STATEMENTS OF POLICY

Title 31—INSURANCE

MEDICAL PROFESSIONAL LIABILITY CATASTROPHE LOSS FUND

[31 PA. CODE CH. 247]

Coverage and Claims Issues

On November 26, 1996, Governor Tom Ridge signed into law Act 135 of 1996. This Legislation amends the Health Care Services Malpractice Act (act) (40 P. S. §§ 1301.101—1301.1004) and constitutes the first substantive changes to the act in over 14 years. The Medical Professional Liability Catastrophe Loss Fund (Fund) was first established under the act in 1976. Its purpose is to provide professional liability insurance to Pennsylvania's health care providers, as defined in the act, at a reasonable cost and ensure just compensation to the victims of alleged professional negligence. See 40 P. S. § 1301.103. The amendments found in Act 135 of 1996 profoundly alter the professional liability insurance marketplace, the Fund's role in the marketplace, and certain of the procedures and processes governing professional liability malpractice litigation in this Commonwealth.

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 who conduct more than 50% of their health care business within this Commonwealth. Professional corporations, professional associations or partnerships, which are entirely owned by health care providers, may elect to insure their basic liability. If they so choose, their participation in the Fund is mandatory.

The act requires that each health care provider who is rendering professional medical services within this Commonwealth must obtain primary professional liability insurance with an insurance carrier licensed or approved by the Insurance Department (Department). The act further requires health care providers, other than hospitals, who conduct more than 50% of their professional medical services within this Commonwealth, to obtain basic limits of coverage for policies issued or renewed in calendar years 1997 through 1998 of $300,000 per occurrence and $900,000 per annual aggregate and must participate in the Fund. Hospitals must obtain basic limits coverage for policies issued or renewed in calendar year 1997 through 1998 of $300,000 per occurrence and $1.5 million per annual aggregate and must participate in the Fund. See § 1301.701(a)(1)(I). For policies issued or renewed in the calendar years 1999 through 2000, a health care provider, other than a hospital, must purchase basic insurance coverage in the amount of $400,000 per occurrence and $1.2 million per annual aggregate, and hospitals located in this Commonwealth must purchase professional liability primary coverage in the amount of $400,000 per occurrence and $2 million per annual aggregate. See § 1301.701(a)(1)(ii). Finally, Act 135 of 1996 provides that for policies issued or renewed in the calendar year 2001 and each year thereafter, a health care provider other than a hospital must obtain primary insurance in the amount of $500,000 per occurrence and $1.5 million per annual aggregate, while hospitals located in this Commonwealth shall insure their professional liability in the amount of $500,000 per occurrence and $2.5 million per annual aggregate. See § 1301.701(a)(1)(iii).

Act 135 of 1996 further provides that for calendar years 1997 through 1998, the limit of liability of the Fund shall be $900,000 for each occurrence for each health care provider and $2.7 million per annual aggregate for each health care provider. For calendar years 1999 through 2000, the limit of liability of the Fund shall be $800,000 for each occurrence for each health care provider and $2.4 million per annual aggregate for each health care provider. Finally as to Fund coverage, for calendar year 2001 and each year thereafter, the limit of liability of the Fund shall be $700,000 for each occurrence for each health care provider and $2.1 million per annual aggregate for each health care provider. See 40 P. S. § 1301.701(d)(1)(3).

The Fund acts as both a primary and excess insurer depending upon the alleged occurrence date of malpractice and the timing of the claim against a health care provider. If a claim against a health care provider is made less than 4 years after the date on which the alleged malpractice occurred, the Fund acts as an excess carrier with its coverage at risk only after the health care provider's primary limits have been exhausted. In this type of claim, responsibility for the cost of defense and first dollar indemnity payment rests with the primary carrier. However, in the event that a claim is made more than 4 years after the alleged malpractice, coverage under section 605 of the act (40 P. S. § 1301.605) is applicable. If a claim qualifies for Section 605 coverage, the Fund operates as a primary carrier by providing the first dollar of indemnity coverage and the cost of defense.

The purpose of this policy statement is to set forth the Fund's position as it relates to claims and coverage questions affecting health care providers and the insurance industry. Publication of this statement of policy ensures widespread dissemination of this information, and will assist in assuring uniform claims handling practices and procedures.

Contact Information

Questions regarding this policy statement of policy may be addressed to the following address:

Commonwealth of Pennsylvania
Medical Professional Liability
Catastrophe Loss Fund
30 North Third Street, Suite 1000
P. O. Box 12030
Harrisburg, PA 17108

Effective Date

This statement of policy shall take effect upon publication in the *Pennsylvania Bulletin*.

JOHN H. REED,
Director

(*Editor's Note*: The regulations of the Medical Professional Liability Catastrophe Loss Fund, 31 Pa. Code, are amended by adding a statement of policy at §§ 247.1 and 247.2 to read as set forth in Annex A.)

Fiscal Note: 20-2. No fiscal impact; (8) recommends adoption.

Annex A

TITLE 31. INSURANCE

PART IX. MEDICAL CATASTROPHE LOSS FUND

CHAPTER 247. COVERAGE AND CLAIMS ISSUES—STATEMENT OF POLICY

Sec.
247.1 Excess coverage—implementation of new limits.
247.2. Section 605 amendment implementation.

§ 247.1. Excess coverage—implementation of new limits.

