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Senate of Pennsylvania

October 13, 1997

SENT BY FAX

John H. Reed, Director
Medical Professional Liability Catastrophe Loss Fund
Post Office Box 12030
Harrisburg, Pennsylvania 17108

Dear Mr. Reed:

As Chairman, Vice Chairman and Minority Chairman, we would like to express our concerns regarding "Proposed Regulation No. 20-1," which was developed in response to Act 135 of 1996.

The Senate Banking and Insurance Committee was active in developing the language that ultimately became law. Since publication of the regulations, the committee has been contacted by various health care provider groups expressing concern that the regulations go beyond the legislative intent of Act 135. We agree with their assessment.

First, is the reduction of time during which a provider may submit the surcharge from 60 days to 20 days. During negotiations, the fund submitted language shortening the remittance time from 60 days to 20 days. The request was rejected and not included in the final legislative package. While the original 60 day time frame was apparently developed through the regulatory process and not specified in statute, the rejection of the fund's request to shorten the time period and language contained in Act 135 indicates legislative acknowledgment of the appropriateness of the 60 days.

If you refer to Section 701(e)(14) you will note that the legislature adopted language to allow health care providers to pay the annual surcharge in equal installments. Those payments commence "60 days" from the date of the policy inception or renewal. If the legislature deemed it appropriate to allow 60 days in this situation, it makes no logical sense to in essence penalize those providers who pay their surcharge in full by shortening their payment period to 20 days. We believe the payment periods should be consistent and that if the fund desires a shorter payment period, the issue should be brought before the legislature.

Second, is the proposed interest on late payments. Again, this issue was raised by the fund during the development of the legislation, however it was not included in the final legislation. While this proposal may have merit, we recommend that the fund work with the provider community to develop an acceptable approach or delete this provision from the regulation.

Third, is the revocation of coverage for the time period during which a payment is late. This issue becomes increasingly critical in light of the reduction in payment remittance time. The intent of Pennsylvania law is to ensure that all providers have liability coverage at all times. Revocation of coverage counteracts that goal and will leave health consumers without a means of recovering damages for malpractice. Some other more appropriate penalty should be developed.

Last, is the lack of involvement of the Advisory Board in developing the regulations. If you refer to Section 706(e)(1) of the Act, the board was given the power and duty to review procedures and operations of the fund. At the September meeting of the board it was made clear that they were not involved in the development of the regulations. This clearly violates the intent of Act 135.

We request that these issues be addressed before the regulations are published in final form. Since the fund has not scheduled a public hearing, the Committee would be willing to hold a public hearing to help facilitate the dialogue necessary to resolve these differences. We look forward to your response.

Sincerely,

EDWIN G. HOLL
Majority Chairman
Banking and Insurance Committee

J. DOYLE CORMAN
Vice Chairman
Banking and Insurance Committee

JAY COSTA, JR.
Minority Chairman
Banking and Insurance Committee

cc: Honorable F. Joseph Loeper
Arthur F. McNulty, Esq.

NICHOLAS A. MICOZZIE, MEMBER
ROOM 45, EAST WING
HOUSE BOX 202020
HARRISBURG, PENNSYLVANIA 17120-2020
PHONE: (717) 783-8808
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6 S. SPRINGFIELD ROAD
CLIFTON HEIGHTS, PENNSYLVANIA 19018
PHONE: (610) 259-2820
FAX: (610) 259-7019

House of Representatives
COMMONWEALTH OF PENNSYLVANIA
HARRISBURG

COMMITTEES

INSURANCE COMMITEE, CHAIRMAN
HEALH & HUMAN SERVICES

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October 7, 1997

Arthur F. McNulty
Chief Counsel
Pennsylvania Medical Professional Liability Catastrophe Loss Fund
10th Floor, Suite 1000
30 North Third Street
P.O. Box 12030
Harrisburg, PA 17108

RE: Proposed Rulemaking
Amendments to 31 PA Code, Part IX, Chapter 242
Medical Professional Liability Catastrophe Loss Fund

Dear Mr. McNulty:

Recent discussions by members of the House Insurance Committee included a discussion of the Medical Professional Liability Catastrophe Loss Fund's proposed regulations. During that discussion, members of the committee unanimously agreed to submission, by the Majority and Minority Chairmen, to the fund a summary of the Committee' objections to the proposed regulations. This joint letter, in accordance with the Regulatory Review Act, states the reasons why the proposed regulations are unacceptable.

The regulations are contrary to, and in several instances go beyond, the statutory authority of the fund and the intent of Act 135 of 1996. The General Assembly's purpose in passing Act 135 was to create an advisory board to provide direction to the fund, provide for the short-term stability of the fund, begin a transition of the fund coverage to the private sector, and require the advisory board to further study privatization of the fund and make specific recommendations concerning the privatization or reform of the fund.

We believe the legislative intent in Act 135 of 1996 was for the board to be consulted on operational changes concerning the Fund policies and operations such as those contained in the proposed regulations.

Based upon our review of the Act 135, it appears that several provisions of the proposed regulations are not addressed in the Act:

- § 242.17. Compliance (c). This change would permanently deny CAT Fund coverage for any period of time when a surcharge payment delinquency exists. This was not addressed in Act 135 and is not a common insurance practice.

- § 242.5. Adjustment of surcharge. (a). This would change the remittance period for Fund surcharge payments from 60 days to 20 days. This was not addressed in Act 135. Given the competitive primary insurance market in Pennsylvania, insurers cannot bill for their primary premium, let alone the CAT Fund surcharge, until the provider selects their insurer. Providers, when deciding between competing insurers, often do not make their selections until their policy renewal date. Insurers serve to lessen the administrative burden on the Fund by collecting and remitting the CAT Fund surcharge payment. It is unreasonable and impractical to expect insurers to bill providers, collect payment, and remit the CAT Fund surcharge within 20 days of the policy renewal date.

- § 242.5 (c) and § 242.17 (c) and (f). These provisions of the proposed regulations require interest on late remittance of surcharge payments. While Act 135 does define "interest," it does not direct the Fund to apply interest to late surcharge remittances.

Furthermore, the proposed regulations are retroactive back to November 26, 1996 which would place an unreasonable hardship on the providers.

For all of the above reasons, in addition to those contained in the many public comments in opposition to these proposed regulations received by our members, the House Insurance Committee urges that the fund not proceed with these regulatory changes until all of these concerns are appropriately addressed. Further, in accordance with Executive Order 1996-1, the fund solicit early and meaningful input from the regulated community.

Sincerely,

Rep. Nicholas A. Micozzie
Majority Chairman
House Insurance Committee
163rd Legislative District

Rep. Nicholas A. Colafella
Democratic Chairman
House Insurance Committee
15th Legislative District

cc: John McGinley, Jr., Chairperson, Independent Regulatory Review Commission
Robert E. Nyce, Executive Director, Independent Regulatory Review Commission

HAP

THE HOSPITAL & HEALTHSYSTEM ASSOCIATION OF PENNSYLVANIA

May 22, 1998

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Honorable Nicholas A. Micozzie
Pennsylvania House of Representatives
45 East Wing
Harrisburg, PA 17120

Dear Representative Micozzie:

At last week's Insurance Committee hearing, Rick Spease raised the issue of the Medical Professional Liability Catastrophe Loss Fund demanding interest penalty payments for late surcharge remittances. I wanted to share with you the current practice of the Fund.

Last year, the Fund attempted to impose an interest penalty and a reduction in the remittance time period via proposed regulation No.20-1. This proposal was not discussed or reviewed by the CAT Fund Advisory Board. You, Representative Colafella, and the majority and minority chairmen of the Senate Banking and Insurance Committee raised objections to these regulations. On October 20, 1997, the Independent Regulatory Review Commission (IRRC) commented,

> "Act 135 confers no specific authority upon the Fund to impose interest penalties for late payments...Therefore, we recommend that the Fund delete interest charge provisions from its final form regulation."

It has come to my attention that the Fund is seeking interest penalties from health care providers. Enclosed is a sample copy of a letter from the Fund demanding interest penalty payment. So far, PHICO Insurance Company has received many similar letters which, in total, demand over $16,000. The letter states that failure to pay the penalty will result in loss of coverage.

We agree that the Fund lacks statutory authority to impose an interest penalty and to deny coverage during the delinquency period. This is an egregious penalty, and defeats the key purpose of the Fund to protect the public by allowing patients to recover damages for harm caused by a health care provider.

4750 Lindle Road
P.O. Box 8600
Harrisburg, PA 17105-8600
717.564.9200 Phone
717.561.5334 Fax
http://www.hap2000.org

HAP

HAP is willing to work with the General Assembly to develop legislation that will result in timely payments to the Fund, including reasonable penalties to encourage compliance. If you agree that such legislation is warranted, I will gladly provide you with draft language. In the interim, I hope you will join me in ending this illegal practice of the Fund.

Sincerely,

JAMES M. REDMOND
Senior Vice President, Legislative Services

/ls
enclosure

c: Honorable Nicholas Colafella
Members of the House Insurance Committee
Paul Tufano, Esq.
Dennis Walsh
John H. Reed
Arthur McNulty, Esq.
Robert Nyce
Members of the CAT Fund Advisory Board

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

May 7, 1998

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Date Received
5-11-98
Corporate Underwriting

PHICO Insurance Company
One Phico Dr., P.O. Box 85
Mechanicsburg, PA 17055

Re: Late Surcharge Remittance -- Interest Penalty Notice

Dear

The regulations of the Medical Professional Liability Catastrophe Loss Fund (hereinafter the "Fund") currently require that the appropriate surcharge must be remitted to the Fund within sixty (60) calendar days of the primary policy inception and/or renewal date. However, your remittance for the health care provider(s) on the enclosed worksheet was not received by the Fund until May 1, 1998.

Act 135 of 1996 provides for payment of interest in the event of a late surcharge remittance. The total interest penalty charged is calculated by multiplying the amount of the late surcharge remittance times the interest rate prescribed in Section 806 of the Fiscal Code (9% per annum for 1998) times the number of days that lapsed between the date on which the payment was due at the Fund and the date on which the payment was actually received at the Fund. Therefore, you are hereby requested to remit to my attention an interest payment of $7,593.587 along with a copy of the enclosed worksheet within twenty (20) calendar days from the date of this letter.

Please be further advised that Fund regulations at 31 Pa. Code Section 242.17(b) provide that any health care provider failing to pay the surcharge within the time limits prescribed shall not be covered by the Fund in the event of loss. Upon receipt of the interest payment set forth above, coverage under the Health Care Services Malpractice Act will be cured for all claims except those claims about which you or your insureds knew or should have known.

Your prompt attention to this matter is appreciated.

Sincerely,

Pamela Bridy
Administrative Officer

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WOMEN'S ASSOCIATION FOR WOMEN'S ALTERNATIVES, INC.

KEEPING FAMILIES TOGETHER

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REVIEW COMMISSION INDEPENDENT REVIEW

May 20, 1998

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Mr. Robert Nyce
Executive Director
Independent Regulatory Review Commission
14th Floor, Harristown 2
333 Market St.
Harrisburg, PA 17101

Dear Mr. Nyce:

Enclosed is a new study, done by a well-regarded national researcher, charting what it takes in each of Pennsylvania's counties for families to truly achieve economic self-sufficiency. The Pennsylvania Self-Sufficiency Standard shows that families with young children face enormous barriers to self-sufficiency, in part because of their child care costs.

With the Pennsylvania state government now reviewing its subsidized child care program, we are pleased to also enclose a recent study by the same researcher, "When Wages Aren't Enough: Using the Self-Sufficiency Standard to Model the Impact of Child Care Subsidies on Wage Adequacy." This study examines the impact on self-sufficiency of the current child care subsidy program as well as the changes proposed to the parent fee.

"When Wages Aren't Enough" focuses on the five counties in the southeastern Pennsylvania region. We think you will be interested to see that families with young children currently experience a gap between basic monthly living expenses with the current child care program; this gap increases under the current published proposal for the new co-payment. The summary table on page 10 shows, for example, that a family living in the suburban Philadelphia area and earning $13,000 yearly (with two children) can pay only 90% of basic monthly living expenses under the current subsidy program. This drops to 87% of monthly expenses under the proposed program, leaving an income "gap" of more than $2,000 each year, which is significant on a $13,000 annual income.

If I or members of my staff can be of assistance to you in reviewing this study, please feel free to call me at (610) 543-5022. This study has been shared with the Pennsylvania Child Care Campaign, which includes, among others, Community Justice Project, Delaware Valley Child Care Council, Pennsylvania Association of Child Care Agencies, Philadelphia Citizens for Children and youth, and Success Against All Odds, and they also may be able to assist you in understanding and interpreting the study findings.

Sincerely,

Carol Goertzel

Carol Goertzel
Executive Director

Administrative Offices: 225 South Chester Road, Suite 6, Swarthmore, PA 19081 • 610-543-5022 FAX: 610-543-6483
Women's Alternative Center: 519 Station Road, Wawa, PA 19063 • 610-459-9177 FAX 610-459-3765
Philadelphia Teen Mother Supervised Independent Living Program: 5630 Walnut Street, Philadelphia, PA 19139 • 215-747-8760 FAX: 215-747-7663
Services to Children in their Own Homes (SCOH): 5630 Walnut Street, Philadelphia, PA 19139 • 215-747-8760 FAX: 215-747-7663
School & Family Together (SFT): NIA Center, 6801 N. 16th Street, Philadelphia, PA 19126 • 215-924-6104 FAX: 215-924-9627
Options for Independence Program: 1616 N. Broad Street, Philadelphia, PA 19121 • 215-236-9911 FAX: 215-978-2649
Delaware County Teen Mother Supervised Independent Living Program: 7226A Alderbrook Road, Upper Darby, PA 19082 • 610-284-6631 FAX: 610-284-6671

When Wages Aren't Enough: Using the Self-Sufficiency Standard to Model the Impact of Child Care Subsidies on Wage Adequacy

by Diana M. Pearce, Ph. D.

Prepared for the Pennsylvania Family Economic Self-Sufficiency Project and the Women's Association for Women's Alternatives, Inc. (W.A.W.A.)

March 1998

The Pennsylvania Family Economic Self-Sufficiency Project

The project is a collaborative effort by government officials and state and local organizations that are part of the business, training and education communities. Its statewide leadership team works to promote discussion and foster state-level policy, legislation and regulations to include strategies that will ensure the economic self-sufficiency of low-income women and their families. Nationally, this project is convened by Wider Opportunities for Women (WOW), with partnerships including the Corporation for Enterprise Development, the Ms. Foundation for Women and the National Economic Development and Law Center. The project focuses on six strategies for economic self-sufficiency that can be adapted in state policies and legislation.

Women's Association for Women's Alternatives, Inc. (W.A.W.A.)

The mission of W.A.W.A. is to ensure that low-income women—from teens through adults—and their children, who have family histories of abuse and neglect, move on to stable, independent and self-sufficient lives; and to enhance the preservation of these at-risk families. These fragile families are at high risk of recurring homelessness, abuse and permanent dependence on the welfare system. W.A.W.A. will achieve its mission through a comprehensive array of supportive services to women and their children including, but not limited to, transitional housing, case management, therapeutic counseling, vocational/educational guidance, employment training/referral, child care and children's programming, and assistance in obtaining permanent housing with after care services.

Carol Goertzel, W.A.W.A. Executive Director &
Statewide Project Coordinator
Lise Reno, Project Coordinator

225 S. Chester Road, Suite 6
Swarthmore, PA 19081
Phone: (610) 543-5022 Fax: (610) 543-6483

This Project is supported by grants from the U.S. Department of Labor Women's Bureau—Region 3, Philadelphia, PA. The Philadelphia Foundation, and the Samuel S. Fels Fund. This report was funded by Child Care Matters, a partnership of The Delaware Valley Association for the Education of Young Children, The Delware Valley Child Care Council, Philadelphia Citizens for Children and Youth, The Philadelphia Early Childhood Collaborative and the United Way of Southeastern Pennsylvania. Copies of the report may be obtained from W.A.W.A. Technical questions should be referred to the author (and originator of the Self-Sufficiency Standard), Dr. Diana Pearce, who can be reached at (206) 545-6504 (Phone/Fax).

When Wages Aren't Enough:
Using the Self-Sufficiency Standard to Model the Impact of Child Care Subsidies on Wage Adequacy

Introduction

With the advent of "welfare reform" and the many related changes in the provision of social services, many families are struggling to meet their families' needs through employment, but at relatively low wage levels. Many advocates, public officials, and service providers have grappled with the issue of how to enable low-income single parents become economically self-sufficient. In the study reported in this paper, the impact of the level of child care subsidy on the adequacy of various wage levels to meet families' basic needs is modeled and evaluated for the Philadelphia metropolitan area.

The study uses the Self-Sufficiency Standard, a measure of income adequacy developed by Dr. Diana Pearce. In 1997, through the Family Self-Sufficiency State Organizing Project, and the partnership of Wider Opportunities for Women and Women's Association for Women's Alternatives, the Standard was calculated for all areas of Pennsylvania, and for 70 different family types. (Interested readers may refer to *The Self-Sufficiency Standard for Pennsylvania*, Fall 1997, available from W.A.W.A.)

The next section of this report introduces the self-sufficiency standard, followed by a section which describes the data used and how the basic standard is calculated. The fourth section examines the impact of three levels of child care subsidies (no subsidy, current child care subsidies, and proposed child care subsidies), together with food stamps where applicable, on the ability of wages at different levels to meet family basic needs adequately. The final section reflects on the findings from the models, and discusses the impact of child care subsidies on single parent families.

What is the Self-Sufficiency Standard?

The Standard is a measure of income adequacy. It defines the amount of income required to meet basic needs (including paying taxes) in the regular "marketplace" without public subsidies-such as public housing, food stamps, Medicaid or child care-or private/informal subsidies-such as free baby-sitting by a relative or friend, food provided by churches or local food banks, or housing shared with relatives or friends.

The Standard, therefore, estimates the level of income necessary for a given family type to become independent of welfare or other public or private subsidies. It answers the question, "How much is enough? That is, how much money does it take for a family of a given size and composition, living in a certain place, to be self-sufficient--paying for their basic necessities out of their own pockets, without resort to public to private assistance?"

The Self-Sufficiency Standard calculates the minimum amount of money necessary for a family to meet its basic needs. That is, the

amounts allotted are sufficient to meet minimum nutrition standards, to obtain housing that is neither substandard nor overcrowded. Thus self-sufficiency does not mean luxury, or even comfort, but means maintaining a decent standard of living and not having to choose between basic necessities—whether to meet one's need for child care but not for nutrition; or housing, but not medical care. A family's income is deemed inadequate if it falls below this minimum amount. In these ways, the Standard is similar to the official measure of poverty calculated by the Census Bureau. The Standard, however, differs from the official poverty measure in several important ways:

- The Standard assumes that all adults work full-time, and therefore, includes costs associated with employment, specifically transportation and taxes, and for families with young children, child care.

- The Standard takes into account that many costs differ not only by family size and composition (as does the official poverty measure), but also by the age of children. While food and medical care costs are slightly lower for younger children, child care costs are much higher-particularly for children not yet in school-and are a substantial budget item not included in the official poverty measure.

- The Standard accounts for regional variations in cost. This is particularly important for housing. Housing in the most expensive areas of the country costs four times as much as in the least expensive areas for equivalent size units. Regional variation also occurs for child care, health care and transportation, although to a lesser extent than for housing. Even within the Philadelphia metropolitan area, there is variation in costs. It is assumed that those in Philadelphia use (less expensive) public transportation, and child care costs vary considerably by county.

- The Standard includes the "cost" of taxes, and the "benefit" of tax credits. It provides for state sales taxes, as well as payroll (Social Security) taxes, and federal and state income taxes. Two credits available to working adults, the Child Care Tax Credit (CCTC) and the Earned Income Tax Credit (EITC) are "credited" against the income needed to meet basic needs-thus reducing the income needed to be self-sufficient.

- The Standard accounts for the fact that, over time, various costs increase at different rates. For example, food costs, on which the official poverty thresholds are based, have not increased as fast as housing costs: the official poverty thresholds, which are based on food costs and do not allow for differential inflation rates among other non-food basic needs, are no longer adequate to meet real needs.

By incorporating these factors, the Self-Sufficiency Standard moves beyond the poverty threshold approach in three important ways. First, the Standard reflects the changing needs of families resulting from two important demographic changes that have occurred over the last three decades-the growth of single-parent families and the increased participation of mothers in the labor force. Second, the Standard allows for changes in net income resulting from changes in tax policy, particularly the much higher level of taxes paid by low-income families today, and the tax credits now available to these families. Third, it reflects the geographical differences in costs-especially housing and child care--not only between different regions and states, but also within states. The Standard defines needs at the most detailed level possible, depending upon data availability, usually at the county level.

How Is the Self-Sufficiency Standard Calculated?

The Self-Sufficiency Standard is calculated using a market basket approach-pricing each component individually. (For detailed information on calculating the Standard, please see *Calculating The Self-Sufficiency Standard*, by Dr. Diana Pearce, et al. forthcoming from Wider Opportunities for Women, Inc.) This market basket approach allows each component to vary independently, so that over time, if some costs rise faster than others, the Standard will reflect the changes in the relative importance of each item and its individual cost or benefit. The market basket approach also allows for adjustments in the Standard if a subsidy becomes available.

Each component included in the Self-Sufficiency Standard is calculated using figures that are either collected and calculated by a single national source (such as the U.S. Bureau of the Census) or calculated by state government agencies using standardized methodology (such as child care costs). All costs presented in The Self-Sufficiency Standard for Pennsylvania are for 1996 or have been updated, using the Consumer Price Index (CPI), so that they are equivalent.

The costs for the Standard are as geographically specific as is possible with the data available, and based on knowledge of variations in costs. Thus, costs that have little or no regional variation (such as food) are standardized, while costs such as housing and child care, which vary substantially, are calculated at the most geographically specific level available, which in Pennsylvania is at the county level. The components of the Self-Sufficiency Standard for Pennsylvania and the assumptions included in the calculations are described below.

Housing: The Standard uses the 1996 Fair Market Rents for housing costs, which are calculated annually by the U.S. Department of Housing and Urban Development for every metropolitan housing market and non-metropolitan county. These "rents" reflect the cost of a given size unit (including utilities but not including telephone) at the 40th percentile level. (At the 40th percentile level, 40% of the housing in a given area would be less expensive than this amount; 60% would be more expensive.) The Fair Market Rents are intended to reflect the costs of housing that meet minimum standards of decency. The Self-Sufficiency Standard adjusts for the size of the unit depending upon the size of the family. It assumes that parents and children should not share the same bedroom and that there should not be more than two children in a bedroom. Therefore, one parent and one child need a two-bedroom apartment, as do two parents with two children.

Child Care: We derived the 1996 child care costs from Pennsylvania's market survey of child care costs. (These surveys were mandated by the Family Support Act of 1988, to be conducted biennially.) The child care amounts provided in the market surveys allow access to 75% of the local child care market, and are based on the age of the child and the type of setting (e.g., whether the child is in a child care home, a center, or a before-and-after-school program). Child care costs at the 75th percentile reflect care that allows for quality, long-term child development. We acknowledge the unfortunate reality that not all families will choose this type of care, however.

Since studies have shown that most families using out-of-home care choose a family day care home for infants and toddlers, and center-

based care for children three to five years old, the Standard assumes that children less than three years of age receive care in registered or licensed day care homes full-time, while preschoolers go to day care centers full-time. School-age children (ages six to twelve) are assumed to receive part-time care in before- and after-school programs.

Food: The Standard uses the U.S. Department of Agriculture's Low-Cost Food Plan for June 1996 to calculate food costs. (USDA does not produce annual averages for food costs. However, we follow the Food Stamp Program and use estimates for June as an annual average.) The amounts for food in the Low-Cost Food Plan are about 25% higher than in the Thrifty Food Plan, which the Census Bureau uses to calculate the official poverty thresholds. The Low-Cost Food Plan also allows for a nutritionally adequate diet and is based on more realistic assumptions about food preparation time and consumption patterns. The food costs in the Standard are varied according to the number and age of children and the number and sex of adults. Since there is little regional variation in these costs, the Standard uses the national average costs for all areas.

Although the Low-Cost Food Plan amounts are higher than the amounts used to calculate the official poverty thresholds, they are conservative estimates of food expenditures. Even though average American families spend about 39% of their food budget on food eaten away from home, according to the Consumer Expenditure Survey, the Low-Cost Food Plan does not allow for any fast-food or restaurant meals.

Transportation: Families living in cities with adequate public transportation-which, in effect, means a city with a rail as well as a bus system that is used by a substantial percentage of the population-are assumed to use public transportation to get to work. In Pennsylvania, only the city of Philadelphia has such a system. For families who live in counties and cities that do not have adequate public transportation systems, it is assumed that *each* adult must own and operate a car. (It is unlikely that two adults with two jobs would be traveling to and from the same place of work, at exactly the same times.)

Private transportation costs are based on the costs of owning and operating an eight-year-old car, or cars. The Standard assumes the car(s) will be used to commute to work five days per week, plus one trip per week for shopping for food and other errands. The costs include monthly variable costs (e.g., gas, oil, tires, maintenance) and fixed costs (e.g., fire and theft insurance, property damage and liability, license, registration and taxes, finance charges). The costs do not, however, include the initial cost of purchasing a car.

The Standard adjusts transportation costs (including mileage) based on whether the family is headed by a single parent, two parents or a single adult with no children. One parent in each household with children is assumed to have a slightly longer weekday trip to allow for "linking" trips to the day care facility. The Standard also adjusts for differences in transportation costs by region of the country. Data for transportation costs were obtained from the American Automobile Manufactures Association and the Consumer Expenditure Survey.

Medical Care: The Self-Sufficiency Standard assumes that a full-time worker has health insurance coverage provided by her/his employer. Health care costs included in the Standard are limited to the employee's share of insurance premiums plus additional out-of-pocket expenses, including co-payments, uncovered expenses (such as costs for dental care and prescriptions) and insurance

deductibles. The Standard assumes that employees will pay one-third of the cost of health insurance. Although workers who do not have employer-provided health insurance often "do without," we stress that families cannot be truly self-sufficient without health insurance. Data for Pennsylvania's medical costs were obtained from the National Medical Expenditure Survey and the Families USA report, Skyrocketing Health Inflation: 1980 - 1993 - 2000.

Miscellaneous: This expense category includes items such as clothing, shoes, paper products, diapers, nonprescription medicines, cleaning products and household items, personal hygiene items, and telephone. Miscellaneous expenses are calculated by taking 10% of all other costs. In comparison to other measures (which usually recommend 15%), this percentage is a conservative estimate.

Taxes: Taxes include sales tax, federal and state income tax, and payroll tax. State tax rates are calculated using the 1996 Commerce Clearinghouse State Tax Handbook and information from the Pennsylvania Department of Revenue. In 1996, the Pennsylvania retail sales tax was 6%, with no tax on food. Sales taxes are calculated only on "miscellaneous" items and, as one does not pay tax on rent, child care, and so forth. Indirect taxes, e.g., on housing, are included in the price of housing passed on by the landlord to the tenant; also, taxes on gasoline are included in the cost of a car. The state income tax rate is 2.8% for all individuals and families, with no deductions or exemptions. However, Pennsylvania provides "tax forgiveness" for families with low incomes, depending upon household size. For example, a one-person household does not pay any taxes if her/his income is less than $6300; a five person family does not pay any state income tax if their income is less than $18,300, but they start paying the full rate at incomes of $19,200 or higher.

Tax for OASDI and Medicare is 7.65% of total earnings (plus an additional 4.7% payroll tax for Philadelphia residents). Although the federal income tax rate is higher than the payroll tax rate--15% of income for families in this range--exemptions and deductions are substantial, so that families do not start to pay income tax until their incomes reach $10,000-$12,000 or more, thus lowering the effective tax rate to 7% -10% for most taxpayers.

Earned Income Tax Credit (EITC): The EITC, or as it is sometimes called, the Earned Income Credit, is a federal tax refund intended to offset the loss of income from taxes owed by working poor and near-poor families. The EITC is a "refundable" tax, i.e., working adults may receive the tax credit-a lump-sum payment-whether or not they owe any federal taxes. The EITC reduces the income needed for a family to be self-sufficient.

Child Care Tax Credit (CCTC): The CCTC is a federal tax credit that allows working parents to deduct a percentage of their child care costs from the federal income taxes they owe. Like the EITC, the CCTC is deducted from the total amount of money a family needs to be self-sufficient. Unlike the EITC, the CCTC is not a "refundable" or "negative" tax. A family may only receive the CCTC as a credit against federal income taxes owed. Therefore, families who owe very little to the federal government in income taxes, receive little CCTC.

The Impact of Child Care Subsidies on the Adequacy of Wages

Calculating the self-sufficiency standard for communities in the Philadelphia area makes clear that, given the relatively high costs of housing, child care, and other basic needs, the wage at which a given family is self-sufficient is often quite high. This is especially true for single parent families with children below school age: for example, a single parent with one infant and one preschooler requires wages of about $17.00 an hour, or about $3000 per month, in order to meet her family's basic needs, including taxes, without public or private subsidies.

One of the single most costly expenses for many families with very young children is child care. By subsidizing this cost, the government helps bridge the gap between the needs of low-income families and their wages. In this section, we use the self-sufficiency standard, and its components, to examine how various levels of child care subsidy, at various wage levels, help make wages in the range of about $6.00 to $12.00 adequate to meet family needs.

In the tables that accompany this section, we have taken one family type—a single parent with a preschooler and an infant--and modeled how providing child care assistance affects the adequacy of wages at various levels. There are five tables, one for each of the five counties in the metropolitan area—Bucks, Chester, Delaware, Montgomery, and Philadelphia.

Each table has two pages: the first page models the effects of current child care subsidies at various income levels, including self-sufficiency level (in which costs are shown for all basic needs, without subsidy, as a comparison), and then at various income levels as multiple of the poverty level, from 100% to 200% of poverty. Also included is the effect of food stamps where families are income-eligible. The second page of each panel models the impact on wage adequacy of decreasing child care subsidies (by increasing the required co-pays) under the proposed new child care subsidy schedule.

Each page of each table has six columns. The first column is the self-sufficiency standard, which provides the full cost of each basic need (food, shelter, child care, and so forth), without subsidies, as well as the self-sufficiency wage for a single parent with a preschooler and an infant in the given community. The next columns are for wages at 100% of the poverty line ($6.31 per hour, $1111 per month, and $13,330 per year), 125% of the poverty line, 150% of the poverty line, 185% of the poverty line, and 200% of the poverty line. Each column shows, for a given wage level, the taxes and tax credits, and monthly living expenses for this family type. (Note that the taxes and tax credits depend on the total income, while the living expenses stay the same, changing only if a subsidy reduces the amount required).

In the last three rows, the total expenses (including taxes) are compared with the income from the given wage level, first showing whether the wages are sufficient to cover expenses (including net taxes). If the expenses are greater than the wage income, this number is negative and the wage adequacy question is answered "no"; if the income is equal to or greater than total expenses, then this question is answered "yes". In the last line adequacy is quantified as the per cent of total expenses covered by the income from wages. Thus if wages at the poverty level, plus food stamps and current child cares subsidies, provide 91% of the amount needed to cover expenses, then the number in the last row of this column will be 91%, as can be seen in the first page of Table 1, for Philadelphia County.

Finally, several differences between the city of Philadelphia (Philadelphia County) and the suburban counties should be noted. Most importantly, it is assumed that Philadelphia residents also work in the city, which subjects these families to a 4.7% payroll tax. This increases the income required to be self-sufficient by about $150, or almost one dollar per hour. (For simplicity's sake, we likewise assume suburban residents also work in the suburbs; if they worked in Philadelphia, their wages required to be self-sufficient would have to be increased by about 5%, the exact amount determined by the impact on tax credits and/or subsidies). On the other hand, while city residents are assumed to use public transportation, in suburban jurisdictions it is assumed that transportation is via a private care, which is more expensive, and child care costs are about $50 to $100 more than in the city of Philadelphia for this family type.

The Impact of Current Child Care Subsidies

In the first page of each of the five tables, the adequacy of wages is evaluated with food stamps (where applicable) and current child care subsidies. Note that, by definition, those on the self-sufficiency standard do not have subsidies, and thus pay the full cost of child care.

The cost of child care for two children, one an infant and one a preschooler, ranges from $941 per month in Philadelphia to $1061, making it by far the single largest item in this single parent family's budget. Child care subsidies substantially reduce this cost, helping the lowest income families the most, substantially increasing the adequacy of their wages. Thus Philadelphia families at the poverty level, with the help of current child care subsidies and food stamps, find that the adequacy of their wages increases to 91%; for those at 125% of the federal poverty level, wage adequacy increases to 97%. Similarly, in Chester County, with the addition of child care subsidies, families at poverty level wages are able to meet 90% of their needs.

The Impact of Proposed Child Care Subsidies

In the second page of each table, the impact of the proposed child care subsidies are shown. These changes raise the parents' co-pays at each income level; additionally, they are higher for those families with greater child care costs. This increases the costs to the families here from about $65 more for those with a poverty level income to $109 more for families at the 185% income level. Note that while current child care subsidies phase out gradutally, ending only when a family's income reaches 235% of the poverty level , under the proposed new child care subsidy schedule, those at the 200% of poverty level are not eligible for any child care subsidy—even though this level of income is not sufficient, in any Philadelphia jurisdiction, to meet their basic needs. The effect of this is to decrease the wage adequacy in each jurisdiction for those at the poverty level by 3%, from 91% to 88% for those in Philadelphia, and from 90% to 87% for those in suburban jurisdictions (Note that while child care costs vary by county, child care subsidies are the same for a family of a given size and income, regardless of location).

Some of the impact of the increased cost of child care is offset by an increase in the food stamp benefit, which takes into account child care costs in the calculation of benefits. However, those at slightly higher income levels—150% and 185% of poverty—are impacted more by these changes as they are not mitigated by changes in food stamp benefits (which they do not receive at all). Families at these levels, in spite of their higher incomes, have their wage adequacy levels

reduced by 4 or 5% just by the change in child care subsidies, to levels that range from 92% to 93% (for those at the 150% of poverty wage level), and 99 to 100% (for those at the 185% of poverty wage level).

In these tables we have modeled the impact of child care subsidies for one family type, a single parent with an infant and a preschooler, for each jurisdiction. With a different family type, and/or different costs in other cities or rural areas in Pennsylvania, the interaction of subsidies and costs would lead to somewhat different impacts on wage adequacy, although the general pattern would be similar.

Geographical differences are not large. Although taxes are higher in the city of Philadelphia, other costs that are higher (child care in particular) in the suburban counties make the latter areas slightly more expensive. At any given level of income and subsidy, wage adequacy is similar across the jurisdictions.

Note that at 185% of poverty, the addition of current child care subsidies makes wages at these levels fully adequate to meet family needs in all five jurisdictions. And, under current subsidies, families at 200% of income, with the help of child care subsidies and food stamps, are able to meet their family's basic neeeds. However, under the proposed child care subsidies, even though their income is higher, families at 200% of poverty do not have adequate income because they are not eligible for *any* child care subsidy. As a result, as a family's income moves from 185% of poverty (or $2055 per month for this family) to 200% of poverty ($2222 per month), or about $167 more, their child care expenses jump from $282 under the proposed child care subsidies to about $1000 (depending upon the jurisdiction). Together with the higher taxes and lesser EITC at the higher wages, their expenses increase about $800 to $900 per month, much more than their income has increased in going from 185% to 200% of poverty.

In the table that accompanies this section, we have summarized the impact of changing the child care subsidies, for Philadelphia and the suburban counties, at the various income levels. This table also presents the shortfall or excess income needed to meet basic needs. As can be seen from this table, it is families struggling to become self-sufficient that will be most impacted by these changes. For example, families in Philadelphia at 150% of poverty will experience an annual shortfall of income $539 under current subsidies, and $1520 under the proposed subsidies, an increase of almost $1000. The effect is most dramatic for those at 200% of poverty, an income which is still only about 80% of the self-sufficiency level in this area, for without any child care subsidy, their shortfall increases by $7500, to over $8000 annually. That is, these families need over $8000 more in income, or subsidies, if they are to minimally meet their families needs, without doubling up, using substandard child care, or scrimping on nutrition or health care.

Conclusions

Because of the high cost of living in the Philadelphia metropolitan area, achieving economic self-sufficiency, i.e., having earnings sufficient to adequately meet a family's basic needs for shelter, food, child care, and so forth, requires quite high incomes. This is particularly true for families with very young children, requiring full-time child care

In general, families whose resources (earnings, or combinations of earnings and subsidies) are below the self-sufficiency standard lack the ability to secure their basic needs such as food, shelter, and child care, at a minimally adequate level. Child care subsidies, because they substantially reduce the cost of what is the single most expensive need for many families, are crucial to help bridging the gap between low wages and adequate resources for these families. For a limited group of families with incomes below 130% of poverty, food stamps also help to bridge this gap.

. With the wages required to meet their needs reduced by these subsidies, families entering employment are able to meet their needs adequately, even though their wages are still quite low. Meeting their needs means that their housing is decent, their child care is dependable, their food budget affords adequate nutrition, and so forth. This level of adequacy also means much more stability than is likely to be the case where families with less than sufficient resources must double up to conserve housing dollars, use poor quality or undependable, but cheap, child care, or skimp on food. With stability, the opportunity to parlay employment into steady earnings and wage increases is enhanced. Thus temporary subsidies help families along the road to long-term economic self-sufficiency.

Wage Adequacy at Various Income Levels, for Single Parent with One Preschooler and One Infant, Philadelphia and Suburban Counties, 1996
Comparison of Food Stamps and Current versus Proposed Child Care Subsidies

INCOME LEVEL	Self-Sufficiency Standard	100% of federal poverty line	125% of federal poverty line	150% of federal poverty line	185% of federal poverty line	200% of federal poverty line
Annual Earnings	$35,811	$13,330	$16,663	$19,995	$24,661	$26,660
Hourly Wage	$16.96	$6.31	$7.89	$9.47	$11.68	$12.62
Philadelphia:						
WAGE ADEQUACY						
--With Current Child Care Subsidies:	100%	91%	97%	97%	105%	107%
--With Proposed Child Care Subsidies:	100%	88%	94%	93%	100%	80%
CHANGE	0%	-3%	-3%	-4%	-5%	-27%
SHORTFALL(-) OR EXCESS(+) INCOME (Annual)						
--With Current Child Care Subsidies:	$0	-$1,256	-$561	-$539	$1,090	$1,628
--With Proposed Child Care Subsidies:	$0	-$1,796	-$1,050	-$1,520	$70	-$6,593
CHANGE*	$0	-$540	-$489	-$981	-$1,020	-$8,221
Suburban Counties						
WAGE ADEQUACY						
--With Current Child Care Subsidies:	100%	90%	95%	96%	104%	105%
--With Proposed Child Care Subsidies:	100%	87%	93%	92%	99%	78%
CHANGE	0%	-3%	-2%	-4%	-5%	-27%
SHORTFALL(-) OR EXCESS(+) INCOME (Annual)						
--With Current Child Care Subsidies:	$0	-$1,508	-$814	-$791	$838	$1,376
--With Proposed Child Care Subsidies:	$0	-$2,060	-$1,302	-$1,772	-$182	-$7,499
CHANGE*	$0	-$552	-$489	-$981	-$1,020	-$8,875

*This figure should be read as the *decreased* amount of annual income due to the change in child care subsidies

Table 1.

