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. 498, 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 Cas. Group of Ins. Companies v. Argonaut Ins. Co.*, 525 A.2d 1195 (Pa. 1987).

§ 242.2. Definitions.

The following words and terms, when used in this chapter, 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.

Authority

The provisions of this § 242.2 issued under sections 206 and 506 of The Administrative Code of 1929 (71 P. S. §§ 66 and 186); and sections 701(e)(4) and 702(a) of the Health Care Services Malpractice Act (40 P. S. §§ 1301.701(e)(4) and 1301.702(a)).

Source

The provisions of this § 242.2 adopted October 15, 1976, effective October 16, 1976, 6 Pa.B. 2565; amended October 7, 1977, effective October 8, 1977, 7 Pa.B. 2893; renumbered February 9, 1979, 9 Pa.B. 498; amended August 29, 1980, effective August 30, 1980, 10 Pa.B. 3514; amended September 30, 1983, effective October 1, 1983, 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

Adequate Remedy

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 Cas. Group of Ins. Companies v. Argonaut Ins. Co.*, 525 A.2d 1195 (Pa. 1987).

Validity of Regulations

Director of Medical Professional Liability Catastrophe Loss Fund (CAT Fund) had statutory authority to adopt regulations requiring health care provider with claims policy to also purchase primary insurance to maintain CAT coverage for claims that involve alleged malpractice occurring during period covered by claims policy but filed after expiration of claims policy. *Paternaster v. Lee*, 863 A.2d 487, 493 (Pa. 2004)

§ 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 change in the amount of surcharge applicable to health care providers and collectible during the following calendar year.

(b) The effective date of a change in the amount of surcharge shall be January 1 and shall be applicable to 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

Relief in Court

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 Cas. Group of Ins. Companies v. Argonaut Ins. Co.*, 525 A.2d 1195 (Pa. 1987).

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

(a) 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 the professional liability insurance, in order to properly determine the surcharge.

(b) Premiums subject to rating adjustments or audits, or both, shall be recomputed at the time of the 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

Adequate Remedy

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 Cas. Group of Ins. Companies v. Argonaut Ins. Co.*, 525 A.2d 1195 (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 days of the effective date required by § 242.6 (relating to reporting forms and procedures). A subsequent adjustment to the premium for the basic insurance coverage shall be reported to the Fund by the basic insurance carrier and the surcharge shall be adjusted accordingly.

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

Authority

The provisions of this § 242.5 issued under sections 206 and 506 of The Administrative Code of 1929 (71 P. S. §§ 66 and 186); and section 701(e) of the Health Care Services Malpractice Act (40 P. S. § 1301.701(e)).

Source

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

Notes of Decisions

These provisions provide for resolution of complaints of adverse agency action, and as such, do not provide adequate remedy or preclude litigant from seeking relief in court, where issue is Cat Fund's failure to pay share of malpractice claim settlement, which places Fund in position of defendant, as opposed to its designed position of participant and/or arbiter. *Ohio Cas. Group of Ins. Companies v. Argonaut Ins. Co.*, 525 A.2d 1195 (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 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) 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 Box 12030; 221 North Second 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 surcharges collected, payable and refundable. The form, accompanied by a check, should be received in the Director's Office within 60 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.

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

(b) Forms may be reproduced as necessary to facilitate compliance with this chapter.

(c) Upon written request, the Director may approve, in writing, modifications of the forms and procedures listed in subsection (a) if more expedient alternatives are available.

(d) Reporting forms submitted to the Fund erroneously completed will be returned to the commercial carrier or self-insured health care provider for correction and resubmission at the discretion of the Director. Surcharge payments that originally accompanied forms to be resubmitted will be returned only when circumstances render retention impracticable.

(e) Notwithstanding subsection (a), in the event that a health care provider is notified by the Fund of its noncompliance with the act's insurance requirements and insurance is purchased under the notice, the health care provider shall disclose this fact to the insurer; and the insurer shall submit the reporting form and remit the surcharge within 30 days of the effective date of the policy.

(f) The emergency surcharge shall be reported to the Fund by the insurer or self insurer utilizing the same forms used when reporting the annual surcharge to the Fund. The forms used when reporting the emergency surcharge shall clearly indicate that it is the emergency surcharge being reported.

Authority

The provisions of this § 242.6 issued under sections 206 and 506 of The Administrative Code of 1929 (71 P. S. §§ 66 and 186); and sections 701(e)(4) and 702(a) of the Health Care Services Malpractice Act (40 P. S. §§ 1301.701(e)(4) and 1301.702(a)).

