1197 (Pa. 1987).

§242.4. Computation of surcharge [when professional liability insurance premium part of a composite rate].

(a) The basic insurance carrier shall obtain from the health care provider a statement as to the address(es) and specialty of the health care provider, and shall provide a copy of the statement to the Fund in line with the reporting requirements contained herein.

[(a)](b) Where the professional liability insurance premium of an insured is included in a composite rate or with other insurance coverage, it shall be the responsibility of the insurer to accurately compute the portion attributable to such professional liability insurance [in order to properly determine the surcharge].

[(b)](c) Premiums subject to rating adjustments or audits, or both, shall be recomputed at the time of [the] such adjustment or audit to determine the gross premium to which the surcharge is applicable.

Source

The provisions of this § 242.4 adopted October 15, 1976, effective October 16, 1976, 6 Pa.B. 2565; renumbered February 9, 1979, 9 Pa.B. 498.

Notes of Decisions

These provisions provide for resolution of complaints of adverse agency action, and as such, do not provide adequate remedy or preclude litigant from seeking relief in court, where issue is Cat Fund's failure to pay share of malpractice claim settlement, which places Fund in position of defendant, as opposed to its designed position of participant and/or arbiter. *Ohio Gas Group of Insurance Companies v. Argonaut Insurance Co.*, 525 A.2d 1195, 1197 (Pa. 1987).

§242.5. Adjustment of surcharge.

(a) Calculation of the surcharge shall be made based on the first policy written or renewed after January 1 of the calendar year. The surcharge amount shall be submitted to the Fund within [60] 20 days of the effective date required by § 242.6 (relating to reporting forms and procedures). [A] Any subsequent adjustment to the premium for the basic insurance coverage shall be reported to the Fund by the basic insurance carrier and the surcharge shall be adjusted accordingly.

(b) In the event of an increase or decrease in the surcharge owed to the fund, the carrier shall submit proper evidence of the modification of the premium for the basic insurance coverage policy and shall indicate on the Form 216 a credit or debit to be applied to the account of the carrier. A refund check [may] shall not be issued to a carrier or health care provider unless unusual circumstances arise which indicate that such a refund [may] shall be made.

(c) Late remittance by the insurer or a self-insurance plan shall result in the payment of interest by the insurer or self-insurance plan, and interest shall be computed pursuant to section 806 of the act of April 9, 1929 (P.L. 343, No. 176), known as "The Fiscal Code."

Authority

The provisions of this § 242.5 issued under AC§§206 and 506 of the act of April 9, 1929 (P.L. 177, No. 175) (71 P.S.§§ 66 and 186); and section 701(e) of the act of October 15, 1975 (P.L. 390, No. 111) (40 P.S. § 1301.701(e)).

Source

The provisions of this § 242.5 adopted October 15, 1976, effective October 16, 1976, 6 Pa.B. 2565; amended March 17, 1978, effective March 18, 1978, 8 Pa.B. 2607; renumbered February 9 1979, 9 Pa.B. 498; amended October 24, 1980, effective October 25, 1980, 10 Pa.B. 4214. Immediately preceding text appears at serial pages (50182) to (50183).

Notes of Decisions

These provisions provide for resolution of complaints of adverse agency action, and as such, do not provide adequate remedy or preclude litigant from seeking relief in court, where issue is Cat Fund's failure to pay share of malpractice claim settlement, which places Fund in position of defendant, as opposed to its designed position of participant and/or arbiter. *Ohio Gas Group of Insurance Companies v. Argonaut Insurance Co.*, 525 A.2d 1195, 1197 (Pa. 1987).

Cross References

This section cited in 31 Pa. Code § 242.7 (relating to discontinuation of basic coverage insurance and notices of noncompliance); and 31 Pa. Code § 242.9 (relating to overpayments, credits, and duplicate payments).

§242.6. Reporting forms and procedures.

(a) The following forms have been promulgated or approved for use under this chapter:

(1) *Form 5116 - Acknowledgment of Insurance and Surcharge Paid.* This form is intended as the acknowledgment from approved self-insured health care providers that they are self-insured in compliance with the act and have paid the Fund surcharge. Basic coverage insurance carriers may also use this form in lieu of the Declarations Page to acknowledge that the health care provider has purchased basic coverage professional liability insurance and paid the Fund surcharge, if prior approval for its continued use has been obtained from the Fund's legal counsel in accordance with paragraph (2)(iii).