Wage Adequacy at Various Income Levels, for Single Parent with One Preschooler and One Infant, Philadelphia County, 1996

Food Stamps and Current Child Care Subsidies

INCOME LEVEL	Self-Sufficiency Standard	100% of federal poverty line	125% of federal poverty line	150% of federal poverty line	185% of federal poverty line	200% of federal poverty line
Monthly Wage	$3,077	$1,111	$1,389	$1,666	$2,055	$2,222
Hourly Wage	$17.48	$6.31	$7.89	$9.47	$11.68	$12.62
TAXES AND TAX CREDITS:						
Taxes	$771	$169	$250	$334	$451	$502
Earned Income Tax Credit (-)	$0	-$266	-$208	-$149	-$67	-$32
Child Care Tax Credit (-)	-$80	$0	-$23	-$27	-$38	-$46
SUBTOTAL--Taxes & Tax Credits	$691	-$97	$20	$158	$346	$424
MONTHLY LIVING EXPENSES:						
Housing	$678	$678	$678	$678	$678	$678
Child Care	$941	$43	$87	$108	$173	$217
Food	$303	$127	$186	$303	$303	$303
Transportation	$93	$93	$93	$93	$93	$93
Medical Care	$154	$154	$154	$154	$154	$154
Miscellaneous	$217	$217	$217	$217	$217	$217
SUBTOTAL--Living Expenses	$2,386	$1,312	$1,415	$1,553	$1,618	$1,662
TOTAL, Taxes, Tax Credits and Living Expense:	$3,077	$1,215	$1,435	$1,711	$1,964	$2,086
Amount of Shortfall(-) or Excess(+) Income	$0	-$105	-$47	-$45	$91	$136
Is income adequate to meet expenses?	no	no	no	yes	yes	yes
Income Adequacy Measure:						
Income as Percent of Total Expenses	100%	91%	97%	97%	105%	107%

Table 1.

Wage Adequacy at Various Income Levels, for Single Parent with One Preschooler and One Infant, Philadelphia County, 1996

Food Stamps and Proposed Child Care Subsidies

INCOME LEVEL	Self-Sufficiency Standard	100% of federal poverty line	125% of federal poverty line	150% of federal poverty line	185% of federal poverty line	200% of federal poverty line
Monthly Wage	$3,077	$1,111	$1,389	$1,666	$2,055	$2,222
Hourly Wage	$17.48	$6.31	$7.89	$9.47	$11.68	$12.62
TAXES AND TAX CREDITS:						
Taxes	$771	$169	$250	$334	$451	$502
Earned Income Tax Credit (-)	$0	-$266	-$208	-$149	-$67	-$32
Child Care Tax Credit (-)	-$80	$0	-$39	-$54	-$62	-$84
SUBTOTAL--Taxes & Tax Credits	$691	-$97	$4	$131	$322	$385
MONTHLY LIVING EXPENSES:						
Housing	$678	$678	$678	$678	$678	$678
Child Care	$941	$108	$173	$217	$282	$941
Food	$303	$107	$157	$303	$303	$303
Transportation	$93	$93	$93	$93	$93	$93
Medical Care	$154	$154	$154	$154	$154	$154
Miscellaneous	$217	$217	$217	$217	$217	$217
SUBTOTAL--Living Expenses	$2,386	$1,357	$1,472	$1,662	$1,727	$2,386
TOTAL, Taxes, Tax Credits and Living Expense:	$3,077	$1,260	$1,476	$1,793	$2,049	$2,771
Amount of Shortfall(-) or Excess(+) Income	$0	-$150	-$87	-$127	$6	-$549
Is income adequate to meet expenses?	no	no	no	no	yes	no
Income Adequacy Measure:						
Income as Percent of Total Expenses	100%	88%	94%	93%	100%	80%

Table 2.

Wage Adequacy at Various Income Levels, for Single Parent with One Preschooler and One Infant, Bucks County, 1996

Food Stamps and Current Child Care Subsidies

INCOME LEVEL	Self-Sufficiency Standard	100% of federal poverty line	125% of federal poverty line	150% of federal poverty line	185% of federal poverty line	200% of federal poverty line
Monthly Wage	$2,984	$1,111	$1,389	$1,666	$2,055	$2,222
Hourly Wage	$16.96	$6.31	$7.89	$9.47	$11.68	$12.62
TAXES AND TAX CREDITS:						
Taxes	$604	$169	$250	$334	$451	$502
Earned Income Tax Credit (-)	$0	-$266	-$208	-$149	-$67	-$32
Child Care Tax Credit (-)	-$80	$0	-$23	-$27	-$38	-$46
SUBTOTAL--Taxes & Tax Credits	$524	-$97	$20	$158	$346	$424
MONTHLY LIVING EXPENSES:						
Housing	$678	$678	$678	$678	$678	$678
Child Care	$995	$43	$87	$108	$173	$217
Food	$303	$127	$186	$303	$303	$303
Transportation	$107	$107	$107	$107	$107	$107
Medical Care	$154	$154	$154	$154	$154	$154
Miscellaneous	$224	$224	$224	$224	$224	$224
SUBTOTAL--Living Expenses	$2,461	$1,333	$1,436	$1,574	$1,639	$1,683
TOTAL, Taxes, Tax Credits and Living Expense:	$2,984	$1,237	$1,456	$1,732	$1,985	$2,107
Amount of Shortfall(-) or Excess(+) Income	$0	-$126	-$68	-$66	$70	$115
Is income adequate to meet expenses?	yes	no	no	no	yes	yes
Income Adequacy Measure:						
Income as Percent of Total Expenses	100%	90%	95%	96%	104%	105%

Table 2.

Wage Adequacy at Various Income Levels, for Single Parent with One Preschooler and One Infant, Bucks County, 1996

Food Stamps and Proposed Child Care Subsidies

INCOME LEVEL	Self-Sufficiency Standard	100% of federal poverty line	125% of federal poverty line	150% of federal poverty line	185% of federal poverty line	200% of federal poverty line
Monthly Wage	$2,984	$1,111	$1,389	$1,666	$2,055	$2,222
Hourly Wage	$16.96	$6.31	$7.89	$9.47	$11.68	$12.62
TAXES AND TAX CREDITS:						
Taxes	$604	$169	$250	$334	$451	$502
Earned Income Tax Credit (-)	$0	-$266	-$208	-$149	-$67	-$32
Child Care Tax Credit (-)	-$80	$0	-$39	-$54	-$62	-$84
SUBTOTAL--Taxes & Tax Credits	$524	-$97	$4	$131	$322	$385
MONTHLY LIVING EXPENSES:						
Housing	$678	$678	$678	$678	$678	$678
Child Care	$995	$108	$173	$217	$282	$995
Food	$303	$108	$157	$303	$303	$303
Transportation	$107	$107	$107	$107	$107	$107
Medical Care	$154	$154	$154	$154	$154	$154
Miscellaneous	$224	$224	$224	$224	$224	$224
SUBTOTAL--Living Expenses	$2,461	$1,379	$1,493	$1,683	$1,748	$2,461
TOTAL, Taxes, Tax Credits and Living Expense	$2,984	$1,283	$1,497	$1,814	$2,070	$2,847
Amount of Shortfall(-) or Excess(+) Income	$0	-$172	-$109	-$148	-$15	-$625
Is income adequate to meet expenses?	yes	no	no	no	no	no
Income Adequacy Measure:						
Income as Percent of Total Expenses	100%	87%	93%	92%	99%	78%

Table 3.

Wage Adequacy at Various Income Levels, for Single Parent with One Preschooler and One Infant, Chester County, 1996

Food Stamps and Current Child Care Subsidies

INCOME LEVEL	Self-Sufficiency Standard	100% of federal poverty line	125% of federal poverty line	150% of federal poverty line	185% of federal poverty line	200% of federal poverty line
Monthly Wage	$3,082	$1,111	$1,389	$1,666	$2,055	$2,222
Hourly Wage	$17.51	$6.31	$7.89	$9.47	$11.68	$12.62
TAXES AND TAX CREDITS:						
Taxes	$629	$169	$250	$334	$451	$502
Earned Income Tax Credit (-)	$0	-$266	-$208	-$149	-$87	-$32
Child Care Tax Credit (-)	-$80	$0	-$23	-$27	-$38	-$46
SUBTOTAL--Taxes & Tax Credits	$549	-$97	$20	$158	$346	$424
MONTHLY LIVING EXPENSES:						
Housing	$678	$678	$678	$678	$678	$678
Child Care	$1,061	$43	$87	$108	$173	$217
Food	$303	$127	$186	$303	$303	$303
Transportation	$107	$107	$107	$107	$107	$107
Medical Care	$154	$154	$154	$154	$154	$154
Miscellaneous	$230	$224	$224	$224	$224	$224
SUBTOTAL--Living Expenses	$2,534	$1,333	$1,436	$1,574	$1,639	$1,683
TOTAL, Taxes, Tax Credits and Living Expenses	$3,082	$1,237	$1,456	$1,732	$1,985	$2,107
Amount of Shortfall(-) or Excess(+) Income	$0	-$126	-$68	-$66	$70	$115
Is income adequate to meet expenses?	yes	no	no	no	yes	yes
Income Adequacy Measure:						
Income as Percent of Total Expenses	100%	90%	95%	96%	104%	105%

Table 3.

Wage Adequacy at Various Income Levels, for Single Parent with One Preschooler and One Infant, Chester County, 1996

Food Stamps and Proposed Child Care Subsidies

INCOME LEVEL	Self-Sufficiency Standard	100% of federal poverty line	125% of federal poverty line	150% of federal poverty line	185% of federal poverty line	200% of federal poverty line
Monthly Wage	$3,082	$1,111	$1,389	$1,666	$2,055	$2,222
Hourly Wage	$17.51	$6.31	$7.89	$9.47	$11.68	$12.62
TAXES AND TAX CREDITS:						
Taxes	$629	$169	$250	$334	$451	$502
Earned Income Tax Credit (-)	$0	-$266	-$208	-$149	-$87	-$32
Child Care Tax Credit (-)	-$80	$0	-$39	-$54	-$62	-$84
SUBTOTAL--Taxes & Tax Credits	$549	-$97	$4	$131	$322	$385
MONTHLY LIVING EXPENSES:						
Housing	$678	$678	$678	$678	$678	$678
Child Care	$1,061	$108	$173	$217	$282	$1,061
Food	$303	$108	$157	$303	$303	$303
Transportation	$107	$107	$107	$107	$107	$107
Medical Care	$154	$154	$154	$154	$154	$154
Miscellaneous	$230	$224	$224	$224	$224	$224
SUBTOTAL--Living Expenses	$2,534	$1,379	$1,493	$1,683	$1,748	$2,527
TOTAL, Taxes, Tax Credits and Living Expense	$3,082	$1,283	$1,497	$1,814	$2,070	$2,913
Amount of Shortfall(-) or Excess(+) Income	$0	-$172	-$109	-$148	-$15	-$691
Is income adequate to meet expenses?	yes	no	no	no	no	no
Income Adequacy Measure:						
Income as Percent of Total Expenses	100%	87%	93%	92%	99%	76%

Table 4.

Wage Adequacy at Various Income Levels, for Single Parent with One Preschooler and One Infant, Delaware County, 1996

Food Stamps and Current Child Care Subsidies

INCOME LEVEL	Self-Sufficiency Standard	100% of federal poverty line	125% of federal poverty line	150% of federal poverty line	185% of federal poverty line	200% of federal poverty line
Monthly Wage	$2,996	$1,111	$1,389	$1,666	$2,055	$2,222
Hourly Wage	$17.02	$6.31	$7.89	$9.47	$11.68	$12.62
TAXES AND TAX CREDITS:						
Taxes	$607	$169	$250	$334	$451	$502
Earned Income Tax Credit (-)	$0	-$266	-$208	-$149	-$67	-$32
Child Care Tax Credit (-)	-$80	$0	-$23	-$27	-$38	-$46
SUBTOTAL--Taxes & Tax Credits	$527	-$97	$20	$158	$346	$424
MONTHLY LIVING EXPENSES:						
Housing	$678	$678	$678	$678	$678	$678
Child Care	$1,003	$43	$87	$108	$173	$217
Food	$303	$127	$186	$303	$303	$303
Transportation	$107	$107	$107	$107	$107	$107
Medical Care	$154	$154	$154	$154	$154	$154
Miscellaneous	$225	$224	$224	$224	$224	$224
SUBTOTAL--Living Expenses	$2,470	$1,333	$1,436	$1,574	$1,639	$1,683
TOTAL, Taxes, Tax Credits and Living Expense:	$2,996	$1,237	$1,456	$1,732	$1,985	$2,107
Amount of Shortfall(-) or Excess(+) Income	$0	-$126	-$68	-$66	$70	$115
Is income adequate to meet expenses?	yes	no	no	no	yes	yes
Income Adequacy Measure:						
Income as Percent of Total Expenses	100%	90%	95%	96%	104%	105%

Table 4.

Wage Adequacy at Various Income Levels, for Single Parent with One Preschooler and One Infant, Delaware County, 1996

Food Stamps and Proposed Child Care Subsidies

INCOME LEVEL	Self-Sufficiency Standard	100% of federal poverty line	125% of federal poverty line	150% of federal poverty line	185% of federal poverty line	200% of federal poverty line
Monthly Wage	$2,996	$1,111	$1,389	$1,666	$2,055	$2,222
Hourly Wage	$17.02	$6.31	$7.89	$9.47	$11.68	$12.62
TAXES AND TAX CREDITS:						
Taxes	$607	$169	$250	$334	$451	$502
Earned Income Tax Credit (-)	$0	-$266	-$208	-$149	-$67	-$32
Child Care Tax Credit (-)	-$80	$0	-$39	-$54	-$62	-$84
SUBTOTAL--Taxes & Tax Credits	$527	-$97	$4	$131	$322	$385
MONTHLY LIVING EXPENSES:						
Housing	$678	$678	$678	$678	$678	$678
Child Care	$1,003	$108	$173	$217	$282	$1,003
Food	$303	$108	$157	$303	$303	$303
Transportation	$107	$107	$107	$107	$107	$107
Medical Care	$154	$154	$154	$154	$154	$154
Miscellaneous	$225	$224	$224	$224	$224	$224
SUBTOTAL--Living Expenses	$2,470	$1,379	$1,493	$1,683	$1,748	$2,469
TOTAL, Taxes, Tax Credits and Living Expense:	$2,996	$1,283	$1,497	$1,814	$2,070	$2,855
Amount of Shortfall(-) or Excess(+) Income	$0	-$172	-$109	-$148	-$15	-$633
Is income adequate to meet expenses?	yes	no	no	no	no	no
Income Adequacy Measure:						
Income as Percent of Total Expenses	100%	87%	93%	92%	99%	78%

Table 5.

Wage Adequacy at Various Income Levels, for Single Parent with One Preschooler and One Infant, Montgomery County, 1996

Food Stamps and Current Child Care Subsidies

INCOME LEVEL	Self-Sufficiency Standard	100% of federal poverty line	125% of federal poverty line	150% of federal poverty line	185% of federal poverty line	200% of federal poverty line
Monthly Wage	$3,053	$1,111	$1,389	$1,666	$2,055	$2,222
Hourly Wage	$17.35	$6.31	$7.89	$9.47	$11.68	$12.62
TAXES AND TAX CREDITS:						
Taxes	$621	$169	$250	$334	$451	$502
Earned Income Tax Credit (-)	$0	-$266	-$208	-$149	-$67	-$32
Child Care Tax Credit (-)	-$80	$0	-$23	-$27	-$38	-$46
SUBTOTAL--Taxes & Tax Credits	$542	-$97	$20	$158	$346	$424
MONTHLY LIVING EXPENSES:						
Housing	$678	$678	$678	$678	$678	$678
Child Care	$1,042	$43	$87	$108	$173	$217
Food	$303	$127	$186	$303	$303	$303
Transportation	$107	$107	$107	$107	$107	$107
Medical Care	$154	$154	$154	$154	$154	$154
Miscellaneous	$228	$224	$224	$224	$224	$224
SUBTOTAL--Living Expenses	$2,513	$1,333	$1,436	$1,574	$1,639	$1,683
TOTAL, Taxes, Tax Credits and Living Expense	$3,053	$1,237	$1,456	$1,732	$1,985	$2,107
Amount of Shortfall(-) or Excess(+) Income	$0	-$126	-$68	-$66	$70	$115
Is income adequate to meet expenses?	yes	no	no	no	yes	yes
Income Adequacy Measure:						
Income as Percent of Total Expenses	100%	90%	95%	96%	104%	105%

Table 5.

Wage Adequacy at Various Income Levels, for Single Parent with One Preschooler and One Infant, Montgomery County, 1996

Food Stamps and Proposed Child Care Subsidies

INCOME LEVEL	Self-Sufficiency Standard	100% of federal poverty line	125% of federal poverty line	150% of federal poverty line	185% of federal poverty line	200% of federal poverty line
Monthly Wage	$3,054	$1,111	$1,389	$1,666	$2,055	$2,222
Hourly Wage	$17.35	$6.31	$7.89	$9.47	$11.68	$12.62
TAXES AND TAX CREDITS:						
Taxes	$622	$169	$250	$334	$451	$502
Earned Income Tax Credit (-)	$0	-$266	-$208	-$149	-$67	-$32
Child Care Tax Credit (-)	-$80	$0	-$39	-$54	-$62	-$84
SUBTOTAL--Taxes & Tax Credits	$542	-$97	$4	$131	$322	$385
MONTHLY LIVING EXPENSES:						
Housing	$678	$678	$678	$678	$678	$678
Child Care	$1,042	$108	$173	$217	$282	$1,042
Food	$303	$108	$157	$303	$303	$303
Transportation	$107	$107	$107	$107	$107	$107
Medical Care	$154	$154	$154	$154	$154	$154
Miscellaneous	$228	$224	$224	$224	$224	$224
SUBTOTAL--Living Expenses	$2,513	$1,379	$1,493	$1,683	$1,748	$2,508
TOTAL, Taxes, Tax Credits and Living Expense:	$3,054	$1,283	$1,497	$1,814	$2,070	$2,894
Amount of Shortfall(-) or Excess(+) Income	$0	-$172	-$109	-$148	-$15	-$672
Is income adequate to meet expenses?	yes	no	no	no	no	no
Income Adequacy Measure:						
Income as Percent of Total Expenses	100%	87%	93%	92%	99%	77%

Buchanan Ingersoll
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May 21, 1998

Ann Marie Bereschak
Deputy Chief Counsel
Independent Regulatory Review Commission
14th Floor, Harristown II
333 Market Street
Harrisburg, PA 17101

Re: CAT Fund Proposed Regulations (No. 20-1)

Dear Ann Marie:

Thank you for providing me with copies of IRRC's comments on the above-referenced regulations as well as comments of other commentors. For your information, I am enclosing comments we filed earlier this week in response to the Fund's request for comments on amendments to the draft regulations.

I am certain we will be in touch with you when the draft final regulations are released.

Sincerely,

Brian J. Clark

BJC/laf
encl.
cc: Bruce B. Aulick, Esquire

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May 18, 1998

VIA HAND DELIVERY

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Arthur F. McNulty
Chief Counsel
Medical Professional Liability Catastrophe Loss Fund
10th Floor, Suite 1000
30 North Third Street
Harrisburg, PA 17108

Re: Proposed CAT Fund Regulations

Dear Mr. McNulty:

On behalf of The Medical Protective Company ("MPCo"), I am submitting the following comments to your letter of April 21, 1998 on the proposed Medical Professional Liability Catastrophe Loss Fund ("Fund") regulations. These comments are organized according to the particular section of the proposed regulation. Our comments are reflective, in large part, of comments previously submitted during the formal comment period on the proposed regulations that appeared in the Pennsylvania Bulletin on August 30, 1997.

1. Late surcharge interest penalty: Section 247.5

MPCo concurs with the comments submitted to the Fund by numerous insurers and by the Independent Regulatory Review Commission ("IRRC"). Specifically, Act 135 does not confer away authority to the Fund to charge interest on late surcharges. "Interest" is defined but never appears in any substantive part of Act 135. You cannot infer a grant of authority from a mere definition. The Act does provide specific authority for action to be taken against healthcare providers who do not comply with the provisions of the Act or its regulations, and that is the Fund's exclusive remedy. The Fund claims its authority under Section 701(e)(11) which merely avoids the question and is contrary to well-established statutory construction principles. In short, nothing in Act 135 provides the Fund the enabling authority needed to assess a late interest penalty.

2. Sixty day submission period of surcharge: Sections 242.5 - 242.7, 242.10, 242.21.

The current regulations require submission of surcharges in 60 days (Sections 242.5 and 242.6). The proposed amendments would reduce the remittance deadline to "30 days of the effective date required by § 242.6 (relating to reporting forms and procedures)." Section 242.5(a). While 30 days is preferable to the 20 days proposed in the August 30, 1997 draft regulation, 30 days is still too tight a deadline. Most insurers allow their policyholders a 30 day grace period. This regulation would require a remittance before the insurer would know the policyholder's final decision. New accounts may be written on a binder while the application is underwritten. Based on MPCo's experience in over twenty-six states, the 30 day remittance deadline is wholly inadequate time for processing application, collecting premiums and then remitting them. MPCo recommends that the 60 day time period be retained.

3. Loss of coverage during delinquency payment: Section 242.17(c).

Under Section 242.17(c) of the proposed regulations, a healthcare provider failing to pay the surcharge or emergency surcharge within the time limits proscribed would not be covered by the Fund for the period of time during which the delinquency exists. Moreover, the healthcare provider would be assessed interest on late payment. As noted above, MPCo concurs with the comments previously submitted on the August 30, 1997 draft regulations which uniformly noted that the Fund is without statutory authority to impose such a penalty on healthcare providers for late remittance of surcharge. No express language in Act 135 or implicit authority under Section 701(e)(11) exists to support the penalty contained in Section 242.17(c). The existing law clearly states what occurs in the event the provider fails to pay the surcharge or emergency surcharge. Specifically, Section 701(f) of the law states "the failure of any healthcare provider to comply with any provisions of this section or any of the rules or regulations issued by the director shall result in the suspension or revocation of the healthcare provider's license by the licensure board." (emphasis added)

As previously noted, the Fund is limited to those powers expressly authorized by the statute. Here, the Fund seeks to keep premiums but not provide the service for which the premium is paid. Its sole statutory remedy, however, is to refer the matter to the appropriate licensing board to the extent the Fund believes that surcharge delinquency, subsequently made whole, warrants such action against the provider. A

commercial insurance company would never be permitted to act in such a manner. As a result, MPCo recommends that this provision be eliminated and revised to reflect Section 701(f) of the law.

In sum, we recommend that further substantive modifications be made to these and other provisions to clarify ambiguities and avoid any disruptions in coverage. On behalf of MPCo, we would be happy to meet with you and members of your staff to discuss these comments in more detail.

Sincerely,

Brian J. Clark

BJC/laf

cc: Bruce Aulick, Esquire
Hannah Leavitt, Esquire

Buchanan Ingersoll

PROFESSIONAL CORPORATION

Attorneys

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May 13, 1998

VIA REGULAR MAIL

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Arthur F. McNulty
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Medical Professional Liability Catastrophe Loss Fund
10th Floor, Suite 1000
30 North Third Street
PO Box 12030
Harrisburg, Pennsylvania 17108

Re: Proposed Fund Regulations

Phillip M. Kofsky, M.D. and Gerald A. Isenberg, M.D. v. John H. Reed,
Pennsylvania Supreme Court/Nos. 0010/0013 M.D. Appeal Docket 1998

Dear Mr. McNulty:

The revised proposed regulations recently circulated by the Medical Professional Liability Catastrophe Loss Fund ("CAT Fund") purport to create discretion in the Director of the CAT Fund to "adopt" or "not adopt" rates of the Joint Underwriting Association ("JUA") in determining a provider's surcharge. The Health Care Services Malpractice Act, Act of October 15, 1975, P.L. 390, *as amended*, 40 P.S. §§ 1301.101-.1006 (generally referred to as "Act 135"), creates no such discretion in the Director. We are shocked that the CAT Fund shows such little regard for a holding of Pennsylvania's Commonwealth Court, which found that the "prevailing primary premium" is the current JUA schedule of rates. Those rates are not frozen at their January 1, 1996 level unless and until the Director "adopts" one of the annual changes to the JUA schedule of rates approved by the Pennsylvania Insurance Commissioner as your counsel so vigorously, yet unsuccessfully, argued to the Commonwealth Court.

As you know, our firm represents Gerald A. Isenberg, M.D. ("Dr. Isenberg") and Philip M. Kofsky, M.D. ("Dr. Kofsky") in litigation adverse to the CAT Fund, relating to the Director's refusal to base the CAT Fund surcharge on the "prevailing primary premium," as mandated by Act 135. This matter is presently on appeal to the Pennsylvania Supreme Court from a January 27, 1998 Memorandum Opinion and Order of the Commonwealth Court, a copy of which is attached hereto as Tab "1".

We have learned through other members of the health care and insurance industries that the CAT Fund has proposed new regulations, the most recent version of which are attached hereto as Tab "2". We understand that you have sought written responses to this version of the proposed regulations by May 18, 1998. Accordingly, we submit this letter as our clients' response to these revised proposed regulations as both litigants in the above-referenced matter and as medical care providers in the Commonwealth that contribute to the CAT Fund. Specifically, Drs. Kofsky and Isenberg object to the definition of "prevailing primary premium" contained in Section 242.2 of the revised proposed regulations.

BACKGROUND & ANALYSIS

Because the phrase "prevailing primary premium" is at the core of the pending litigation between Drs. Kofsky and Isenberg and the CAT Fund, and because the Commonwealth Court has already ruled against the CAT Fund, we are sure that you and the Director are painfully aware that the phrase "prevailing primary premium" is defined in Act 135 as follows:

> "Prevailing primary premium" means the schedule of occurrence rates approved by the Insurance Commissioner for the Joint Underwriting Association.

40 P.S. § 1301.103. Notwithstanding this definition in Act 135, in the proposed regulation published by the CAT Fund in the Pennsylvania Bulletin, Vol. 27, No. 35, August 30, 1997, the Director proposed an alternate and conflicting definition:

> *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**.

The brackets indicate omission of the word "occurrence" that appears in the Act 135 definition, and the bold and underscored text indicates language added by the CAT Fund that does not appear in the Act 135 definition of "prevailing primary premium".

Clearly, the definition proposed by the CAT Fund as published in the Pennsylvania Bulletin "differs" from the definition in Act 135, as the Independent Regulatory Review Commission ("IRRC") noted at page 5 of its comments to the proposed regulations dated October 30, 1997, a copy of which is attached hereto as Tab "3". In its comments, IRRC recommended:

> . . . For consistency with Act 135 and to avoid use of a date which will become inconsistent with practice in the future, we recommend the [CAT Fund] adopt the definition from the Act in its final-form rulemaking.

In standard cavalier fashion, however, the CAT Fund has ignored the recommendation of IRRC (Tab 3) in the most recent version of the proposed regulations (Tab 2). Instead of incorporating the statutory definition of "prevailing primary premium" as recommended by IRRC, the CAT Fund has chosen to proceed in the opposite direction by departing even further from the statutory definition:

> *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, **and as thereafter amended by the Joint Underwriting Association, and adopted by the Director of the Fund.**

The bold and underscored text indicates language added by the CAT Fund that does not appear in the Act 135 definition and that did not appear in the proposed regulations published in the Pennsylvania Bulletin.

What public comment did the CAT Fund receive that prompted it to ignore IRRC's recommendation and add this new language that is clearly contrary to the statutory definition? We would suggest that the CAT Fund received no such comment. Instead, the CAT Fund added this new language as a result of its defeat in the Commonwealth Court (Tab 1). At page 3 of its Memorandum Opinion, the Commonwealth Court correctly noted, and the CAT Fund acknowledged by stipulation, that the phrase "prevailing primary premium" is defined by Act 135. To the CAT Fund's disappointment, the Commonwealth Court concluded as a matter of law:

> The newly amended statute makes it clear JUA is the source of the amount of the primary prevailing (sic) premium. . . . Thus, *only JUA with the approval of the commissioner sets the rates*. . . .
>
> . . . .
>
> Thus, the CAT fund surcharge for 1998 should be based upon the JUA rates approved by the commissioner and effective January 1, 1998.

Mem. Opinion at 11, 14.

Notwithstanding the definition of "prevailing primary premium" in Act 135, IRRC's recommendations, and the Commonwealth Court's ruling of law, the CAT Fund continues to exceed its authority under Act 135 by proposing a definition for "prevailing primary premium" that is contrary to the definition in Act 135. This reckless and unlawful conduct will not go unchallenged.

Finally, we note that the January 1, 1996 date proposed in the definition of "prevailing primary premium" is erroneous because Act 135 was not effective until January 1, **1997**. Accordingly, the JUA's rates in effect as of January 1, 1996 have no relationship to Act 135.

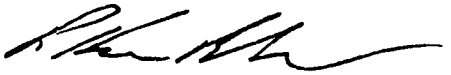
SPECIFIC OBJECTIONS

For the reasons set forth above, Drs. Kofsky and Isenberg object to the revised proposed regulations (Tab 2) for the following reasons:

1. The definition of "prevailing primary premium" proposed by the CAT Fund is contrary to the definition of the same phrase provided in Act 135 and the ruling of the Commonwealth Court (Tab 1); and

2. The January 1, 1996 date proposed in the definition of "prevailing primary premium" is erroneous because Act 135 was not effective until January 1, **1997**. Accordingly, the JUA's rates in effect as of January 1, 1996 have no relationship to Act 135.

Very truly yours,



P. Kevin Brobson

PKB/wlrp

cc: Hon. D. Michael Fisher, Attorney General
Hon. Stewart J. Greenleaf, State Senator
Hon. Edwin G. Holl, State Senator
Dennis M. Walsh, Sec'y Legislative Affairs
Paul A. Tufano, General Counsel
Robert E. Nyce, Executive Director, IRRC
John H. Reed, Director, CAT Fund
Guy A. Donatelli, Esquire

IN THE COMMONWEALTH COURT OF PENNSYLVANIA

PHILLIP M. KOFSKY, M.D. and GERALD A. ISENBERG, M.D., Petitioners	:	
v.	:	
JOHN H. REED, Director of the Medical Professional Liability Catastrophe Loss Fund, Respondent	:	No. 1066 M.D. 1997

ORDER

AND NOW, this twenty-seventh day of January, 1998, upon consideration of the application for special relief (in the nature of peremptory mandamus) of petitioners, Phillip M. Kofsky, M.D., and Gerald A. Isenberg, M.D., pursuant to PaR.A.P. No. 1532(a), it is hereby ordered, adjudged and decreed that the application is granted in part as follows:

1. Judgment is entered against John H. Reed, Director of the Medical Professional Liability Catastrophe Loss Fund. Director Reed is hereby ordered to:

(a) base the fund's 1998 surcharge on the prevailing primary premium, which is defined under the Health Care Services Malpractice Act, as amended by Act 135,

as "the schedule of occurrence rates approved by the Insurance Commissioner for the Joint Underwriting Association." 40 P.S. §§ 1301.103,.701(e)(1); and

(b) base the fund's 1998 surcharge on colon-rectal surgeons on the Joint Underwriting Association's rate and rate classifications, as approved by the Commissioner of the Pennsylvania Insurance Department effective January 1, 1998.

In granting petitioners' application, the Court finds that respondent is free to exercise his statutory discretion to adjust the prevailing primary premium up or down in line with the Joint Underwriting Association's filing approved by the Commissioner so as to ensure solvency of the fund. 40 P.S. § 1301.701(e)(3).

The matter of counsel fees is reserved for future hearing after appropriate applications and proof. The request for damages is denied.

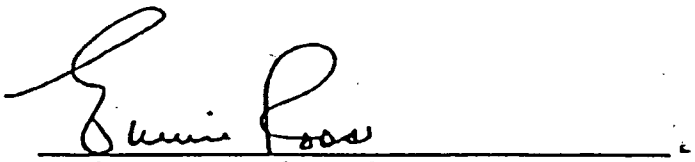
CERTIFIED FROM THE RECORD
AND ORDER EXIT

JAN 2 7 1998

Deputy Prothonotary - Chief Clerk

Eunice Ross, Senior Judge

The relief sought will be allowed within the limitations of this opinion.



Eunice Ross, Senior Judge

COMMENTS OF THE INDEPENDENT REGULATORY REVIEW COMMISSION

ON

PENNSYLVANIA MEDICAL PROFESSIONAL LIABILITY CATASTROPHE LOSS FUND REGULATION NO. 20-1

MEDICAL PROFESSIONAL LIABILITY CATASTROPHE LOSS FUND AND MEDIATION

OCTOBER 30, 1997

We have reviewed this proposed regulation from the Medical Professional Liability Catastrophe Loss Fund (Fund) and submit for your consideration the following objections and recommendations. Subsections 5.1(h) and 5.1(i) of the Regulatory Review Act specify the criteria the Commission must employ to determine whether a regulation is in the public interest. In applying these criteria, our Comments address issues that relate to statutory authority, legislative intent, policy decisions requiring legislative review, economic and fiscal impact on the public and private sector, clarity, and reasonableness of the regulations. We recommend that these Comments be carefully considered as you prepare the final-form regulation.

1. Section 242.4. Computation of surcharge - Clarity

Section 242.4(a) states the basic insurance carrier shall obtain from the health care provider "a statement as to the addresses and specialty of the health care provider." Further, Subsection (a) requires the insurance carrier to provide a copy of the statement to the Fund in line with "reporting requirements in this chapter." Commentators have concerns with providing information which they state is already provided on Form 216. We suggest the Fund consider a cross-reference to indicate that Form 216 is the only place that they are required to provide this information.

2. Section 242.5. Interest Payment - Statutory authority

Section 242.5(c) of the proposal provides that late remittance by an insurer or a self-insurance plan shall result in the payment of interest by the insurer or self-insurer plan, to be computed under Section 806 of the Fiscal Code. The Fund believes the General Assembly's grant of regulatory writing authority regarding establishment and operation of the Fund, as well the addition of the definition of "interest" in Act 135 warrants the interest charge in this proposal.

Although a definition of "interest" was included in Act 135, Act 135 contains no specific authority for the Fund to assess interest. In its comments, the House Insurance Committee (House Committee) agrees that the definition of "interest" does not direct the Fund to apply interest to late surcharge remittances. Further, the Act contains specific action which may be

taken against health care providers who do not comply with provisions of the Act or its regulations. Failure of a health care provider to comply with provisions "shall result in the suspension or revocation of the health care provider's license by the licensure board."

Case law is clear as to the regulatory authority of agencies. The Commonwealth Court has stated that agencies are vested only with those powers conferred by the statute or such as are necessarily implied from a grant of such powers. The legislative grant of power must be clear; a doubtful power does not exist. *DeMarco v. Department of Health*, 397 A.2d 61 (1979); *See also, PA Liquor Control Bd. v. Office of Atty. General*, 534 A.2d 1146 (1987).

Here, Act 135 confers no specific authority upon the Fund to impose interest penalties for late payments. The authority to impose interest cannot be necessarily implied from the Act's grant of broad rulemaking authority to issue regulations regarding the establishment and operation of the Fund and the levying, payment and collection of the surcharges, particularly when the Act sets forth a remedy for the Fund to pursue for noncompliance with the Act and its regulations.

Likewise, the authority to impose interest cannot be implied from a definition contained in the Act. The definition of interest does nothing more than define that term; it does not establish any substantive right on the Fund to impose interest. *See Schoepple v. Lower Saucon Township*, 624 A.2d 699 (1993). Therefore, we recommend that the Fund delete interest charge provisions from its final-form regulation. Further, we encourage the Fund to work with the licensure boards to establish a procedure for expeditiously implementing suspension or revocation of licensees where health care providers are not meeting their obligations under the Act.

3. Sections 242.5 - 242.7, 242.10, and 242.21. 20-day periods for remittance and submissions - Policy decision requiring legislative review; Reasonableness

Existing regulations at Sections 242.5 and 242.6 require submission of surcharges in 60 days. Under the proposed regulation the time periods in both of these sections would be decreased to 20 days. Amendments to Section 242.7 will require additional surcharge payments necessitated by a change in the terms of a health care provider's coverage to be made within 20 days. Section 242.10 (self-insurers) is also revised to reflect the 20-day payment requirement and Section 242.21 (Correction) requires that a correction form be submitted within 20 days after notification of erroneous submission.

Commentators have indicated that the 20-day time period does not allow sufficient time for billing, collection and remittance. They also believe the new time period will require insurers to advance surcharge payments to the Fund. The Senate Banking and Insurance Committee (Senate Committee) points out that Section 701(c)(14) of Act 135 allows health care providers to pay the annual surcharge in equal installments which "commence 60 days from the date of policy inception or renewal with payment due each 60 days thereafter until the full remittance is paid." The Senate Committee further explains that the proposal's 20-day requirement would penalize providers who pay their surcharge in full.

The Senate Committee believes that if the Fund desires a shorter payment period, the issue should be brought before the General Assembly. In its comments, the House Committee states that it is unreasonable and impractical to expect insurers to bill providers, collect payment, and remit the Fund surcharge within 20 days of the policy renewal date. We agree that the 20-day time periods are unreasonable and could impose costs on insurers. We also believe the comments of the standing committees reflect a need for legislative review before the Fund proceeds with the 20-day payment requirements. Therefore, we recommend the 20-day requirements be eliminated from the proposal and the 60-day time periods be retained.

4. Section 242.9. Overpayments, credits and duplicate payments - Statutory authority; Economic impact

The proposal adds a provision to Section 242.9 to require that refunds be paid directly to health care providers by the agent or insurer. Upon a showing of proof of payment, the Fund would issue the appropriate credit to the agent or insurer.

PHICO questions the legal authority of the Fund to require an insurer to advance funds before it is entitled to an adjustment. Further, they believe the requirement is administratively and financially burdensome.

We question the Fund's statutory authority to require an insurer to pay a provider prior to receiving the adjustment. We can find no specific power for the provision, nor can we necessarily imply the authority from the Fund's broad grant of regulatory authority. Further, we question why the insurer will be issued a credit rather than a refund. Because of the lack of authority and the potential administrative and financial burden on insurers, we recommend that this provision be deleted from the final-form regulation.