(a) The act of November 26, 1996 (P. L. 776, No. 135) (Act 135) amended the Health Care Services and Malpractice Act (act) (40 P. S. §§ 1301.101—1301.1004). Act 135 redistributes coverage responsibilities between the primary carriers and the Medical Professional Liability Catastrophe Loss Fund (Fund). This redistribution continues the maximum statutory limit of $1.2 million per claim for each health care provider. This is an indication that the General Assembly did not intend to reduce the available insurance coverage to pay settlements or awards in excess medical malpractice cases.

(b) The structure of Act 135 is such that an issue arises as to the timing of a particular claim and the policy year in which a loss (that is, claim) arises. By way of example, an annual primary policy issued November 1, 1996, which runs until October 31, 1997, shall by law carry a $200,000 primary limit. If a claim occurs pre-December 31, 1996, the Fund's limit of liability, per the statute, will be $1 million. However, if the claim arises on or after January 1, 1997, through October 31, 1997, the plain language of the statute would mandate the Fund's liability is only $900,000. Neither the amendments themselves nor the Legislative history suggest that this was a result intended by the General Assembly. Therefore, in instances where the coverage level of the primary policy and the Fund limits do not reach the $1.2 million total, the Fund will provide its coverage as required by law, recognizing the amount of primary coverage available from the insurance policy, issued in compliance with Act 135, against which the claim is made.

§ 247.2. Section 605 amendment implementation.

(a) The act of November 26, 1996 (P. L. 776, No. 135) (Act 135) added language to section 605 of the Health Care Services and Malpractice Act (act) (40 P. S. § 1301.605). Specifically, Act 135 added a notification provision, under which the primary carrier must notify the Medical Professional Liability Catastrophe Loss Fund (Fund) within 180 days of the date on which the notice of claim was received by the health care provider or his insurer. Secondly, Act 135 added language with regard to the issue of "continuing course of treatment." This latter provision relates to multiple treatments or consultations which take place less than 4 years before the date on which a claim was made against a health care provider (40 P. S. § 1301.605). Both amendments to Section 605 were made effective immediately by Act 135, and by implication, will return to primary carriers additional cases for coverage and defense, and will place the Fund in the role of excess carrier for the claim.

(b) The notification requirements of Act 135 are procedural in nature, and require as a condition precedent to Section 605 status that timely notice of the claim must be provided to the Fund. Therefore, it is incumbent upon insureds, self-insureds and primary carriers to timely notify the Fund of a claim. Because of its procedural nature, the amendment will be implemented commensurate with the effective date of Act 135, that is November 27, 1996, and will apply to all claims reported on or after that date.

(c) The Fund will implement the continuing course of treatment amendments effective November 27, 2000, which is 4 years after the effective date of the Section 605 amendments. This determination is intended to provide primary carriers with the ability to build into their rate filings the costs associated with additional risks and liabilities that will accrue once the new amendments have been fully implemented.

(d) As to the continuing course of treatment provision, the Fund believes that the General Assembly intended that the continuing course of care relate to the manifestation of the claimed injury, and should not apply to unrelated treatments or consultations. By way of example, when a patient has been treated by a physician for routine cancer screening and examinations more than 4 years prior to a claim being made for delay in diagnosis of cancer, and sees the same physician within the 4-year period only for treatment of a hangnail, Section 605 coverage would apply to the claim of delay in diagnosis of cancer. In contrast, a claim alleging professional liability revolving around the hangnail would be considered an excess claim.

[Pa.B. Doc. No. 97-1032. Filed for public inspection June 27, 1997, 9:00 a.m.]

Title 61—REVENUE

DEPARTMENT OF REVENUE

[61 PA. CODE CH. 60]

Computer Services

The Department of Revenue (Department) has adopted a revised statement of policy under the authority contained in § 3.2 (relating to statements of policy). This statement of policy revises § 60.13 (relating to computer services) and shall take effect immediately upon publication in the *Pennsylvania Bulletin*.

The purpose of the amendment to § 60.13 is to advise the public of the effect of the repeal of taxation on computer services, effective July 1, 1997, as set forth in Act 7 of 1997.

Specific questions relating to information provided in this statement of policy may be directed to the Department of Revenue, Office of Chief Counsel, Department 281061, Harrisburg, PA 17128-1061.

ROBERT A. JUDGE,
Secretary

(*Editor's Note*: The regulations of the Department, 61 Pa. Code Chapter 60, are amended by amending § 60.13 to read as set forth in Annex A, with ellipses referring to the existing text of the statement of policy.)

Fiscal Note: 15-389. No fiscal impact; (8) recommends adoption.

Annex A

TITLE 61. REVENUE

PART I. DEPARTMENT OF REVENUE

Subpart B. GENERAL FUND REVENUES

ARTICLE II. SALES AND USE TAX

CHAPTER 60. SALES AND USE TAX PRONOUNCEMENTS—STATEMENTS OF POLICY

§ 60.13. Computer services.

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(b) *Scope.*

(1) *Taxable use of computer service.* Effective October 1, 1991, through June 30, 1997, the sale-at-retail or use of a computer service is subject to tax upon the purchase price if the predominate use of the service is in this Commonwealth. A charge for a computer service that is rendered prior to and after July 1, 1997, shall be subject to Sales or Use Tax only for that portion of the purchase price representing the rendition of the computer service prior to July 1, 1997. An invoice for a computer service dated on or after July 1, 1997, for a computer service rendered prior to July 1, 1997, shall be subject to Sales or Use Tax on the entire purchase price of the service. If the charge for computer services is comprised of charges for multiple services, only individual services which are predominately used in this Commonwealth are subject to tax. A computer service which is incidental to providing a nontaxable service is not subject to tax.

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[Pa.B. Doc. No. 97-1033. Filed for public inspection June 27, 1997, 9:00 a.m.]