(I) The original of the form or the Declarations Page — whichever is applicable — is to be mailed to the health care provider [; and a copy is to be submitted to the Fund, accompanied by the surcharge payment and Form 216,] within [60] 20 days of the effective date of the policy or self-insurance period.

(ii) Licensed physicians and podiatrists covered under policies issued to hospitals, nursing homes, and primary health centers shall also be provided with a completed acknowledgment form. [Individual copies of the form or the Declarations Page — whichever is applicable — accompanied by the surcharge payments for each of these health care providers and Form 216 are to be submitted to the Fund attached to the acknowledgment form applicable to the hospital, nursing home, or primary health center.]

(2) *Declarations Page — Acknowledgment of Insurance and Surcharge Paid.* A copy of this form, which forms a part of the medical malpractice policy issued by a commercial carrier, shall be submitted to the Fund in lieu of and in the same manner as Form 5116 as explained in paragraph (1).

(I) The Declarations Page shall display all of the following:

(A) All information requested on the Form 5116, explained in paragraph (1).

(B) The amount of surcharge paid.

(ii) The copy to be submitted to the Fund shall be marked, "Catastrophe Loss Fund," at the bottom of the form.

(iii) The Declarations Page shall be submitted to the legal counsel of the Director for approval prior to use. After July 1, 1980, no form will be accepted from a commercial carrier unless circumstances preclude the use of the Declarations Page, and prior approval for the continued use of the Form 5116 has been obtained from the legal counsel of the Director. Requests for approval shall be submitted to: Legal Counsel; [Post Office] P.O. Box 12030; [221 North Second Street] 30 North Third Street; Harrisburg, Pennsylvania 17108.

(3) *Form 216 — Remittance Advice.* This form is to be used by basic professional liability insurance carriers and approved self-insurers for summarizing all surcharges collected, payable, and refundable. The form, accompanied by a check, [should] shall be received in the Director's Office within [60] 20 days from the effective date of the policy. On installment policies, the surcharge applicable to the full annual policy period shall be collected and remitted to the Director at the inception of the policy. This form shall be dated and include the underwriting insurance company's or self-insurer's name, the name of an authorized contact person, and telephone number of authorized contact person, as a heading. This form shall also include the most current Pennsylvania license number, name and address of health care provider, coverage dates, policy type (if claims made, retroactive date must be provided), policy number, specialty code, geographic territory, basic coverage limits, gross premium, surcharge, and slot positions when applicable and other information as may be required by the Director.

(4) *Form C416 — Insurance Company Report.* This completed form shall be submitted by the insurer or self-insurer to the Director, as notice to the Fund of claims reasonably believed to exceed the coverage of the insurer or the retained limits of the self-insured.

* * *

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Cross References

This section cited 31 Pa. Code § 242.2 (relating to definitions); 31 Pa. Code § 242.5 (relating to adjustment of surcharge); 31 Pa. Code § 242.7 (relating to discontinuation of basic coverage insurance and notices of noncompliance); 31 Pa. Code § 242.10 (relating to self-insurers); 31 Pa. Code § 245.6 (relating to remittance of emergency surcharge amounts); and 31 Pa. Code § 245.9 (relating to reporting forms)

§242.7. Discontinuation of basic coverage insurance and notices of noncompliance.

(a) *Cancellation or nonrenewal.*

(1) Cancellation or nonrenewal of coverage resulting from the request of the insured or the cancellation or nonrenewal by the insurer or self-insurer automatically releases the Fund from liability for claims for injuries or death from services which were rendered or which should have been rendered by the health care provider which occur after the effective date of cancellation or nonrenewal.

(2) Cancellation or nonrenewal of claims made coverage resulting from the request of the insured or the cancellation or nonrenewal by the insurer without the purchase of the reporting endorsement, prior acts coverage or its substantial equivalent automatically releases the Fund from all liability for claims for injuries or death from services which were rendered or which should have been rendered by the health care provider which occur or which are reported to the basic coverage insurance carrier after the effective date of cancellation or nonrenewal.

(b) Copies of cancellation evidence, that is, notices, confirmation and so forth, and evidence in support of refunds under § 242.5 (relating to adjustment of surcharge) shall be submitted to the Director along with Form 216.