5. Section 242.17. Loss of coverage during delinquent payment period - Statutory authority; Legislative intent; Reasonableness

According to Section 242.17(c) of the proposed regulation, a health care provider failing to pay the surcharge or emergency surcharge within the time limits prescribed would not be covered by the Fund in the event of loss for the period of time during which a delinquency exists. In addition, the health care provider will be assessed interest on the late payment. We have a number of concerns with this provision.

First, the Fund is without statutory authority to impose such an egregious penalty on health care providers for the late remittance of surcharges. The House Insurance Committee points out that permanent denial of Fund coverage for any period of time when a surcharge payment delinquency exists was not addressed in Act 135. We can find no specific language in Act 135 for the penalty contained in Subsection (c), nor can we imply the Fund's authority from Section 701(e)(11) of Act 135.

The Senate Committee believes that if the Fund desires a shorter payment period, the issue should be brought before the General Assembly. In its comments, the House Committee states that it is unreasonable and impractical to expect insurers to bill providers, collect payment, and remit the Fund surcharge within 20 days of the policy renewal date. We agree that the 20-day time periods are unreasonable and could impose costs on insurers. We also believe the comments of the standing committees reflect a need for legislative review before the Fund proceeds with the 20-day payment requirements. Therefore, we recommend the 20-day requirements be eliminated from the proposal and the 60-day time periods be retained.

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First, the Fund is without statutory authority to impose such an egregious penalty on health care providers for the late remittance of surcharges. The House Insurance Committee points out that permanent denial of Fund coverage for any period of time when a surcharge payment delinquency exists was not addressed in Act 135. We can find no specific language in Act 135 for the penalty contained in Subsection (c), nor can we imply the Fund's authority from Section 701(e)(11) of Act 135.

Second, the language of Subsection (c) defeats the legislative intent of Act 135. Act 135 was designed to protect the public by allowing patients to recover damages for harm caused by a health care provider. In its comments, the Senate Committee states the intent of the Pennsylvania law is to ensure that health care providers have liability coverage at all times. We agree with the Senate Committee that the proposed regulation defeats Act 135's goal of providing a means for consumers to recover damages due to medical malpractice.

Furthermore, we question the reasonableness of Subsection (c). The provision unreasonably penalizes a health care provider, and ultimately the health care consumer, even though payment was submitted to the insurance carrier, but the remittance was not made to the Fund. We question what occurs when consumers file a malpractice claim and how denial of a claim because of delinquent payment achieves the intent of the Act as stated in the Senate Committee's letter.

Therefore, we recommend that the Fund delete Subsection (c) from the final-form regulation. Also, as discussed in ISSUE #2, we recommend that the Fund delete Subsection (f). The Fund's recourse against a health care provider who fails to comply with the Act and its regulations is clearly set forth in Section 701(f) of Act 135. We recommend that the Fund incorporate or cross-reference the statutory penalty of Act 135 in the final-form regulation.

6. Section 242.18. Retroactive Effective date - Statutory authority; Reasonableness

Section 242.18 provides that the effective date of this chapter as well as the commencement date for using the prescribed forms is November 26, 1996. Numerous commentators have expressed concerns with the retroactive effective date of the regulation.

According to case law, the retroactive application of a regulation is prohibited unless clearly intended by the General Assembly or if the regulation intrudes on otherwise vested rights. *R & P Services v. Dept. of Revenue*, 541 A.2d 432 (1988). Applying this rule to the regulation, the retroactive application of the regulation may effect the contractual rights already entered into among providers, insurers, and the Fund. Therefore, we recommend that the Fund delete the effective date provision from the final-form regulation or replace it with a provision which will make the regulations effective on a specific date after final publication.

7. Section 246.6. Mediation time periods - Reasonableness; Clarity

Section 246.6 states that notice of a mediation session shall be provided to all parties at least three working days in advance of the session. Several commentators recommended a longer notice, such as ten days to two weeks. We question whether a three-day notice is reasonable and suggest the Fund consider a longer notice period.

We also have a concern with Section 246.7(a) which states that mediation sessions in noncomplex cases not requiring testimonial evidence should be completed within three hours. Is

the time limit a requirement? If so, it should be stated as such. If it is not a requirement, the sentence should be eliminated from the proposal at final-form rulemaking.

8. Advisory Board Participation - Legislative Intent

Section 706 of Act 135 establishes the Medical Professional Liability Insurance Catastrophe Loss Fund Advisory Board (Advisory Board). In their comments, both the House Committee and the Senate Committee stated concern with the lack of consultation with both the Advisory Board and the public during the development of this proposal. Further, we note the Governor's Executive Order #1996-1 states that regulations shall be drafted and promulgated with early and meaningful input from the regulated community. Prior to submitting the final-form regulation, we encourage the Fund to consult with the Advisory Board and the regulated community.

9. Sections 242.2 and 246.2. Definitions; Clarity

Interest

The definition of interest states the rate prescribed in Section 506 of the Fiscal Code will apply. Section 242.17(f) also references Section 506 of the Fiscal Code. The correct section is 806. If the Fund is able to provide authority and justification for the interest provisions as discussed in ISSUE #2, the citation should be corrected in the final-form rulemaking. Otherwise, we suggest that the definition be deleted.

Prevailing primary premium

The proposal describes this term as the schedule of rates approved by the Insurance Commissioner and in use by the Joint Underwriting Association *as of January 1, 1996.* However, Act 135 states "prevailing primary premium" means the schedule of occurrence rates approved by the Insurance Commissioner for the Joint Underwriting Association. The proposed definition differs from the definition in Act 135 by referencing the schedule of rates in use as of January 1, 1996. For consistency with Act 135 and to avoid use of a date which will become inconsistent with practice in the future, we recommend the Department adopt the definition from the Act in its final-form rulemaking.

Mediation

This definition contains substantive information which goes beyond the meaning of the term "mediation."

We recommend the second sentence of the definition be included in Section 246.3 (Agreement of parties). The third sentence of the definition should be relocated to Section 246.11 (Confidentiality). Further, we agree with the comment from the Pennsylvania Medical Society Liability Insurance Company that the phrase "should not be considered public information" should read "*shall* not be considered public information."

10. Miscellaneous Clarity Issues

Section 242.6(a)(3) details the information required on Form 216 Remittance Advice. It states the form shall include the most current Pennsylvania license number, the name, dates, policy type, policy number, specialty code, geographic territory, basic coverage limits, gross premium, surcharge and slot positions when applicable *and any other information as may be required by the Director.* The phrase, "any other information as may be required" is vague and inappropriate when added to a specific, detailed list. We recommend the Fund eliminate the phrase "any other information as may be required by the Director" from the proposal.

The last sentence in Section 246.9 (Conclusions of the mediator) states that if parties so agree, they will share equally in payment of the additional mediator compensation. This sentence should be moved from Section 246.9 to Section 246.10 (Expenses) which addresses costs and expenses.

PART IX. MEDICAL CATASTROPHE LOSS FUND

CHAPTER 242. MEDICAL PROFESSIONAL LIABILITY CATASTROPHE LOSS FUND

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 *806* 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, *and as thereafter amended by the Joint Underwriting Association, and adopted by the Director of the Fund.*

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(c)(4) and 702(a) of the act of October 15, 1975 (P.L. 390, No. 111) (40 P.S. §§ 1301.701(c)(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] *30* 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.

large carrier cannot process apps, reinstance, etc within 30 days - really need 60 days

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(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(c) of the act of October 15, 1975 (P.L. 390, No. 111) (40 P.S. § 1301.701(c)).

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 5116 — 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.

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] thirty (30) 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(c)(4) and 702(a) of the act of October 15, 1975 (P.L. 390, No. 111) (40 P.S. §§ 1301.701(c)(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] *30* days of the effective date of the self-insurance plan and on an annual basis thereafter within [60] [20] *30* 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(c)(4) and 702(a) of the act of October 15, 1975 (P.L. 390, No. 111) (40 P.S. §§ 1301.701(c)(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.

(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.] *as defined in this Chapter for the period of any delinquency, subject to a disclaimer of Fund coverage for the period of delinquency if the health care provider knew or should have known of a "claim" during that time. Such payment of interest will avoid referral of the health care provider to the Licensure Board.*

[(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 *806* 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.] *30 days following final publication of the regulations in the Pennsylvania Bulletin.*

• • •

§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] 30 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 or training in medical malpractice litigation and/or experience or training in 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. ***Upon the consent of all parties to any mediation proceeding, the mediation shall be binding, and the parties shall be bound by the conclusions of the mediator.***

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." Additionally, all documents produced for and relating to the mediation 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 the facts, issues, and arguments of the parties. Parties will be represented by a person with authority 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. ***All mediation proceedings are confidential and shall not be considered public information subject to disclosure under the Right-***

To-Know Law and the "Sunshine Act."

Section 246.12. Effective Date

The effective date of this chapter shall be [November 26, 1996.] ***30 days following final publication of the regulations in the Pennsylvania Bulletin.***

HAP

THE HOSPITAL & HEALTHSYSTEM ASSOCIATION OF PENNSYLVANIA

ORIGINAL: 1880
COPIES: Coccodrilli

Harris
Sandusky
Legal (2)

May 22, 1998

Honorable Edwin G. Holl
Senate of Pennsylvania
350 Main Capitol
Harrisburg, PA 17120

Dear Senator:

Last year, the Medical Professional Liability Catastrophe Loss Fund attempted to impose an interest penalty and a reduction in the remittance time period via proposed regulation No.20-1. This proposal was not discussed or reviewed by the CAT Fund Advisory Board. You, along with the Vice Chairman and minority chairmen of the Senate Banking and Insurance Committee, expressed concerns over these proposed regulations. On October 20, 1997, the Independent Regulatory Review Commission (IRRC) commented,

> "Act 135 confers no specific authority upon the Fund to impose interest penalties for late payments...Therefore, we recommend that the Fund delete interest charge provisions from its final form regulation."

It has come to my attention that the Fund is seeking interest penalties from health care providers. Enclosed is a sample copy of a letter from the Fund demanding interest penalty payment. So far, PHICO Insurance Company has received many similar letters which, in total, demand over $16,000. The letter states that failure to pay the penalty will result in loss of coverage.

We agree that the Fund lacks statutory authority to impose an interest penalty and to deny coverage during the delinquency period. This is an egregious penalty, and defeats the key purpose of the Fund to protect the public by allowing patients to recover damages for harm caused by a health care provider.

4750 Lindle Road
P.O. Box 8600
Harrisburg, PA 17105-8600
717.564.9200 Phone
717.561.5334 Fax
http://www.hap2000.org

HAP

HAP is willing to work with the General Assembly to develop legislation that will result in timely payments to the Fund, including reasonable penalties to encourage compliance. If you agree that such legislation is warranted, I will gladly provide you with draft language. In the interim, I hope you will join me in ending this illegal practice of the Fund.

Sincerely,

JAMES M. REDMOND
Senior Vice President, Legislative Services

/ls
enclosure

c: Honorable F. Joseph Loeper
Members of the Senate Bank & Insurance Committee
Paul Tufano, Esq.
Dennis Walsh
John H. Reed
Arthur McNulty, Esq.
Robert Nyce
Members of the CAT Fund Advisory Board

COMMONWEALTH OF PENNSYLVANIA

MEDICAL PROFESSIONAL LIABILITY CATASTROPHE LOSS FUND

JOHN H. REED
DIRECTOR

May 7, 1998

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

ORIGINAL: 1880
COPIES: Coccodrilli

Harris
Sandusky
Legal (2)

Date Received 5-11-98 Corporate Underwriting

PHICO Insurance Company
One Phico Dr., P.O. Box 85
Mechanicsburg, PA 17055

Re: Late Surcharge Remittance -- Interest Penalty Notice

Dear

The regulations of the Medical Professional Liability Catastrophe Loss Fund (hereinafter the "Fund") currently require that the appropriate surcharge must be remitted to the Fund within sixty (60) calendar days of the primary policy inception and/or renewal date. However, your remittance for the health care provider(s) on the enclosed worksheet was not received by the Fund until May 1, 1998.

Act 135 of 1996 provides for payment of interest in the event of a late surcharge remittance. The total interest penalty charged is calculated by multiplying the amount of the late surcharge remittance times the interest rate prescribed in Section 806 of the Fiscal Code (9% per annum for 1998) times the number of days that lapsed between the date on which the payment was due at the Fund and the date on which the payment was actually received at the Fund. Therefore, you are hereby requested to remit to my attention an interest payment of $7,593.587 along with a copy of the enclosed worksheet within twenty (20) calendar days from the date of this letter.

Please be further advised that Fund regulations at 31 Pa. Code Section 242.17(b) provide that any health care provider failing to pay the surcharge within the time limits prescribed shall not be covered by the Fund in the event of loss. Upon receipt of the interest payment set forth above, coverage under the Health Care Services Malpractice Act will be cured for all claims except those claims about which you or your insureds knew or should have known.

Your prompt attention to this matter is appreciated.

Sincerely,

Pamela Bridy
Administrative Officer

PB:ds
Enclosure
050198/086

PMSLIC

Original: 1880
cc: Coccodrilli
Harris
Sandusky
Wyatte
Bereschak

September 24, 1997

Arthur F. McNulty, Esq., Chief Counsel
Medical Professional Liability
Catastrophe Loss Fund
P. O. Box 12030
Harrisburg, PA 17108

RE: PROPOSED REGULATIONS

CERTIFIED MAIL/RETURN
RECEIPT REQUESTED

Dear Mr. McNulty:

Please accept these suggestions and objections on behalf of the Pennsylvania Medical Society Liability Insurance Company (PMSLIC) with regard to the proposed regulations published in the "Pennsylvania Bulletin" on August 30, 1997. Although PMSLIC appreciates the efforts of the Medical Professional Liability Catastrophe Loss Fund (Fund) to improve the current system, for the reasons more fully discussed below we believe that many of the proposed changes are actually not consistent with that goal. Our comments will follow the order of the proposed regulations as contained in Annex A.

In §242.3 we note that the Fund has not taken this opportunity to amend the date by which it is required to publish the CAT Fund surcharge for the following year. As you are aware, a large number of physician policies renew effective January 1 of each year. Bills for these policies are mailed in mid November to allow the insureds sufficient time to pay before policy inception. Given the stability of the JUA rates as the premium base for the Fund's surcharge calculation, the only other major variable would be the claims payouts. Given that the Fund uses an August 31 cut off for payouts, we would suggest that the Fund commit in these regulations to publish the surcharge for the following year by October 1 in lieu of December 1.

In §242.4 the Fund is proposing that the basic insurance carriers "obtain from the health care provider a statement as to the addresses and specialty of the health care provider, and shall provide a copy of the statement to the Fund in line with the reporting requirements in

this chapter." Basic insurance carriers currently know a physician's specialty and territory in order to appropriately underwrite. It appears from the language proposed by the Fund that more is being requested of the insurance companies as well as the health care provider. We would suggest that this section be amended to require that the basic insurance carrier receive "information" as to the addresses and specialty of the health care provider and that such "information" be provided to the Fund.

In §242.5 the Fund is proposing a 20 day remittance period in lieu of the current 60 days. We believe this is fundamentally unreasonable. It is not uncommon for health care providers to seek coverage effective on the day they contact us. By the time we provide them any reasonable period to actually pay the bill, 20 days has already lapsed. For complicated accounts, determining the details of the CAT Fund remittance can take well in excess of 20 days. In fact, it is my understanding that given the complexity of some accounts, 60 days is really inadequate. Thus, we would at least propose that the Fund maintain the 60 day remittance period and, in fact, consider extending it to 90 days. Alternatively, if the Fund wishes to shorten the remittance period, it would seem more appropriate for the Fund to collect the surcharge directly from the health care provider rather than through the basic insurers.

In §242.5(c) the Fund proposes to impose interest charges on late remittances. (I would note that in the definition section of the proposed regulations "interest" refers to §506 of the Fiscal Code while the reference in §242.5(c) of the proposed regulations is to §806 of the Fiscal Code. It is our understanding that the reference to §806 is correct.) While we are in concurrence with the Fund's desire to have remittances submitted to the Fund on time, we question the statutory authority to collect interest. While "interest" is defined in Act 135, we have failed to find the term mentioned again in our reading of the statute. Nowhere in the statute does it say "Health care providers shall pay interest on late surcharge payments" or "The Fund may collect interest on late surcharge payments." This is in sharp contrast to the statute referenced above to define the term "interest" which states "All taxes due the Commonwealth shall bear simple interest..." 72 P.S. §806. As a state agency, the Fund's powers are limited to those granted by statute. (See Judge v. Allentown and Sacred Heart Hospital Center, 467 A.2d 899 (1983), reversed on other grounds, 487 A.2d 817 (1985). Thus, we would suggest that the Fund is without the statutory authority to collect interest.[1]

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[1] One might wonder why "interest" was a defined term in Act 135 of 1996 if the Fund was not intended by the Legislature to collect interest on late surcharge payments. Act 135 of 1996 was a combination of Fund reform and tort reform. Some of the Fund reform concepts and language are derived from Senate Bill 1122 (a copy of which is attached). In Senate Bill 1122, the term "interest" was defined and the Fund was given both the specific authority to charge interest on late remittances for the twice a year surcharge payments contemplated by SB1122 (see pages 9-10) and the Fund was required to pay interest on late

In addition, even if the Fund does have the authority to collect interest on late surcharge payments, we would respectfully suggest that the payment of interest will be an unwieldy and unworkable tool. (This comment will be even more profound if the Fund reduces the remittance period to 20 days.) Remittances can be "late" for any number of reasons. For example, the health care provider may pay the surcharge to the basic carrier late, the basic carrier can have difficulty reconciling the surcharge payment, the account may be so complex that billing for the surcharge amount may take almost the entire 60 days. To require the payment of interest for a late remittance will place an additional administrative burden on the basic insurance carriers, increase negative interactions with our insureds if we are placed in the position of being the "collection agent" for the interest payment from our health care providers and will result in, we would suggest, additional administrative problems for the Fund. Thus, we would strongly recommend that late remittances not result in the payment of interest. In the alternative, the Fund could directly bill the health care provider for the surcharge and be in a better position to charge interest for late payments.

In §242.6(1)(i) the Fund is again using a 20 day remittance period. We would renew our previously expressed concerns regarding this time. We have the same concerns with regard to §§242.6(a)(3), 242.7(g), and 242.10(b).

In §242.17 the Fund proposes what will happen when a health care provider fails to pay the surcharge or emergency surcharge in a timely manner or fails to pay at all. The CAT Fund enabling statute very clearly states what is to occur in these circumstances. In Title 40 P.S. §1301.701(f), the law states "The failure of any health care provider to comply with any provisions of this section or any of the 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." (emphasis added) Nowhere in the statutory authority of the Fund is denial of coverage authorized. As was previously discussed, as a state agency the Fund is limited to those activities authorized by statute. The statutory remedy for failure to pay the surcharge makes sense from a public policy perspective since the stated purpose of the Fund is to "pay all awards, judgments and settlements for loss or damages against a health care provider entitled to participate in the fund...to the extent such health care provider's share [of an award, judgment or settlement] exceeds his basic coverage insurance..." 40 P.S. §1301.701(d). (emphasis added). If there is an injured plaintiff who is entitled to

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payments to plaintiffs (see page 10). The failure of the Legislature to include these provisions in the final legislation is evidence of legislative intent not to give the Fund the authority it now seeks to get through regulation. Given the speed with which Act 135 of 1996 was compiled during the waning days of the 1996 legislative session, it is entirely conceivable that the definition of "interest" remained when all the statutory sections using the term were deleted in the drafting of the final language due to an oversight.

compensation in excess of the basic insurance coverage, the injured party should be compensated regardless of whether the health care provider actually paid CAT Fund surcharge. This is one of the benefits of a government run catastrophe fund as compared to a private insurance policy which would not provide coverage if premium was not paid. The proposed regulation would absolve the Fund of liability in a situation where the health care provider failed to pay the surcharge. We do not believe that the statutory authority of the Fund provides for the relief proposed in the regulations and also believe the Fund's position is against public policy.

We find the proposed effective date objectionable as the Fund proposes an effective date that is almost a year earlier than the publication of the proposed regulations.

In §242.6 mediation is defined. In the definition, the proposed regulations currently state "mediation proceedings are confidential and should not be considered public information..." We would suggest that this be changed to "shall not" to make it consistent with the statutory authorization for mediation.

As always, please do not hesitate to contact me or my staff if we can be of any further assistance.

Sincerely,

Sarah H. Lawhorne
President

Enclosure

cc: Senate Banking and Insurance Committee (w/enclosure)
House Insurance Committee (w/enclosure)
Independent Regulatory Review Commission (w/enclosure)
John H. Hobart, M.D. (w/enclosure)
Theodore G. Otto, III, Esq. (w/enclosure)

PRIOR PRINTER'S NO. 1304 PRINTER'S NO. 1487

THE GENERAL ASSEMBLY OF PENNSYLVANIA

SENATE BILL

No. 1122 Session of 1995

INTRODUCED BY HOLL, SALVATORE, JONES, HELFRICK, WENGER, HART, CORMAN, AFFLERBACH, HECKLER, O'PAKE, JUBELIRER AND LEMMOND, JUNE 21, 1995

SENATOR HOLL, BANKING AND INSURANCE, AS AMENDED, OCTOBER 17, 1995

AN ACT

Amending the act of October 15, 1975 (P.L.390, No.111), entitled "An act relating to medical and health related malpractice insurance, prescribing the powers and duties of the Insurance Department; providing for a joint underwriting plan; the Arbitration Panels for Health Care, compulsory screening of claims; collateral sources requirement; limitation on contingent fee compensation; establishing a Catastrophe Loss Fund; and prescribing penalties," further providing for definitions, for statutes of limitation, for professional liability insurance and the Medical Professional Liability Catastrophe Loss Fund, for administration of that fund, for liability of excess carriers, for plan operation and rates, for reports to the Insurance Commissioner, for forms of doing business and for the Joint Study Committee.

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

Section 1. Section 103 of the act of October 15, 1975 (P.L.390, No.111), known as the Health Care Services Malpractice Act, amended July 15, 1976 (P.L.1028, No.207) and November 6, 1985 (P.L.311, No.78), is amended to read:

Section 103. Definitions.--As used in this act:

"Administrator" means the office of Administrator for Arbitration Panels for Health Care.

"Arbitration panel" means Arbitration Panels for Health Care.

"Board" means the Board of Directors responsible for administering the Medical Professional Liability Catastrophe Loss Fund under section 702.

"Claims made" means a policy of professional liability insurance that would limit or restrict the liability of the insurer under the policy to only those claims made or reported during the currency of the policy period and would exclude coverage for claims reported subsequent to the termination even when such claims resulted from occurrences during the currency of the policy period.

"Claims period" means the six-month period:

(1) beginning March 1 and ending August 31; or

(2) beginning September 1 and ending on the last day of February.

"Commissioner" means the Insurance Commissioner of this Commonwealth.

"Final claim" means any of the following:

(1) A payment made by the fund directly to a claimant.

(2) A payment made by the fund to a basic insurance carrier or self-insured provider to reimburse it for a payment made from the fund coverage limits.

(3) A payment the fund is obligated by this act to make to a basic insurance carrier of self-insured provider for a payment, made from the fund coverage limits to a claimant, which is not reimbursed, including interest, due to a lack of surcharge receipts. In no event shall a payment or obligation to pay be included in more than one claims period for the purposes of surcharge calculation.

"Fund" means the Medical Professional Liability Catastrophe

Loss Fund established under section 701(d).

"Fund coverage limits" means the coverage provided by the Medical Professional Liability Catastrophe Loss Fund under section 701(d).

"Government" means 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 practice entity" means a professional corporation, restricted limited liability corporation, professional association, partnership or limited liability partnership which:

(1) provides professional services; and

(2) is, as determined by the Medical Professional Liability Catastrophe Loss Fund, owned entirely by health care providers.

"Health care provider" means a primary health center or a person, corporation, UNIVERSITY OR OTHER EDUCATIONAL INSTITUTION, facility, institution or other entity licensed or approved by the Commonwealth to provide health care or professional medical services as a physician, an osteopathic physician or surgeon, a certified nurse midwife, a podiatrist, hospital, nursing home, birth center, and except as to section 701(a), an officer, employee or agent of any of them acting in the course and scope of his employment. <—

"Informed consent" means for the purposes of this act and of any proceedings arising under the provisions of this act, the

consent of a patient to the performance of health care services by a physician or podiatrist: Provided, That prior to the consent having been given, the physician or podiatrist has informed the patient of the nature of the proposed procedure or treatment and of those risks and alternatives to treatment or diagnosis that a reasonable patient would consider material to the decision whether or not to undergo treatment or diagnosis. No physician or podiatrist shall be liable for a failure to obtain an informed consent in the event of an emergency which prevents consulting the patient. No physician or podiatrist shall be liable for failure to obtain an informed consent if it is established by a preponderance of the evidence that furnishing the information in question to the patient would have resulted in a seriously adverse effect on the patient or on the therapeutic process to the material detriment of the patient's health.

"Interest" means interest at the rate prescribed in section 806 of the act of April 9, 1929 (P.L.343, No.176), known as "The Fiscal Code."

"Licensure Board" means the State Board of [Medical Education and Licensure] Medicine, the State Board of Osteopathic [Examiners] Medicine, the State Board of Podiatry [Examiners], the Department of Public Welfare and the Department of Health.

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

"Prevailing primary rate" means a schedule of professional liability insurance premium rates for health care providers of similar class, size, risk and kind within defined regions as determined by the Medical Professional Liability Catastrophe Loss Fund under section 701(e)(2).

"Primary health center" means 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.

"Professional liability insurance" means 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.

"Surcharge period" means the six-month period:

(1) beginning January 1 and ending June 30; or

(2) beginning July 1 and ending December 31.

Section 2. Section 605 of the act, amended July 15, 1976 (P.L.1028, No.207), is amended to read:

Section 605. Statute of Limitations~~[.--] and Defense.--(a)~~ <—

.--(A) All claims for recovery pursuant to this act must be <—
commenced within the existing applicable statutes of limitation. In the event that any claim is made against a health care provider subject to the provisions of Article VII more than four years after the breach of contract or tort occurred which is filed within the statute of limitations, such claim shall be defended and paid by the [Medical Professional Liability Catastrophe Loss Fund established pursuant to section 701] fund. If such claim is made after four years because of the willful concealment by the health care provider or his insurer, the fund shall have the right of full indemnity including defense costs from such health care provider or his insurer. A filing pursuant to section 401 shall toll the running of the limitations

contained herein.

(b) ~~Basic insurance coverage carriers and self-insured providers may, at their discretion, undertake the defense of cases under this section.~~ The fund coverage limits for cases under this section reported on or after the effective date of this subsection shall be $1,200,000.

~~(c) Upon the conclusion of a claim under this section in which the basic insurance coverage carrier or self-insured provider has provided a defense, the basic insurance coverage carrier or self-insured provider shall be reimbursed from the fund:~~

~~(1) upon request, reasonable costs incurred up to $15,000; and~~

~~(2) upon request and approval by the fund, reasonable costs incurred in excess of $15,000.~~

Section 3. Section 701(b), (C), (e) and (f) of the act, amended October 15, 1980 (P.L.971, No.165), is amended to read:

Section 701. Professional Liability Insurance and Fund.--~~(a)~~

* * *

(b) [No] (1) EXCEPT AS PROVIDED IN SECTION 702(G), NO insurer or self-insurance plan providing professional liability insurance shall be liable for the defense or payment of any claim against a health care provider for any loss or damages awarded in a professional liability action in excess of the basic coverage insurance, as provided in subsection (a)(1) for each health care provider against whom an award is made unless the health care provider's professional liability policy or self-insurance plan provides for a higher annual aggregate limit.

(2) If a claim exceeds the aggregate limits of an insurer or

a self-insurance plan, the fund shall be responsible for the payment of the claim and any related expense up to the fund coverage limits.

(C) A GOVERNMENT MAY SATISFY ITS OBLIGATIONS PURSUANT TO THIS ACT, AS WELL AS THE OBLIGATIONS OF ITS EMPLOYEES TO THE EXTENT OF THEIR EMPLOYMENT, BY EITHER PURCHASING INSURANCE OR ASSUMING SUCH OBLIGATION AS A SELF-INSURER AND INCLUDING THE PAYMENT OF ALL SURCHARGES UNDER THIS ACT. <—

* * *

(e) (1) [The] After December 31, 1995, the fund shall be funded by the levying of [an annual surcharge on or after January 1 of every year] a semiannual surcharge on all health care providers entitled to participate in the fund. [The] Within 30 days following the end of a claims period, the surcharge shall be determined by the [director appointed pursuant to section 702 and subject to the prior approval of the commissioner.] fund, filed with the commissioner and communicated to all basic insurance coverage carriers and self-insured providers. The surcharge shall be based on the [cost to] prevailing primary rate for each health care provider for maintenance of professional liability insurance and shall be the appropriate percentage thereof, necessary to produce an amount sufficient to reimburse the fund for the payment of [all claims paid] final claims and expenses incurred during the preceding [calendar year] claims period and to provide an amount necessary to maintain an additional [$15,000,000.] 15% OF THE FINAL CLAIMS AND EXPENSES INCURRED DURING THE PRECEDING CLAIMS PERIOD. The surcharge shall be exempt from approval by the commissioner prior to imposition. If, after imposition, a surcharge is disapproved by the commissioner due to the surcharge being <—

inadequate or excessive, the fund shall make an adjustment to the next surcharge calculation to reflect the appropriate increase or decrease.

(2) [Health care providers having approved self-insurance plans shall be surcharged an amount equal to the surcharge imposed on a health care provider of like class, size, risk and kind as determined by the director. The fund and all income from the fund shall be held in trust, deposited in a segregated account, invested and reinvested by the director, and shall not become a part of the General Fund of the Commonwealth. All claims shall be computed on August 31, 1981 for all claims which become final between January 1, 1981 and August 31, 1981 and annually thereafter on August 31 for all claims which became final between that date and September 1 of the preceding year. All such claims shall be paid on or before December 31 following the August 31 by which they became final, as provided above. All claims which become final between January 1, 1980 and the effective date of this amendatory act shall be computed on the effective date of this amendatory act and shall be paid on or before December 31, 1980.] The prevailing primary rate shall be determined by the fund based on the average of the basic insurance coverage rates filed with and approved by the commissioner by June 30 of the year in which the prevailing primary rate is determined by three nursing home insurers, three hospital insurers and three insurers for other health care providers, that have the largest share of their respective markets in this Commonwealth. The market share shall be determined by the fund based on total surcharges collected by the primary coverage carriers in the preceding calendar year. The fund shall determine the prevailing primary rate by August

31 every two years

(3) [Notwithstanding the above provisions relating to an annual surcharge, the commissioner shall have the authority, during September 1981 and during September of each year thereafter, if the fund would be exhausted by the payment in full of all claims which have become final and the expenses of the office of the director, to determine and levy an emergency surcharge on all health care providers then entitled to participate in the fund. Such emergency surcharge shall be the appropriate percentage of the cost to each health care provider for maintenance of professional liability insurance necessary to produce an amount sufficient to allow the fund to pay in full all claims determined to be final as of August 31, 1981 and August 31 of each year thereafter and the expenses of the office of the director, as of December 31, 1980 and December 31 of each year thereafter.] In addition to the surcharge calculation in ~~paragraph (1), the following shall apply:~~ <—

~~(i) For the surcharge period beginning January 1, 1996, the fund is authorized to include in the surcharge calculation an amount sufficient to allow the fund to pay in full all final claims as of August 31, 1995, taking into account existing surcharge receipts.~~

~~(ii) For the surcharge period beginning July 1, 1996, the~~ PARAGRAPH (1), FOR THE SURCHARGE PERIOD BEGINNING JANUARY 1, <—
1996, THE fund is authorized to include in the surcharge calculation an amount sufficient to allow the fund to pay in full all final claims as of December 31, 1995, taking into account existing surcharge receipts.

(3.1) Surcharges shall be due 20 days following commencement of the applicable surcharge period. Late remittance by carriers

of surcharges collected from health care providers and late remittance of surcharges due from self-insured providers shall include interest.

(3.2) The annual surcharge of 102% of the cost to each health care provider for maintenance of professional liability insurance levied by the fund in 1994 shall continue to be in force for all policies renewed in 1995. Prorated credit for the 1995 annual surcharge applicable beyond December 31, 1995, shall be credited against the semiannual surcharges levied under this subsection.

(3.3) The fund and all income from the fund shall be held in trust, deposited in a segregated account and invested and reinvested by the fund and shall not become a part of the General Fund.

(3.4) Claims shall be paid as follows:

(i) Final claims as of August 31, 1995, shall be paid by January 20, 1996.

(ii) Final claims ~~after~~ AS OF December 31, 1995, shall be paid by July 20, 1996. <—

~~(iii) For final claims as of December 31, 1995, basic coverage insurance carriers or self-insured providers shall make payment to plaintiffs for the basic coverage and the fund coverage limits at the same time. The fund shall, within 30 days of submission of payment information, reimburse basic coverage insurance carriers and self-insured providers for the fund's portion of payments made to plaintiffs. Late reimbursement by the fund shall include interest.~~ <—

(III) FINAL CLAIMS AFTER DECEMBER 31, 1995, SHALL BE PAID TO THE PLAINTIFF WITHIN 90 DAYS OF NOTIFICATION OF SETTLEMENT OR VERDICT. LATE PAYMENTS SHALL INCLUDE INTEREST. <—

(4) The [annua' and emergency] surcharges n health care providers and any income realized by investment or reinvestment shall constitute the sole and exclusive sources of funding for the fund. No claims or expenses against the fund shall be deemed to constitute a debt of the Commonwealth or a charge against the General Fund [of the Commonwealth. The director shall issue rules and regulations consistent with this section regarding the establishment and operation of the fund including all procedures and the levying, payment and collection of the surcharges except that the commissioner shall issue rules and regulations regarding the imposition of the emergency surcharge. A fee shall be charged by the director to all self-insurers for examination and approval of their plans].

(f) The failure of any health care provider to comply with any of the provisions of this section or any of the rules and regulations issued by the [director] fund shall result in the suspension or revocation of the health care provider's license by the licensure board.

* * *

Section 4. Section 702 of the act, amended July 15, 1976 (P.L.1028, No.207) and October 15, 1980 (P.L.971, No.165), is amended to read:

Section 702. Director and Administration of Fund.--(a) The fund shall be supervised and administered by a [director who shall be appointed by the Governor and whose salary shall be fixed by the Executive Board.] Board of Directors.

(1) The board shall consist of seven members appointed by the Governor in accordance with the following:

(i) One physician shall be appointed for a three-year term, and one physician shall be appointed for a one-year term.

(ii) One representative of a hospital shall be appointed for a three-year term, and one representative of a hospital shall be appointed for a one-year term.

(iii) One representative of the public at large shall be appointed for a two-year term.

(iv) One representative of a casualty insurer with a 1% or less share of the medical malpractice insurance market in this Commonwealth shall be appointed for a two-year term.

(v) One podiatrist or one representative of a nursing home shall be appointed for a three-year term. The podiatrist and the representative of a nursing home shall alternate terms.

(vi) After the initial terms under this paragraph have been completed, all terms shall be for a period of three years.

(2) No member of the board may serve more than two successive terms.

(3) Board members may be reimbursed by the fund for reasonable expenses incurred in the performance of duties of office.

(4) The [director] board may employ a director and [fix the compensation of such clerical and other assistants] staff as [may be deemed] necessary [and].

(a.1) The fund may promulgate rules and regulations [relating to] consistent with this act regarding the establishment and operation of the fund, including procedures [for] related to the payment of surcharges and the reporting of claims to the fund.

(b) The [director] fund shall be provided with adequate offices in which the records shall be kept and official business shall be transacted, and the [director] fund shall also be provided with necessary office furniture and other supplies.

†(c) The basic coverage insurance carrier or self-insured provider shall promptly notify the [director of any case where it reasonably believes that the value of the claim exceeds the basic insurer's coverage or self-insurance plan or falls under section 605. Such information shall be confidential, notwithstanding the act of July 19, 1974 (P.L.486, No.175) referred to as the Public Agency Open Meeting Law, and act of June 21, 1957 (P.L.390, No.212) referred to as the Right To Know Law] FUND. Failure to so notify the [director] FUND shall make the basic coverage insurance carrier or self-insured provider responsible for the payment of the entire award or verdict, provided that the fund has been prejudiced by the failure of notice.† <—

(d) The basic coverage insurance carrier or self-insured provider shall be responsible to provide a defense to the claim, including defense of the fund, except as provided for in section 605. [In such instances where the director has been notified in accordance with subsection (c), the director may, at his option, join in the defense and be represented by counsel.]

(e) [In the event that the basic coverage insurance carrier or self-insured provider enters into a settlement with the claimant to the full extent of its liability as provided above, it may obtain a release from the claimant to the extent of its payment, which payment shall have no effect upon any excess claim against the fund or its duty to continue the defense of the claim.] Until December 31, 1995, the fund has the responsibility to settle or compromise claims payable by the fund, subject to concurrence by the basic coverage insurance carrier or self-insured provider.

(f) [The director is authorized] After December 31, 1995,

the basic coverage insurance carrier or self-insured provider shall be responsible to defend, litigate, settle or compromise any claim payable by the fund. [A health care provider's basic insurance coverage carrier shall have the right to approve any settlement entered into by the director on behalf of its insured health care provider. If the basic insurance coverage carrier does not disapprove a settlement prior to execution by the director, it shall be deemed approved by the basic insurance coverage carrier. In the event that more than one health care provider defendant is party to a settlement, the health care provider's basic insurance coverage carrier shall have the right to approve only that portion of the settlement which is contributed on behalf of its insured health care provider.]

(g) The [director] fund is hereby empowered to purchase, on behalf of the fund, as much insurance or re-insurance as is necessary to preserve the fund.

[(h) Nothing in this act shall preclude the director from adjusting or paying for the adjustment of claims.]

~~(i) The basic insurance carrier and the fund are liable for any act committed in bad faith and are liable for payment of the entire award on verdict in such instances.~~ <—

~~(j) Upon the request of a party to a case within the fund coverage limits, and with the agreement of the other parties to the case, the fund may provide for a mediator in instances where multiple carriers disagree on a case.~~

(I) THE FUND SHALL BE LIABLE FOR ANY ACTIONS TAKEN, COMMITTED OR OMITTED, IN BAD FAITH UNDER THIS ACT AND IS LIABLE FOR PAYMENT OF THE ENTIRE AWARD ON VERDICT IN SUCH INSTANCES. IF AND TO THE EXTENT THAT A BASIC INSURANCE CARRIER OR SELF-INSURED PROVIDER ACTS FOR OR ON BEHALF OF THE FUND UNDER THIS ACT, <—

WHETHER AS AN AGENT OR DELEGATEE, THE BASIC INSURANCE CARRIER OR SELF-INSURED PROVIDER, AS APPLICABLE, SHALL BE LIABLE UNDER THIS SUBSECTION.

