INDEPENDENT REGULATORY REVIEW COMMISSION
COMMONWEALTH OF PENNSYLVANIA
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October 30, 1997

Honorable John H. Reed, Esq., Director
Medical Professional Catastrophe Loss Fund
30 North Third Street
Harrisburg, PA 17101

Re: IRRC Regulation #20-1 (#1880)
Medical Professional Catastrophe Loss Fund
Medical Professional Liability Catastrophe Loss Fund and Mediation

Dear Director Reed:

The Independent Regulatory Review Commission (Commission) has enclosed comments on your proposed regulation #20-1. These comments outline areas of concern raised by the Commission. The comments also offer suggestions for your consideration when you prepare the final version of this regulation. These comments should not, however, be viewed as a formal approval or disapproval of the proposed version of this regulation.

If you or your staff have any questions on these comments or desire to meet to discuss them in greater detail, please contact Mary Lou Harris at 772-1284. She has been assigned to review this regulation.

Sincerely,

Robert E. Nyce
Executive Director

REN:wbg
cc: Arthur F. MuNulty
Kenneth J. Serafin
Office of General Counsel
Office of Attorney General
Pete Tartline

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(e)(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.

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.

INDEPENDENT REGULATORY REVIEW COMMISSION

To: Dee McHugh
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From: Kristine M. Shomper, Executive Assistant
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Date: October 30, 1997
# of Pages: 6

Comments: We are submitting the Independent Regulatory Review Commission's comments on the Pennsylvania Medical Professional Liability Catastrophe Loss Fund's regulation #20-1 (#1880). Upon receipt, please sign below and return to me immediately at our fax number 783-2664. We have sent the original through interdepartmental mail. You should expect delivery in a few days. Thank you.

Accepted by: D McHugh **Date:** 10/30/97