(c) Notice of cancellation of a claims made policy shall clearly indicate that it is a claims made policy which has been canceled. Such notice shall also clearly indicate whether the health care provider has purchased a reporting endorsement for tail coverage.

(d) In the event that a health care provider elects to purchase prior acts coverage or its substantial equivalent rather than the reporting endorsement, it is the duty of the insurer providing this coverage to immediately notify the Fund of the election, in writing, specifying the full name of the health care provider, license number, specialty code, effective and retroactive dates of coverage and previous carrier. Submission of the declarations page and remittance of the surcharge shall be made as provided for in § 242.6 (relating to reporting forms and procedures).

(e) The insurer shall notify the Fund of those health care providers who either fail to procure increased basic coverage insurance limits under section 701(a) of the act (40 P.S. § 1301.701(a)) and pay the surcharge thereon or who fail to pay the emergency surcharge when levied.

(f) All notices required under this section with the exception of subsection (d) shall be given as soon as possible upon the expiration of the remittance period established by the insurer's billing.

(g) When a health care provider changes the term of his professional liability coverage, the surcharge shall be calculated on an annual base and shall reflect the surcharge percentages in effect for all the calendar years over which the policy is in effect. Any additional payment necessitated by this subsection shall be remitted within twenty (20) days of the effective date of the annual surcharge.

(h) Cancellations shall be reported on Form 216 by indicating the unused portion of the policy. These dates, the return premium and the return surcharge shall be recorded in parentheses.

Authority

The provisions of this § 242.7 issued under sections 206 and 506 of the act of April 9, 1929 (P.L. 177, No. 175) (71 P.S. §§ 66 and 186); and sections 701(e)(4) and 702(a) of the act of October 15, 1975 (P.L. 390, No. 111) (40 P.S. §§ 1301 701(e)(4) and 1301.702(a)).

Source

The provisions of this § 242.7 adopted October 15, 1976, effective October 16, 1976, 6 Pa.B. 2565; amended March 17, 1978, effective March 18, 1978, 8 Pa.B. 755; renumbered February 9, 1979, 9 Pa.B. 498; amended September 30, 1983, effective October 1, 1983, 13 Pa.B. 2969; amended April 27, 1984, effective April 28, 1984, 14 Pa.B. 1453. Immediately preceding text appears at serial pages (85383) to (853384).

Notes of Decision

These provisions provide for resolution of complaints of adverse agency action, and as such, do not provide adequate remedy or preclude litigant from seeking relief in court, where issue is Cat Fund's failure to pay share of malpractice claim settlement, which places Fund in position of defendant, as opposed to its designed position of participant and/or arbiter. *Ohio Gas Group of Insurance Companies v. Argonaut Insurance Co.*, 525 A.2d 1195, 1197 (Pa. 1987).

§242.8. New acknowledgment.

A new Form 5116 shall be issued upon payment of the surcharge on a new or reinstated basic coverage insurance policy.

Source

The provisions of this § 242.8 adopted October 15, 1976, effective October 16, 1976, 6 Pa.B. 2565; renumbered February 9, 1979, 9 Pa.B. 498.

Notes of Decision

These provisions provide for resolution of complaints of adverse agency action, and as such, do not provide adequate remedy or preclude litigant from seeking relief in court, where issue is Cat Fund's failure to pay share of malpractice claim settlement, which places Fund in position of defendant, as opposed to its designed position of participant and/or arbiter. *Ohio Gas Group of Insurance Companies v. Argonaut Insurance Co.*, 525 A.2d 1195, 1197 (Pa. 1987).

§242.9. Overpayments, credits, and duplicate payments.

When overpayments are made by insureds, agents or insurers, they [may] shall be recovered by offsets against amounts due from companies to the Fund.

[The] Such offsets shall be recorded on Form 216 with minus signs or brackets to distinguish them from debits and shall be accompanied by evidence in support of refunds resulting from premium reductions under § 242.5(a)(1) (relating to adjustment of surcharge). Surcharge credits of amounts less than $10 may be waived in accordance with the insurer's policy relative to small return premiums. Refunds shall be paid directly to the health care provider by the agent or insurer, and upon a showing of proof of payment, the Fund will issue the appropriate credit to the agent or insurer.