(J) UPON THE REQUEST OF A PARTY TO A CASE WITHIN THE FUND COVERAGE LIMITS, THE FUND MAY PROVIDE FOR A MEDIATOR IN INSTANCES WHERE MULTIPLE CARRIERS DISAGREE ON A CASE. UPON THE CONSENT OF ALL PARTIES TO ANY PROCEEDING HEREUNDER THAT MEDIATION SHALL BE BINDING, THE PARTIES SHALL BE BOUND BY THE CONCLUSIONS OF THE MEDIATOR. THE FUND SHALL PROMULGATE SUCH RULES AND REGULATIONS AS ARE NECESSARY TO IMPLEMENT THIS PROVISION. PROCEEDINGS CONDUCTED UNDER 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, AND THE ACT OF JULY 3, 1986 (P.L.388, NO.84), KNOWN AS THE "SUNSHINE ACT."

(k) Delay damages and postjudgment interest applicable to the fund's liability in a case shall be paid by the fund and shall not be charged against the insured's annual aggregate limits.

(l) The fund coverage limits shall be exempt from requirements to furnish appeal bonds.

(m) The fund shall determine who is a health care provider for the purpose of having access to the liability coverage provided by the fund.

(N) THE FUND SHALL HAVE THE AUTHORITY TO BORROW MONEY FOR PERIODS OF LESS THAN ONE YEAR IN ORDER TO PAY CLAIMS AND EXPENSES UNTIL SUFFICIENT REVENUES ARE REALIZED BY THE FUND THROUGH THE SEMIANNUAL SURCHARGES. <—

Section 5. Section 705 of the act, added July 15, 1976 (P.L.1028, No.207), is amended to read:

Section 705. Liability of Excess Carriers.- (a) No insurer providing excess professional liability insurance to any health care provider eligible for coverage under the [Medical Professional Liability Catastrophe Loss Fund] fund shall be liable for payment of any claim against a health care provider for any loss or damages except those in excess of the fund coverage limits [of liability provided by the Medical Professional Liability Catastrophe Loss Fund].

(b) No carrier providing excess professional liability insurance for a health care provider covered by the [Medical Professional Catastrophe Loss Fund] fund shall be liable for any loss resulting from the insolvency or dissolution of the [catastrophe loss] fund.

Section 6. Section 803 of the act, amended October 15, 1980 (P.L.971, No.165), is amended to read:

Section 803. Plan Operation, Rates and Deficits.--(a) Subject to the supervision and approval of the commissioner, insurers may consult and agree with each other and with other appropriate persons as to the organization, administration and operation of the plan and as to rates and rate modifications for insurance coverages provided under the plan. Rates and rate modifications adopted or changed for insurance coverages provided under the plan shall be approved by the commissioner in accordance with the act of June 11, 1947 (P.L.538, No.246), known as "The Casualty and Surety Rate Regulatory Act," except as may be inconsistent with subsection (c).

(b) In the event that the Joint Underwriting Association suffers a deficit in any calendar year, the board of directors of the Joint Underwriting Association shall so certify to the director of the [Catastrophe Loss Fund and the Insurance

Commissioner] fund and the commissioner. Such certification shall be subject to the review and approval of the [Insurance Commissioner] commissioner. Within 60 days following such certification and approval the director of the fund shall make sufficient payment to the Joint Underwriting Association to compensate for said deficit. A deficit shall exist whenever the sum of the earned premiums collected by the Joint Underwriting Association and the investment income therefrom is exhausted by virtue of payment of or allocation for the Joint Underwriting Association's necessary administrative expenses, taxes, losses, loss adjustment expenses and reserves, including reserves for: (1) losses incurred, (2) losses incurred but not reported, (3) loss adjustment expenses, (4) unearned premiums.

(c) Within 60 days following the certification that the Joint Underwriting Association has suffered a deficit, as set forth in subsection (b), the board of directors of the Joint Underwriting Association shall file with the [Insurance Commissioner and the Insurance Commissioner] commissioner and the commissioner shall approve a premium increase sufficient to generate the requisite income to:

(1) reimburse the fund for any payment made by the fund to compensate for said deficit; and

(2) increase premiums to a level actuarially sufficient to avoid an operating deficit by the Joint Underwriting Association during the following 12 months.

The Joint Underwriting Association shall reimburse the fund with interest at a rate equal to that earned by the fund on its invested assets within one year of any payment made by the fund as compensation for any deficit incurred by the Joint Underwriting Association.

Section 7. Section 809 of the act is amended to read:

Section 809. [Annual Reports to Insurance Commissioner.--The plan shall report to the commissioner annually on a date and, on a form prescribed by the commissioner the total amount of premium dollars collected,] Reports to Commissioner and Claims Information.--(a) Ten days after the close of a claims period, basic coverage insurance carriers and self-insured providers shall report to the fund the claims information specified in subsection (b).

(b) Thirty days after the close of a claims period, the fund shall prepare a report for the commissioner. The report shall contain the total amount of claims paid and expenses incurred therewith, the total amount of reserve set aside for future claims, the nature and substance of each claim, the date and place in which each claim arose, the amounts paid, if any, and the disposition of each claim (judgment of arbitration panel, judgment of court, settlement or otherwise)[, and such additional information as the commissioner shall require]. For final claims during the claims period, the report shall include details by basic coverage insurance carriers and self-insured providers of the amount of surcharge collected, the number of reimbursements paid and the amount of reimbursements paid.

(c) If, in two consecutive claims periods, a basic coverage insurance carrier or self-insured provider receives reimbursement proportionately higher than the amount of surcharges collected from them, the board shall investigate the reasons for this occurrence. If more than one basic coverage insurance carrier or self-insured provider receives reimbursement proportionately higher than the amount remitted to the fund, the board's investigation shall be limited to the two

basic coverage insurance carriers or self-insured providers with the proportionately highest ratios. The board shall consider pre-1995 ratios of reimbursement to surcharge remitted by the basic coverage insurance carrier or self-insured provider in its investigation. If the board finds, in an adjudication, that a basic coverage insurance carrier or self-insured provider is not administering claims in a manner consistent with the adequate protection of the assets of the fund, the board may require the basic coverage insurance carrier or self-insured provider to seek and obtain prior approval of the fund before committing the fund coverage limits to the settlement of a claim for a stated period of time, known as a probationary period, not to exceed one year. Adjudications under this subsection are subject to 2 Pa.C.S. Ch. 5 Subch. A (relating to practice and procedure of Commonwealth agencies) and Ch. 7 Subch. A (relating to judicial review of Commonwealth agency action).

(d) During the probationary period under subsection (c), the following shall apply:

(1) The basic coverage insurance carrier or self-insured provider shall promptly notify the fund of any case where it reasonably believes that the value of the claim exceeds the basic insurer's coverage or self-insurance plan or falls under section 605. Upon failure to notify under this paragraph, the basic coverage insurance carrier or self-insured provider shall be responsible for the payment of the entire award or verdict if the fund has been prejudiced by the failure.

(2) The fund must approve any settlement which represents a liability of the fund entered into by the basic coverage insurance carrier or self-insured provider on behalf of its insured health care provider.

(e) Claim information 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 the act of July 3, 1986 (P.L.388, No.84), known as the "Sunshine Act."

Section 8. Sections 811 and 1006 of the act, amended or added November 26, 1978 (P.L.1324, No.320), are amended to read:

Section 811. [Professional Corporations, Professional Associations and Partnerships] Health Care Practice Entities.--(a) The Joint Underwriting Association shall offer basic coverage insurance to [such professional corporations, professional associations and partnerships entirely owned by health care providers] health care practice entities who cannot conveniently obtain insurance through ordinary methods at rates not in excess of those applicable to similarly situated [professional corporations, professional associations and partnerships.] health care practice entities.

(b) In the event that a [professional corporation, professional association or partnership entirely owned by health care providers] health care practice entity elects to be covered by basic coverage insurance and upon payment of the [annual] surcharge as required by section 701(e), the [professional corporation, professional association or partnership] health care practice entity shall be entitled to such excess coverage from the [Medical Professional Liability Catastrophe Loss Fund] fund as is provided in this act.

(c) Any [professional corporation, professional association, or partnership] health care practice entity which acquires basic coverage insurance from the Joint Underwriting Association pursuant to subsection (a) or from an insurer licensed or

approved by the Commonwealth of Pennsylvania shall be required to participate in and contribute to the [Medical Professional Liability Catastrophe Loss Fund] fund as provided in this act.

(d) Any [professional corporation, professional association or partnership] health care practice entity which participates in or contributes to the [Medical Professional Liability Catastrophe Loss Fund] fund shall be subject to all other provisions of this act. The fund is responsible for making the determination of whether a health care practice entity is entitled to fund coverage.

Section 1006. Joint Committee.--There is hereby created a committee to consist of the commissioner as chairman, the Secretary of Health and two members of the Senate, one member of each party, to be appointed by the President pro tempore and two members of the House of Representatives, one member of each party, to be appointed by the Speaker of the House of Representatives. The committee shall study the distribution of professional liability insurance costs as among the various classes of physicians and health care providers and shall report its findings and recommendations to the General Assembly within one year of the effective date of this act. The committee shall also study all phases and the financial impact of the operations of the [Medical Professional Liability Catastrophe Loss Fund] fund and shall report its findings and recommendations to the General Assembly on or before July 1, 1977. This committee shall also study actual or potential problems of conflicts of interest which exist or may exist among members of the arbitration panel with each other and with other persons appearing before the arbitration panel or having their interests represented before the arbitration panel. The committee shall promulgate a proposed

Code of Ethics with suggested legal sanctions to deal with any violators of the Code of Ethics on or before July 1, 1976. This committee shall study the act, its application and operation to determine if any changes in the present act are necessary or advisable. This study shall include consideration of the advisability and potential effect of the application of the act to mental health/mental retardation facilities. The committee shall report on this study on or before July 1, 1979 and each year thereafter.

Section 9. This act shall take effect immediately.

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JEANNETTE DISTRICT
MEMORIAL HOSPITAL

Robert J. Bulger
President/Chief Executive Officer

September 25, 1997

John McGinley, Jr.
Chairperson
Independent Regulatory Review Commission
333 Market Street, 14th Floor
Harrisburg, PA 17101

Dear Mr. McGinley:

This letter is to express our concerns regarding the published proposed regulations in the August 30, 1997 Pennsylvania Bulletin regarding the Medical Professional Liability Catastrophe Loss Fund (CAT Fund).

Of particular concern to this institution are the issues regarding the reduction in the remittance period for surcharge payments from 60 days to 20 days; the proposal that providers will lose CAT Fund coverage for the period of time in which any surcharge delinquencies exist; and the fact that interest will be charged on late surcharge remittances.

This Hospital feels that the surcharge remittance period remain at 60 days and that the denial of CAT Fund coverage for claims that occurred during the surcharge delinquency period, even after surcharges have been paid with interest, is not appropriate.

We appreciate your attention and understanding in this matter. If we can be of any further assistance, please contact me at your convenience.

Thank you.

Sincerely,

Robert J. Bulger
President/Chief Executive Officer

RJB/lv

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September 25, 1997

Arthur McNulty, Esq.
Chief Counsel
Catastrophe Loss Fund
10th Floor, Suite 1000
30North Third Street
Harrisburg, PA 17108

RE: PA CAT Fund
Proposed Rulemaking - 31 PA Code Chs. 242 and 246

Dear Mr. McNulty:

Please accept this in response to your request for comment on the above proposed rulemaking regarding the PA CAT Fund as listed in the PA Bulletin of 8/30/97.

With regard to the Chapter 242 proposed revisions we have the following comments:

1) Section 242.5 - Submission of Surcharge payment within 20 days of renewal.
As an academic health center, subject to the annual medical school re-appointment and rotation scheduling procedures, a 20 day payment deadline is simply impossible to meet. It takes 30 days from the date of renewal alone to compile data from the various departments on each physician and resident and another week to generate invoices. This leaves 3 weeks to receive payment, produce the proper CAT Fund documentation and forward the filing to the Fund. We recommend that the filing deadline remain not less than 60 days from the date of renewal.

2) Section 242.17 Compliance. The payment of interest on late payments is a justifiable recognition of the time value of money. Denial of coverage, however, is extreme particularly when interest is assessed for late payments. The penalty of denial of coverage should only be implemented after a notice of a delinquency is given and the surcharge remains unpaid for a reasonable period of time.

Also, it seems somewhat inequitable for the Fund to assess interest on late payments due the Fund, while the Fund is not obligated to return overpayments or pay interest on credit balances it owes to its insureds and/or primary carriers. Consideration should be given to providing a 5 day grace period before any interest should be assessed by the Fund or alternatively, interest should be assessed on all credit balances owed by the Fund at the same interest rate as charged for late payments.

With regard to the Mediation provisions in Chapter 246, we have the following comments:

1) Section 246.3 - Provision by the Fund of the Mediator. As a likely party to any coverage dispute subject to mediation, and the only insurer/party not subject to the duty of good faith, the CAT Fund should not have sole authority to appoint a mediator which would be perceived by all as a lack of good faith, objectivity and impartiality. Rather, the mediator should be agreed upon by all of the parties when possible, or when agreement is not possible then each side should choose a mediator with those appointed then selecting a neutral member of the mediation panel.

2) 246.1 - (Definitions) Plaintiff included in definition of party. As drafted, Chapter 246 appears to permit Plaintiffs to a malpractice suit to initiate and/or participate in the proposed mediation process. We think plaintiff participation is unwarranted for any number of good reasons.

   First, there are already a number of avenues for alternative dispute resolution and/or pre-trial settlement discussions involving plaintiffs, dependents and carriers provided by the various court systems. Allowing plaintiff's to participate in this mediation process would add additional expense and delay without any benefit to the settlement process.

   Secondly, the purpose of Chapter 246 is to provide a forum for coverage disputes among carriers, (including the Fund) not another alternate dispute resolution mechanism for the underlying claim. Participation of plaintiffs in a coverage dispute would not facilitate its resolution and in most cases would act as a hindrance and/or obstruction.

   We recommend that Plaintiffs removed from the definition of party and excluded from the coverage dispute mediation process except upon agreement by all of the other parties involved.

If you have any questions, or would like to discuss any of the above recommendations, please feel free to contact us.

Sincerely,

Ms. Karen L. Hartley

cc: George Board, Dr. PH
John Paul

KLH:tlm

• AHERF

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INDEPENDENT REGULATORY REVIEW COMMISSION

OFFICE OF LEGAL AFFAIRS

INDEPENDENT REGULATORY REVIEW COMMISSION

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MLH
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DATE: 9/29/97

TRANSMIT TO: JOHN McGINLEY

COMPANY: _____ **DEPARTMENT:** _____

FAX NO.: 717-783-2664 **PHONE NO.:** _____

Number of pages including cover sheet: 10

FROM: BONNIE BROCCOLI, EXECUTIVE SECRETARY

PHONE: (412) 359-8122

REGARDING: _____

COMMENTS/MESSAGE: _____

If there are any problems with reception please call (412) 359-6060.

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September 26, 1997

Arthur F. McNulty
Chief Counsel
Pennsylvania Medical Professional
Liability Catastrophe Loss Fund
10th Floor, Suite 1000
30 North Street
PO Box 12030
Harrisburg, PA 17108

Dear Mr. McNulty:

I am writing in response to the proposed regulations which appeared in the August 30, 1997, *Pennsylvania Bulletin.*

At a time when all providers, institutional and physician alike, are dealing with drastic changes in the health care environment and operating under severe budget constraints, the proposed regulations addressing surcharge remittance loom as an administrative nightmare. Not only are significantly increased operational burdens imposed by these proposed regulations but the time frame for payment of any surcharge is substantially reduced. For many the new requirements will require the hiring of additional staff to prepare and process the additional paperwork that will be required within a third of the time currently allotted. The suggestion that these proposed amendments are to be construed as "minor" changes, as noted in the Summary section of the Bulletin, is grossly misleading and unfair. The mere thought that primary carriers, self-insurers, and insurance brokers should have to hire additional staff in order to comply with these regulations is inconsistent with the frequently published statements made by the Fund that one of its primary goals is to reduce total expenses for all providers.

We support the proposal to establish some form of a mediation process that would accelerate settlement of disputes between and among carriers and the Fund. As currently proposed, however, the language needs to be clarified to address certain operational issues.

We believe that these regulations, if enacted, would create significant changes in many aspects of the Cat Fund process. Given this and the various problems involved in the publication and dissemination of the proposed regulations, we strongly recommend that the proposed regulations published in the August 30, 1997 *Pennsylvania Bulletin* be withdrawn and substantially modified before being reproposed.

Our specific comments on Chapters 242 and 246 are attached. I would be happy to answer any questions you may have in this regard.

Sincerely,

Nancy A. Wynstra

Nancy A. Wynstra
Executive Vice President
and General Counsel

cc: Members of the CAT Fund Advisory Board
John McGinley, Jr., Chairperson, Independent Regulatory Review Commission
Carolyn F. Scanlan, HAP
Majority/Minority Chairs, House Health and Human Services Committee
Majority/Minority Chairs, Sen. Public Health and Welfare Committee
Majority /Minority Chairs, House Insurance Committee
Majority/Minority Chairs, Sen. Banking and Insurance Committee
Rick Grinaldi, Deputy General Counsel, Governor's Office

PGH: 30184.1

CHAPTER 242. MEDICAL PROFESSIONAL LIABILITY CATASTROPHE LOSS FUND

§ 242.4. Computation of surcharge.

Proposed: **(a) The basic insurance carrier shall obtain from the health care provider a statement as to the addresses and specialty of the health care provider, and shall provide a copy of the statement to the Fund in line with the reporting requirements in this chapter.**

Comments: The proposal that basic carriers provide copies of statements from each provider, confirming address and specialty, is preposterous within the framework of an integrated academic health system. The AHERF Liability Insurance Program insures several thousands of physicians and residents. Of these, approximately 2,500 are reportable to the CAT Fund. Under the current system, AHERF staff maintain detailed information on each individually licensed provider insured under the system's program. This information is forwarded to the insurance broker who, in turn, passes it on to the Fund. The process is fully automated and those individuals charged with reporting providers to the broker are able to access various databases across the system to obtain detailed information on each provider from the Medical Staff and Graduate Medical Education Offices. Requiring the completion, collection, and submission of 2,500 individual pieces of paper would completely upset this process and require many hours of manual labor.

Requiring solo practitioners to submit individual confirmations may not be construed as overly burdensome, imposing the same requirement on system employers is truly onerous. While we recognize the validity and importance of having accurate and up-do-date information on providers' location and specialty, we would recommend some modification to the language, if not deleting it altogether. We would recommend additional language as follows: "For health care providers who are employed and or insured under a health care institutional policy, the above requirement will be satisfied by a statement from the institution confirming the individual provider's primary practice site and specialty."

§ 242.5 Adjustment of surcharge.

Proposed: (a) ...The surcharge amount shall be submitted to the Fund within **[60] 20** days of the effective date ...

(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...

Comments: We strongly oppose the proposal to reduce the remittance period for surcharge payments from 60 to 20 days. Prudent business practice dictates that we maintain current and complete listings of our physicians and residents at all times. The sheer volume of activity level, however, particularly on January 1 and July 1 can result in some number of physicians or residents not being reported until a few days after the rotation begins. The expectation that basic carriers can identify all insureds, secure individual confirmations for specialty and address from each one, calculate the surcharge, bill the premium, collect the monies from the insureds, and remit all of this to the CAT Fund within 20 days is nonsensical. To impose such a requirement would, without a doubt, impose massive compliance problems for all carriers and self-insureds in the Commonwealth of Pennsylvania. The administrative aspects of complying with the existing CAT Fund policies are difficult enough.

While the proposed payment terms would appear to increase the interest earned by the CAT Fund, it cannot increase the Fund's surplus position as that position is statutorily defined at 15% of loss payments. There is no benefit to the provider population either. The interest income earned by the Fund will be offset by the lost interest income suffered by the provider population. This is certainly the case for the self-insured provider population which directly pays its surcharge, and will prove equally true for those providers who remit their surcharge payments through an insurance company intermediary. It would be naive to think that commercial primary insurers will not either accelerate payment terms to their insureds or otherwise recoup their lost interest income through additional premium changes.

We strongly urge that the current timetable for making surcharge payments be retained.

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

Proposed: **(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. An additional payment necessitated by this subsection shall be remitted within 20 days of the effective date of the annual surcharges.

Comments: While we have no objection to the proposed methodology for computing the annual surcharge for providers who change policy terms, we take exception to the 20 day remittance period, as noted above in our comments on § 242.5.

§ 242.17. Compliance.

Proposed: **(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 a delinquency exists.**

Comments: This would appear to suggest that even after the surcharge has been paid with interest, the CAT Fund will continue to deny coverage. This is completely and absolutely inappropriate and unethical, and, if applied in connection with the proposed 20 day payment requirement, would create immense administrative problems in clarifying coverage.

§ 242.18. Effective date.

Proposed: The effective date of this chapter as well as the commencement date for using the prescribed forms is November 26, 1996.

Comments: Does this mean that individual providers have to retroactively submit confirmation of their address and specialty? What about large delivery systems with thousands of residents and physicians, some of whom have already left the system? Do these individuals need to be tracked down as well? How can rules for operation and administration of CAT Fund reporting and payment be retroactively imposed? It's certainly absurd to suggest that the reporting period be reduced from 60 to 20 days on a retroactive basis! We suggest that any modification to the current rule become effective on January 1, 1998.

CHAPTER 246. MEDIATION

§ 246.3. Agreement of Parties.

Proposed: Upon the request of a party, the Fund may provide for a mediator in cases where multiple insurers or the Fund, or both, disagree on a case. The procedures in this chapter apply when any of the parties have agreed to mediation.

Comments: Why should the Fund be the exclusive source of mediators? We submit that any person who obtains monies as a mediator will look kindly upon the entity that retains him or her. Furthermore, the language indicates that the Fund "may" provide for a mediator - does this mean that the Fund is not required to do so, even upon "request of a party"?

This section also seems to indicate that insurers or the Fund can put a case into mediation without the agreement of all the other parties. Mediation is not usually beneficial unless all participants are there voluntarily. Forcing a party into arbitration is not usually productive.

We suggest use of the following language:

> Upon the request of a party **and the agreement of all other parties proposed to be involved [the Fund may provide for] a mutually acceptable mediator may be selected to mediate** in cases where multiple insurers or the Fund, or both, disagree on a case. The procedures in this chapter apply when any of the parties have agreed to mediation**[.], but the outcome of any mediation shall be binding only upon those parties who have agreed to participate in the mediation, and only as to those issues which those parties agree to submit to mediation.**

§ 246.4. Administration and delegation of duties.

Proposed: Upon the request of a party to a case within the Fund coverage limits, the Fund may provide for a mediator....If a party thereafter objects to the 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.

Comments: This section provides that the mediator is initially selected by the Fund, and that the Fund's choice may only be objected to on the basis of "identifiable bias, interest or unavailability". We find this somewhat troublesome as the Fund itself may well be an interested party in the mediation, and the power of selection of the mediator will in that situation create an inherent bias in the Fund's favor. A better approach would be to require that the identity of the mediator be subject to the initial agreement of all parties.. Furthermore, how does one go about proving "identifiable bias" or "interest"?

§ 246.6. Date, time and location of mediation proceedings.

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Proposed: (a)...Notice of a mediation session shall be provided to all parties at least 3 working days in advance of the session...

Comments: In order to assure the presence of all parties, we would propose 10 days or 2 weeks notice in lieu of 3 working days, particularly if it is anticipated that any mediation session will take place in Harrisburg.

Proposed: (b) The mediator may meet with or request information pertinent to the mediation from one or more parties prior to scheduling a mediation session.

Comments: This is suggestive of *ex parte* meetings and not appropriate to the overall process. We suggest modifying this section to read as follows:

(b) The mediator may, **with the agreement of all parties to the mediation,** meet with or request information pertinent to the mediation from one or more parties prior to scheduling a mediation session.

§ 246.7. Mediation sessions.

Proposed: (a)...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...

Comments: Why should the Fund be the entity that decides what materials are submitted to the mediator? What constitutes a complex case? The number of parties? The number of issues? The size of the demand? Why not allow the Fund or any party to the mediation to request that the case be designated as complex?

Proposed: ...The mediator may conduct separate meetings with each party in order to improve the mediator's understanding of the respective positions of each party.

Comments: Either the mediator is going to mediate and, in so doing, meet with the parties jointly and separately, or the mediator will be the judge or arbitrator and everything submitted to him must be done in the presence of the adverse party. Permitting a mediator to obtain off the record, hearsay, prejudicial and other extraneous materials without the ability of having it rebutted is unfair and improper.

§ 246.9. Conclusions of the mediator.

Proposed: ...The decision shall specify the remedy, if any, and there shall be no formal opinion unless all parties agree. If the parties so agree, they will share equally in payment of the additional mediator compensation.

Comments: Although § 246.10. addresses the general subject of "expenses", the issue of "compensation" of the mediator is not addressed anywhere. Thus, the phrase "additional mediator compensation" is unclear.

Furthermore, we propose that this section expressly state that the mediator's conclusions are to be confidential, inadmissable in litigation or arbitration of the dispute and not discoverable under the Sunshine Act.

§ 246.11. Confidentiality.

Proposed: 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 litigation or arbitration of their dispute, to the extent allowed by law...

Comments: This statement may give a false sense of security because, contrary to the suggestion made in this sentence, the Supreme Court has established that under Pennsylvania law not all statements are protected merely because they are made in the context of settlement negotiations. Additional affirmative protections are required in order to ensure the confidentiality of

the mediation proceedings and to avoid a built-in disincentive against participation.

Proposed: If the parties previously agreed to binding mediation, the conclusions of the mediator shall have the effect of a settlement and will be legally enforceable and admissible in court or arbitration proceedings to compel enforcement.

Comments: This sentence fails to recognize that some settlements, e.g. minors settlements, are subject to court approval. We would suggest modifying this sentence as follows: "If the parties previously agreed to binding mediation, the conclusions of the mediator shall have the effect of a settlement subject to any judicial approval which may be required, and as such, will be legally enforceable and admissible in court or arbitration proceedings to compel enforcement to the extent otherwise permitted or authorized by law.

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September 26, 1997

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INDEPENDENT REGULATORY REVIEW COMMISSION

Via Fax and FEDEX

Arthur F. McNulty, Esquire
Chief Counsel
Medical Professional Liability
Catastrophe Loss Fund
1062 Lancaster Avenue
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Rosemont, PA 19010

RE: **Comments on Proposed Rule Making Title 31, Chapter 246 Mediation**

Dear Mr. McNulty:

Please accept these comments as the suggestions of PIC Insurance Group, Inc. to the proposed amendments to Title 31 of the Pennsylvania Code which were published by the Medical Catastrophe Loss Fund (the "Fund") in the Pennsylvania Bulletin on August 30, 1997. These comments focus specifically on Chapter 246, regarding Mediation.

Chapter 246 purports to implement Section 702(i) of the Health Care Services Malpractice Act, as amended by Act 135 of 1996. As explained more fully below, however, the proposed Chapter 246 fails to carry out the intention of the General Assembly and in many instances would create absurd and unworkable results. Moreover, at no point does the proposed regulation define what issues the mediator is permitted to address.

The Regulation Conflicts with Both the Letter and Intent of Section 702(i)

As crafted by the General Assembly, Section 702(i) permits the fund to provide for a mediator: (1) only upon the request of a party to a case; (2) only if the case is within the fund coverage limits; and (3) only if multiple carriers disagree on the case:

> "(l) Upon the request of a party to a case within the fund coverage limits, the fund may provide for a mediator in instances where multiple carriers disagree on a case. Upon the consent of all parties to any proceeding hereunder that mediation shall be binding, the parties shall be bound by the conclusions of the mediator. The fund shall promulgate such rules and regulations as are necessary to implement this provision. Proceedings conducted under this section shall be confidential and shall not be considered public information subject to disclosure under the Right-to-Know Law and the "Sunshine Act". (Emphasis supplied). 40 P.S.§1301.702(l).

The proposed rulemaking ignores or contravenes each of these requirements.

First, Section 246.2 defines "party" to include the Fund. Thus, in derogation of the General Assembly's direction that mediation should occur only upon the request of a party to a case, Section 246.3 allows the Fund itself to request the mediation. The Fund would thus be operating in the dual capacity of both adjudicator and litigant, with the Director of the Fund determining when a mediation should be requested, when it should be provided and who should be conducting it, even though the Fund's interests will be at stake in the proceeding. This situation raises serious constitutional issues of due process under Lyness v. State Board of Medicine, 529 Pa. 535 (1992) and is rife with potential for abuse. The General Assembly avoided this conflict, in part, by specifying in Section 702(i) that only the parties to the case, and not the Fund, could request mediation.

Second, the proposed rulemaking contains no criteria for determining when a case is "within the fund coverage limits". We submit that the General Assembly intended a case to meet this requirement only if the plaintiff's demand as to each defendant was equal to or below the limit of liability set forth in Section 701(d)[1]. Absent this definition, bizarre results could occur. For example, a case could involve four defendants, each of whom is covered by the Fund. The mere fact that the plaintiff's demand might be equal to of less than the sum of the coverage available to all of the defendants (here, $1,200,000 per defendant or $4,800,000 in the aggregate) should not mean that the case is "within the fund coverage limits" because the mediator could apportion liability in such a manner that one or more of the defendants could bear responsibility in excess of the fund coverage limit. In the

[1]We note that Section 103 of the Act defines "fund coverage limits" as the coverage provided by the Medical Professional Liability Catastrophe Loss Fund under Section 701(a). However, Section 701(a) only deals with basic insurance coverage and not the coverage provided by the Fund. Clarification of the incorrect reference would be prudent and advisable.

hypothetical just posed, for example, the mediator might find that defendant A is liable for $1,500,000, defendant B is liable for $3,300,000 and defendants C and D shoulder no liability at all. No party would ever agree to make the mediation binding in this situation because it would expose the party to liability in excess of the available insurance coverage without any avenue for appeal. Moreover, if an excess carrier was involved or the defendant has a self-insured layer of insurance above the coverage provided by the Fund, in the interest of fashioning a settlement and accommodating the Fund, the mediator--who, after all, is appointed by the Fund--could tap into the excess layer rather than have the Fund put up its available coverage for each of the defendants. Similarly, in many cases, a health care provider's loss experience is such that less than full "coverage limits" or none of the Fund coverage limits are available because of near or full exhaustion of the health care provider's aggregate limits. Clearly, the other Defendants would be placed at a disadvantage in a mediation with a defendant whose fund coverage limits as defined by the Act are not available. The above examples would produce results that are unfair, inequitable and directly contrary to that intended by the General Assembly. For this reason, great care should be taken to define cases "within the fund coverage limits" as those cases where each defendant may be liable only for an amount that is within the fund coverage limits and wherein each defendant has available the full fund coverage limits.

Finally, Section 246.3 of the proposed regulation provides that the Fund may provide for a mediator in cases where multiple insurers or the Fund, or both, disagree on a case. Similarly, Section 246.2 defines the term "mediation" to mean a meeting at which the insurers and the Fund will explore issues, needs and settlement options. Section 702(l), by contrast, provides for mediation only where multiple carriers disagree on a case. There is no authorization in Section 702(l) to permit mediation simply because the Fund disagrees with a carrier. Also, because the purpose of the mediation authorized by Section 702(l) is to resolve disputes between and among multiple carriers, there is no reason why the Fund should be accorded the right of automatic participation in the mediation session.

The Regulation Contains No Standards for Guiding the Director's Discretion as to When Mediation Should be Provided

Section 246.3 and 246.4 vest with the Director of the Fund exclusive discretion as to whether to have mediation and to appoint a mediator. Absent explicit guidelines stating how and when this discretion should be exercised, the regulation places the Director of the Fund in the awkward and conflicted position of having to weigh the parties' desire to use the mediation procedure against the Fund's interest in litigating or refusing to settle the dispute.

For example, the Fund is required to defend providers under Section 605 when the claim is stale. In a situation where a primary carrier is also involved and the primary carrier has tendered its policy limits, the Fund would be the only impediment to settlement. These are the cases wherein a primary carrier would be most likely to ask for mediation, especially if the case is appealed and the carrier is forced to pay the cost of the appeal because the Fund refuses to pay the judgment entered. In these cases, where the primary carrier and the plaintiff would both reap substantial benefit from resolution of the dispute, the Director of the Fund could honor a request for mediation only by violating his fiduciary duty to the Fund to oppose settlement in his capacity as a litigant[2].

The proposed regulations are also silent on what happens when the case involves defendants, like manufacturers or nurses, whose insurance coverage is provided completely outside of the Health Care Services Malpractice Act. Although the Fund may "provide" for mediation, it cannot compel these parties to participate actively and fully. Notwithstanding the confidentiality provisions of the regulation, a party could very well use the mediation process as yet another vehicle for discovery and building its case. Or a party could ignore the mediation sessions, making a mockery out of the entire process. For these reasons, the regulations should make clear that the Director may provide for mediation only if all parties involved in the litigation voluntarily agree to submit the matter to mediation (even if the mediation is nonbinding). To prevent coercion and favoritism, the identity of the parties who consented or objected to mediation in a particular case should be kept secret.

The Manner of Appointing Mediators

Section 246.2 of the proposed regulation defines a Mediator as "[a]n individual having specific training or experience in one or more of the following:

(i) Mediation,
(ii) Medical malpractice litigation,
(iii) Insurance law."

Inasmuch as one of the laudable purposes of the Act is to make the system more

[2]The regulations could avoid this result by making clear that, inasmuch as a Section 605 case involves the fund, and not a carrier, cases wherein one of the parties is being indemnified and defended by the fund pursuant to that section are not cases where "multiple carriers" disagree as Section 702(i) requires for the commencement of mediation. The same would be true of cases wherein the Fund had "dropped down" to cover a health care provider because the provider's primary aggregate limits had been exhausted.

equitable for health care providers, the blatant exclusion of health care providers from the pool of possible mediators is unwarranted and unjustified. Particularly in cases which might turn on expert opinion, health care providers can play a constructive role in educating the parties and working toward a mutually satisfactory solution.

Also, because the interests of the Fund itself will be at stake in the mediation, it is absolutely imperative that the mediator be appointed independently of the Director of the Fund. Otherwise, the Fund will be commingling adjudicatory and prosecutorial functions in violation of Lyness and, as explained above, the Director will be placed in a position of conflicting fiduciary duties--one as adjudicator seeking prompt and fair resolution of disputes and the other as litigant seeking a resolution of particular disputes that is in the best interests of the Fund. Moreover, mediators should not be chosen based on the extent to which they have resolved cases in a manner favorable to the Fund.

The Mediation Should Not Be An Evidentiary Proceeding

In enacting Section 702(i), it is significant that the General Assembly provided for mediation, not arbitration. The General Assembly clearly envisioned a proceeding in which positions could be advanced, discussed and negotiated without a hearing or an adversarial process. In Section 246.7 of the proposed regulation, however, the mediator is authorized to require testimonial evidence. Converting the mediation to a fact-finding session based on testimony of record exposes the health care provider covered by the Act to additional cross-examination that may not be imposed on parties who do not consent to the mediation. This makes it all the more likely that the mediation will be used as a discovery device rather than a means for promoting resolution of controversies. To avoid this result, the regulation should provide that the mediator is not authorized to take testimony, though the parties may make submissions and presentations as to what the testimony would be if the matter were to be litigated.

The Time Frames for Mediation Sessions Are Unworkable

Finally, the notice of mediation provided by Section 246.6 of "3 working days" in advance of the mediation session is completely inadequate in light of most trial counsel's busy trial schedules and the further burden this would impose on the health care provider's schedule. As it is unlikely that all of the parties to any malpractice case will agree to binding mediation, particularly in light of the fact that these proposed rules do not set forth any of the parameters of the proposed mediation or the issues to be resolved, this proposed mediation process will do little more than add

another costly proceeding to be borne by primary carriers and self-insured and wreck further havoc on the busy schedules of health care providers. In light of the fact that mediation is under the absolute discretion of the Fund, this extra burden will be shouldered by primary carriers and health care providers for the sole benefit of the Fund and perhaps Plaintiff's counsel who will request early mediation in an attempt to place their case in a preferential position for settlement.

Conclusion

One must keep in mind that the Fund is not an end in and of itself. It is a legislatively created tool to insure that low cost professional liability insurance remains available for health care providers. As currently drafted, these proposed regulations place the Fund's interests over those of the parties that the Fund was designed to protect and in essence defeats a major goal of the Act. Finally, the results of these mediations should be compiled so that a record is available enabling health care providers and insurers to make an informed decision as to whether they wish to waive their constitutional right to a jury trial in favor of mediation.

Very truly yours,

David W. Galloway
General Counsel

DWG/mas
cc: Christopher A. Lewis, Esquire
Blank, Rome, Comisky & McCauley

HAP

THE HOSPITAL & HEALTHSYSTEM ASSOCIATION OF PENNSYLVANIA

Original: 1880
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September 26, 1997

Arthur F. McNulty
Chief Counsel
Pennsylvania Medical Professional Liability Catastrophe Loss Fund
10th Floor, Suite 1000
30 North Third Street
P.O. Box 12030
Harrisburg, PA 17108

Re: CAT Fund Proposed Regulation (Published: August 30, 1997)

Dear Mr. McNulty:

On behalf of the hospitals and health systems of Pennsylvania and the communities they serve, I strongly recommend that the Medical Professional Liability Catastrophe Loss Fund withdraw the proposed regulations published in the August 30, 1997 *Pennsylvania Bulletin*. The notice in the *Pennsylvania Bulletin* contained a series of inaccurate and/or misleading representations. Additionally, the Regulatory Analysis Form (IRRC Number: 1880) was incomplete and failed to address fundamental questions, such as "Explain the compelling public interest that justifies the regulations."

It is The Hospital & Healthsystem Association of Pennsylvania's (HAP's) belief that the Fund's proposed regulations should be withdrawn for the following reasons:

1. The notice indicated that the "Board" (the Medical Professional Liability Catastrophe Loss Fund Advisory Board, we assume) had submitted the proposed regulations to the Independent Regulatory Review Commission and the appropriate committees of standing in the House and Senate. While we believe the legislative intent in Act 135 of 1996 was for the board to be consulted on operational changes concerning the Fund policies and operations such as those contained in the proposed regulations, it was obvious from the September 24, 1997 Advisory Board meeting that the board members were not consulted on the proposed regulations and were not aware that the Fund had proposed regulations.