Source

The provisions of this § 242.6 adopted October 15, 1976, effective October 16, 1976, 6 Pa.B. 2565; amended October 7, 1977, effective October 8, 1977, 7 Pa.B. 2894; renumbered February 9, 1979, 9 Pa.B. 498; amended April 25, 1980, effective April 26, 1980, 10 Pa.B. 1665; amended July 16, 1982, effective July 17, 1982, 12 Pa.B. 2282; amended October 8, 1982, effective October 9, 1982, 12 Pa.B. 3640; amended September 30, 1983, effective October 1, 1983, 13 Pa.B. 2969; amended through April 27, 1984, effective April 28, 1984, 14 Pa.B. 1453. Immediately preceding text appears at serial pages (85380) to (85383).

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 Cas. Group of Ins. Companies v. Argonaut Ins. Co.*, 525 A.2d 1195 (Pa. 1987).

Cross References

This section cited in 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 § 245.7 (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 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 cancelled. The 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) 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.

Authority

The provisions of this § 242.7 issued under sections 206 and 506 of The Administrative Code of 1929 (71 P. S. §§ 66 and 186); and sections 701(e)(4) and 702(a) of the Health Care Services Malpractice Act (40 P. S. §§ 1301.701(e)(4) and 1301.702(a)).

Source

The provisions of this § 242.7 adopted October 15, 1976, effective October 16, 1976, 6 Pa.B. 2565; amended March 17, 1978, effective March 18, 1978, 8 Pa.B. 755; renumbered February 9, 1979, 9 Pa.B. 498; amended September 30, 1983, effective October 1, 1983, 13 Pa.B. 2969; amended April 27, 1984, effective April 28, 1984, 14 Pa.B. 1453. Immediately preceding text appears at serial pages (85383) to (85384).

Notes of Decisions

Relief in Court

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 Cas. Group of Ins. Companies v. Argonaut Ins. Co.*, 525 A.2d 1195 (Pa. 1987).

Tail Coverage

Patient brought action against Medical Care Availability and Reduction of Error Fund (Fund) and pediatrician, asserting Fund was required to defend and indemnify pediatrician in patient's medical malpractice action; pediatrician did not purchase tail coverage or its substantial equivalent when he terminated his claims made policy, therefore, Fund was not required to indemnify and defend claims arising after policy termination. *Gingerlowski v. Commonwealth Ins. Dept.*, 961 A.2d 237, 243 (Pa. Cmwlth. 2008).

§ 242.7a. Allowable time periods for application to fund for surcharge credits as a result of policy cancellations—statement of policy.

(a) For all policies issued or renewed in 2001, the Fund should be notified of any cancellation of a health care provider's basic coverage insurance policy, or

self-insured arrangement, and should receive any corresponding application for credit, no later than 1 year from the date of the cancellation. For example, if a policy or coverage period on a particular health care provider runs from January 1, 2001, to December 31, 2001, and there is a cancellation of the policy effective September 1, 2001, notification of the cancellation and any corresponding application for credit shall be reported to the Fund by September 1, 2002, if not sooner. A basic coverage insurance carrier or self-insured health care provider will have at least 60 days to notify the Fund of a cancellation and provide the Fund with the corresponding application for credit.

(b) For policies issued or renewed in 2002, and every year thereafter, the Fund should be notified of any cancellation of a provider's basic coverage insurance policy, or self-insured arrangement, and should receive any corresponding application for credit, within 60 days from the date of the cancellation.

(c) On a going forward basis, the Fund will not accept applications for surcharge credits for policies issued or renewed before January 1, 2001.

Source

The provisions of this § 242.7a adopted December 14, 2001, effective December 15, 2001, 31 Pa.B. 6825.

§ 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 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 Cas. Group of Ins. Companies v. Argonaut Ins. Co.*, 525 A.2d 1195 (Pa. 1987).

§ 242.9. Overpayments, credits, and duplicate payments.

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

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 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 Cas. Group of Ins. Companies v. Argonaut Ins. Co.*, 525 A.2d 1195 (Pa. 1987).

§ 242.10. Self-insurers.

(a) This chapter applies 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 days of the effective date of the self-insurance plan and on an annual basis thereafter within 60 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 Administrative Code of 1929 (71 P. S. §§ 66 and 186); section 701(e)(4) of the Health Care Services Malpractice Act (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 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 Cas. Group of Ins. Companies v. Argonaut Ins. Co.*, 525 A.2d 1195 (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-insured, submit Form C416 to the Director.

Source

The provisions of this § 242.11 adopted October 15, 1976, effective October 16, 1976, 6 Pa.B. 2565; renumbered February 9, 1979, 9 Pa.B. 498.

Notes of Decisions

Adequate Remedy

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 Cas. Group of Ins. Companies v. Argonaut Ins. Co.*, 525 A.2d 1195 (Pa. 1987).

§ 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 Administrative Code of 1929 (71 P. S. § 186); and sections 701(e)(4) and 702(a) of the Health Care Services Malpractice Act (40 P. S. §§ 1301.701(e)(4) and 1301.702(a)).

Source

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

Notes of 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 Cas. Group of Ins. Companies v. Argonaut Ins. Co.*, 525 A.2d 1195 (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 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 Cas. Group of Ins. Companies v. Argonaut Ins. Co.*, 525 A.2d 1195 (Pa. 1987).