Source

The provisions of this § 242.9 adopted October 15, 1976, effective October 16, 1976, 6 Pa.B. 2565; amended March 17, 1978, effective March 18, 1978, 8 Pa.B. 755; renumbered February 9, 1979, 9 Pa.B. 498. Immediately preceding text appears at serial page (32052).

Notes of Decision

These provisions provide for resolution of complaints of adverse agency action, and as such, do not provide adequate remedy or preclude litigant from seeking relief in court, where issue is Cat Fund's failure to pay share of malpractice claim settlement, which places Fund in position of defendant, as opposed to its designed position of participant and/or arbiter. *Ohio Gas Group of Insurance Companies v. Argonaut Insurance Co.*, 525 A.2d 1195, 1197 (Pa. 1987).

§242.10. Self-insurers.

(a) [This chapter applies] The provisions of this chapter shall apply to approved and accepted self-insurance plans and self-insurers.

(b) Self-insurers shall pay the surcharge to the Fund accompanied by the reporting forms required under § 242.6 (relating to reporting forms and procedures) within [60] 20 days of the effective date of the self-insurance plan and on an annual basis thereafter within [60] 20 days of the inception of the annual self-insurance period.

Authority

The provisions of this § 242.10 issued under sections 206 and 506 of the act of April 9, 1929 (P.L. 177, No. 175) (71 P.S.§§ 66 and 186); section 701(e)(4) of the act of October 15, 1975 (P.L. 390, No. 111) (40 P.S. § 1301.701(e)(4)); and 2 Pa.C.S. § 102(a).

Source

The provisions of this § 242.10 adopted October 15, 1976, effective October 16, 1976, 6 Pa.B. 2565; renumbered February 9, 1979, 9 Pa.B. 498; amended July 16, 1982, effective July 17, 1982, 12 Pa.B. 2282. Immediately preceding text appears at serial page (36684).

Notes of Decision

These provisions provide for resolution of complaints of adverse agency action, and as such, do not provide adequate remedy or preclude litigant from seeking relief in court, where issue is Cat Fund's failure to pay share of malpractice claim settlement, which places Fund in position of defendant, as opposed to its designed position of participant and/or arbiter. *Ohio Gas Group of Insurance Companies v. Argonaut Insurance Co.*, 525 A.2d 1195, 1197 (Pa. 1987).

§242.11. Notice of claims exceeding basic coverage insurance.

The insurer or self-insurer shall, within 30 days of determining that a claim is likely to exceed the basic coverage of the insurer, or the retained limits of the self-insurer, submit Form C416 to the Director.

§242.12. Determination of health care provider.

(a) The insurer or self-insurer shall be responsible for making the initial determination of who is a health care provider for purposes of having access to the liability coverage provided by the Fund.

(b) The initial determination of health care provider status by the insurer or self-insurer shall not preclude a review of this determination by the Fund.

Authority

The provisions of this § 242.12 issued under section 506 of the act of April 9, 1929 (P.L. 177, No. 175) (71 P.S. § 186); and sections 701(e)(4) and 702(a) of the act of October 15, 1975 (P.L. 390, No. 111) (40 P.S. §§ 1301.701(e)(4) and 1301.702(a)).

Source

The provisions of this § 242.12 adopted October 15, 1976, effective October 16, 1976 6 Pa.B. 2565; renumbered February 9, 1979, 9 Pa.B. 498; amended April 27, 1984, effective April 28, 1984, 14 Pa.B. 1453. Immediately preceding text appears at serial page (85385).

Notes of Decision

These provisions provide for resolution of complaints of adverse agency action, and as such, do not provide adequate remedy or preclude litigant from seeking relief in court, where issue is Cat Fund's failure to pay share of malpractice claim settlement, which places Fund in position of defendant, as opposed to its designed position of participant and/or arbiter. *Ohio Gas Group of Insurance Companies v. Argonaut Insurance Co.*, 525 A.2d 1195, 1197 (Pa. 1987).

§242.13. Audits.

The Director has the authority to conduct or arrange audits of the records of insurers, health care providers, and the Joint Underwriting Association, in order to protect the rights and responsibilities of the Fund.

Source

The provisions of this § 242.13 adopted October 15, 1976, effective October 16, 1976 6 Pa.B. 2565; renumbered February 9, 1979, 9 Pa.B. 498.