2. The notice indicated that the Chairpersons of the House Committee on Health and Welfare and the Senate Committee on Public Health and Welfare were sent copies of the proposed regulations. It is our understanding that proposed regulations are to be

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sent to the House and Senate committees with primary responsibility for oversight of the issue impacted by the proposed regulations. In this case, the committees with primary jurisdiction are the House Insurance Committee and the Senate Banking and Insurance Committee.

3. Based upon the notice published in the *Pennsylvania Bulletin* and the Regulatory Analysis Form filed with the IRRC, the Fund has indicated that the proposed regulations were mandated by Act 135 of 1996. Based upon our review of the Act, it appears that several provisions of the proposed regulations were not addressed in the Act:

   - § 242.17. Compliance. (c). This change would permanently deny CAT Fund coverage for any period of time when a surcharge payment delinquency exists. This was not addressed in Act 135 and is not a common insurance practice.

   - § 242.5. Adjustment of surcharge. (a). This would change the remittance period for Fund surcharge payments from 60 days to 20 days. This was not addressed in Act 135. Given the competitive primary insurance market in Pennsylvania, insurers cannot bill for their primary premium, let alone the CAT Fund surcharge, until the provider selects their insurer. Providers, when deciding between competing insurers, often do not make their selections until their policy renewal date. Insurers serve to lessen the administrative burden on the Fund by collecting and remitting the CAT Fund surcharge payment. It is unreasonable and impractical to expect insurers to bill providers, collect payment, and remit the CAT Fund surcharge within 20 days of the policy renewal date.

   - § 242.5 (c) and § 242.17 (c) and (f). These provisions of the proposed regulations require interest on late remittance of surcharge payments. While Act 135 does define "interest," it does not direct the Fund to apply interest to late surcharge remittances.

4. These proposed regulations are retroactive back to November 26, 1996.

Act 135 calls for voluntary arbitration which we support, however, we do not see value in pursuing mediation without unanimity among the defendents. While Act 135 directed the CAT Fund to promulgate regulations for voluntary mediation of disputes between insurers, self-insurers, or the CAT Fund in medical malpractice actions, we believe that mediation should not be initiated unless all of the parties to the case agree. Further, it is our understanding that the mediation provision of Act 135 was to apply to cases in which all defendants in a case agreed on the efficacy and the cost of settling the case, but could not agree on the apportionment of the cost of the case among the defendants.

Again, we respectfully request that the Fund withdraw the proposed regulations, and in accordance with Executive Order 1996-1, new regulations be drafted and promulgated with early and meaningful input from the regulated community. If we can be of further assistance in the development of regulations consistent with Act 135 please do not hesitate to call either myself at (717) 561-5344 or Martin J. Ciccocioppo of my staff at (717) 561-5363.

Sincerely,

Paula Bussard

PAULA A. BUSSARD
Senior Vice President, Policy and Regulatory Services

c: Members of the CAT Fund Advisory Board
The Hon. Nicholas A Colafella, Minority Chair, House Insurance Committee
The Hon. Jay Costa, Minority Chair, Senate Banking &Insurance Committee
The Hon. Edwin G. Holl, Chair, Senate Banking & Insurance Committee
John McGinley, Jr., Chairperson, Independent Regulatory Review Commission ✓
Rick Grimaldi, Deputy General Council, Governor's Office
The Hon. Nicholas A. Micozzie, Chair, House Insurance Committee
The Hon. Harold F. Mowery, Jr., Chair, Senate Public Health & Welfare Committee
Robert E. Nyce, Executive Director, Independent Regulatory Review Commission
The Hon. Dennis M. O' Brien, Chair, House Health & Human Services Committee
The Hon. Frank L. Oliver, Minority Chair, House Health & Human Services Committee
The Hon. Hardy Williams, Minority Chair, Senate Public Health & Welfare Committee

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September 26, 1997

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10th Floor, Suite 1000
30 North Third Street
Harrisburg, PA 17108

VIA FACSIMILE

RE: Proposed Rulemaking, 31 PA Code, Part IX, Chapter 246

Dear Mr. McNulty:

On August 30, 1997, the Medical Professional Liability Catastrophe Loss Fund (Fund) proposed a new regulation, identified as Chapter 246, to implement Section 702 (i) of the Health Care Services Malpractice Act (Act) (40 P.S. Section 1301.702(i)).

PHICO Insurance Company, a Pennsylvania domiciled insurer, is the largest writer of medical malpractice insurance in the Commonwealth. Because of our market share, PHICO will be directly impacted by the new procedures outlined in this proposed regulation should they be adopted. We offer the following comments relating to proposed Chapter 246.

Section 702 (i) establishes a process for mediation under certain specific circumstances. It appears that the legislature intended, through this section of the Act, to provide a forum for resolution of disputes among insurers that are involved in a claim which carries into the Fund layer of coverage. The description of those circumstances in proposed Chapter 246 clearly differs from that set forth in the Act in that the Fund has been added (see Section 246.3 and the definition of "mediation"), thereby enlarging the participants in the mediation beyond those contemplated in the Act.

In addition, the definition of "party" in the proposed regulation creates internal inconsistencies within the regulation. By way of example, the definition of mediation limits participation in the process to insurers and the Fund. However, the use of "parties" in other sections suggests a role for individuals or entities beyond the participants in the mediation process. PHICO would suggest that the Fund amend the proposed rulemaking to resolve these inconsistencies.

PHICO believes there is the impression of a potential conflict of interest within the proposed rulemaking under the following scenario. The Fund and one or more insurers have a dispute relating to a claim. Under the proposed rulemaking, the Fund could initiate mediation proceedings and appoint the mediator. At a minimum, it seems that, in those instances where mediation directly involves the Fund, the selection of the mediator should be consensual among the parties rather than at the sole discretion of the Fund. Obviously, if the proposed rulemaking is revised to be more consistent with Section 702 (i) this issue may be simultaneously resolved.

PHICO offers a few additional suggestions that should enhance the effectiveness of the mediation process contemplated in the aforementioned section of the Act and this proposed regulation. The Fund should consider:

- revising the definition of "mediator" to require that, as a qualification for mediator, an individual have specific training or experience in more than one of the three delineated areas.

- adding language to Section 246.3 that requires notice to all insurers involved in a claim when the Fund provides a mediator for a mediation proceeding being initiated under this Chapter.

- deleting the suggested three hour time limit for mediation sessions in non-complex cases since it is nothing more than a general guideline.

- reviewing the various timelines set out in the procedures in that some seem exceedingly short.

- giving the authority for designation of a case as complex or not complex to the mediator.

In closing, I want to stress that PHICO is fully supportive of mediation as a dispute resolution process. We believe that certain changes need to be made to this proposed regulation to provide greater clarity. If you have any questions, or want to discuss these comments in greater detail, please do not hesitate to contact me at your convenience.

Very truly yours,

Ronald E. Chronister
Vice President, Industry and Regulatory Affairs

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PHICO

September 26, 1997

Arthur F. McNulty
Chief Counsel
PA Medical Professional Liability Catastrophe Loss Fund
10th Floor, Suite 1000
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RE: Proposed Rulemaking, Amendments to 31 PA Code, Part IX, Chapter 242

Dear Mr. McNulty:

PHICO Insurance Company is the largest writer of medical malpractice business in the Commonwealth of Pennsylvania with a market share in excess of 20% of direct medical malpractice premiums in the state. PHICO insures more than 120 institutions and over 8,000 physicians that are health care providers as defined by the Health Care Services Malpractice Act (Act) . Consequently, PHICO is directly impacted by, and has a significant interest in, the changes that are being proposed as amendments to current regulations. To be quite clear, PHICO is extremely concerned by the imposition of unreasonable burdens that would be placed on both insurers and health care providers under this proposed rulemaking.

Our primary concern relates to the financial impact that will flow from the unrealistic timeframe proposed for insurers to bill, collect and remit surcharges to the Fund and the interest penalty for failure to comply with this timeline. Secondarily, we note the proposed establishment of several additional administrative burdens through this proposed rulemaking.

At the outset, I would like to remind you that insurers which provide basic coverage to health care providers in Pennsylvania perform an administrative role in assisting the Fund to collect the surcharges which provide it the necessary funds to pay claims settled each year. Insurers have no legal liability under the Act to pay the surcharges themselves; rather insurers are only responsible for calculating, billing, collecting and remitting surcharges. Through the dramatic and

unreasonable reduction in the time period for completing these tasks from 60 days to 20 days, the Fund would seek to have insurers, in many cases, advancing surcharge payments in order to protect both the insurer and its insureds. We question both the Fund's statutory authority in this regard and the constitutionality of such a proposal.

As you are well aware, the medical malpractice market in Pennsylvania is quite competitive. Many accounts are subject to competing insurers offering quotes. In our experience many insureds, particularly institutional insureds, decide upon an insurer on or near the effective date for the upcoming policy year. Consequently, insurers are not in position to bill such accounts in advance of policy effective dates. Therefore, the 20 days proposed in this rulemaking allows insufficient time, especially when you consider that billing, collection and remittance must all be accomplished within these 20 days. PHICO strenuously opposes these amendments because they virtually mandate the insurers advance surcharge payments to the Fund. PHICO strongly urges that the current 60 day requirement be retained and the proposed rulemaking be revised accordingly. We believe that healthcare providers also oppose this proposed change.

With respect to the issue of interest penalties, there is no legal authority within the Act for the Fund to assess such penalties. Specifically, Section 701(e)(10) states that "the annual and emergency surcharges on health care providers and any income realized by investment or reinvestment shall constitute the **sole and exclusive** sources of funding for the Fund." (Emphasis added). Further, under paragraph (e) (11) of the same section, the Director of the Fund is authorized to issue rules and regulations consistent with this Section. Clearly, the attempt to impose interest on late payments of surcharges is inconsistent with Section 701(e) (10) and therefore not permitted in this rulemaking. The definition of interest and the references to interest must be stricken from the proposed changes to the regulations.

Section 242.9 as proposed requires insurers to actually pay surcharge credits to insureds and present evidence of that payment in order to receive a credit against future remittances to the Fund. This proposed change, if adopted, would present a new and extremely burdensome requirement on insurers. Where is the legal authority to require an insurer to advance funds before it is entitled to an adjustment on subsequent remittances? To realize the practical implications of this change, one only need look at PHICO's remittance reports. Those reports show that for most institutional accounts there are numerous changes in coverage that occur throughout each policy year. These changes necessitate modifications in our premium and also result in both additional surcharges and credits. If PHICO were required to both pay the refunds to insureds and create documentation to that effect before it would be allowed to use the credit against future remittances, the insurer would face both an administrative and financial burden.

Section 242.17(c), as proposed, is ambiguous as to whether the potential loss of coverage for a

period of delinquency exists beyond the date when the delinquency is cured through payment of the surcharge and/or interest. If this provision is retained in final rulemaking, it is critical that the language be revised to clarify the Fund's intent. If the Fund's intent is to penalize health care providers with a permanent loss of coverage for the period of delinquency, there will be a material impact upon insurers. Given the gravity of the penalty, serious disputes will undoubtedly arise over the cause for delinquency in remittance of the surcharge to the Fund. Those disputes will be greater in number should the proposed 20 day remittance requirement be retained in final rulemaking. Insurers will be forced to remit surcharges in advance of collections from their insured health care providers to avoid those disputes. The unacceptable alternative for insurers is facing exposure for both the CAT Fund layer of coverage that is lost through this penalty and damages sought under a civil action initiated by an insured for bad faith against its insurer.

Throughout the amendments there are also several areas where new administrative burdens are being placed on insurers.

> Section 242.4 (a) requires an insurer to obtain a statement from each insured health care provider and to submit same to the Fund. Form 216 already includes disclosure of addresses and specialties, giving the Fund the information being sought in this section. Additionally, this new requirement, if implemented in conjunction with the proposed reduction in time for remitting surcharges and this information, will be extremely burdensome to both providers and insurers.
>
> Section 242.6 (a) (3) requires insurers to send the Fund information on Form 216, along with the surcharge payment. The proposed additional information to be included on Form 216 is a codification of current practice. However, unlike current practice, information on specific health care providers would now be required to be received within 20 days of the effective date of the provider's policy. PHICO has been submitting these reports on a weekly basis but, if the 20 day time frame were adopted, would have to prepare and submit these reports more frequently (perhaps daily). Within the additional information delineated in this paragraph is the "gross premium" which would no longer be defined in the regulation and which is no longer the basis upon which surcharges are calculated. Therefore, this information appears no longer pertinent as part of a remittance advice to the Fund. Finally, there is a broad grant of authority for the Director to request "other information as may be required by the Director". Given the extensive information that the Director is already authorized to obtain throughout the regulation, and these proposed revisions, it does not seem appropriate to "write the Director a blank check" for any additional information he desires.

Section 242.21 establishes new requirements for handling corrections to data filed with the Fund. This change imposes additional administrative burdens upon insurers with respect to separate reporting and, more importantly, the time frame to submit corrected information.

With all of these new requirements that clearly impose additional financial and administrative burdens on insurers, it is surprising to note that the fiscal impact described on page 4462 of the Bulletin notice states that there will be no added cost to insurers and makes no comment about increased cost to health care providers. Further, the commentary under the caption "Affected Organizations and Individuals" asserts that the proposed amendments will have a positive effect on insurers and, again, is silent on the effect on health care providers. We request commentary regarding the positive effects these proposed changes to the regulation would have upon insurers.

If the reduction in the time for billing, collecting and remitting surcharges is codified, I can assure you that there will be a fiscal impact on insurers. Moreover, the imposition of additional, duplicative paperwork will increase costs for insurers, providers and the Fund.

There are additional concerns that I would also like to bring to your attention. First, the proposed definition of "prevailing primary premium" is different from that in the Act in that it includes "as of January 1, 1996". The surcharges on policies with effective dates in 1997 are being calculated based upon JUA rates as of January 1, 1997. In future years the JUA rates may be modified from those in effect on January 1, 1997. This descriptive phrase should be deleted.

Section 242.3 (b) is being revised by deleting the last portion of the paragraph. I cannot discern from the proposed rulemaking what the Fund intends through this revision. PHICO would appreciate clarification of the intent of this revision.

The proposed rulemaking includes a change in the effective date for Chapter 242 from November 1, 1976 to November 26, 1996. Clearly, given the substantive nature of the proposed changes, the effective date for any revisions to the regulation that alter administrative practices or procedural requirements should be prospective rather than retroactive.

Finally, throughout the proposed rulemaking the terms "submit", "remit" and "received" have been used in the context of payment of surcharges and sending information to the Fund. I would suggest that the same term be used consistently to avoid any confusion over what constitutes compliance with the requirements in the regulation.

PHICO is quite frankly surprised that its first notice of these very substantial changes was the publication of proposed rulemaking. As nearly as we can tell, the Fund did not seek any input or

comment from health care providers or insurers as it was drafting these revisions. Insurers have expressed a willingness to provide the layer of coverage currently afforded through the Fund and the Fund's attempt to impose such significant new administrative and financial costs on insurers only serves to focus further attention on the efficacy of the current system. PHICO will actively oppose these amendments to the existing regulation should the changes we have suggested not be incorporated into any proposed final rulemaking.

I am available to discuss PHICO's comments in greater detail at your convenience.

Very truly yours,

Ronald E. Chronister,
Vice President, Industry & Regulatory Affairs

cc: Senator Edwin G. Holl
Representative Nicholas A. Micozzie
M. Diane Koken, Acting Insurance Commissioner
Frank J. Ertz, Executive Director, IRRC

UPMC Health Systems
Treasury Department
FAX COVER SHEET

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cc: Coccodrilli
Harris
Sandusky
Wyatte
Bereschak

From Fax Number: 412-647-5792

DATE: Sept. 26, 1997 **NUMBER OF PAGES:** 3
(inclusive)

TO: John McGinley, Jr.

FAX NUMBER: 717-783-2664

FROM: Ms. Karen L. Hartley

TELEPHONE NUMBER: 412-647-8482

If you do not receive all of the pages, please call the number listed above.

MESSAGE:

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UNIVERSITY of PITTSBURGH
MEDICAL CENTER

Treasurer's Office

200 Lothrop Street
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Pittsburgh, PA 15213-2582
412-647-8648
Fax: 412-647-5792

September 25, 1997

John McGinley, Jr.
Chairman,
Independent Regulatory Commission
333 Market Street
14th Floor
Harrisburg, PA 17101

RE: PA CAT Fund
Proposed Rulemaking - 31 PA Code Chs. 242 and 246

Dear Mr. McNulty:

Please accept this in response to your request for comment on the above proposed rulemaking regarding the PA CAT Fund as listed in the PA Bulletin of 8/30/97.

With regard to the Chapter 242 proposed revisions we have the following comments:

1) Section 242.5 - Submission of Surcharge payment within 20 days of renewal.
As an academic health center, subject to the annual medical school re-appointment and rotation scheduling procedures, a 20 day payment deadline is simply impossible to meet. It takes 30 days from the date of renewal alone to compile data from the various departments on each physician and resident and another week to generate invoices. This leaves 3 weeks to receive payment, produce the proper CAT Fund documentation and forward the filing to the Fund. We recommend that the filing deadline remain not less than 60 days from the date of renewal.

2) Section 242.17 Compliance. The payment of interest on late payments is a justifiable recognition of the time value of money. Denial of coverage, however, is extreme particularly when interest is assessed for late payments. The penalty of denial of coverage should only be implemented after a notice of a delinquency is given and the surcharge remains unpaid for a reasonable period of time.

Also, it seems somewhat inequitable for the Fund to assess interest on late payments due the Fund, while the Fund is not obligated to return overpayments or pay interest on credit balances it owes to its insureds and/or primary carriers. Consideration should be given to providing a 5 day grace period before any interest should be assessed by the Fund or alternatively, interest should be assessed on all credit balances owed by the Fund at the same interest rate as charged for late payments.

With regard to the Mediation provisions in Chapter 246, we have the following comments:

1) Section 246.3 - Provision by the Fund of the Mediator. As a likely party to any coverage dispute subject to mediation, and the only insurer/party not subject to the duty of good faith, the CAT Fund should not have sole authority to appoint a mediator which would be perceived by all as a lack of good faith, objectivity and impartiality. Rather, the mediator should be agreed upon by all of the parties when possible, or when agreement is not possible then each side should choose a mediator with those appointed then selecting a neutral member of the mediation panel.

2) 246.1 - (Definitions) Plaintiff included in definition of party. As drafted, Chapter 246 appears to permit Plaintiffs to a malpractice suit to initiate and/or participate in the proposed mediation process. We think plaintiff participation is unwarranted for any number of good reasons.

First, there are already a number of avenues for alternative dispute resolution and/or pre-trial settlement discussions involving plaintiffs, dependents and carriers provided by the various court systems. Allowing plaintiff's to participate in this mediation process would add additional expense and delay without any benefit to the settlement process.

Secondly, the purpose of Chapter 246 is to provide a forum for coverage disputes among carriers, (including the Fund) not another alternate dispute resolution mechanism for the underlying claim. Participation of plaintiffs in a coverage dispute would not facilitate its resolution and in most cases would act as a hindrance and/or obstruction.

We recommend that Plaintiffs removed from the definition of party and excluded from the coverage dispute mediation process except upon agreement by all of the other parties involved.

If you have any questions, or would like to discuss any of the above recommendations, please feel free to contact us.

Sincerely,

Ms. Karen L. Hartley

cc: George Board, Dr. PH
John Paul

KLH:tlm

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Sandusky
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Bereschak

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

September 29, 1997

97 SEP 30 PM 2 23
INDEPENDENT REGULATORY REVIEW COMMISSION

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

Re: IRRC Regulation No. 20-1
Medical Professional Catastrophe Loss Fund
Medical Professional Liability Catastrophe Loss Fund and Mediation

Dear Director Nyce:

Enclosed are comments this office has received to date concerning the above-referenced regulation, notice of which was published in the August 30, 1997 edition of the Pennsylvania Bulletin. Should we receive any further comments, I will forward them to you.

We look forward to receiving your comments. In the meanwhile, feel free to contact me if you have any questions or comments.

Sincerely,

Kenneth J. Serafin
Assistant Counsel

KJS/lt
Enclosures

cc: John H. Reed, Esq., Director
Arthur F. McNulty, Chief Counsel
Mary Lou Harris, Regulatory Analyst

John McGinley, Jr., Chairperson
Fax Number: (717) 783-7659

ST.
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HEALTH
SYSTEM

ST. FRANCIS MEDICAL CENTER

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SISTER FLORENCE BRANDT
Senior Vice President - SFHS
Chief Executive Officer - SFMC
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412/622-4212
FAX: 412/622-4858

September 24, 1997

John McGinley, Jr., Chairperson
Independent Regulatory Review Commission
333 Market Street
14th Floor
Harrisburg, PA 17101

RE: Proposed Regulations of Act 135 of 1986, the Medical Professional Liability Catastrophe Loss Fund (CAT Fund) on Surcharge Remittance

Dear Mr. McGinley:

I am writing to you with grave concern for the potential effects of proposed regulations on our Medical Center.

The 1997 CAT Fund premium surcharge increased $313,000 or 74.8 percent over the 1996 premium. At the same time, the statutory limit of liability for attachment at the primary layer increased to $300,000 per occurrence and $1,500,000 per annual aggregate from $200,000/$1,000,000 in 1996.

I strongly encourage that the remittance period for payments remain sixty days. Under no circumstance should a delinquency period be considered an uncovered period for claims.

In John Reed's letter dated August 15, 1997, he said " . . . the Fund's operations have been successful in its efforts to work in partnership with hospital claims . . . " yet proposes mandatory binding mediation. If major changes are cause for an adversarial relationship with Pennsylvania's health care providers, then "privatization" would be feasible and proper.

Sincerely,

Sister Florence Brandt
Chief Executive Officer

SFB:jfs

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Sandusky
Wyatte
Bereschak

HIGHMARK.
Blue Cross Blue Shield

September 29, 1997

Arthur F. McNulty, Chief Counsel
Pennsylvania Medical Professional Liability
Catastrophe Loss Fund
10th Floor, Suite 1000
30 North Third Street
P.O. Box 12030
Harrisburg, PA 17108

Re: Proposed Changes to CAT Fund Regulations
31 Pa. Code §242.1, et. al.

Dear Mr. McNulty:

Pursuant to the Notice of Proposed Rulemaking published in the Pennsylvania Bulletin on August 30, 1997, comments regarding amendments to Chapter 242 (CAT Fund Regulations) are to be submitted to your office. We have reviewed the proposed amendments and are writing to express our concern regarding the general reduction in reporting and payment period requirements from sixty (60) to twenty (20) days. Based on information provided by appropriate personnel within our company, it is our understanding that shortening these time frames would not provide sufficient time in which to complete all of the administrative tasks necessary to submit timely reporting and payment.

In addition, a specific comment or an indication should be placed in the Regulations making it clear that while refunds of previously paid non-emergency surcharges will only be made in unusual circumstances, these same amounts will, in the absence of a refund, always be recoverable in the form of offsets and not forfeited.

Finally, the Regulations should be clarified to indicate that the effective date of excess coverage provided by the Fund coincides with that provided through a policy of insurance issued by a basic coverage insurer or under a self-insurance plan. This will avoid any misinterpretation of the Regulations suggesting that there may be a gap in coverage provided by the Fund.

If you have any questions regarding these comments, please feel free to contact me at (412) 544-4249.

Very truly yours,

Cynthia M. Maleski

Cynthia M. Maleski
Vice President, Regulatory Compliance

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Pennsylvania
MEDICAL SOCIETY®

September 30, 1997

Arthur F. McNulty,Esq.
Chief Counsel
Pennsylvania Medical Professional Liability Catastrophe Loss Fund
10th Floor, Suite 1000
30 North Third Street
P.O. Box 12030
Harrisburg, PA 17108

Re: CAT Fund Proposed Regulations

Dear Mr. McNulty:

I understand that you have already received detailed comments from the Pennsylvania Medical Society Liability Insurance Company on the proposed regulations published by the Fund in the August 30, 1997 Pennsylvania Bulletin. We would like to comment on three points from the proposed regulations.

Interest. Neither Act 111 nor Act 135 make any provision for the Fund to collect interest on overdue surcharge amounts. Indeed, the provisions in at least one earlier bill that would have allowed the collection of interest by the Fund were subsequently deleted. That seems to mean that the legislature intended to continue past practice and did not intend the Fund to collect interest for late payment.

Coverage for physicians who have not paid the CAT Fund surcharge. The draft regulations propose that the delinquent physician would not have CAT Fund coverage. That means that an injured patient may have no recourse for serious injury. We believe that is an unacceptable result. At the same time, we believe the statutory penalties which can include loss of license are sufficient deterrents to prevent abuse.

Reduction of remittance period from 60 to 20 days. Insurers tell us that often they have not received payments within the twenty day time frame and that they believe that the 60 day time frame has proven workable. When coupled with a requirement that interest be paid, we do not believe the twenty days remittance period is adequate.

We suggest that these provisions be deleted from the regulations.

Sincerely,

Victor F. Greco, MD
President
Pennsylvania Medical Society

cc: Senate Banking and Insurance Committee
House Insurance Committee
Independent Regulatory Review Committee
Sarah H. Lawhorne, PMSLIC
Roger Mecum, Pennsylvania Medical Society

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COMMONWEALTH OF PENNSYLVANIA
MEDICAL PROFESSIONAL LIABILITY CATASTROPHE LOSS FUND

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

JOHN H. REED
DIRECTOR

October 15, 1997

Mary Lou Harris
Regulatory Analyst
Independent Regulatory Review Commission
14th Floor, Harristown 2
333 Market Street
Harrisburg, PA 17101

RE: Medical Professional Liability Catastrophe Loss Fund Regulations

Dear Ms. Harris:

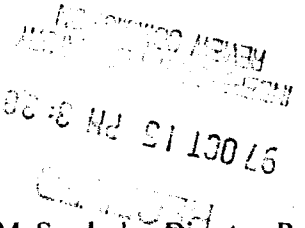
I wanted to take this opportunity to thank you and other members of the Independent Regulatory Review Commission staff for taking the time to meet with Ken Serafin and me earlier today. As you requested, enclosed you will find copies of the Fund's 1997 Surcharge Manual and copies of the American Arbitration Association's Guidelines.

Additionally, I would take this opportunity to restate that the Fund's proposed regulations, as they relate to interest payments, were intended to add a degree of reasonableness to the existing process. Indeed, given the General Assembly's grant of regulatory writing authority regarding "the establishment and operation of the Fund including all procedures and the levying, payment and collection of the surcharges, in conjunction with the addition of "interest" by way of Act 135, warrants the proposed regulations." Indeed, I believe all health care providers are better served by having the ability to pay interest and thereby avoid the draconian consequences associated with a Fund disclaimer of coverage.

Thank you for your attention to this matter. I would be happy to discuss this further with you at your convenience.

Sincerely,

Arthur F. McNulty
Chief Counsel



AFM/lt
Enclosures

cc: Richard M. Sandusky, Director, Regulatory Analysis
Ann Marie Bereschak, Esquire

The EXCELLERATION© Program
Blue-ribbon Arbitrators,
Fast Track Timing.

The EXCELLERATION© Program

Responding to concerns over rising costs and delays in grievance arbitration, a joint committee of labor and management leaders cooperated with the American Arbitration Association in establishing The EXCELLERATION Program. Features of the Program include scheduling of hearings within 15 days of filing with the AAA and awards rendered no later than 24 hours after the hearing. In return for giving up certain features of traditional labor arbitration, such as transcripts, briefs, and extensive opinions, the parties using these simplified procedures can get prompt decisions and cost savings.

A national roster of arbitrators selected from among the most active members of the National Academy of Arbitrators has been established by a joint labor/management committee. The AAA will appoint arbitrators to hear cases submitted under this Program from the aforementioned roster.

A special feature of the Program is the opportunity, if the parties agree, to have the matter decided by the arbitrator based on written submissions only, without the necessity of conducting an oral hearing.

Leading labor arbitrators have indicated a willingness to offer their services under these procedures, and the Association will only assign experienced, qualified arbitrators available to hear cases within 15 days of filing.

1. Agreement of Parties

These procedures shall apply whenever the parties have agreed to arbitrate under them.

2. Appointment of Neutral Arbitrator

The AAA shall appoint a single neutral arbitrator from its Panel of Labor Arbitrators qualified under this Program. The arbitrator shall hear and determine the case within 15 days of submission of the matter to the AAA.

3. Qualifications of Neutral Arbitrator

No person shall serve as a neutral arbitrator in any arbitration in which that person has any financial or personal interest in the result of the arbitration. Prior to accepting an appointment, the prospective arbitrator shall disclose any circumstance likely to prevent a prompt hearing or to create a presumption of bias. Upon receipt of such information, the AAA shall immediately replacethat arbitrator or communicate the information to the parties.

4. Vacancies

The AAA is authorized to substitute another arbitrator if a vacancy occurs or if an appointedarbitrator is unable to serve promptly.

5. Date, Time, and Place of Hearing

The arbitrator shall fix the date, time, and place of the hearing, notice of which must be given atleast 24 hours in advance. Such notice may be given orally or by facsimile.

6. No Stenographic Record

There shall be no stenographic record of the proceedings.

7. Proceedings

The hearing shall be conducted by the arbitrator in whatever manner will most expeditiously permitfull presentation of the evidence and arguments of the parties. The arbitrator shall make appropriate minutes of the proceedings. Normally, the hearing shall be completed within 3 hours. In unusual circumstances and for good cause shown, the arbitrator may schedule an additional hearing to be held promptly.

8. Desk Arbitration

When the parties agree that the matter will be decided on the basis of document submission, eachshall send two copies of their respective documentation to the AAA and to each other withinseven days of the filing. The parties will have an additional seven days to file any answeringstatements with the AAA and each other. Thereafter, the AAA shall forward the documents to the arbitrator, which shall be done within seven

days.

9. Posthearing Briefs

There shall be no posthearing briefs.

10. Time of Award

The award shall be rendered promptly by the arbitrator no later than 24 hours from the date of the closing of the hearing unless otherwise agreed by the parties.

11. Form of Award

The award shall be in writing and shall be signed by the arbitrator. The award will specify the remedy, if any, and there will be no opinion unless all parties agree or one is otherwise required. If an opinion is required, the parties will share the additional arbitrator compensation.

Administrative Fees

Program Fee

A fee of $275 per party is due to the AAA within 45 days of submission of the case to the Program. This fee includes the administrative fee of the AAA ($200) as well as 3 hours' compensation for the arbitrator ($350).

If the case goes beyond 3 hours, the parties will be billed for additional arbitrators' compensation on a pro rata basis.

A surcharge of $35 will be due from any party that does not pay the Program fee within 45 days.

Additional Hearing Fees

A fee of $50 is payable by each party for each hearing held after the first hearing.

Hearing Room Rental

There may be a rental fee for the use of an AAA hearing room. Please check with the local AAA regional office for availability and rates.

Postponement Fees

A fee of $50 is payable by a party causing a postponement of any scheduled hearing.

parties will be expected to produce all information reasonably required for the mediator to understand the issues presented. Such information will usually include relevant written materials and a description of what each witness, if any, could testify to. For more complex cases, the mediator or UNITED STATES ARBITRATION AND MEDIATION OF THE NORTHEAST, INC. may ask the parties for written materials or information in advance of the mediation session.

At the mediation session(s), the mediator will conduct an orderly settlement negotiation. Parties will be represented by a person with authority to settle the case. The mediator may conduct separate meetings (caucus) with each party in order to improve the mediator's understanding of the respective positions of each party.

6. **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 inadmissible in any litigation or arbitration of their dispute, to the extent allowed by law. The parties agree to not subpoena or otherwise require the mediator to testify or produce records, notes or work product in any future proceedings and no recording or stenographic record will be made of the mediation session. However, evidence that is otherwise admissible or discoverable shall not be rendered inadmissible or non-discoverable as a result of its use in the mediation session. In the event that the parties do reach a settlement agreement, said agreement will be legally enforceable, and admissible in court or arbitration proceedings to enforce it, unless the parties agree otherwise. Any information disclosed to the mediator in a private caucus shall remain confidential unless the party agrees that it may disclosed.

7. **Discovery:** If any of the parties has substantial need for discovery in order to prepare for the mediation session, the parties shall attempt in good faith to agree on a plan for such necessary discovery. Should they fail to reach agreement, the parties will present the matter to the mediator for a non-binding recommendation.

8. **Not Acting As Legal Counsel or Expert:** All parties recognize: that at the mediation session(s) and at every other point of the proceedings, neither UNITED STATES ARBITRATION AND MEDIATION OF THE NORTHEAST, INC. or the mediator will be acting as a legal advisor or legal representative for either or both of the parties;

That neither UNITED STATES ARBITRATION AND MEDIATION OF THE NORTHEAST, INC. or the mediator has a duty to assert, analyze, or protect any legal right or obligation including lien rights, statutes of limitation or any other time limit or claim requirement; That neither UNITED STATES ARBITRATION AND MEDIATION OF THE NORTHEAST, INC. or the mediator has a duty to make an independent expert analysis of the situation or raise issues not raised by the parties, or determine that additional necessary parties should participate in the mediation; And that neither UNITED STATES ARBITRATION AND MEDIATION OF THE NORTHEAST, INC. or the mediator can guarantee that the mediation session will result in a settlement.

9. **Non-Binding Decision:** If all parties request it, the mediator may render a non-binding decision. Such decision is to be considered a non-binding arbitration award based on the presentations of the parties and not legal or expert advice. Unless all parties agree otherwise, the decision is inadmissible in any arbitration or litigation to the extent allowed by law.

10. **Termination:** The mediation shall be terminated in any of the following circumstances:

1. By the execution of a settlement agreement by the parties;
2. By a declaration of the mediator to the effect that, in the judgment of the mediator, further efforts at mediation are no longer worthwhile; or
3. By a declaration by any party to the effect that the mediation proceedings are terminated.

Mediation Costs:

The costs of the mediation depend on the nature of the dispute and the amount of mediator time involved. Most cases involve a basic administrative fee and an hourly mediator fee.

In many cases, the parties agree to split the mediation costs, although it is not uncommon for one party to agree to pay the entire costs.

For more information consult:

UNITED STATES ARBITRATION AND MEDIATION OF THE NORTHEAST, INC.

Administrative office
P.O. Box 451
Bensalem, Pa 19020

Mediation Center
1424 Chestnut Street
Philadelphia, PA 19102

(800) 354-2478
(FAX) (215) 750-6367

UNITED STATES ARBITRATION AND MEDIATION OF THE NORTHEAST, INC.

Mediation Procedures

"I firmly believe that individuals and business concerns can dramatically impact on resolving their own problems outside of the courts."

–Supreme Court Justice Sandra Day O'Connor

MEDIATION

Mediation involves representatives from each side of a dispute sitting down with an impartial person, the "mediator", to attempt to reach a settlement. The mediator, who has received special training in resolving disputes, will usually also be an expert in the particular subject of the dispute. The mediator, at a "mediation session", assists the parties in defining their differences and helps them work toward an acceptable solution. Mediation involves no formal court procedures or rules of evidence, and the mediator does not have the power to force an agreement on the parties.

Mediation has proven to be very effective in resolving disputes and, as a result, the use of mediation is expanding rapidly. Mediation is designed to work quickly and informally to allow the parties every opportunity to settle their differences. It is an option that should be considered in every dispute.

The Mediation Session: All sides to a dispute will be present at the mediation session. Each side is to be represented by an attorney. Mediators are attorneys and experts who have been trained in mediation techniques.

After the mediator has begun the session by explaining the mediation process and answering questions, each side will be given the opportunity to describe the facts of the case and explain their position. Such explanations will usually include any relevant written materials, and a description of witnesses and what each witness could testify to. These presentations give everyone involved the opportunity to fully understand the case so that they may effectively analyze their risks. The mediator will then discuss settlement possibilities with each side, often in a confidential "caucus" without the other party, in an attempt to help the parties reach agreement. The mediator will thereafter continue to work with the parties to explore possible settlement options.

THE ADVANTAGES OF MEDIATION

Cases are Handled Quickly: A mediation session has the effect of bringing settlement negotiations "to a head" much earlier than if a case proceeded to trial. Mediation is appropriate at any time after all parties have obtained enough information for them to reasonably settle the case. In most cases, all parties have an incentive to settle disputes as quickly as possible.

Expenses of Litigation: Mediation helps parties take every step possible to settle a case before it goes to trial. Mediation has a good success rate, and mediation fees are relatively low. Although, a result cannot be guaranteed in any particular case, mediation is generally a cost-effective way to settle cases earlier.

Keep Cases from Expanding: The longer a case goes on, the more likely it is that it will expand to include additional issues or claims.

Unreasonable Claims or Expectations: It is easy to claim an excessive amount of money or take an unreasonable position in settlement letters or court proceedings However, it is much harder to sustain an unreasonable position during a detailed, face-to-face analysis in a mediation session. The mediator will usually ask each party to describe every claim and position in detail.

Poor Communication: In many cases, communication is poor between the parties or their representatives in a dispute, therefore, negotiation is difficult because the parties may not fully understand the other side's position. The mediation session allows the parties to present their case fully and directly to the person who must make the settlement decision. In addition, the presence of the mediator helps the parties to fully explore all positions as well as possible settlement options and keeps the discussions on a civil level.

Informally Explore Settlement Options: A party may discuss a settlement proposal with the mediator in a confidential caucus. The specific proposal will not be communicated to the other side; such discussion allows the mediator to view the party's real position and to see if a settlement is possible. Thus, a party can test a settlement without actually making an offer.

Multiple Parties or Issues: One-on-one settlement negotiations are very difficult when there are numerous parties involved in a dispute. For example, a plaintiff may have a difficult time negotiating with co-defendants who must also negotiate between themselves. The same is true when there are multiple issues. A mediation session will bring everyone "to the table" and the mediator will help coordinate the settlement negotiations so that the issues can be approached by all parties in an orderly manner.

Liability or Damage Issues: Mediation can be effective in either situation.

Continuing Relationships: Mediation is particularly appropriate where the disputing parties will have to work together after the dispute is settled. Some example situations: construction projects, commercial leases, partners, business suppliers. Mediation allows the parties to stay on the best terms possible by doing everything they can to settle their dispute quickly and avoid litigation.

Compliance: Parties are more likely to fully comply with a resolution that they agreed to. In addition, most mediation agreements take the form of legally binding settlement contracts.
Impartial Opinion: When requested by the parties, a mediator may give a non-binding opinion on an issue. This may help to move a party from an unreasonable position.

Flexibility: The mediation process is designed to be responsive to the needs of the parties. Thus, mediation sessions can be set up very quickly and can be held at convenient times and locations. In addition, parties may negotiate a settlement that involves responsibilities other than paying money, or they may agree on a settlement for the present, with the negotiations to be re-opened on the happening of a certain contingency. The mediation process is as creative as the parties wish it to be.