Notes of Decision

These provisions provide for resolution of complaints of adverse agency action, and as such, do not provide adequate remedy or preclude litigant from seeking relief in court, where issue is Cat Fund's failure to pay share of malpractice claim settlement, which places Fund in position of defendant, as opposed to its designed position of participant and/or arbiter. *Ohio Gas Group of Insurance Companies v. Argonaut Insurance Co.*, 525 A.2d 1195, 1197 (Pa. 1987).

* * *

* * *

§242.17. Compliance.

(a) The failure of the health care provider to comply with section 701 of the act (40 P.S. § 1301.701) or this chapter will result in notification by the Director to the applicable Licensure Board. Section 701(f) of the act (40 P. S. § 1301.701(f) provides that failure of a health care provider to comply with section 701 of the act or rules and regulations issued by the Director shall result in the suspension or revocation of the health care provider's license by the Licensure Board.

(b) A health care provider failing to pay the surcharge or emergency surcharge [within the time limits] prescribed will not be covered by the Fund in the event of loss.

90-1
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(c) A health care provider failing to pay the surcharge or emergency surcharge within the time limits prescribed shall be responsible for the payment of interest, and will not be covered by the Fund in the event of loss for the period of time in which any delinquency exists.

[(c)](d) [A] Any health care provider failing to procure increased basic coverage insurance limits under section 701(a) of the act (40 P.S. § 1301.701(a)) and pay the surcharge thereon [will] shall not be covered by the Fund in the event of loss.

[(d)](e) The Fund will be relieved of its responsibility in the following case:

(1) The Fund will be relieved of its responsibility to a health care provider to defend and indemnify a claim reported to the Fund under section 605 of the act (40 P.S. § 1301.605) if, at the time of [the] occurrence, the health care provider fails to maintain basic coverage insurance in compliance with the act and this chapter.

(2) Notwithstanding paragraph (1), if at the time of the occurrence the health care provider is insured on a claims made basis and thereafter fails to purchase the reporting endorsement, prior acts coverage or its substantial equivalent upon cancellation or nonrenewal of the claims made policy, and subsequently a claim is reported to the Fund under section 605 of the act (40 P.S. § 1301.605), the Fund will be relieved of its responsibility to the health care provider to defend and indemnify the claim under section 605 of the act.

[(e)](f) Late remittance by carriers of surcharges collected from health care providers and late remittance of surcharges due from self-insurance providers shall include interest at the rate prescribed in section 506 of the act of April 9, 1929 (P.L. 343, No. 176), known as "The Fiscal Code."

Authority

The provisions of this § 242.17 issued under section 506 of the act of April 9, 1929 (P.L. 177, No. 175) (71 P.S. § 186); and sections 701(e)(4) and 702(a) of the act of October 15, 1975 (P.L. 390, No. 111) (40 P.S. §§ 1301.701(e)(4) and 1301.702(a)).

Source

The provisions of this § 242.17 adopted October 15, 1976, effective October 16, 1976 6 Pa.B. 2565; renumbered February 9, 1979, 9 Pa.B. 498; amended April 27, 1984, effective April 28, 1984, 14 Pa.B. 1453. Immediately preceding text appears at serial page (72789).

Notes of Decision

These provisions provide for resolution of complaints of adverse agency action, and as such, do not provide adequate remedy or preclude litigant from seeking relief in court, where issue is Cat Fund's failure to pay share of malpractice claim settlement, which places Fund in position of defendant, as opposed to its designed position of participant and/or arbiter. *Ohio Gas Group of Insurance Companies v. Argonaut Insurance Co.*, 525 A.2d 1195, 1197 (Pa. 1987).

§242.18. Effective date.

The effective date of this chapter as well as the commencement date for using the prescribed forms shall be [November 1, 1976] November 26, 1996.

* * *

* * *

§242.21 Corrections

(a) Corrections to previously submitted Form 216 shall be clearly marked "Correction". Correction Form 216 shall be separate from other reporting forms and shall identify the original Form 216 being corrected. This form shall contain only the health care provider(s) erroneously submitted.

(b) The insurer or self-insurer shall respond with a Correction Form 216 within 20 days after being notified of erroneous submission.

REGULATIONS
CHAPTER 246. MEDIATION

Section 246.1. Purpose.

The purpose of this chapter is to provide uniform procedures to be used in conducting mediation where primary medical malpractice insurance carrier (s) disagree on a case involving the Medical Professional Liability Catastrophe Loss Fund.

Section 246.2. Definitions.

The following words and terms, when used in this chapter shall have the following meanings, unless the context clearly indicates otherwise:

Act – The Health Care Services Malpractice Act (40 P.S. §§1301.101 - 1301.1006).

Fund – The Medical Professional Liability Catastrophe Loss Fund established by section 701 of the Act (40 P.S. §1301.701.).

Insurer – The insurance company or self-insurer providing basic coverage insurance.

Mediation– A meeting, or meetings, between insurer(s) and the Fund, their representatives and a mediator to explore issues, needs and settlement options. Upon the consent of all parties to any mediation proceeding, that mediation shall be binding, and the parties shall be bound by the conclusions of the mediator. All mediation proceedings are confidential and should not be considered public information subject to disclosure under the Right-To-Know Law and the "Sunshine Act."

Mediator – Individuals having specific training or experience in mediation and/or experience in training in medical malpractice litigation and/or insurance law.

Party – The Fund, all basic coverage insurers, self-insurers, plaintiff(s) and all defendants in medical malpractice litigation involving the Fund.

Section 246.3. Agreement of Parties.

Upon the request of any party, the Fund may provide for a mediator in cases where multiple insurers and/or the Fund disagree on a case. The following procedures shall apply whenever any of the parties have agreed to mediation.

Section 246.4. Administration and Delegation of Duties.

Upon the request of a party to a case within the Fund coverage limits, the Fund may, within its discretion, provide for a mediator. No individual shall serve as a mediator in any dispute in which that person has any financial or personal interest in the case at issue or the result of the mediation. Immediately upon selection, the selected mediator shall disclose any circumstances likely to create a presumption of bias or interest in the outcome of the proceedings, or any circumstances that may prevent a prompt meeting with the parties. In the event that any party thereafter objects to such a mediator on the basis of identifiable bias, interest or unavailability, a new mediator will be selected who is agreeable to all participants in the mediation.

Section 246.5. Binding Mediation.

If all parties agree that mediation shall be binding, the parties shall be bound by the conclusions of the mediator. As provided by the Act, the administration of the mediation and all proceedings conducted thereafter shall be confidential and shall not be considered public information subject to the "Sunshine Act." All documents produced for and relating to the mediation shall be considered part of the Fund's claim file, shall be confidential and shall not be considered public information subject to disclosure under the Right-To-Know Law. If the parties do not agree to binding mediation, the parties should utilize the assistance of an impartial mediator in an attempt to work toward a mutually satisfactory solution, through good faith negotiation.

Section 246.6. Date, Time and Location of Mediation Proceedings.

Upon selection, the mediator will work with the parties to establish the time and location of a mediation session. Additional mediation sessions may be scheduled as agreed to by the parties and the mediator. Notice of a mediation session must be provided to all parties at least three (3) working days in advance of such session. Notice may be given orally or through facsimile communication.

The mediator may, at his or her discretion, meet with or request information pertinent to the mediation from one or more parties prior to scheduling a mediation session.

Section 246.7. Mediation Sessions.

Mediation sessions shall be conducted by the mediator in whatever manner would most expeditiously permit full production of all information reasonably required for the mediator to understand the issues presented. Such information will usually include relevant written materials and a description of the testimony of each witness. For cases designated by the Fund as complex, the mediator may ask the parties for written materials or information in advance of the mediation session in the manner specified in Section 246.6 above. Mediation sessions in non-complex cases not requiring testimonial evidence should be completed within three (3) hours.

At mediation sessions, mediators will conduct an orderly settlement negotiation, considering

to resolve and/or settle disputes. The mediator may conduct separate meetings with each party in order to improve mediator's understanding of the respective positions of each party.

Section 246.8. Mediation by Document Submission.

When all parties agree that a dispute will be decided on the basis of document submission, they must jointly file a signed statement to that effect with the mediator. Each party shall then send two (2) copies of their respective documentation to the mediator, and one (1) copy to each other within seven (7) days of filing with the mediator. The parties will then have an additional seven (7) days to file any answering statements with the mediator and each other.

Section 246.9. Conclusions of the Mediator.