MEDIATION PROCEDURES:

1. **Agreement of Parties:** Mediation is a voluntary process wherein the parties to a dispute, with the help of an impartial third-party, attempt to work toward a mutually satisfactory solution. By agreeing to mediate, parties agree to negotiate, in good faith, to settle their differences. Mediation is a voluntary process and neither UNITED STATES ARBITRATION AND MEDIATION OF THE NORTHEAST, INC., or any mediator has the power or authority to force the parties to accept an agreement.

Whenever parties have agreed to mediate in accordance with the Mediation Procedures of UNITED STATES ARBITRATION AND MEDIATION OF THE NORTHEAST, INC., these mediation procedures will be followed in the form existing at the time mediation is initiated, except by agreement of the parties.

2. **Initiating the Mediation Process:** To begin the mediation process, either party should contact UNITED STATES ARBITRATION AND MEDIATION OF THE NORTHEAST, INC. When all parties have acknowledged a willingness to mediate, they will then enter into an Agreement to Mediate.

3. **Selection of Mediator:** Upon agreement of the parties to mediate, UNITED STATES ARBITRATION AND MEDIATION OF THE NORTHEAST, INC. will help the parties select a mediator. No person shall serve as a mediator in any dispute in which that person has any financial or personal interest in 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 prevent a prompt meeting with the parties. In the event, that either party thereafter objects to such mediator, a new mediator will be selected. Parties recognize that mediators when mediating are independent contractors and not agents or employees of UNITED STATES ARBITRATION AND MEDIATION OF THE NORTHEAST, INC.

4. **Scheduling:** Upon appointment, the mediator or UNITED STATES ARBITRATION AND MEDIATION OF THE NORTHEAST, INC. 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.

5. **Conduct of Mediation Sessions:** At the first session, the

Duplicate

A Guide to Mediation and Arbitration

FOR BUSINESS PEOPLE

INTRODUCTION

In the normal course of day-to-day business affairs, disputes are often inevitable. Parties mightdisagree as to their individual rights and obligations no matter how carefully a contract is written. This can lead to delayed shipments, complaints about the quality of merchandise, claims ofnonperformance, and similar misunderstandings. The resolution of such disputes, however, needno t be costly and acrimonious. Alternative means of dispute resolution can SAVE TIME AND MONEY, and can help to put the dispute behind you while preserving valuable businessrelationships.

The American Arbitration Association administers a broad range of dispute resolution serviceswhich address the needs of businesses and individuals mired in conflict. These services include:

Mediation

A meeting between disputants, their representatives and a mediator to discuss settlement. Themediator's role is to help the disputants explore issues, needs and settlement options. The mediator may offer suggestions and point out issues that the disputants may have overlooked, butresolution of the dispute rests with the disputants themselves. A mediation conference can bescheduled very quickly and requires a relatively small amount of preparation time. The conferenceusually begins with a joint discussion of the case, followed by the mediator working with the disputants both together and separately, if appropriate, to resolve the case. Many cases are resolved within a few hours. Perhaps most important, mediation works! Statistics show that 85% of commercial matters and 95% of personal injury matters end in written settlement agreements.

Arbitration

Arbitration is referral of a dispute to one or more impartial persons for final and binding determination. Private and confidential, it is designed for quick, practical, and economicalsettlements. Parties can exercise additional control over the arbitration process by adding specificprovisions to their contracts' arbitration clauses or, when a dispute arises, through the modification of certain of the arbitration rules to suit a particular dispute. Stipulations may be made regarding confidentiality of proprietary information used; evidence, locale, number of arbitrators; and issuessubject to arbitration, as examples. The parties may also provide for expedited arbitration procedures, including the time limit for rendering an award, if they anticipate a need for hearings to be scheduled on short notice. All such mutual agreements will be binding on the American Arbitration Association as well as the arbitrator. The AAA has also developed special Supplementary Procedures for Large, Complex Disputesfor cases in which the disclosed claim ofany party is at least $1,000,000.

Prior to the initial hearing in a case, the AAA may schedule either an administrative conference with the parties or a preliminary hearing with the arbitrator(s) and the parties to arrange for such matters as the production of relevant documents and the identification of witnesses, and for discussion ofand agreement by the parties to any desired rule modifications. AAA administration is guided bythose decisions that the parties make as to how to handle such sensitive issues as privacy ofproceedings, confidentiality, trade secrets, evidence, proprietary information, and injunctive relief.

THE ROSTER OF NEUTRALS

To serve the community with mediators and arbitrators representing all fields of specialization, theAAA maintains a national roster of approximately 20,000 trained experts throughout the United States and the rest of the world.

The AAA requires that applicants have 8 to 10 years of experience in their fields of expertise priorto being considered for the roster.

Selected qualities in arbitrators and mediators for which the AAA looks are:

- Commitment to impartiality and objectivity
- Dispute management skills
- Judicious temperament: impartiality, patience, courtesy
- Respect of bar or business community for integrity, patience and courtesy
- Strong academic background and professional or business credentials

The American Arbitration Association is committed to maintaining an ongoing review of the qualityof its roster of neutrals. Current panelists and new applicants are evaluated by regional officecommittees to guarantee neutrals' possession of superior management skills, commitment, ethics, training and suitability to the caseload. Then, external review committees evaluate the neutralsaccording to a number of criteria including substantive expertise, preeminence in the field, fairness, and the manner in which they conduct proceedings. A final internal review by the Associationmonitors the integrity of the process, the quality of roster composition and balance in terms of gender, racial and ethnic diversity. The bottom line is a roster of neutrals crafted to meet the needsof the parties.

An AAA Glossary of Dispute Resolution Terms

Some of the commonly used terms follow.

Arbitration is submission of a dispute to one or more impartial persons for a final and binding decision.

Awards are the decisions of arbitrators. Awards are made in writing and are enforceable in court under state and federal statutes. Enforcement actions, when necessary, are brought by the partiesto the arbitration.

Case administrators are the AAA staff persons assigned to administer cases. The case administrator is responsible for the general management of a particular case, including panel selection, scheduling and exchange of information among the parties, and all of the other administrative details involved in moving cases through the system.

Caucuses are meetings in which a mediator talks with the parties individually to discuss the issues.

Claimants are filing parties, also known as plaintiffs.

Counterclaims are counter demands made by a respondent in his or her favor against a claimant. They are not mere answers or denials of the claimant's allegations.

Demands for Arbitration are unilateral filings of claims in arbitration, based on a contractual or statutory right; also, the form used.

Factfinding is a process by which parties present the arguments and evidence to a neutral personwho then issues a nonbinding report on the findings, usually recommending a basis for settlement.

Hearing is a proceeding in which evidence is taken for the purpose of determining the facts of adispute and reaching a decision based on evidence.

Mediation is a process in which a neutral assists the parties in reaching their own settlement but does not have the authority to make a binding decision.

Mediation-arbitration (med-arb) employs a neutral selected to serve as both mediator andarbitrator in a dispute. It combines the voluntary techniques of persuasion, as in mediation, with anarbitrator's authority to issue a final and binding decision, when necessary.

Mini-trial is a confidential, nonbinding exchange of information, intended to facilitate settlement.The goal of mini-trial is to encourage prompt, cost-effective resolution of complex litigationMini-trial seeks to narrow the areas of controversy, dispose of collateral issues, and encourage afair and equitable settlement.

Negotiation is a process in which disputants communicate their differences to one another and withthis knowledge try to resolve them.

Parties are the disputants.

Respondents are responding parties, also known as defendants.

Submission is filing of a dispute to a dispute resolution process after it arises.

A Guide to Mediation for Business People

How Does Mediation Differ From Arbitration?

Arbitration is less formal than litigation, and mediation is even less formal than arbitration. Unlike an arbitrator, a mediator does not have the power to render a binding decision. A mediator does nothold evidentiary hearings as would an arbitrator but instead conducts informal joint and separate meetings with the parties to understand the issues, facts, and positions of the parties. The separate meetings are known as caucuses. In contrast, arbitrators hear testimony and receive evidence in ajoint hearing, on which they render a final and binding decision known as an award.

In joint sessions or caucuses with each side, a mediator tries to obtain a candid discussion of theissues and priorities of each party. Gaining certain knowledge or facts from these meetings, amediator can selectively use the information derived from each side to:

- reduce the hostility between the parties and help them to engage in a meaningful dialogue onthe issues at hand;
- open discussions into areas not previously considered or inadequately developed;
- communicate positions or proposals in understandable or more palatable terms;
- probe and uncover additional facts and the real interests of parties;
- help each party to better understand the other parties' views and evaluations of a particularissue, without violating confidences;
- narrow the issues and each party's positions, and deflate extreme demands;
- gauge the receptiveness for a proposal or suggestion;
- explore alternatives and search for solutions;
- identify what is important and what is expendable;
- prevent regression or raising of surprise issues; and
- structure a settlement to resolve current problems and future parties' needs.

Types of Disputes Resolved by Mediation

Any type of civil dispute can be resolved by mediation. The kinds of conflicts brought to AAAmediations

have been as varied as the types of industries and business specialties using theprocess. Just about any type of dispute that parties want resolved quickly and inexpensively can besubmitted to mediation.

The Benefits of Mediation

The benefits of successfully mediating a dispute to settlement vary, depending on the needs andinterests of the parties. The most common advantages are that:

- parties are directly engaged in the negotiation of the settlement;
- the mediator, as a neutral third party, can view the dispute objectively and can assist theparties in exploring alternatives which they might not have considered on their own;
- as mediation can be scheduled at an early stage in the dispute, a settlement can be reachedmuch more quickly than in litigation;
- parties generally save money through reduced legal costs and less staff time;
- parties enhance the likelihood of continuing their business relationship;
- creative solutions or accommodations to special needs of the parties can become a part ofthe settlement.

In the interest of swift and low-cost dispute resolution, arbitrations pending under the Rules of the American Arbitration Association can be submitted to mediation under the applicable mediationrules at no additional administrative fee.

Occurrence of Mediation

Mediations can originate in different ways. First, mediation can occur when a dispute initially arisesand before a lawsuit is ever filed. Second, mediation can occur as an adjunct procedure to pendinglitigation. That is, as soon as the parties file a lawsuit, they can use mediation in an effort to resolvethe dispute at the inception of litigation or at any time thereafter but prior to a trial being held. Third, mediation can occur during or immediately after a trial but before a decision is announcedby a judge or jury. Fourth, mediation can occur after a judgment has been rendered in litigation. There might be a disagreement over the meaning or manner of carrying out a judgment, or concern about the possibility of lengthy court appeals. The parties can seek the assistance of a mediator tohelp them resolve these problems.

The Neutrals

AAA mediators are carefully selected attorneys, retired judges, and experts in various professionaland business fields. Each candidate has been trained by the AAA in mediation skills and closelyevaluated to determine the level of skills attained. Only highly respected and experiencedindividuals are selected and trained by the AAA to be mediators. The mediators on the panel arechosen to serve on a particular case based on their expertise in the area of the dispute.

Scheduling a Mediation

Once parties have agreed to submit their dispute to mediation and have executed the appropriateforms, a mediation can be conducted on the first mutually available date. Of course, the partiesmay agree to have their mediation set for an earlier or later date depending on the circumstances oftheir case.

Stages of a Mediation

I. The Agreement to Mediate

As mediation is a voluntary process, the parties must agree in writing that their dispute will be conducted under the applicable mediation rules of the AAA. This may be accomplished in anumber of ways.

Request for Mediation

The parties can provide for the resolution of future disputes by including a mediation clause in their contract. A typical mediation clause reads as follows:

> *If a dispute arises out of or relates to this contract or the breach thereof and if the dispute cannot be settled through negotiation, the parties agree first to try in good faith to settle the dispute by mediation administered by the American Arbitration Association under its Commercial Mediation Rules before resorting to arbitration, litigation, or some other dispute resolution procedure.*

The clause may also provide for the qualifications of the mediator, the method of payment, thelocale of meetings, and any other item of concern to the parties. When a party files a Request forMediation, the requesting party must forward a copy of the mediation clause contained in thecontract under which the dispute arose. A facsimile of the Request for Mediation can be foundhere.

Submission to Mediation

Where the parties did not provide in advance for mediation, they may submit an existing dispute to mediation by the filing of a submission form that has been duly executed by the parties or theirauthorized representatives. A facsimile of the Submission to Dispute Resolution can be found onhere.

An Alternative Submission Process

Any party may request the AAA to invite other parties to join in a submission to mediation. Thisrequest may be made by a letter or a telephone call. Upon receipt of the names, telephonenumbers, and addresses of the parties to be contacted and a brief description of the dispute, theAAA will write to the other parties to explain the program, enclosing a submission form and a copy of the rules. Within ten (10) days of sending that letter, an AAA representative will telephone the other parties to further explain the program and answer questions. Although several telephone calls might be necessary to gain a submission, this has proved to be a most effective way ofobtaining an agreement. Frequently, once the letter has been sent and telephone contact has been made by the AAA, the parties engage in discussion which then leads to a settlement. If the other parties do not agree to submit the matter to dispute resolution, there will be no charge to the filing party, except that, if the case settles after AAA involvement but prior to submission to disputeresolution, the filing party will be charged a filing fee.

The document initiating mediation, whether in the form of a Request for Mediation or a Submission,is filed with the AAA and should include a brief description of the nature of the dispute, togetherwith the appropriate administrative fee (check with your local AAAregional officefor specific feeinformation). The parties are also free to conduct the mediation through correspondence in lieu ofan oral presentation, provided that all of the necessary information is included. Upon receipt of aproperly filed request or submission form, the AAA assigns the case to a case administrator. It is the function of the administrator to appoint a mediator, to make the necessary arrangements for the scheduling of a meeting between the mediator and the parties, and to be generally at the disposal of both the parties and the mediator, offering whatever assistance is required in accordance with the applicable rules.

II. Selection of the Mediator

Upon receipt of the Request for Mediation or the Submission to Dispute Resolution, theadministrator will appoint a qualified mediator to serve on the case. The parties will be providedwith a biographical sketch of the mediator. The parties are instructed to review the sketch closelyand advise the Association of any objections they may have to the appointment. Since it is essentialthat the parties have complete confidence in the mediator's ability to be fair and impartial, the Association will replace any mediator not acceptable to the parties.

III. Preparation for the Mediation Session

To prepare for mediation:

1 define and analyze the issues involved in the dispute;
2 recognize the parameters of the given situation (what you can realistically expect, timeconstraints, available resources, legal ramifications, business or trade practices, costs, etc.);
3 identify your needs and interests in settling the dispute;
4 prioritize the issues in light of your needs;
5 determine courses of action, positions, and tradeoffs and explore a variety of possiblesolutions-an initial proposal (ideal "wants" high enough to allow room to negotiate)-a fallback proposal (acceptable alternative proposal)-a bottom line proposal (a final optionwhich you absolutely must have);
6 seek to make your proposals reasonable and legitimate and be willing to accommodateneeds of the other party;
7 ascertain the strengths and weaknesses of your case;
8 ready facts, documents, and sound reasoning to support your claims;
9 anticipate the other party's needs, demands, strengths and weaknesses, positions, and version of facts;
10 focus on the interests, not the position, of each party;
11 develop your strategies and tactics through discussion of issues, presentation of proposalsand testing of the other party's positions.

IV. The Mediation Conference

The parties should come to the mediation conference prepared with all of the evidence anddocumentation they feel will be necessary to discuss their respective cases. Parties are, of courseentitled to representation by counsel.

At the outset, mediators describe the procedures and ground rules covering each party'sopportunity to talk, order of presentation, decorum, discussion of unresolved issues, use ofcaucuses, and confidentiality of proceedings.

After these preliminaries, each party describes respective views of the dispute. The initiating partydiscusses his/her understanding of the issues, the facts surrounding the dispute, what he/she wants, and why. The other party then responds and makes similar presentations to the mediator. In this initial session, the mediator gathers as many facts as possible and clarifies discrepancies. Themediator tries to understand the perceptions of each party, their interests, and their positions on the issues.

When joint discussions have reached a stage where no further progress is being made, themediator often meets with each party in caucuses. While holding separate sessions with each party,the mediator may shuttle back and forth between parties and bring them back to joint sessions atappropriate intervals. During each caucus, the mediator attempts to clarify each party's version ofthe facts, priorities, and positions, loosen rigid stances, explore alternative solutions, and seekpossible tradeoffs. The mediator probes, tests, and challenges the validity of each party'spositions. The mediator serves not as an advocate but as an "agent of reality." The mediator must make each party think through demands, priorities, and views, and deal with the other party's arguments.

An effective mediator knows that demands and priorities shift as ideas meet opposition, differentfacts are considered, and underlying circumstances change as parties reappraise and modifypositions. In effect, the mediator increases the parties' perceptions of their cases in order toconstruct a settlement range within which the parties can assess the consequences of continuing orresolving the dispute. By having parties focus on the risks and burdens of litigation, the mediator creates in the minds of the parties the idea that there are alternatives to seek. The parties articulatethese possibilities by moving toward tradeoffs and acceptable accommodations.

During the final caucuses and joint sessions, the mediator narrows the differences between theparties and

obtains agreement on major and minor issues. The mediator reduces a disagreement into a workable solution. At appropriate times, the mediator makes suggestions about a final settlement, stresses the consequences of failure to reach agreement, emphasizes the progresswhich has been made, and formalizes offers to gain an agreement.

The mediator acts as a facilitator to keep discussions focused and avoid new outbreaks offlisagreement. The mediator will often have the parties negotiate the final terms of a settlement in ajoint session. The mediator will then verify the specifics of an agreement and make sure that theterms are comprehensive, specific, and clear in the final session.

V. The Settlement

When the parties reach an agreement, they should reduce the terms to writing and exchange releases. They may also request that the agreement be put in the form of a consent award, forwhich the AAA will make the arrangements.

If the mediation fails to reach a settlement of any or all of the issues, the parties may submit tobinding arbitration. Such arbitration would be administered under the appropriate arbitration rules, and, in accordance with the rules, the information offered in mediation may not be used inarbitration (or in subsequent litigation).

Administrative Fees

The case filing fee is to be borne equally or as otherwise agreed by the parties.

Additionally, the parties are charged a fee based on the number of hours of mediator time. Thehourly fee is for the compensation of both the mediator and the AAA and varies according toregion. Check with your local AAA regional office for specific availability and rates.

There is no charge to the filing party where the AAA has been requested to invite other parties tojoin in a submission to mediation and they refuse. However, if a case settles after AAAinvolvement, the requesting party will be charged a fee.

The expenses of the AAA and the mediator, if any, are generally borne equally by the parties. Theparties may vary this arrangement by agreement.

Where the parties have attempted mediation under these rules but have failed to reach a settlement,the AAA will apply the administrative fee of the mediation toward any subsequent AAAarbitration which is filed with the AAA within ninety (90) days of the termination of the mediation.

Deposits

Before the commencement of mediation, the parties shall each deposit such portion of the feecovering the cost of mediation as the Association shall direct and all appropriate additional sumswhich the AAA deems necessary to defray the expenses of the proceeding. When the mediationhas terminated, the AAA will render an accounting and return any unexpended balance to the parties.

Refunds

Once the parties agree to mediate, no refund of the administrative fee will be made.

A Guide to Arbitration

for Business People

STAGES OF AN ARBITRATION

I. The Agreement to Arbitrate

The most important step in initiating arbitration is the agreement to arbitrate. This agreement can be of one of two kinds: it can take the form of a future-dispute arbitration clause in a contract or,where the parties did not provide in advance for arbitration, it can take the form of a submission ofan existing dispute to arbitration. The AAA will, without charge, attempt to get all parties to agree to arbitration of such a dispute.

The parties can provide for the arbitration of future disputes by inserting the following clause intotheir contracts.

Standard Arbitration Clause

> *Any controversy or claim arising out of or relating to this contract, or the breach thereof, shall be settled by arbitration administered by the American Arbitration Association under its Commercial Arbitration Rules, and judgment on the award rendered by the arbitrator(s) may be entered in any court having jurisdiction thereof.*

Arbitration of existing disputes may be accomplished by the use of the following.

> *We, the undersigned parties, hereby agree to submit to arbitration administered by the American Arbitration Association under its Commercial Arbitration Rules the following controversy: (cite briefly). We further agree that the above controversy be submitted to (one)(three) arbitrator(s). We further agree that we will faithfully observe this agreement and the rules, that we will abide by and perform any award rendered by the arbitrator(s), and that a judgment of the court having jurisdiction may be entered on the award.*

Regardless of how the agreement to arbitrate was reached, filing of a claim with the AAA alongwith the appropriate filing fee, as provided in the schedule, and serving the defending party are allthat is required to set the machinery for arbitration into motion. Upon receiving the initiating papers together with the filing fee, the AAA assigns the case to one of its staff members, whose official titlds case administrator and who, from that point onward, is at the disposal of the parties, expediting administration and assisting both sides in all procedural matters until the award is rendered. Pursuant to the rules, the parties and the AAA may use facsimile transmission, telegrams, or other written forms of electronic communication to give the notices required by the rules.

> Click here for a sample of a Demand for Arbitration (to be signed by the demanding party).A Submission to Dispute Resolution (to be signed by both parties) is shownhere. The American Arbitration Association will supply these forms free of charge on request butarbitration may also be initiated through ordinary correspondence, provided that all of the essential information is included.

Special attention is sometimes required to determine in which state and city hearings are to takeplace. If the place of arbitration has not been designated in the contract or the Submission to Dispute Resolution, or if the parties have not otherwise notified the AAA of their agreement on locale, it will designate the city in accordance with its rules. Among the factors considered are

- locations of the parties,
- locations of witnesses and documents,
- the location of sites or the place of materials,
- relative costs to the parties,
- the place of performance of the contract,

- laws applicable to the contract,
- places of previous court actions, if any,
- the location of the most appropriate panel of arbitrators, and
- any other reasonable arguments that might affect the locale determination.

Hearings may be held in any geographical area, not just where the AAA maintains regional offices.

Expedited Procedures outlined in Sections 53-57 of the rules, are applied in any case where no disclosed claim or counterclaim exceeds $50,000, exclusive of interest and arbitration costs. Those procedures provide for direct appointment of the arbitrator, although a list can be obtained at the request of all parties for an additional fee. The procedures also provide for notice of arbitrator appointment and notice of hearing by telephone and for the award of the arbitrator to be rendered no later than fourteen (14) days from the date of closing of the hearing.

A CHECKLIST FOR INITIATING ARBITRATION

	By Demand for Arbitration	By Submission to Arbitration
Disposition of the Original	Mailed to the Respondent	Filed with the AAA in Duplicate
Copies Needed by the AAA	Three.	Two.
Copies Retained by the Parties	The demanding party retains one.	Each party retains one.
Signatures Required	An authorized person for the demanding party signs and lists his or her title.	Authorized persons for both parties sign, listing their titles.
Identification of Parties	The responding party should be clearly identified by official name and address	Official names and addresses of both parties should appear, with signatures and titles
Contract Clauses	Arbitration clauses should be quoted in full (may be attached separately if more convenient). Include date of the document	Not Applicable.
The Filing Fee	A nonrefundable filing fee must be advanced by the demanding party. The arbitrator later apportions the fee. See the schedule here.	The fee may be shared equally. The arbitrator later apportions the fee. See the schedule here.
The Statement of the Dispute	It should be brief but clear and include the amount claimed, if any, and the relief sought.	Claims and answers should be brief but clear and include the amount claimed, if any, and the relief sought.
Answering Statements	The respondent may mail the answering statement to the claimant and file two copies with the AAA. If a counterclaim is asserted, a filing fee must be paid.	See the preceding.
Composition of the Arbitration Panel	The AAA will determine the number of arbitrators unless composition is stated in the arbitration clause.	The number of arbitrators desired may be stated. If not stated, the AAA will determine the composition of the panel.
Locale of Arbitration	If not provided for in arbitration clause, the demanding party should indicate its preference.	Locale should be indicated if possible.

II. Selection of the Arbitrator

To serve the business community with arbitrators representing all fields of specialization, theAmerican Arbitration Association now maintains a Roster of Neutrals of approximately 20,000 individuals throughout the United States and the rest of the world. Usually nominated by leadingfigures in their industries, trades, or professions, arbitrators are added to the panel after careful checking of qualifications and reputations.

Unless the parties agree otherwise, members of the Roster of Commercial Arbitrators appointedas neutrals on cases administered under the Expedited Procedures with claims not exceeding$10,000, will customarily serve without compensation for the first day of service. In cases withclaims exceeding $10,000, arbitrators generally charge a rate consistent with his or her stated rate of compensation, beginning with the first day of hearing. When appointed by the AAA, neutrals serve under its Commercial Arbitration Rules and their conduct is guided by the Code of Ethics for Arbitrators in Commercial Disputes, a copy of which is sent to them upon their appointment to a case. Arbitrators deserve the same respect and courtesy given to all who dedicate themselves to the public good.

Parties can show their appreciation to the arbitrators and at the same time serve their own best interests by presenting their cases in an expeditious and orderly way, thereby facilitating the task ofthe arbitrator.

Unless the parties have indicated another method, the AAA uses the following simple and effectivesystem for selecting the arbitrator.

1 Upon receiving a Demand for Arbitration or a Submission to Dispute Resolution, the case administrator sends each party a copy of the same specially prepared list of proposedarbitrators to resolve the controversy. A sample list appearshere. In drafting the list, the case administrator is guided by the nature of the dispute. Biographical information on eacharbitrator accompanies the list.
2 Parties are allowed ten (10) days to study the list, strike names to which they object, andnumber the remaining names in the order of preference. In a single arbitrator case, each party may strike three names on a peremptory basis. On a multiarbitrator case, each party may strike five names on a peremptory basis. ***Additional information about the proposed arbitrators is available through the administrator. While the AAA makes every effort to keep its information current, each party is encouraged to do further research on the persons suggested.*** If administration is under the Expedited Provisions of the rules and all parties have requested a list, they are allowed seven (7) days to study the list of five proposed arbitrators, strike two names on a peremptory basis, and number the remaining names in order of preference; absent such a request, arbitrators are appointed directly.
3 When these lists are returned to the AAA, the case administrator compares indicated preferences and makes note of the mutual choices. Where parties are unable to find amutual choice on a list, the AAA has the power to make the appointment without submitting additional lists, although additional lists may be submitted at the request of both parties.
4 If the parties cannot agree on an arbitrator, the AAA will make an administrative appointment, but in no case will an arbitrator whose name was crossed out by either partybe appointed.

Panels with Party-Appointed Arbitrators

Under some arbitration clauses in use, each party to a dispute appoints one arbitrator (who mightor might not be a member of the AAA's Roster of Neutrals) and the two select a third arbitratorfrom the AAA's panels in accordance with procedures just described in steps 2-4. To avoid thedanger that a compromise award might have to be rendered for the sake of a majority, the partiessometimes provide, and the AAA recommends, that the third arbitrator be permitted to render the award alone when a unanimous award is not possible. This may be done by the parties in theiragreement to arbitrate or in a later stipulation.

It is recommended that the neutral arbitrator ascertain from the party-appointed arbitrators the nature and extent of any relationship between the arbitrators and the parties that appointed the arbitrators and whether there will be any direct communication between such arbitrators and theparties that appointed them.

III. Preparation for the Hearing

The case administrator consults all parties and arbitrators to determine a mutually convenient day and time for the hearing. If the parties cannot agree, the arbitrator is empowered to set dates.

> *Note that, in this as in all other administrative matters, the case administrator manages details and arrangements. This has a twofold advantage: it relieves the arbitrator of the burden and eliminates the necessity of direct communication between the parties and the arbitrator except at the hearing. By specifically forbidding communication with the arbitrator, except in the presence of both parties, AAA rules avoid the danger that one side will offer arguments or evidence that the other has no opportunity to rebut.*

At the request of any party or at the discretion of the AAA, an administrative conference with the AAA and the parties and/or their representatives will be scheduled in appropriate cases to expedite the proceedings. There is no administrative fee for this service.

In large or complex cases, at the request of any party or at the discretion of the arbitrator or the AAA, a preliminary hearing with the parties and/or their representatives and the arbitrator may be scheduled by the arbitrator to specify the issues to be resolved, to stipulate uncontested facts, and to consider other matters that will expedite the arbitration proceedings. Consistent with the expedited nature of arbitration, the arbitrator may, at the preliminary hearing, establish (i) the extent of and a schedule for the production of relevant documents and other information, (ii) the identification of all witnesses to be called, and (iii) a schedule for further hearings to resolve the dispute. For purposes of arbitrator compensation, the preliminary hearing will be considered the first day of service.

Occasionally, a party needs to postpone a scheduled hearing. When this is necessary, the party seeking postponement should first contact its adversary to obtain its consent, as well as alternate hearing dates, before contacting the case administrator. If the adversary does not consent to the postponement, the case administrator should be so advised. The administrator will, in turn, coordinate having the arbitrator decide whether the hearing should be postponed, as the rules provide. In no event should the parties contact the arbitrator directly. Please note the postponement fee set forth here.

Since the arbitrator will make the award on the basis of the facts and exhibits presented at the hearing, it is essential that the parties or their representatives prepare for arbitration carefully.

1. Assemble all documents and papers that you will need at the hearing. Always make photocopies for the arbitrator and the other party. If documents that are needed are in the possession of the other party, ask that they be brought to the arbitration. Under some state arbitration laws, the arbitrator or another person has authority to subpoena documents and witnesses. A checklist of documents and exhibits will be helpful toward your orderly presentation.
2. If it will be necessary for the arbitrator to visit a building site or warehouse for an on-the-spot investigation, make plans in advance. The arbitrator will have to be accompanied by representatives of both parties, unless they specifically authorize that the investigation be conducted without their presence or unless one party fails to attend after being notified.
3. Interview all of your witnesses. Make certain that each one understands the whole case and particularly the importance of his or her own testimony within it.
4. If there is a possibility that others, not on your regular list of witnesses, might have to appear, alert them to be available on call without delay.
5. Make a written summary of what each witness will prove. This will be useful as a checklist at the hearing and will help you make sure that nothing is overlooked.
6. Study the case from the other side's point of view. Be prepared to answer the opposition's evidence.
7. If a transcript of the hearing is needed, the parties are responsible for making the arrangements and notifying the other parties of such arrangements in advance of the hearing.

The right to representation in arbitration by counsel or another authorized person is guaranteed by the rules

of the American Arbitration Association. A party who desires to be represented shouldnotify the other side and file a copy of the notice with the case administrator at least three (3) daysbefore the hearing. When arbitration is initiated by a representative or when the respondent replies through a representative, however, such notice is deemed to have been given.

IV. Presentation of the Case

Arbitration hearings are conducted somewhat like court trials, except that arbitrations are less formal. Arbitrators are not required to follow strict rules of evidence. They must hear all of theevidence material to an issue but they may determine for themselves what is relevant. Arbitratorsare therefore inclined to accept evidence that might not be allowed by judges.

This does not mean, however, that all evidence will be considered of equal weight.

> *Direct testimony of witnesses is usually more persuasive than hearsay evidence, and facts will be better established by documents and exhibits than by argument only.*

It is customary for the claimant to proceed first with its case, followed by the respondent. Thisorder may be varied, however, when the arbitrator thinks it necessary. In any event, the "burden ofproof" is not on one side more than the other; each party must try to convince the arbitrator of thecorrectness of its position and no hearing is closed until both have had a full opportunity to do so. That is why it is equally the responsibility of the claimant and the respondent to present their cases to the arbitrator in an orderly and logical manner. This includes:

1. An opening statement that clearly but briefly describes the controversy and indicates what isto be proved. Such a statement lays the groundwork and helps the arbitrator understand the relevance of testimony to be presented.
2. A discussion of the remedy sought. This is important because the arbitrator's power isconferred by the agreement of the parties. Each party should try to show that the relief that itrequests is within the arbitrator's authority to grant.
3. Introduction of witnesses in a systematic order to clarify the nature of the controversy and to identify documents and exhibits. Cross examination of witnesses is important, but each party should plan to establish its case by its own witnesses.
4. A closing statement that should include a summary of the evidence and arguments and arefutation of points made by the opposition.

Above all, a cooperative attitude is essential for effective arbitration. Overemphasis onexaggeration, concealing of facts, introduction of legal technicalities with the objective of delayingproceedings, or, in general, disregard of ordinary rules of courtesy and decorum can have anadverse effect on arbitrators.

After both sides have had an equal opportunity to present all of their evidence, the arbitratordeclares the hearing closed. Under AAA rules, the arbitrator has thirty (30) days from that time within which to render an award, unless the agreement provides otherwise. If the case wasadministered under the expedited provisions in the rules, the arbitrator has fourteen (14) days within which to render an award.

PROCEDURE FOR ORAL HEARINGS

	Who Decides	Who Makes Arrangements	Notice
Time	The arbitrator, at the convenience of the parties	The case administrator, who consults the parties and the arbitrator.	At least ten (10) days, given by the case administrator unless the parties agree otherwise.
Representation by Counsel	The individual party.	The individual party.	Three (3) days' notice to the other party unless arbitration was initiated by counsel, in which case notice is deemed to have been given.
Stenographic Records and Interpreters	The requesting party.	The requesting party.	The requesting party notifies the other party in advance of the hearing and may inquire of the other side as to whether it would like to share the cost and get a copy of the record.
Attendance at Hearing	Parties attend and bring witnesses. Arbitrators decide which other interested persons may attend and may require withdrawal of witnesses during the testimony of others.	Parties arrange for attendance of witnesses.	Parties notify their own interested persons.
Affidavits and Documents	The arbitrator decides whether to receive such evidence when it is presented.	Each party arranges to submit its own documents. If they are in the possession of the other party, documents may be requested directly.	None is required.
Subpoenas of Witnesses and Documents	The arbitrator issues subpoenas on showing of need by a party. In New York State, attorneys of record may also issue subpoenas.	The case administrator obtains signature of arbitrator for subpoena supplied by party and returns subpoena to party for service.	Subpoenas are served by parties directly on the witness or the custodian of the documents.
Inspection or Investigation	The arbitrator may decide on his or her own initiative or at the request of a party, if the arbitrator deems it necessary.	The case administrator.	Parties are notified of time and place of inspection so that they can be present.
Closing of Oral Hearings	The arbitrator closes hearing after both sides complete proofs and witnesses. If briefs, investigations, or more date are required, the hearings are kept open.	The case administrator arranges for receipt of posthearing matters and makes a record of the closing of hearings on instructions from the arbitrator.	The case administrator notifies parties of all official closing dates.

The Award

The award is the decision of the arbitrator on the matters submitted to him or her under the arbitration

agreement. If the arbitration panel consists of more than one arbitrator, the majority decision, under AAA rules, is binding. The purpose of the award is to dispose of the controversyfinally and conclusively. It is made within the limits of the arbitration agreement and it rules on each claim submitted. Arbitrators are not required to write opinions explaining the reasons for their decisions. As a general rule, AAA commercial awards consist of a brief direction to the parties ona single sheet of paper. Written opinions can generate attacks on the award because they identifytargets for the losing party. In some cases, both parties will request an opinion or the arbitration agreement provides for one. The AAA then has no objection. Usually, however, the parties look to the arbitrator for a decision, not an explanation.

> *The power of the arbitrator ends with the making of the award. An award may not bechanged by the arbitrator, once it is made, unless the parties agree to restore the power of the arbitrator or unless the law provides otherwise.*

When the parties agree to request a clarification or interpretation of a disputed ruling, the agreement must be in writing. Such an agreement is filed with the AAA, which then proceeds to make the necessary arrangements with the arbitrator. In some jurisdictions, the law permits arbitrators to clarify or modify the award upon the request of a party. The administrator will provide copies of the state arbitration law upon request.

The services of the AAA are generally concluded with the transmittal of the award. Although thereis voluntary compliance with the majority of awards, judgment on the award can be entered in acourt having appropriate jurisdiction if necessary.

Large, Complex Case Procedures

Recognizing that large, complex commercial arbitrations often present unique procedural problems,the AAA, working with attorneys, arbitrators, and industry advisory groups, has developed special Supplementary Procedures for Large, Complex Disputes The overall purpose of these proceduresis to provide for efficient, economical, and speedy resolution of larger disputes. Cases areadministered by senior AAA staff. The procedures provide for an early administrative conferencewith the AAA and a preliminary hearing with the arbitrators. Documentary exchanges and other essential exchanges of information are facilitated, as is preparation of a statement of reasonsaccompanying the award. The procedures apply when the disclosed claim of any party is at least$1,000,000, if all parties agree or a court or a governmental agency orders their use. They are meant to complement the applicable rules that the parties have agreed to use and may be modifiedby the parties.

International Cases

In order to best serve the parties in international arbitrations, the AAA devised the Supplementary Procedures for International Commercial Arbitration, which may be used in conjunction withvarious sets of arbitration rules. These procedures do not supersede any provision in the applicablerules but merely codify various procedures that are used in international arbitrations. Among the more interesting features are provisions governing consecutive hearing days, language of thehearings, and opinions. The thrust of the procedures is to expedite international commercialarbitrations and to keep them as economical as possible. In a case involving a panel of U.S. nonnationals, for instance, the AAA attempts to appoint resident foreign nationals in order to minimize travel expenses. Pursuant to the Commercial Arbitration Rules, a request for a foreign-national arbitrator must be made by the time set for the appointment of the arbitrator asagreed by the parties or set by the rules. In March 1991, the AAA also promulgated International Arbitration Rules.

Administrative Fees

The AAA's administrative fees are based on the amount of the claim or counterclaim, ranging from$500 on claims below $10,000 to a negotiated rate for claims in excess of $5,000,000. Inaddition, there are service charges for hearings held and postponements. The fees cover AAA administrative services; they do not cover arbitrator compensation or expenses, if any, reporting services, or any postaward charges incurred by the parties in enforcing the award.

The following charges are based on filing and service fees. Arbitrator compensation, if any, is notincluded in this schedule. Unless the parties agree otherwise, arbitrator compensation and administrative fees are subject to allocation by the arbitrator in the award.

Filing Fees

A nonrefundable filing fee is payable in full by a filing party when a claim, counterclaim oradditional claim is filed, as provided below.

Amount of Claim	Filing Fee
Up to $10,000	$500
Above $10,000 to $50,000	$750
Above $50,000 to $100,000	$1,250
Above $100,000 to $250,000	$2,000
Above $250,000 to $500,000	$3,500
Above $500,000 to $1,000,000	$5,000
Above $1,000,000 to $5,000,000	$7,000

When no amount can be stated at the time of filing, the minimum fee is $2,000, subject to increasewhen the claim or counterclaim is disclosed.

When a claim or counterclaim is not for a monetary amount, an appropriate filing fee will bedetermined by the AAA.

The minimum filing fee for any case having three or more arbitrators is $2,000.

The administrative fee for claims in excess of $5,000,000 will be negotiated.