The mediator shall promptly issue and distribute to all parties his or her decision no later than two (2) business days from the date of closing of the final mediation session or complete submission of documents by the parties. The decision shall be in writing and shall be signed by the mediator. The decision will specify the remedy, if any, and there will be no formal opinion unless all parties agree. If the parties so agree, they will share equally in payment of the additional mediator compensation.

Section 246.10. Expenses.

The expenses of witnesses for any party shall be paid by the party producing such witnesses. All other expenses of the mediation, including required travel and other expenses of the mediator, and the expenses of any witness and the cost of any proof produced at the direct request of the mediator, shall be borne equally by all parties, unless they agree otherwise. In the case of mediation by document submission, each party will be responsible for costs associated with their own document submission excluding the expenses of any witness and the cost of any proof produced at the direct request of the mediator, which shall be borne equally by all parties, unless they agree otherwise.

Section 246.11. Confidentiality.

The parties recognize that mediation sessions are settlement negotiations and that all offers, promises, conduct and statements, whether written or oral, made in the course of the proceedings are inadmissable in any litigation or arbitration of their dispute, to the extent allowed by law. The parties agree not to subpoena or otherwise require the mediator to testify or produce records, notes or work product in any future proceedings. No recording or stenographic record will be made of the mediation session(s). If the parties previously agreed to binding mediation, the conclusions of the mediator shall have the force in effect of a settlement and will be legally enforceable and admissible in court or arbitration proceedings to compel enforcement.

Section 246.12. Effective Date

The effective date of this chapter shall be November 26, 1996.

Regulatory Analysis Form

This space for use by IRRC

(1) Agency

Medical Professional Liability Catastrophe Loss Fund

(2) I.D. Number (Governor's Office Use)

IRRC Number:

(3) Short Title

(4) PA Code Cite

31 Pa. Code §§241 et seq.

(5) Agency Contacts & Telephone Numbers

Primary Contact: Arthur F. McNulty (717)733-3770

Secondary Contact: Kenneth J. Serafin

(6) Type of Rulemaking (Check One)

XX Proposed Rulemaking
____ Final Order Adopting Regulation
____ Final Order, Proposed Rulemaking Omitted

(7) Is a 120-Day Emergency Certification Attached?

____ No
____ Yes: By the Attorney General
____ Yes: By the Governor

(8) Briefly explain the regulation in clear and nontechnical language.

The regulations are intended to implement the changes brought about by Act 135 of 1996, and to update regulations that have not been amended since 1984. Specifically, these regulations would:

(1) Insert into the existing regulations, amendments prompted by the reforms brought about by Act 135 of 1996;

(2) Add technical changes to the process by which primary carriers collect, remit and report the Fund surcharge to the Fund;

(3) Provide uniform procedures to be used in conducting voluntary mediation among basic insurance carriers and the Fund.

(9) State the statutory authority for the regulation and any relevant state or federal court decisions.

40 P.S. §1301.701 et seq.

Regulatory Analysis Form

(10) Is the regulation mandated by any federal or state law or court order, or federal regulation? If yes, cite the specific law, case or regulation, and any deadlines for action.

Amendments are warranted by Act 135 of 1996.

(11) Explain the compelling public interest that justifies the regulation. What is the problem it addresses?

(12) State the public health, safety, environmental or general welfare risks associated with non-regulation.

(13) Describe who will benefit from the regulation. (Quantify the benefits as completely as possible and approximate the number of people who will benefit.)

Basic insurance carriers, health care providers, the Fund and, ultimately, the parties to medical malpractice litigation.

Regulatory Analysis Form

(14) Describe who will be adversely affected by the regulation. (Quantify the adverse effects as completely as possible and approximate the number of people who will be adversely affected.)

(15) List the persons, groups or entities that will be required to comply with the regulation. (Approximate the number of people who will be required to comply.)

(16) Describe the communications with and input from the public in the development and drafting of the regulation. List the persons and/or groups who were involved, if applicable.

The proposed mediation regulations were drafted with specific reference to Common Rules established by the American Arbitration Association.

(17) Provide a specific estimate of the costs and/or savings to the regulated community associated with compliance, including any legal, accounting or consulting procedures which may be required.

(18) Provide a specific estimate of the costs and/or savings to local governments associated with compliance, including any legal, accounting or consulting procedures which may be required.

(19) Provide a specific estimate of the costs and/or savings to state government associated with the implementation of the regulation, including any legal, accounting, or consulting procedures which may be required.