Expedited Procedures, outlined in sections 53-57 of the rules, are applied in any case where nodisclosed claim or counterclaim exceeds $50,000, exclusive of interest and arbitration cost. Underthose procedures, arbitrators are directly appointed by the AAA. Where the parties request a listof proposed arbitrators under those procedures, a service charge of $150 will be payable by eachparty. There is no hearing fee for the initial hearing in cases in which no party's claim exceeds $10,000, administered under the Expedited Procedures.

Hearing Fees

For each day of hearing held before a single arbitrator, an administrative fee of $150 is payable byeach party.

For each day of hearing held before a multiarbitrator panel, an administrative fee of $250 ispayable by each party.

There is no AAA hearing fee for the initial Procedural Hearing.

Postponement/Cancellation Fees

A fee of $150 is payable by a party causing a postponement of any hearing scheduled before a single arbitrator.

A fee of $250 is payable by a party causing a postponement of any hearing scheduled before a multiarbitrator panel.

Suspension for Nonpayment

If arbitrator compensation or administrative charges have not been paid in full, the administrator may so inform the parties in order that one of them may advance the required payment. If such payments are not made, the tribunal may order the suspension or termination of the proceedings.

If no arbitrator has yet been appointed, the administrator may suspend the proceedings.

Hearing Room Rental

The Hearing Fees described above do not cover the use of hearing rooms, which are available on a rental basis. Check with the administrator for availability and rates.

The American Arbitration Association

The AAA provides services in administration of arbitration, mediation and other alternative dispute resolution methods. The Association also provides educational programs and publications as well as research into the uses of ADR for settling all types of disputes.

The educational aspects of Association work are supported by tax-deductible contributions and membership fees. Its membership rolls include companies, labor unions, trade associations, civic groups, foundations, and organizations of all kinds, as well as individuals who believe in alternative dispute resolution. It is inherent in the impartial nature of the Association that in the conduct of any ADR proceeding members and nonmembers are treated equally; no advantage accrues to any party from membership in the AAA, insofar as case administration is concerned.

Members of the AAA receive publications in their area of practice and have access to the Association's research and educational facilities. Business people who would like more information about how they may participate are invited to address their inquiries to the AAA's Membership Department.

Medical Professional Liability Catastrophe Loss Fund

1997 Surcharge Manual

(Revised 2/97)

MEDICAL PROFESSIONAL LIABILITY CATASTROPHE LOSS FUND

SURCHARGE MANUAL

Calculation of the Fund Surcharge for 1997

Act 135 of 1996 was signed into law on November 26, 1996, and substantially changes the methodology by which a Health Care Provider's surcharge is to be calculated. The Act redefines the base upon which the surcharge is calculated to mean the rates in effect for the Joint Underwriting Association and applies to all surcharges for policies issued or renewed in calendar year 1997 and thereafter.

This manual addresses several of the calculation issues prompted by the Act, and is intended to assist in calculating the Fund surcharge for 1997. Please note that this document is based on the Joint Underwriting Association rates for $200,000/$600,000 in coverage for non-hospital Health Care Providers, and $200,000/$1,000,000 in coverage for hospitals - which is the proper rate level to be used in the surcharge calculation.

I. CALCULATION OF FUND SURCHARGES

A. Physicians, Podiatrists & Certified Nurse Midwives

1. Determine Specialty and Class of Health Care Provider (See Fund Exhibit 3).

2. Determine Territory of Health Care Provider (See Fund Exhibit 1).

3. Determine appropriate Prevailing Primary Premium (See Fund Exhibit 1).

4. The Fund surcharge for a Physician, Podiatrist or Certified Nurse Midwife will be calculated by multiplying the Prevailing Primary Premium by the 1997 Annual Surcharge of 75%.

5. Factor in other applicable considerations as outlined in Section II.

B. Birth Centers (Fund Specialty Code 80402)

1. The Fund surcharge for a Birth Center will be calculated by computing the sum of 25% of the **total** applicable Fund surcharges for **all** Health Care Providers who use the facility or who have ownership interest.

2. Factor in other applicable considerations as outlined in Section II.

3. Birth Center Worksheet (See Fund Exhibit 9).

C. Partnerships, Professional Associations & Professional Corporations (Fund Specialty Code 80999)

1. The Fund surcharge for a Partnership, Professional Association or Professional Corporation will be calculated by computing:

   a. the sum of 10% of the **total** applicable Fund surcharges for **each** shareholder, owner or partner;

   PLUS

   b. the sum of 25% of the **total** applicable Fund surcharges for **each** employed Health Care Provider (other than shareholders, owners or partners).

2. Report must include the Specialty Code of the Health Care Provider.

3. Factor in other applicable considerations as outlined in Section II.

4. Partnerships, Professional Associations & Professional Corporations Worksheet (See Fund Exhibit 5).

NOTE: Partnerships, Professional Associations and Professional Corporations are **not entitled** to utilize the 1997 installment plan provision.

D. Deep Radiation/X-Ray Therapy - Insured Physician and Surgeon (Fund Specialty Code 80201)

1. **Additional** Fund surcharges for Deep Radiation/X-Ray Therapy will be calculated as follows:

   a. For Classes 006, 007, 010 and 015: 75% of Class 010 rate (See Fund Exhibit 1).

   b. For Classes 020 and above: No Additional Charge.

2. Report must include the Specialty Code of the Health Care Provider.

3. Factor in other applicable considerations as outlined in Section II.

E. Hospitals (Fund Specialty Codes 80611/80612)

1. Determine Territory of Hospital (See Fund Exhibit 2).

2. The **total** Prevailing Primary Premium for a Hospital will be calculated by computing:

   a. The sum of the **annual** occupied (patient days divided by 365) bed count (for **each** of the following bed types: Hospital (acute care); Mental Health/Mental Rehabilitation; Extended Care; Out Patient Surgical; and Health Institution) multiplied by the appropriate Prevailing Primary Premium Rate (See Fund Exhibit 2).

   PLUS

   b. The sum of the **annual** visit count (for **each** of the following visit types: Emergency; Other; Mental Health/Mental Rehabilitation; Extended Care; Out Patient Surgical; Health Institution; and Home Health Care) divided by 100 and multiplied by the appropriate Prevailing Primary Premium Rate (See Fund Exhibit 2).

3. The Fund surcharge for a Hospital will be calculated by multiplying the **total** Prevailing Primary Premium by the 1997 Annual Surcharge of 75%.

4. Factor in other applicable considerations as outlined in Section II.

5. Hospitals Worksheet (See Fund Exhibit 6).

F. Self-Insureds

1. Self-Insureds shall continue to remit reporting information directly to the Fund; however, the new Remittance Advice Form 216 (See Fund Exhibit 4) must be used. The Fund will continue to bill self-insureds, but will use JUA manual rates in calculating the self-insured surcharge.

2. Self-Insureds Worksheets (See Fund Exhibits 5 and 6) **must be used**.

G. Nursing Homes (Fund Specialty Codes 80923-Profit or 80924-Non-Profit)

1. The **total** Prevailing Primary Premium for a Nursing Home will be calculated by computing the sum of the **annual** occupied (patient days divided by 365) bed count (for **each** of the following bed types: Convalescent; and Skilled Nursing) multiplied by the appropriate Prevailing Primary Premium Rate (See Fund Exhibit 2).

2. The Fund surcharge for a Nursing Home will be calculated by multiplying the **total** Prevailing Primary Premium by the 1997 Annual Surcharge of 75%.

3. Factor in other applicable considerations as outlined in Section II.

4. Nursing Home Worksheet (See Fund Exhibit 7).

H. Primary Health Centers (Fund Specialty Code 80614)

1. Determine Territory of Primary Health Center (See Fund Exhibit 2).

2. The **total** Prevailing Primary Premium for a Primary Health Center will be calculated by computing the sum of the **annual** visit count (for **each** of the following visit types: Emergency; Other; Mental Health/Mental Rehabilitation; Out Patient Surgical; and Home Health Care) divided by 100 and multiplied by the appropriate Prevailing Primary Premium Rate (See Fund Exhibit 2).

3. The Fund surcharge for a Primary Health Center will be calculated by multiplying the **total** Prevailing Primary Premium by the 1997 Annual Surcharge of 75%.

4. Factor in other applicable considerations as outlined in Section II.

5. Primary Health Centers Worksheet (See Fund Exhibit 8).

II. OTHER CONSIDERATIONS

A. Multiple Classifications/Territories: When two or more Classifications and/or Territories are applicable to a Health Care Provider, the Fund surcharge for the highest Classification and/or Territory will apply.

B. Classification/Territory Change: A Health Care Provider who advises his/her Primary Carrier and the Fund of a change in Classification and/or Territory during a policy term, will have the appropriate debit/credit calculated and assessed to his/her Fund surcharge.

C. Part-time Physicians: A Health Care Provider in any Class who advises his/her Primary Carrier and the Fund in writing that they practice 16 hours or less per week shall be charged a Fund surcharge equal to 75% of the Fund surcharge they would otherwise be charged for their Classification and Territory. The prevailing primary premium is to be multiplied by the Fund surcharge percentage and then the Part-time Physician percentage is to be applied.

D. **Retired Physicians (Prescription Writing for Self and Immediate Family Only):** The Fund surcharge is to be applied to the Joint Underwriting Association's minimum premium. The Joint Underwriting Association's manual states that "the lowest premium amount for which insurance coverage may be written is $300."

E. **Slot Positions:** When multiple physicians maintain the various slots of a position, the Fund surcharge will be prorated among them accordingly.

F. ***Locum Tenens*:** When a physician provides health care services *in locum tenens*, and is otherwise qualified for Fund coverage, the Fund surcharge will be prorated accordingly.

G. **Tail Coverage:** For claims made policies which initiate on or after January 1, 1997, there is no surcharge for the tail; however, primary carriers must continue to make discontinuance reports and report all tail purchases. For claims made policies which originated before January 1, 1997, the appropriate tail charge is 164% of the premium charged by the primary carrier based upon 1996 rates.

III. REMITTANCE ADVICE

A. Please refer to Form 216 (See Fund Exhibits 4 and 4.1-Definitions) illustrating the nature and format of the information which the Fund will require to be submitted for each Health Care Provider along with payment of the 1997 Fund surcharge.

IV. OTHER QUESTIONS

A. Consult Joint Underwriting Association Rate Manual (See Fund Exhibit 3).

NOTES: The Fund Exhibits 1 and 2 have already taken into account the conversion from the Joint Underwriting Association's semi-annual rates to the Fund's annual surcharge.

The 1997 Fund surcharge will be assessed on the Joint Underwriting Association rates approved at the time of the 1997 surcharge filing, which rates were based on $200,000/$600,000 in coverage for physicians and $200,000/$1,000,000 in coverage for hospitals.

V. PERIODIC INSTALLMENT PAYMENT SCHEDULE (1997 Only)

For 1997 only, Health Care Providers may elect to pay their surcharges in equal installment payments. The number of equal installment payments, not exceeding a total of four, for which Health Care Providers are eligible is determined by their policy inception or renewal dates. Installment payments are due 60 days after the policy inception or renewal and each 60 days thereafter until the full surcharge is remitted.

Please refer to Fund Exhibit 11 for the installment schedule which must be followed if Health Care Providers elect to participate in the installment plan. **All payments pursuant to an installment plan must be received at the Fund on or before December 10, 1997.**

If Health Care Providers elect to pay in installments, the primary carrier must provide copies of the written notices of such elections by the Health Care Providers.

Health Care Providers whose policy inception or renewal dates are August 13, 1997 or later are **not entitled** to utilize the 1997 installment plan provision and must remit their full surcharge within 60 days from the policy inception or renewal date.

NOTE: Partnerships, Professional Associations and Professional Corporations are **not entitled** to utilize the 1997 installment plan provision.

Exhibit 1

Medical Professional Liability Catastrophe Loss Fund

Prevailing Primary Premium*
for Physicians, Surgeons and other Health Care Professionals

	Territory***				
Class**	1	2	3	4	5
006	3,582	1,752	1,870	3,228	2,326
007	4,358	2,130	2,274	3,926	2,828
010	6,352	3,106	3,316	5,724	4,122
015	7,864	3,846	4,104	7,086	5,104
020	12,164	5,948	6,350	10,960	7,894
030	16,224	7,934	8,468	14,616	10,528
035	17,640	8,626	9,208	15,894	11,448
050	23,452	11,468	12,242	21,130	15,220
060	27,904	13,646	14,566	25,142	18,110
070	35,844	17,528	18,710	32,296	23,262
080	39,960	19,540	20,860	36,004	25,934
100	55,104	26,946	28,764	49,648	35,762
120	2,788	1,364	1,456	2,512	1,810
130	12,510	6,118	6,530	11,272	8,118
900	3,176	1,554	1,658	2,862	2,062

* Fund surcharges will be assessed on annualized JUA rates
** As defined by JUA (See Fund Exhibit 3)
*** As defined by JUA:
Territory 1: Delaware (23), Montgomery (46), Philadelphia (51)
Territory 2: Remainder of State (01, 03-08, 10-14, 16-22, 24-45, 47-50, 52-67)
Territory 3: Allegheny (02)
Territory 4: Bucks (09), Schuylkill (54)
Territory 5: Chester (15), Lackawanna (35), Mercer (43), Monroe (45), Westmoreland (65)

Exhibit 2

Medical Professional Liability Catastrophe Loss Fund

Prevailing Primary Premium*
for Hospitals, Nursing Homes and Primary Health Centers

Territory**	Exposure Base	Specialty Code	Exposure Type***	Prevailing Primary Premium
Hospitals ($200,000/$1,000,000 Limits)				
1, 4	Per Occupied Bed	80611/80612	Hospital (acute care)	3,026.00
1, 4	Per Occupied Bed	80611/80612	Mental Health/Mental Rehabilitation	1,514.00
1, 4	Per Occupied Bed	80611/80612	Extended Care	136.00
1, 4	Per Occupied Bed	80611/80612	Out Patient Surgical	3,026.00
1, 4	Per Occupied Bed	80611/80612	Health Institution	606.00
1, 4	Per 100 Visits	80611/80612	Emergency	302.62
1, 4	Per 100 Visits	80611/80612	Other	121.05
1, 4	Per 100 Visits	80611/80612	Mental Health/Mental Rehabilitation	75.66
1, 4	Per 100 Visits	80611/80612	Extended Care	6.72
1, 4	Per 100 Visits	80611/80612	Out Patient Surgical	302.62
1, 4	Per 100 Visits	80611/80612	Health Institution	45.39
1, 4	Per 100 Visits	80611/80612	Home Health Care	75.66
2, 3	Per Occupied Bed	80611/80612	Hospital (acute care)	1,514.00
2, 3	Per Occupied Bed	80611/80612	Mental Health/Mental Rehabilitation	756.00
2, 3	Per Occupied Bed	80611/80612	Extended Care	68.00
2, 3	Per Occupied Bed	80611/80612	Out Patient Surgical	1,514.00
2, 3	Per Occupied Bed	80611/80612	Health Institution	304.00
2, 3	Per 100 Visits	80611/80612	Emergency	151.32
2, 3	Per 100 Visits	80611/80612	Other	60.52
2, 3	Per 100 Visits	80611/80612	Mental Health/Mental Rehabilitation	37.82
2, 3	Per 100 Visits	80611/80612	Extended Care	3.36
2, 3	Per 100 Visits	80611/80612	Out Patient Surgical	151.32
2, 3	Per 100 Visits	80611/80612	Health Institution	22.70
2, 3	Per 100 Visits	80611/80612	Home Health Care	37.82
Nursing Homes ($200,000/$600,000 Limits)				
All	Per Occupied Bed	80923/80924	Convalescent	44.00
All	Per Occupied Bed	80923/80924	Skilled Nursing	38.00
Primary Health Centers ($200,000/$600,000 Limits)				
1, 4	Per 100 Visits	80614	Emergency	297.78
1, 4	Per 100 Visits	80614	Other	119.12
1, 4	Per 100 Visits	80614	Mental Health/Mental Rehabilitation	74.45
1, 4	Per 100 Visits	80614	Out Patient Surgical	297.78
1, 4	Per 100 Visits	80614	Home Health Care	74.45
2, 3	Per 100 Visits	80614	Emergency	148.88
2, 3	Per 100 Visits	80614	Other	59.55
2, 3	Per 100 Visits	80614	Mental Health/Mental Rehabilitation	37.22
2, 3	Per 100 Visits	80614	Out Patient Surgical	148.88
2, 3	Per 100 Visits	80614	Home Health Care	37.22

* Fund surcharges will be assessed on annualized JUA rates

** As defined by PHICO Insurance Company, and adopted by J.U.A.:
- Territory 1: Delaware, Montgomery, Philadelphia
- Territory 2: Remainder of State
- Territory 3: Allegheny
- Territory 4: Bucks, Chester

*** As defined by PHICO Insurance Company, and adopted by J.U.A.

**** Based on PHICO Insurance Company rates as of 9/1/94, as adopted and modified by J.U.A.

PHYSICIANS, SURGEONS AND OTHER HEALTH CARE PROFESSIONALS CLASSIFICATIONS

CLASS 006 - Physicians, No Surgery

This classification applies to specialists hereafter listed who do not perform obstetrical procedures or surgery (other than incision of boils and superficial abscesses or suturing of skin and superficial fascia), who do not assist in surgical procedures, and who do not perform any of the procedures determined to be extra-hazardous by the JUA.

JUA Codes	Specialty Descriptions
00602	Allergy/Immunology - No Surgery
00605	Forensic Medicine - No Surgery
00608	Hematology - No Surgery
00609	Industrial/Occupational Medicine - No Surgery
00612	Ophthalmology - No Surgery
00614	Otolaryngology - No Surgery
00617	Preventive Medicine - No Surgery
00618	Proctology - No Surgery
00623	Urology - No Surgery
00634	Administrative Medicine - No Surgery
00638	Geriatrics - No Surgery
00642	Nephrology - No Surgery
00643	Oncology - No Surgery
00644	Pulmonary Diseases - No Surgery
00645	Rheumatology - No Surgery
00651	Non-Active/Retired - Rx Writing (Self & Immediate Family Only)
00656	Utilization Review
00657	General Medicine/Prescription Writing
00658	Hematology/Oncology - No Surgery
00699	Physicians Not Otherwise Classified (NOC)

CLASS 007 - Physicians, No Surgery

This classification applies to specialists hereafter listed who do not perform obstetrical procedures or surgery (other than incision of boils and superficial abscesses or suturing of skin and superficial fascia), who do not assist in surgical procedures, and who do not perform any of the procedures determined to be extra-hazardous by the JUA.

JUA Codes	Specialty Descriptions
00721	Rehabilitation/Physiatry - No Surgery

CLASS 010 - Physicians, No Surgery

This classification applies to specialists hereafter listed who do not perform obstetrical procedures or surgery (other than incision of boils and superficial abscesses or suturing of skin and superficial fascia), who do not assist in surgical procedures, and who do not perform any of the procedures determined to be extra-hazardous by the JUA.

JUA Codes	Specialty Descriptions
01004	Dermatology - No Surgery
01006	Gastroenterology - No Surgery
01007	Gynecology - No Surgery
01011	Neurology - No Surgery nor Radiopaque Dye Procedures
01013	Orthopedics - No Surgery
01015	Pathology - No Surgery
01019	Psychiatry - No Surgery
01020	Public Health - No Surgery
01022	Radiology - No Surgery nor Radiopaque Dye Procedures
01035	Bariatrics - No Surgery
01037	Endocrinology - No Surgery
01040	Infectious Diseases - No Surgery
01049	Nuclear Medicine - No Surgery
01050	Good Samaritan
01059	Radiation Oncology - No Surgery
01099	Physicians Not Otherwise Classified (NOC)

CLASS 015 - Physicians, No Surgery

This classification applies to specialists hereafter listed who do not perform obstetrical procedures or surgery (other than incision of boils and superficial abscesses or suturing of skin and superficial fascia), who do not assist in surgical procedures, and who do not perform any of the procedures determined to be extra-hazardous by the JUA.

JUA Codes	Specialty Descriptions
01501	General Practice - No Surgery
01503	Cardiology - No Surgery nor Catheterization Other than Swan-Ganz
01510	Internal Medicine - No Surgery
01516	Pediatrics - No Surgery
01533	Family Practice - No Surgery
01541	Neonatology - No Surgery
01544	Pulmonary Medicine - No Surgery Except Bronchoscopy
01599	Physicians Not Otherwise Classified (NOC)

CLASS 020 - Physicians, Minor Surgery or Assisting in Major Surgery on Own Patients; Anesthesiologists; Ophthalmologists; and Urologists, Excluding Major Surgery

This classification applies to specialists hereafter listed who perform minor surgery; who perform extra-hazardous medical techniques as determined by the JUA; or who assist in major surgery on their own patients.

JUA Codes	Specialty Descriptions
02001	General Practice - Minor Surgery
02002	Allergy - Minor Surgery
02003	Cardiology - Minor Surgery and Right Heart Catheterization
02004	Dermatology - Minor Surgery
02005	Forensic Medicine - Minor Surgery
02006	Gastroenterology - Minor Surgery
02007	Gynecology - Minor Surgery
02008	Hematology - Minor Surgery
02009	Industrial Medicine - Minor Surgery
02010	Internal Medicine - Minor Surgery
02011	Neurology - Minor Surgery and Radiopaque Dye Procedures
02013	Orthopedics - Minor Surgery
02014	Otolaryngology - Minor Surgery
02015	Pathology - Minor Surgery
02016	Pediatrics - Minor Surgery
02017	Preventive Medicine - Minor Surgery
02018	Proctology - Minor Surgery
02019	Psychiatry - Minor Surgery
02020	Public Health - Minor Surgery
02021	Rehabilitation/Physiatry - Minor Surgery
02022	Radiology - Minor Surgery and Radiopaque Dye Procedures
02023	Urology - Minor Surgery
02027	Anesthesiology
02028	Obstetrics - Minor Surgery
02029	Obstetrics/Gynecology - Minor Surgery
02033	Family Practice - Minor Surgery
02037	Endocrinology - Minor Surgery
02038	Geriatrics - Minor Surgery
02040	Infectious Diseases - Minor Surgery
02042	Nephrology - Minor Surgery

02043	Oncology - Minor Surgery
02044	Pulmonary Medicine - Minor Surgery
02049	Nuclear Medicine - Minor Surgery
02055	Ophthalmology
02059	Radiation Oncology - Minor Surgery and Radiopaque Dye Procedures
02099	Physicians Not Otherwise Classified (NOC)

CLASS 030 - **Cardiology, Urology, and Specialists Performing Major Surgery or Assisting in Major Surgery on Other Than Own Patients**

This classification applies to specialists hereafter listed who perform procedures normally included in the practice of cardiology or urology; and to other specialists who assist in major surgery on other than their own patients; who perform normal obstetrical deliveries; or who perform extra-hazardous medical techniques as determined by the JUA.

JUA Codes	Specialty Descriptions
03001	General Practice - Major Surgery
03003	Cardiology - Including Left Heart Catheterizations
03004	Dermatology - Major Surgery
03007	Gynecology - Major Surgery
03010	Internal Medicine - Major Surgery
03018	Proctology - Major Surgery
03023	Urology
03029	Obstetrics/Gynecology - Major Surgery
03033	Family Practice - Major Surgery
03043	Oncology - Major Surgery
03099	Surgeons Not Otherwise Classified (NOC)

CLASS 035 - **Emergency Medicine and Prison Physicians - Minor Surgery**

This classification applies to Emergency Medicine physicians and to other specialists hereafter listed who work in a hospital emergency medicine environment or in a prison environment more than eight (8) hours per week.

JUA Codes	Specialty Descriptions
03501	General Practice - Minor Surgery
03502	Allergy - Minor Surgery
03503	Cardiology - Minor Surgery and Including Right Heart Catheterization
03504	Dermatology - Minor Surgery
03505	Forensic Medicine - Minor Surgery
03506	Gastroenterology - Minor Surgery
03507	Gynecology - Minor Surgery

03508	Hematology - Minor Surgery
03509	Industrial Medicine - Minor Surgery
03510	Internal Medicine - Minor Surgery
03511	Neurology - Minor Surgery and Radiopaque Dye Procedures
03513	Orthopedics - Minor Surgery
03514	Otolaryngology - Minor Surgery
03515	Pathology - Minor Surgery
03516	Pediatrics - Minor Surgery
03517	Preventive Medicine - Minor Surgery
03518	Proctology - Minor Surgery
03519	Psychiatry - Minor Surgery
03520	Public Health - Minor Surgery
03521	Rehabilitation - Minor Surgery
03522	Radiology - Minor Surgery and Radiopaque Dye Procedures
03523	Urology - Minor Surgery
03531	Emergency Medicine - Minor Surgery
03533	Family Practice - Minor Surgery
03537	Endocrinology - Minor Surgery
03538	Geriatrics - Minor Surgery
03540	Infectious Diseases - Minor Surgery
03542	Nephrology - Minor Surgery
03543	Oncology - Minor Surgery
03544	Pulmonary Medicine - Minor Surgery
03549	Nuclear Medicine - Minor Surgery
03599	Physicians Not Otherwise Classified (NOC)

CLASS 050 - Surgeons - Specialists

This classification applies to specialists hereafter listed.

JUA Codes	Specialty Descriptions
05004	Dermatology - Including Plastic Surgery (cosmetic surgery not more than 20% of practice)
05014	Otolaryngology
05099	Surgeons Not Otherwise Classified (NOC)

CLASS 060 - Gynecologists

This classification applies to specialists hereafter listed who perform surgical gynecology procedures normally included in the practice of Gynecology.

JUA Codes	Specialty Descriptions
06007	Gynecology
06099	Surgeons Not Otherwise Classified (NOC)

CLASS 070 - Surgeons - Specialists

This classification applies to specialists hereafter listed.

JUA Codes	Specialty Descriptions
07001	General Practice - Major Surgery
07003	Cardiac Surgery
07024	General Surgery
07025	Thoracic Surgery
07026	Vascular Surgery
07033	Family Practice - Major Surgery
07046	Cardio-Vascular Surgery
07047	Colon-Rectal Surgery
07048	Cardio-Vascular and Thoracic Surgery
07053	Cardio-Thoracic Surgery
07054	Vascular and Thoracic Surgery
07099	Surgeons Not Otherwise Classified (NOC)

CLASS 080 - Surgeons - Specialists

This classification applies to specialists hereafter listed.

JUA Codes	Specialty Descriptions
08001	General Practice - Major Surgery
08004	Dermatology - Including Plastic Surgery (cosmetic surgery more than 20% of practice)
08028	Obstetrics
08029	Obstetrics/Gynecology
08030	Plastic Surgery
08033	Family Practice - Major Surgery
08099	Surgeons Not Otherwise Classified (NOC)

CLASS 100 - Surgeons - Specialists

This classification applies to specialists hereafter listed.

JUA Codes	Specialty Descriptions
10011	Neurosurgery
10013	Orthopedic Surgery
10099	Surgeons Not Otherwise Classified (NOC)

CLASS 120 - Podiatrists - Non-Surgical

This classification applies to specialists hereafter listed who perform non-surgical podiatric procedures.

JUA Codes	Specialty Descriptions
80993	Podiatry - No Surgery

CLASS 130 - Podiatrists - Surgical

This classification applies to specialists hereafter listed who perform surgical podiatric procedures.

JUA Codes	Specialty Descriptions
80994	Podiatry - Surgery

CLASS 802 - Additional Charges: Other

JUA Codes	Specialty Descriptions
80425	Deep Radiation/X-ray Therapy - Insured Physician and Surgeon
80999	Corporate/Association/Partnership Liability
80402	Birth Centers

CLASS 900 - Certified Nurse Midwives

JUA Codes	Specialty Descriptions
80116	Certified Nurse Midwife (CNM)

1. Definitions. For classification assignment purposes, the following definitions apply:

   (a) Major Surgery: Includes operations in or upon any body cavity, including but not limited to the cranium, thorax, abdomen, or pelvis: any other operation which, because of the condition of the patient, or the length or circumstances of the operation, presents a distinct hazard to life. It also includes but is not limited to: removal of tumors, open bone fractures, amputations, the removal of any gland or organ, plastic surgery, and any other operation performed under general anesthesia.

   (b) Minor Surgery: Any operation not defined as Major surgery.

   (c) No Surgery: The term "no surgery" applies to general practitioners and specialists who do not perform obstetrical procedures or surgery (other than incision of boils and superficial abscesses, or suturing of skin and superficial fascia), and who do not ordinarily assist in surgical procedures.

Exhibit 4

Medical Professional Liability Catastrophe Loss Fund
Remittance Advice Form 216
P.O. Box 12030, Harrisburg, PA 17108
Telephone: 717-783-3770 --- Fax: 717-787-0651

Page #: _____
Date: _____

Insurance Co.: _____
Contact Person: _____
Address: _____
City, State, Zip: _____
Telephone: _____ Fax: _____

Policy Modifier Codes	Tail Type Codes	Policy Type Codes
DX: Deep Radiation/X-Ray Therapy	A: Automatic Tail	CM: Claims Made
LT: Locum Tenens	P: Prior Acts	OC: Occurrence
PT: Part-time	R: Retro	OP: Occurrence Plus
RP: Retired Physician	ST: Slot Tail	
S: Slot Position	T: Tail	

Health Care Provider License #	Health Care Provider Name and Work Address	Primary Limits	Retro Date	Coverage from Date	Coverage to Date	Policy Modifiers	Tail Type	Policy Type	Primary Policy #	Installment # / #	County Code	JUA Specialty Code	Annual Prevailing Primary Premium	Full-time Equivalent	*Remitted Fund Surcharge	Annual Primary Carrier Premium
A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q

* Note: Please include Fund surcharge total for each page at bottom right of each page

Exhibit 4.1

Definitions for Remittance Advice Form 216

A. Health Care Provider's License # - Most current license number issued by the Department of State Bureau of Professional and Occupational Affairs.

B. Health Care Provider Name and Work Address - Exact name as listed on the Health Care Provider's license and the work address at which the Health Care Provider is working for the period reported.

C. Primary Limits - Amount of separate limits of liability for each Health Care Provider.

D. Retro Date - Initial effective date for a Claims Made policy.

E. Coverage from Date - Start date of the Health Care Provider's policy being reported.

F. Coverage to Date - End date of the Health Care Provider's policy being reported.

G. Policy Modifiers - Type of policy being reported, as follows (indicate all that apply):

DX - Deep Radiation/X-Ray Therapy
LT - *Locum Tenens*
PT - Part-time
RP - Retired Physician
S - Slot Position

H. Tail Type - Type of tail coverage being reported, as follows:

A - Automatic Tail - (Occurrence Plus policies only)
P - Prior Acts
R - Retro
ST - Slot Tail
T - Tail

I. Policy Type - Type of policy being reported, as follows:

CM - Claims Made
OC - Occurrence
OP - Occurrence Plus

J. Primary Policy # - Policy number for Health Care Provider's policy being reported.

K. Installment # / # - First # indicating which installment is being reported / Second # indicating total number of installments for which the Health Care Provider is eligible and elects to remit - Refer to Section V. of the Surcharge Manual.

L. County Code - Highest rated county in which Health Care Provider practices - Refer to Fund Exhibit 10.

M. JUA Specialty Code - Refer to Fund Exhibit 3.

N. Annual Prevailing Primary Premium - Refer to Surcharge Manual and Fund Exhibits 1, 2 and 10.

O. Full Time Equivalent (F.T.E.) - Percentage (0.01 - 1.00) of year practicing; for slot position and *locum tenens* policies.

P. Remitted Fund Surcharge - Amount actually remitted for Health Care Provider.

Q. Annual Primary Carrier Premium - Amount of premium paid for primary policy.

Exhibit 5

Worksheet
for
Partnerships, Professional Associations & Professional Corporations
(Specialty Code 80999)

Current Name: _____
(Exact Title as Filed with the Corporation Bureau)

Principle Location: _____
_____
_____
_____

County Code (See Exhibit 10 for List of County Codes): _____

Has This Title Changed from the Last Filing: Yes ~ No
If **Yes**, a copy of the new filing must be attached.
If **Yes**, state the old title: _____

Articles of Incorporation Attached (If Applicable): _____
Amendments Attached (If Applicable): _____

List all Shareholders, Owners or Partners:
(Please Print License Number, Name, JUA Specialty Code and Fund Surcharge Amount)

List all other Employed Health Care Providers:
(Please Print License Number, Name, JUA Specialty Code and Fund Surcharge Amount)

NOTE: SUBMIT WITH REMITTANCE ADVICE FORM 216

Exhibit 6

Worksheet
for
Hospitals
(Specialty Code 80611 & 80612)

Name of Hospital: _____

Address of Hospital: _____

_____

_____

_____

County Code (See Exhibit 10 for List of County Codes): _____

List Annual Occupied Bed Counts:

- Hospital (acute care): _____
- Mental Health/Mental Rehabilitation: _____
- Extended Care: _____
- Out Patient Surgical: _____
- Health Institution: _____

List Annual Visit Counts:

- Emergency: _____
- Other: _____
- Mental Health/Mental Rehabilitation: _____
- Extended Care: _____
- Out Patient Surgical: _____
- Health Institution: _____
- Home Health Care: _____

NOTE: SUBMIT WITH REMITTANCE ADVICE FORM 216

Exhibit 7

Worksheet
for
Nursing Homes
(Specialty Code 80923 & 80924)

Name of Nursing Home: _____
(Exact Title as Filed with the Department of Health)

Address of Facility: _____
_____
_____
_____

County Code (See Exhibit 10 for List of County Codes): _____

List Annual Occupied Bed Counts:

Convalescent: _____

(Free-standing facility providing skilled nursing care and treatment for patients requiring continuous health care, but do not provide any hospital services, such as surgery, and 50% or more of the patients are 65 and under)

Or

Skilled Nursing: _____

(Free-standing facility providing the same services as a convalescent facility, except that 50% or more of the patients are over 65)

NOTE: SUBMIT WITH REMITTANCE ADVICE FORM 216

Exhibit 8

Worksheet
for
Primary Health Centers
(Specialty Code 80614)

Name of Primary Health Center: _____

Address of Facility: _____
_____
_____
_____

County Code (See Exhibit 10 for List of County Codes): _____

List Annual Visit Counts:

Emergency: _____
Other: _____
Mental Health/Mental Rehabilitation: _____
Out Patient Surgical: _____
Home Health Care: _____

NOTE: SUBMIT WITH REMITTANCE ADVICE FORM 216

Exhibit 9

Worksheet
for
Birth Centers
(Specialty Code 80402)

Current Name: _____
(Exact Title as Filed with the Department of Health)

Principle Location: _____

_____

_____

_____

List all Health Care Providers who Use the Facility or Have an Ownership Interest in the Facility:
(Please Print License Number, Name, JUA Specialty Code and Fund Surcharge Amount)

NOTE: SUBMIT WITH REMITTANCE ADVICE FORM 216

Exhibit 10

County Code List

01 Adams	18 Clinton	35 Lackawanna	52 Pike
02 Allegheny	19 Columbia	36 Lancaster	53 Potter
03 Armstrong	20 Crawford	37 Lawrence	54 Schuylkill
04 Beaver	21 Cumberland	38 Lebanon	55 Snyder
05 Bedford	22 Dauphin	39 Lehigh	56 Somerset
06 Berks	23 Delaware	40 Luzerne	57 Sullivan
07 Blair	24 Elk	41 Lycoming	58 Susquehanna
08 Bradford	25 Erie	42 McKean	59 Tioga
09 Bucks	26 Fayette	43 Mercer	60 Union
10 Butler	27 Forest	44 Mifflin	61 Venango
11 Cambria	28 Franklin	45 Monroe	62 Warren
12 Cameron	29 Fulton	46 Montgomery	63 Washington
13 Carbon	30 Greene	47 Montour	64 Wayne
14 Centre	31 Huntingdon	48 Northampton	65 Westmoreland
15 Chester	32 Indiana	49 Northumberland	66 Wyoming
16 Clarion	33 Jefferson	50 Perry	67 York
17 Clearfield	34 Juniata	51 Philadelphia	

Territory Distribution:

For Hospitals, Nursing Homes and Primary Health Centers:

Territory 1:	Delaware (23), Montgomery (46), Philadelphia (51)
Territory 2:	Remainder of State (01, 03-08, 10-14, 16-22, 24-45, 47-50, 52-67)
Territory 3:	Allegheny (02)
Territory 4:	Bucks (09), Chester (15)

For All Other Health Care Providers:

Territory 1:	Delaware (23), Montgomery (46), Philadelphia (51)
Territory 2:	Remainder of State (01, 03-08, 10-14, 16-22, 24-34, 36-42, 44, 47-50, 52-53, 55-64, 66-67)
Territory 3:	Allegheny (02)
Territory 4:	Bucks (09), Schuylkill (54)
Territory 5:	Chester (15), Lackawanna (35), Mercer (43), Monroe (45), Westmoreland (65)

Exhibit 11

Surcharge Installment Payment Schedule

Policy Inception/ Renewal Date	1st Due Date	2nd Due Date	3rd Due Date	4th Due Date
	HCPs Eligible for Four Installments			
01/01/97	03/02/97	05/01/97	06/30/97	08/29/97
01/02/97	03/03/97	05/02/97	07/01/97	08/30/97
01/03/97	03/04/97	05/03/97	07/02/97	08/31/97
01/04/97	03/05/97	05/04/97	07/03/97	09/01/97
01/05/97	03/06/97	05/05/97	07/04/97	09/02/97
01/06/97	03/07/97	05/06/97	07/05/97	09/03/97
01/07/97	03/08/97	05/07/97	07/06/97	09/04/97
01/08/97	03/09/97	05/08/97	07/07/97	09/05/97
01/09/97	03/10/97	05/09/97	07/08/97	09/06/97
01/10/97	03/11/97	05/10/97	07/09/97	09/07/97
01/11/97	03/12/97	05/11/97	07/10/97	09/08/97
01/12/97	03/13/97	05/12/97	07/11/97	09/09/97
01/13/97	03/14/97	05/13/97	07/12/97	09/10/97
01/14/97	03/15/97	05/14/97	07/13/97	09/11/97
01/15/97	03/16/97	05/15/97	07/14/97	09/12/97
01/16/97	03/17/97	05/16/97	07/15/97	09/13/97
01/17/97	03/18/97	05/17/97	07/16/97	09/14/97
01/18/97	03/19/97	05/18/97	07/17/97	09/15/97
01/19/97	03/20/97	05/19/97	07/18/97	09/16/97
01/20/97	03/21/97	05/20/97	07/19/97	09/17/97
01/21/97	03/22/97	05/21/97	07/20/97	09/18/97
01/22/97	03/23/97	05/22/97	07/21/97	09/19/97
01/23/97	03/24/97	05/23/97	07/22/97	09/20/97
01/24/97	03/25/97	05/24/97	07/23/97	09/21/97
01/25/97	03/26/97	05/25/97	07/24/97	09/22/97
01/26/97	03/27/97	05/26/97	07/25/97	09/23/97
01/27/97	03/28/97	05/27/97	07/26/97	09/24/97
01/28/97	03/29/97	05/28/97	07/27/97	09/25/97
01/29/97	03/30/97	05/29/97	07/28/97	09/26/97
01/30/97	03/31/97	05/30/97	07/29/97	09/27/97
01/31/97	04/01/97	05/31/97	07/30/97	09/28/97
02/01/97	04/02/97	06/01/97	07/31/97	09/29/97
02/02/97	04/03/97	06/02/97	08/01/97	09/30/97
02/03/97	04/04/97	06/03/97	08/02/97	10/01/97
02/04/97	04/05/97	06/04/97	08/03/97	10/02/97
02/05/97	04/06/97	06/05/97	08/04/97	10/03/97
02/06/97	04/07/97	06/06/97	08/05/97	10/04/97
02/07/97	04/08/97	06/07/97	08/06/97	10/05/97
02/08/97	04/09/97	06/08/97	08/07/97	10/06/97
02/09/97	04/10/97	06/09/97	08/08/97	10/07/97
02/10/97	04/11/97	06/10/97	08/09/97	10/08/97
02/11/97	04/12/97	06/11/97	08/10/97	10/09/97
02/12/97	04/13/97	06/12/97	08/11/97	10/10/97
02/13/97	04/14/97	06/13/97	08/12/97	10/11/97
02/14/97	04/15/97	06/14/97	08/13/97	10/12/97
02/15/97	04/16/97	06/15/97	08/14/97	10/13/97