Regulatory Analysis Form

(20) In the table below, provide an estimate of the fiscal savings and costs associated with implementation and compliance for the regulated community, local government, and state government for the current year and five subsequent years.

	Current FY Year	FY +1 Year	FY +2 Year	FY +3 Year	FY +4 Year	FY +5 Year
SAVINGS:	$	$	$	$	$	$
Regulated Community						
Local Government						
State Government						
Total Savings						
COSTS:						
Regulated Community						
Local Government						
State Government						
Total Costs						
REVENUE LOSSES:						
Regulated Community						
Local Government						
State Government						
Total Revenue Losses						

(20a) Explain how the cost estimates listed above were derived.

Regulatory Analysis Form

(20b) Provide the past three year expenditure history for programs affected by the regulation.

Program	FY -3	FY -2	FY -1	Current FY

(21) Using the cost-benefit information provided above, explain how the benefits of the regulation outweigh the adverse effects and costs.

(22) Describe the nonregulatory alternatives considered and the costs associated with those alternatives. Provide the reasons for their dismissal.

(23) Describe alternative regulatory schemes considered and the costs associated with those schemes. Provide the reasons for their dismissal.

Regulatory Analysis Form

(24) Are there any provisions that are more stringent than federal standards? If yes, identify the specific provisions and the compelling Pennsylvania interest that demands stronger regulation.

(25) How does this regulation compare with those of other states? Will the regulation put Pennsylvania at a competitive disadvantage with other states?

(26) Will the regulation affect existing or proposed regulations of the promulgating agency or other state agencies? If yes, explain and provide specific citations.

(27) Will any public hearings or informational meetings be scheduled? Please provide the dates, times, and locations, if available.

Regulatory Analysis Form

(28) Will the regulation change existing reporting, record keeping, or other paperwork requirements? Describe the changes and attach copies of forms or reports which will be required as a result of implementation, if available.

(29) Please list any special provisions which have been developed to meet the particular needs of affected groups or persons including, but not limited to, minorities, elderly, small businesses, and farmers.

(30) What is the anticipated effective date of the regulation; the date by which compliance with the regulation will be required; and the date by which any required permits, licenses or other approvals must be obtained?

(31) Provide the schedule for continual review of the regulation.

COMMONWEALTH OF PENNSYLVANIA
MEDICAL PROFESSIONAL LIABILITY
CATASTROPHE LOSS FUND

JOHN H. REED
DIRECTOR

10TH FLOOR, SUITE 1000
30 NORTH THIRD STREET
P.O. BOX 12030
HARRISBURG, PA 17108
717-783-3770

August 14, 1997

Robert Nyce
Executive Director
Independent Regulatory Review Commission
333 Market Street, 14th Floor
Harrisburg, PA 17101

RE: Pennsylvania Medical Professional Liability Catastrophe Loss Fund
Proposed Regulation No. 20-1

Dear Mr. Nyce:

Enclosed for your review are proposed regulations promulgated by the Medical Professional Liability Catastrophe Loss Fund.

Thank you for your attention to this matter. Feel free to contact my office if you have any questions or comments that arise during the review process.

Sincerely,

John H. Reed, Esq.
Director

JHR:lt
Enclosure

cc: Dennis Walsh, Secretary for Legislative Affairs

TRANSMITTAL SHEET FOR REGULATIONS SUBJECT TO THE REGULATORY REVIEW ACT

I.D. NUMBER: 20-1

SUBJECT: Mediation

AGENCY: Medical Professional Liability Catastrophe Loss FundCorrections

TYPE OF REGULATION

X Proposed Regulation

Final Regulation

Final Regulation with Notice of Proposed Rulemaking Omitted

120-day Emergency Certification of the Attorney General

120-day Emergency Certification of the Governor

FILING OF REGULATION

DATE	SIGNATURE	DESIGNATION
8-15-97	Sheila Cochat	HOUSE INSURANCE COMMITTEE
8/15/97	Diane Akinick	
8/15/97	Denise Potter	SENATE BANKING AND INSURANCE COMMITTEE
8/15/97	Bob Sturm	
8/15/97	William Beuschal	INDEPENDENT REGULATORY REVIEW COMMISSION
		ATTORNEY GENERAL
8/15/97	Maya Stuiger	LEGISLATIVE REFERENCE BUREAU

July 31, 1997