Exhibit 11

Surcharge Installment Payment Schedule

Policy Inception/ Renewal Date	1st Due Date	2nd Due Date	3rd Due Date	4th Due Date
02/16/97	04/17/97	06/16/97	08/15/97	10/14/97
02/17/97	04/18/97	06/17/97	08/16/97	10/15/97
02/18/97	04/19/97	06/18/97	08/17/97	10/16/97
02/19/97	04/20/97	06/19/97	08/18/97	10/17/97
02/20/97	04/21/97	06/20/97	08/19/97	10/18/97
02/21/97	04/22/97	06/21/97	08/20/97	10/19/97
02/22/97	04/23/97	06/22/97	08/21/97	10/20/97
02/23/97	04/24/97	06/23/97	08/22/97	10/21/97
02/24/97	04/25/97	06/24/97	08/23/97	10/22/97
02/25/97	04/26/97	06/25/97	08/24/97	10/23/97
02/26/97	04/27/97	06/26/97	08/25/97	10/24/97
02/27/97	04/28/97	06/27/97	08/26/97	10/25/97
02/28/97	04/29/97	06/28/97	08/27/97	10/26/97
03/01/97	04/30/97	06/29/97	08/28/97	10/27/97
03/02/97	05/01/97	06/30/97	08/29/97	10/28/97
03/03/97	05/02/97	07/01/97	08/30/97	10/29/97
03/04/97	05/03/97	07/02/97	08/31/97	10/30/97
03/05/97	05/04/97	07/03/97	09/01/97	10/31/97
03/06/97	05/05/97	07/04/97	09/02/97	11/01/97
03/07/97	05/06/97	07/05/97	09/03/97	11/02/97
03/08/97	05/07/97	07/06/97	09/04/97	11/03/97
03/09/97	05/08/97	07/07/97	09/05/97	11/04/97
03/10/97	05/09/97	07/08/97	09/06/97	11/05/97
03/11/97	05/10/97	07/09/97	09/07/97	11/06/97
03/12/97	05/11/97	07/10/97	09/08/97	11/07/97
03/13/97	05/12/97	07/11/97	09/09/97	11/08/97
03/14/97	05/13/97	07/12/97	09/10/97	11/09/97
03/15/97	05/14/97	07/13/97	09/11/97	11/10/97
03/16/97	05/15/97	07/14/97	09/12/97	11/11/97
03/17/97	05/16/97	07/15/97	09/13/97	11/12/97
03/18/97	05/17/97	07/16/97	09/14/97	11/13/97
03/19/97	05/18/97	07/17/97	09/15/97	11/14/97
03/20/97	05/19/97	07/18/97	09/16/97	11/15/97
03/21/97	05/20/97	07/19/97	09/17/97	11/16/97
03/22/97	05/21/97	07/20/97	09/18/97	11/17/97
03/23/97	05/22/97	07/21/97	09/19/97	11/18/97
03/24/97	05/23/97	07/22/97	09/20/97	11/19/97
03/25/97	05/24/97	07/23/97	09/21/97	11/20/97
03/26/97	05/25/97	07/24/97	09/22/97	11/21/97
03/27/97	05/26/97	07/25/97	09/23/97	11/22/97
03/28/97	05/27/97	07/26/97	09/24/97	11/23/97
03/29/97	05/28/97	07/27/97	09/25/97	11/24/97
03/30/97	05/29/97	07/28/97	09/26/97	11/25/97
03/31/97	05/30/97	07/29/97	09/27/97	11/26/97
04/01/97	05/31/97	07/30/97	09/28/97	11/27/97
04/02/97	06/01/97	07/31/97	09/29/97	11/28/97
04/03/97	06/02/97	08/01/97	09/30/97	11/29/97

Surcharge Installment Payment Schedule

Policy Inception/ Renewal Date	1st Due Date	2nd Due Date	3rd Due Date	4th Due Date
04/04/97	06/03/97	08/02/97	10/01/97	11/30/97
04/05/97	06/04/97	08/03/97	10/02/97	12/01/97
04/06/97	06/05/97	08/04/97	10/03/97	12/02/97
04/07/97	06/06/97	08/05/97	10/04/97	12/03/97
04/08/97	06/07/97	08/06/97	10/05/97	12/04/97
04/09/97	06/08/97	08/07/97	10/06/97	12/05/97
04/10/97	06/09/97	08/08/97	10/07/97	12/06/97
04/11/97	06/10/97	08/09/97	10/08/97	12/07/97
04/12/97	06/11/97	08/10/97	10/09/97	12/08/97
04/13/97	06/12/97	08/11/97	10/10/97	12/09/97
04/14/97	06/13/97	08/12/97	10/11/97	12/10/97
HCPs Eligible for Three Installments				
04/15/97	06/14/97	08/13/97	10/12/97	*N/A*
04/16/97	06/15/97	08/14/97	10/13/97	*N/A*
04/17/97	06/16/97	08/15/97	10/14/97	*N/A*
04/18/97	06/17/97	08/16/97	10/15/97	*N/A*
04/19/97	06/18/97	08/17/97	10/16/97	*N/A*
04/20/97	06/19/97	08/18/97	10/17/97	*N/A*
04/21/97	06/20/97	08/19/97	10/18/97	*N/A*
04/22/97	06/21/97	08/20/97	10/19/97	*N/A*
04/23/97	06/22/97	08/21/97	10/20/97	*N/A*
04/24/97	06/23/97	08/22/97	10/21/97	*N/A*
04/25/97	06/24/97	08/23/97	10/22/97	*N/A*
04/26/97	06/25/97	08/24/97	10/23/97	*N/A*
04/27/97	06/26/97	08/25/97	10/24/97	*N/A*
04/28/97	06/27/97	08/26/97	10/25/97	*N/A*
04/29/97	06/28/97	08/27/97	10/26/97	*N/A*
04/30/97	06/29/97	08/28/97	10/27/97	*N/A*
05/01/97	06/30/97	08/29/97	10/28/97	*N/A*
05/02/97	07/01/97	08/30/97	10/29/97	*N/A*
05/03/97	07/02/97	08/31/97	10/30/97	*N/A*
05/04/97	07/03/97	09/01/97	10/31/97	*N/A*
05/05/97	07/04/97	09/02/97	11/01/97	*N/A*
05/06/97	07/05/97	09/03/97	11/02/97	*N/A*
05/07/97	07/06/97	09/04/97	11/03/97	*N/A*
05/08/97	07/07/97	09/05/97	11/04/97	*N/A*
05/09/97	07/08/97	09/06/97	11/05/97	*N/A*
05/10/97	07/09/97	09/07/97	11/06/97	*N/A*
05/11/97	07/10/97	09/08/97	11/07/97	*N/A*
05/12/97	07/11/97	09/09/97	11/08/97	*N/A*
05/13/97	07/12/97	09/10/97	11/09/97	*N/A*
05/14/97	07/13/97	09/11/97	11/10/97	*N/A*
05/15/97	07/14/97	09/12/97	11/11/97	*N/A*
05/16/97	07/15/97	09/13/97	11/12/97	*N/A*
05/17/97	07/16/97	09/14/97	11/13/97	*N/A*
05/18/97	07/17/97	09/15/97	11/14/97	*N/A*

Surcharge Installment Payment Schedule

Policy Inception/ Renewal Date	1st Due Date	2nd Due Date	3rd Due Date	4th Due Date
05/19/97	07/18/97	09/16/97	11/15/97	N/A
05/20/97	07/19/97	09/17/97	11/16/97	N/A
05/21/97	07/20/97	09/18/97	11/17/97	N/A
05/22/97	07/21/97	09/19/97	11/18/97	N/A
05/23/97	07/22/97	09/20/97	11/19/97	N/A
05/24/97	07/23/97	09/21/97	11/20/97	N/A
05/25/97	07/24/97	09/22/97	11/21/97	N/A
05/26/97	07/25/97	09/23/97	11/22/97	N/A
05/27/97	07/26/97	09/24/97	11/23/97	N/A
05/28/97	07/27/97	09/25/97	11/24/97	N/A
05/29/97	07/28/97	09/26/97	11/25/97	N/A
05/30/97	07/29/97	09/27/97	11/26/97	N/A
05/31/97	07/30/97	09/28/97	11/27/97	N/A
06/01/97	07/31/97	09/29/97	11/28/97	N/A
06/02/97	08/01/97	09/30/97	11/29/97	N/A
06/03/97	08/02/97	10/01/97	11/30/97	N/A
06/04/97	08/03/97	10/02/97	12/01/97	N/A
06/05/97	08/04/97	10/03/97	12/02/97	N/A
06/06/97	08/05/97	10/04/97	12/03/97	N/A
06/07/97	08/06/97	10/05/97	12/04/97	N/A
06/08/97	08/07/97	10/06/97	12/05/97	N/A
06/09/97	08/08/97	10/07/97	12/06/97	N/A
06/10/97	08/09/97	10/08/97	12/07/97	N/A
06/11/97	08/10/97	10/09/97	12/08/97	N/A
06/12/97	08/11/97	10/10/97	12/09/97	N/A
06/13/97	08/12/97	10/11/97	12/10/97	N/A
HCPs Eligible for Two Installments				
06/14/97	08/13/97	10/12/97	N/A	N/A
06/15/97	08/14/97	10/13/97	N/A	N/A
06/16/97	08/15/97	10/14/97	N/A	N/A
06/17/97	08/16/97	10/15/97	N/A	N/A
06/18/97	08/17/97	10/16/97	N/A	N/A
06/19/97	08/18/97	10/17/97	N/A	N/A
06/20/97	08/19/97	10/18/97	N/A	N/A
06/21/97	08/20/97	10/19/97	N/A	N/A
06/22/97	08/21/97	10/20/97	N/A	N/A
06/23/97	08/22/97	10/21/97	N/A	N/A
06/24/97	08/23/97	10/22/97	N/A	N/A
06/25/97	08/24/97	10/23/97	N/A	N/A
06/26/97	08/25/97	10/24/97	N/A	N/A
06/27/97	08/26/97	10/25/97	N/A	N/A
06/28/97	08/27/97	10/26/97	N/A	N/A
06/29/97	08/28/97	10/27/97	N/A	N/A
06/30/97	08/29/97	10/28/97	N/A	N/A
07/01/97	08/30/97	10/29/97	N/A	N/A
07/02/97	08/31/97	10/30/97	N/A	N/A

Surcharge Installment Payment Schedule

Policy Inception/ Renewal Date	1st Due Date	2nd Due Date	3rd Due Date	4th Due Date
07/03/97	09/01/97	10/31/97	N/A	N/A
07/04/97	09/02/97	11/01/97	N/A	N/A
07/05/97	09/03/97	11/02/97	N/A	N/A
07/06/97	09/04/97	11/03/97	N/A	N/A
07/07/97	09/05/97	11/04/97	N/A	N/A
07/08/97	09/06/97	11/05/97	N/A	N/A
07/09/97	09/07/97	11/06/97	N/A	N/A
07/10/97	09/08/97	11/07/97	N/A	N/A
07/11/97	09/09/97	11/08/97	N/A	N/A
07/12/97	09/10/97	11/09/97	N/A	N/A
07/13/97	09/11/97	11/10/97	N/A	N/A
07/14/97	09/12/97	11/11/97	N/A	N/A
07/15/97	09/13/97	11/12/97	N/A	N/A
07/16/97	09/14/97	11/13/97	N/A	N/A
07/17/97	09/15/97	11/14/97	N/A	N/A
07/18/97	09/16/97	11/15/97	N/A	N/A
07/19/97	09/17/97	11/16/97	N/A	N/A
07/20/97	09/18/97	11/17/97	N/A	N/A
07/21/97	09/19/97	11/18/97	N/A	N/A
07/22/97	09/20/97	11/19/97	N/A	N/A
07/23/97	09/21/97	11/20/97	N/A	N/A
07/24/97	09/22/97	11/21/97	N/A	N/A
07/25/97	09/23/97	11/22/97	N/A	N/A
07/26/97	09/24/97	11/23/97	N/A	N/A
07/27/97	09/25/97	11/24/97	N/A	N/A
07/28/97	09/26/97	11/25/97	N/A	N/A
07/29/97	09/27/97	11/26/97	N/A	N/A
07/30/97	09/28/97	11/27/97	N/A	N/A
07/31/97	09/29/97	11/28/97	N/A	N/A
08/01/97	09/30/97	11/29/97	N/A	N/A
08/02/97	10/01/97	11/30/97	N/A	N/A
08/03/97	10/02/97	12/01/97	N/A	N/A
08/04/97	10/03/97	12/02/97	N/A	N/A
08/05/97	10/04/97	12/03/97	N/A	N/A
08/06/97	10/05/97	12/04/97	N/A	N/A
08/07/97	10/06/97	12/05/97	N/A	N/A
08/08/97	10/07/97	12/06/97	N/A	N/A
08/09/97	10/08/97	12/07/97	N/A	N/A
08/10/97	10/09/97	12/08/97	N/A	N/A
08/11/97	10/10/97	12/09/97	N/A	N/A
08/12/97	10/11/97	12/10/97	N/A	N/A
HCPs Not Eligible for Installment Payments				
08/13/97	10/12/97	N/A	N/A	N/A
08/14/97	10/13/97	N/A	N/A	N/A
08/15/97	10/14/97	N/A	N/A	N/A
08/16/97	10/15/97	N/A	N/A	N/A

Surcharge Installment Payment Schedule

Policy Inception/ Renewal Date	1st Due Date	2nd Due Date	3rd Due Date	4th Due Date
08/17/97	10/16/97	N/A	N/A	N/A
08/18/97	10/17/97	N/A	N/A	N/A
08/19/97	10/18/97	N/A	N/A	N/A
08/20/97	10/19/97	N/A	N/A	N/A
08/21/97	10/20/97	N/A	N/A	N/A
08/22/97	10/21/97	N/A	N/A	N/A
08/23/97	10/22/97	N/A	N/A	N/A
08/24/97	10/23/97	N/A	N/A	N/A
08/25/97	10/24/97	N/A	N/A	N/A
08/26/97	10/25/97	N/A	N/A	N/A
08/27/97	10/26/97	N/A	N/A	N/A
08/28/97	10/27/97	N/A	N/A	N/A
08/29/97	10/28/97	N/A	N/A	N/A
08/30/97	10/29/97	N/A	N/A	N/A
08/31/97	10/30/97	N/A	N/A	N/A
09/01/97	10/31/97	N/A	N/A	N/A
09/02/97	11/01/97	N/A	N/A	N/A
09/03/97	11/02/97	N/A	N/A	N/A
09/04/97	11/03/97	N/A	N/A	N/A
09/05/97	11/04/97	N/A	N/A	N/A
09/06/97	11/05/97	N/A	N/A	N/A
09/07/97	11/06/97	N/A	N/A	N/A
09/08/97	11/07/97	N/A	N/A	N/A
09/09/97	11/08/97	N/A	N/A	N/A
09/10/97	11/09/97	N/A	N/A	N/A
09/11/97	11/10/97	N/A	N/A	N/A
09/12/97	11/11/97	N/A	N/A	N/A
09/13/97	11/12/97	N/A	N/A	N/A
09/14/97	11/13/97	N/A	N/A	N/A
09/15/97	11/14/97	N/A	N/A	N/A
09/16/97	11/15/97	N/A	N/A	N/A
09/17/97	11/16/97	N/A	N/A	N/A
09/18/97	11/17/97	N/A	N/A	N/A
09/19/97	11/18/97	N/A	N/A	N/A
09/20/97	11/19/97	N/A	N/A	N/A
09/21/97	11/20/97	N/A	N/A	N/A
09/22/97	11/21/97	N/A	N/A	N/A
09/23/97	11/22/97	N/A	N/A	N/A
09/24/97	11/23/97	N/A	N/A	N/A
09/25/97	11/24/97	N/A	N/A	N/A
09/26/97	11/25/97	N/A	N/A	N/A
09/27/97	11/26/97	N/A	N/A	N/A
09/28/97	11/27/97	N/A	N/A	N/A
09/29/97	11/28/97	N/A	N/A	N/A
09/30/97	11/29/97	N/A	N/A	N/A
10/01/97	11/30/97	N/A	N/A	N/A
10/02/97	12/01/97	N/A	N/A	N/A

Exhibit 11

Surcharge Installment Payment Schedule

Policy Inception/ Renewal Date	1st Due Date	2nd Due Date	3rd Due Date	4th Due Date
10/03/97	12/02/97	N/A	N/A	N/A
10/04/97	12/03/97	N/A	N/A	N/A
10/05/97	12/04/97	N/A	N/A	N/A
10/06/97	12/05/97	N/A	N/A	N/A
10/07/97	12/06/97	N/A	N/A	N/A
10/08/97	12/07/97	N/A	N/A	N/A
10/09/97	12/08/97	N/A	N/A	N/A
10/10/97	12/09/97	N/A	N/A	N/A
10/11/97	12/10/97	N/A	N/A	N/A
10/12/97	12/11/97	N/A	N/A	N/A
10/13/97	12/12/97	N/A	N/A	N/A
10/14/97	12/13/97	N/A	N/A	N/A
10/15/97	12/14/97	N/A	N/A	N/A
10/16/97	12/15/97	N/A	N/A	N/A
10/17/97	12/16/97	N/A	N/A	N/A
10/18/97	12/17/97	N/A	N/A	N/A
10/19/97	12/18/97	N/A	N/A	N/A
10/20/97	12/19/97	N/A	N/A	N/A
10/21/97	12/20/97	N/A	N/A	N/A
10/22/97	12/21/97	N/A	N/A	N/A
10/23/97	12/22/97	N/A	N/A	N/A
10/24/97	12/23/97	N/A	N/A	N/A
10/25/97	12/24/97	N/A	N/A	N/A
10/26/97	12/25/97	N/A	N/A	N/A
10/27/97	12/26/97	N/A	N/A	N/A
10/28/97	12/27/97	N/A	N/A	N/A
10/29/97	12/28/97	N/A	N/A	N/A
10/30/97	12/29/97	N/A	N/A	N/A
10/31/97	12/30/97	N/A	N/A	N/A
11/01/97	12/31/97	N/A	N/A	N/A
11/02/97	01/01/98	N/A	N/A	N/A
11/03/97	01/02/98	N/A	N/A	N/A
11/04/97	01/03/98	N/A	N/A	N/A
11/05/97	01/04/98	N/A	N/A	N/A
11/06/97	01/05/98	N/A	N/A	N/A
11/07/97	01/06/98	N/A	N/A	N/A
11/08/97	01/07/98	N/A	N/A	N/A
11/09/97	01/08/98	N/A	N/A	N/A
11/10/97	01/09/98	N/A	N/A	N/A
11/11/97	01/10/98	N/A	N/A	N/A
11/12/97	01/11/98	N/A	N/A	N/A
11/13/97	01/12/98	N/A	N/A	N/A
11/14/97	01/13/98	N/A	N/A	N/A
11/15/97	01/14/98	N/A	N/A	N/A
11/16/97	01/15/98	N/A	N/A	N/A
11/17/97	01/16/98	N/A	N/A	N/A
11/18/97	01/17/98	N/A	N/A	N/A

Surcharge Installment Payment Schedule

Policy Inception/ Renewal Date	1st Due Date	2nd Due Date	3rd Due Date	4th Due Date
11/19/97	01/18/98	N/A	N/A	N/A
11/20/97	01/19/98	N/A	N/A	N/A
11/21/97	01/20/98	N/A	N/A	N/A
11/22/97	01/21/98	N/A	N/A	N/A
11/23/97	01/22/98	N/A	N/A	N/A
11/24/97	01/23/98	N/A	N/A	N/A
11/25/97	01/24/98	N/A	N/A	N/A
11/26/97	01/25/98	N/A	N/A	N/A
11/27/97	01/26/98	N/A	N/A	N/A
11/28/97	01/27/98	N/A	N/A	N/A
11/29/97	01/28/98	N/A	N/A	N/A
11/30/97	01/29/98	N/A	N/A	N/A
12/01/97	01/30/98	N/A	N/A	N/A
12/02/97	01/31/98	N/A	N/A	N/A
12/03/97	02/01/98	N/A	N/A	N/A
12/04/97	02/02/98	N/A	N/A	N/A
12/05/97	02/03/98	N/A	N/A	N/A
12/06/97	02/04/98	N/A	N/A	N/A
12/07/97	02/05/98	N/A	N/A	N/A
12/08/97	02/06/98	N/A	N/A	N/A
12/09/97	02/07/98	N/A	N/A	N/A
12/10/97	02/08/98	N/A	N/A	N/A
12/11/97	02/09/98	N/A	N/A	N/A
12/12/97	02/10/98	N/A	N/A	N/A
12/13/97	02/11/98	N/A	N/A	N/A
12/14/97	02/12/98	N/A	N/A	N/A
12/15/97	02/13/98	N/A	N/A	N/A
12/16/97	02/14/98	N/A	N/A	N/A
12/17/97	02/15/98	N/A	N/A	N/A
12/18/97	02/16/98	N/A	N/A	N/A
12/19/97	02/17/98	N/A	N/A	N/A
12/20/97	02/18/98	N/A	N/A	N/A
12/21/97	02/19/98	N/A	N/A	N/A
12/22/97	02/20/98	N/A	N/A	N/A
12/23/97	02/21/98	N/A	N/A	N/A
12/24/97	02/22/98	N/A	N/A	N/A
12/25/97	02/23/98	N/A	N/A	N/A
12/26/97	02/24/98	N/A	N/A	N/A
12/27/97	02/25/98	N/A	N/A	N/A
12/28/97	02/26/98	N/A	N/A	N/A
12/29/97	02/27/98	N/A	N/A	N/A
12/30/97	02/28/98	N/A	N/A	N/A
12/31/97	03/01/98	N/A	N/A	N/A

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THE HOSPITAL & HEALTHSYSTEM ASSOCIATION OF PENNSYLVANIA
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FAX Cover Sheet

3 # of pages (including cover sheet)

To: Mary Lou Harris

Fax: 783-2664

From: Betsy Taylor

Date: October 16, 1997

Message: Mary Lou — Martin Ciccocioppo will call you back on your question tomorrow. His direct dial number is 561-5363 in case you need to call him in the future on the CAT fund. Also, Jim Redmond thought you'd be interested in the attached letter. (FYI only!)

ANNUAL MANAGEMENT CONFERENCE

Leadership

OCTOBER 23, 1997
HERSHEY LODGE & CONVENTION CENTER
HERSHEY, PENNSYLVANIA

Call (717) 561-5341 for more information!

Senate of Pennsylvania

October 13, 1997

SENT BY FAX

John H. Reed, Director
Medical Professional Liability Catastrophe Loss Fund
Post Office Box 12030
Harrisburg, Pennsylvania 17108

Dear Mr. Reed:

As Chairman, Vice Chairman and Minority Chairman, we would like to express our concerns regarding "Proposed Regulation No. 20-1," which was developed in response to Act 135 of 1996.

The Senate Banking and Insurance Committee was active in developing the language that ultimately became law. Since publication of the regulations, the committee has been contacted by various health care provider groups expressing concern that the regulations go beyond the legislative intent of Act 135. We agree with their assessment.

First, is the reduction of time during which a provider may submit the surcharge from 60 days to 20 days. During negotiations, the fund submitted language shortening the remittance time from 60 days to 20 days. The request was rejected and not included in the final legislative package. While the original 60 day time frame was apparently developed through the regulatory process and not specified in statute, the rejection of the fund's request to shorten the time period and language contained in Act 135 indicates legislative acknowledgment of the appropriateness of the 60 days.

If you refer to Section 701(e)(14) you will note that the legislature adopted language to allow health care providers to pay the annual surcharge in equal installments. Those payments commence "60 days" from the date of the policy inception or renewal. If the legislature deemed it appropriate to allow 60 days in this situation, it makes no logical sense to in essence penalize those providers who pay their surcharge in full by shortening their payment period to 20 days. We believe the payment periods should be consistent and that if the fund desires a shorter payment period, the issue should be brought before the legislature.

Second, is the proposed interest on late payments. Again, this issue was raised by the fund during the development of the legislation. however it was not included in the final legislation. While this proposal may have merit, we recommend that the fund work with the provider community to develop an acceptable approach or delete this provision from the regulation.

Third, is the revocation of coverage for the time period during which a payment is late. This issue becomes increasingly critical in light of the reduction in payment remittance time. The intent of Pennsylvania law is to ensure that all providers have liability coverage at all times. Revocation of coverage counteracts that goal and will leave health consumers without a means of recovering damages for malpractice. Some other more appropriate penalty should be developed.

Last, is the lack of involvement of the Advisory Board in developing the regulations. If you refer to Section 706(e)(1) of the Act, the board was given the power and duty to review procedures and operations of the fund. At the September meeting of the board it was made clear that they were not involved in the development of the regulations. This clearly violates the intent of Act 135.

We request that these issues be addressed before the regulations are published in final form. Since the fund has not scheduled a public hearing, the Committee would be willing to hold a public hearing to help facilitate the dialogue necessary to resolve these differences. We look forward to your response.

Sincerely,

EDWIN G. HOLL
Majority Chairman
Banking and Insurance
Committee

J. DOYLE CORMAN
Vice Chairman
Banking and Insurance
Committee

JAY COSTA, JR.
Minority Chairman
Banking and Insurance
Committee

cc: Honorable F. Joseph Loeper
Arthur F. McNulty, Esq.

PHONE: (717) 783-5417
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INDEPENDENT REGULATORY REVIEW COMMISSION

333 MARKET STREET, 14TH FLOOR, HARRISBURG, PA 17101

August 30, 1999

John H. Reed, Esq., Director
Medical Professional Catastrophe Loss Fund
30 North Third Street, 10th Floor
Harrisburg, PA 17108

Re: IRRC Regulation #20-1 (#1880)
Medical Professional Catastrophe Loss Fund
Medical Professional Liability Catastrophe Loss Fund and Mediation

Dear Mr. Reed:

Section 5.1(a) of the Regulatory Review Act allows two years from the end of the public comment period to submit a final-form regulation. If the referenced regulation is not submitted in final form by September 29, 1999, it will be deemed withdrawn.

In order to promulgate the regulation after September 29, 1999, it must be published as a new proposed regulation in accordance with the Commonwealth Documents Law.

If you or your staff have any questions, please contact me at 783-5506, or Mary Lou Harris at 772-1284, the analyst assigned to review the regulation.

Sincerely,

Robert E. Nyce

Robert E. Nyce
Executive Director

REN:wbg
cc: Arthur F. McNulty
Kenneth J. Serafin
Honorable Edwin G. Holl, Chairman
Honorable Jay Costa, Jr., Minority Chairman
Honorable Nicholas A. Micozzie, Majority Chairman
Honorable Anthony DeLuca, Democratic Chairman
Office of General Counsel
Office of Attorney General

Original: 1880
Copies: Coccodrilli
Harris
Sandusky
Legal (2)

THE MEDICAL PROFESSIONAL LIABILITY CATASTROPHE LOSS FUND
30 North Third Street ■ 10th Floor ■ Suite 1000 ■ Harrisburg, PA 17108
Phone (717) 783-3770 ■ Facsimile (717) 787-7659

FACSIMILE

To: MARYLOU KARRIS, IRRC
Phone:
Fax Phone: 3-2664

From: KEN SCRAFFEN
Phone:
Email:
Fax Phone:

Remarks: ☐ Urgent ☑ For your review ☐ Reply ASAP ☐ Please Comment

MARYLOU,
BRIEF INFORMATIONAL SUMMARY OF THE FUND ATTACHED.
Ken

WHAT IS THE CATASTROPHE LOSS FUND?

The Medical Professional Liability Catastrophe Loss Fund is an agency of the Commonwealth of Pennsylvania created under the Health Care Services Malpractice Act of 1975, 40 P.S. Section 1301.101, et seq. The Fund's purpose is to provide a source of funds to pay for judgments, awards or settlements in medical malpractice claims which exceed the basic limits of coverage provided in the professional liability insurance policy. Participation in the Fund is mandatory for hospitals, nursing homes, birth centers, primary health centers, physicians, osteopathic physicians, podiatrists, and nurse midwives licensed or approved by the Commonwealth of Pennsylvania who conduct more than 50% of their health care business within this state. Professional corporations, associations or partnerships may elect to insure their basic liability. If they so chose, then participation in the Fund is mandatory. The following are exceptions to the mandatory insurance and surcharge requirements of the Act: one not practicing in Pennsylvania; federal government employee; Commonwealth employee; forensic pathologist; retired; volunteers; and members of Pennsylvania or U.S. military forces.

The Act mandates that each health care provider who is rendering professional medical services within the Commonwealth must obtain professional liability insurance with an insurance carrier licensed or approved by the Pennsylvania Insurance Department. The Act further requires health care providers, other than hospitals, who conduct more than 50% of their professional medical services within the Commonwealth to obtain basic limits of coverage of $300,000 per occurrence and $900,000 per annual aggregate and must participate in the Fund. Hospitals must obtain basic limits of coverage of $300,000 per occurrence and $1,500,000 per annual aggregate and must participate in the Fund. A health care provider who conducts 50% or less of their professional medical services within the Commonwealth must obtain basic coverage insurance, in the amounts of $300,000 per occurrence and $900,000 per annual aggregate but is not entitled to participate in the Fund. These policy limits are in effect for 1997 and 1998. The percentage of health care services is determined by the total number of patients treated within an annual period. The Act does permit a health care provider to self-insure his professional liability if the self-insurance plan is submitted to, and approved by the Insurance Commissioner. A fee is charged by the Insurance Department for approval of self-insurance plans.

The primary insurance carrier must submit verification of insurance to the Fund for each policy in the form of the policy's Declarations Page and/or a Form 5116 Acknowledgment of Insurance and Surcharge and Form 216 Remittance Advice. The Fund has the authority to collect a surcharge amount from health care providers when a surcharge year is designated. The surcharge fee is calculated as a percentage of the prevailing primary premium of the Pennsylvania Joint Underwriting Association in accordance with the formula set forth in the

Act. The surcharge for 1997 will be 75%. The health care provider must pay the surcharge fee to the insurance carrier and the carrier is responsible for forwarding verification of insurance and payment of surcharge to the Fund within 60 days of the effective date of the policy. In 1997 only, health care providers are permitted to pay the surcharge in equal installment payments. Health care providers having approved self-insurance plans will be surcharged an amount equal to the surcharge imposed on a health care provider of like class, size, risk and kind as determined by the Director of the Fund. Failure to carry the basic coverage insurance in the form mandated by the Act or the failure to pay the surcharge required of participants will result in the Director certifying such non-compliance to the appropriate licensure board for possible disciplinary action against the health care provider's license.

The basic coverage insurance carrier or self-insurer must submit a Form C416 as notice to the Fund when a medical malpractice claim is reasonably believed to exceed the basic coverage limits. If the judgment, award or settlement exceeds the basic coverage limits, the Fund then provides coverage up to $900,000 per occurrence and $2,700,000 annual aggregate.

The Fund consists of two offices, Harrisburg and Rosemont. Because of its geographic proximity to health care providers generating the largest number of claims, the primary function of the Rosemont office is to review claims reported as possibly requiring excess coverage in the Philadelphia area. The primary functions of the Harrisburg office are the processing of insurance information, handling Section 605 claims for the entire state and excess claims for all areas except Philadelphia and its surrounding counties, the monitoring of compliance by health care providers, and the investment of surcharge monies. The Fund is administered by a Director, who is appointed by the Governor, and is responsible for the overall operation of the Fund.

The Fund falls, to a limited degree, under the auspices of the Insurance Department in its role as an excess insurer. The Insurance Commissioner has the authority to approve self-insurance plans and the Insurance Department furnishes information to the Fund concerning the approval of insurance companies to do business in the Commonwealth. The Fund computes the surcharge to be applied for the following year; however, a review is conducted by the Insurance Commissioner. The Insurance Commissioner also has the authority to determine and levy an emergency surcharge, should circumstances warrant such action.

This narrative is provided for information purposes only. For additional information, contact the Fund at the following:

Medical Professional Liability Catastrophe Loss Fund
30 North Third Street, Suite 1000
P.O. Box 12030
Harrisburg, PA 17108
(717) 783-3770

Rev. 3/10/97

Original: 1880
Copies: None
Letter to Chairman
copied for: McGinley
Nyce
Harris
Sandusky
Legal (2)

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

October 21, 1997

The Honorable Nicholas A. Colafella, Democratic Chairman
House Insurance Committee
Pennsylvania House of Representatives
300 Main Capitol Building
Harrisburg, PA 17120

RE: Proposed Rulemaking
Amendments to 31 Pa. Code, Part IX, Chapter 242
Medical Professional Liability Catastrophe Loss Fund

Dear Representative :

Thank you for the October 7, 1997, letter regarding the above-referenced rules. The Fund appreciates your analysis and comments to the proposed Rules and certainly takes them into account as the Independent Regulatory Review Commission and its process moves forward. I thought it would be worthwhile for me to present you with the reasons underlying the proposed changes as well as the process by which they were undertaken.

The Regulations have their genesis in the "Health Care Services Malpractice Act" as amended by Act 135. The Act has always placed responsibility for regulations on the Fund's Director. Specifically, Section 701 (e) (4) states as follows:

> The Director shall issue rules and regulations consistent with this Section regarding the establishment and operation of the Fund including all procedures and levying, payment and collection of the surcharges . . . .

40 P.S. §1301.701 (e) (4).

Against this background, I would like to address certain of the specific issues raised in your letter.

As to the changes surrounding §242.17 relating to compliance, the current state of the Fund's long-standing regulations is that the Fund has no discretion with regard to disclaiming a health care provider who fails to timely remit his surcharge. Subsections (b) and (c) of §242.17 mandate that the Fund not provide coverage in instances where a health care provider fails to pay

the surcharge or fails to do so in a timely fashion.

My understanding of Act 135 is that it provided the Fund with an opportunity to ameliorate the draconian consequences which could result from the nonpayment or non-timely payment of the Fund's surcharge. Instead, the Fund would be in a position to charge interest to reflect the loss of the time value of money for untimely payments. The Fund's thinking was that with the payment of interest, assuming no claim was filed prior to the payment, then coverage could be salvaged and implemented. As such, the Fund believes it's proposed regulations are rational and would bring some reasonableness to a currently difficult situation.

Secondly, as to the determination to move the surcharge remittance from 60 days to 20 days, there were several reasons for the proposal. Specifically, as you point out in your letter, primary carriers do collect the Fund's surcharge from health care providers and subsequently remit it to the Fund. This is not unlike the sales and use tax where vendors collect the tax and thereby remit it to the Commonwealth. The remittance period for sales and use tax collection is 20 days. Moreover, under the personal income tax, large sums of withholding are, in some instances, required to be forwarded to the State within 10 days. Furthermore, as you may be aware, Senate Bill 1122, which was supported by the Pennsylvania Medical Society, the Hospital Association of Pennsylvania and the Pennsylvania Travelers' Association, included a provision that would have required remittance of the Fund surcharge - on a twice a year basis - within 20 days of policy issuance or renewal. Additionally, the Fund believes that a 20 day period for remittance of the surcharge will assist in compliance efforts and thereby assure that health care providers in this Commonwealth are adhering to the statutory requirements of Act 135.

Finally on this issue, I would point out that the Fund does not expect insurers to bill providers, collect payment, and remit the surcharge within 20 days of the policy renewal date. In fact, industry sources have related that billings to health care providers and primary carrier collection efforts occur several months prior to policy inception and/or renewal. Indeed, for January 1, 1998, renewals, I am informed that the bills are in preparation and will be mailed out within the next 30 days.

Thirdly, as to the issue of interest charges by the Fund, we believe there is little question that Act 135 envisioned the use of interest as a vehicle for the Fund's collection of the surcharge in instances of untimeliness. The addition of the definition, in conjunction with the regulatory writing authority of the Fund leads to the conclusion that interest is a tool which will work to the benefit of all health care providers in this Commonwealth.

Finally, as to the question of retroactivity, it was never the intention of the Fund to apply new regulations on a retroactive basis. Instead, in our drafting of the regulations, we noted that the current regulations have an effective date consistent with the initial passage of Act 111. See

§242.18 (relating to effective date). We simply mirrored this language in the proposed regulations. Obviously, we are prepared to correct any problems which may result from this drafting rationale.

Thank you again for your insights and comments with regard to the regulations. They will obviously play a vital role as the regulations proceed through the independent regulatory process.

Thank you for your attention to this matter. Please feel free to contact me at 3-3770 should you have any questions.

Sincerely,

Arthur F. McNulty, Chief Counsel

cc: John H. Reed, Esquire, Director
John McGinley, Esquire, Chairperson, IRRC
Robert E. Nyce, Esquire,, Director, IRRC

Original: 1880
Copies: McGinley
Nyce
Harris
Sandusky
Legal (2)
Original letter also sent to
Democratic Chairman Colafella

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

October 21, 1997

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House Insurance Committee
Pennsylvania House of Representatives
Room 45, East Wing
House Box 202020
Harrisburg, Pa 17120-2020

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Sincerely,

Arthur F. McNulty, Chief Counsel

AFM:gms

cc: John H. Reed, Esq., Director
John McGinley, Esq., Chairperson, IRRC
Robert E. Nyce, Esq., Director, IRRC