§ 242.14. Bulletins and notices.

Bulletins and notices will be issued periodically by the Director to clarify or modify procedures. Insurers, agents, brokers, health care providers and others requiring the information will, upon request to the Director, be placed on a mailing list for such bulletins.

Source

The provisions of this § 242.14 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 Cas. Group of Ins. Companies v. Argonaut Ins. Co.*, 525 A.2d 1195 (Pa. 1987).

§ 242.15. Notification to the Director.

(a) *Persons accountable.* Insurers and self-insurers shall notify the Director in writing of the responsible person accountable for procedures and timely remittances applicable to Article VII of the act (40 P. S. §§ 1301.701—1301.702).

(b) *Pennsylvania license numbers.* Insurers and self-insurers shall record and report the Pennsylvania medical license numbers of the health care providers to the Director on forms prescribed in this chapter, on new and renewal business written subsequent to October 31, 1976.

Authority

The provisions of this § 242.15 issued under section 506 of The Administrative Code of 1929 (71 P. S. § 186); and sections 701(e)(4) and 702(a) of the Health Care Services Malpractice Act (40 P. S. §§ 1301.701(e)(4) and 1301.702(a)).

Source

The provisions of this § 242.15 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 Decisions

Right to Appeal

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 Cas. Group of Ins. Companies v. Argonaut Ins. Co.*, 525 A.2d 1195 (Pa. 1987).

§ 242.16. Retention of records.

Insurers and self-insurers shall be responsible for the retention of forms and records described in this chapter, in accordance with the applicable Commonwealth statute of limitations.

Source

The provisions of this § 242.16 adopted October 15, 1976, effective October 16, 1976, 6 Pa.B. 2565; renumbered February 9, 1979, 9 Pa.B. 498.

Notes of Decisions

Adequate Remedy

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 Cas. Group of Ins. Companies v. Argonaut Ins. Co.*, 525 A.2d 1195 (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 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 not be covered by the Fund in the event of loss.

(d) 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.

Authority

The provisions of this § 242.17 issued under section 506 of The Administrative Code of 1929; and sections 701(e)(4) and 702(a) of the Health Care Services Malpractice Act (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 Decisions

Malpractice Action

Implicit in grant of authority to the Pennsylvania Medical Professional Liability Catastrophe Loss (CAT) Fund to levy and collect surcharges from health care providers entitled to participate in the fund was the authority to assess penalty for failure of providers to timely pay charges on time; therefore, regulation providing that health care provider who failed to pay fund surcharges would not be covered by fund in event of loss was valid. *Lloyd v. CAT Fund*, 821 A.2d 1230, 1235 (Pa. 2003).

It was error for the court to hold appellant, Medical Professional Liability Catastrophe Loss Fund, liable for excess liability coverage where the doctor failed to pay the required surcharges, despite appellant's failure to report the doctor to the applicable licensure board. *Dellenbaugh v. Medical Professional Liability Catastrophe Loss Fund and Pennsylvania Medical Society Liability Insurance Co.*, 756 A.2d 1172 (Pa. 2000).

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 Cas. Group of Ins. Companies v. Argonaut Ins. Co.*, 525 A.2d 1195 (Pa. 1987).

Tail Coverage

Patient brought action against Medical Care Availability and Reduction of Error Fund (Fund) and pediatrician, asserting Fund was required to defend and indemnify pediatrician in patient's medical malpractice action; pediatrician did not purchase tail coverage or its substantial equivalent when he terminated his claims made policy, therefore, Fund was not required to indemnify and defend claims arising after policy termination. *Gingerlowski v. Commonwealth Ins. Dept.*, 961 A.2d 237, 243 (Pa. Cmwlth. 2008).

Validity of Regulation

Regulation providing that health care provider who failed to timely pay fund surcharges would not be covered by fund in event of loss was valid exercise of the Pennsylvania Medical Professional Liability Catastrophe Loss (CAT) Fund's rulemaking authority. *Lloyd v. CAT Fund*, 821 A.2d 1230 (Pa. 2003).

Regulations requiring health care provider with claims policy to maintain primary insurance after claims policy expires by purchasing prior acts coverage to maintain Medical Professional Liability Catastrophe Loss Fund coverage for claims involving alleged malpractice occurring during period covered by claims policy, but filed after expiration of claims policy were consistent with the Health Care Services Malpractice Act. *Paternaster v. Lee*, 863 A.2d 487, 494 (Pa. 2004)

§ 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.

Source

The provisions of this § 242.18 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 Cas. Group of Ins. Companies v. Argonaut Ins. Co.*, 525 A.2d 1195 (Pa. 1987).

§ 242.19. Investment transactions.

For the purposes of investing funds generated by the operations of the Fund, and only for investment purposes, the Director will cause all investments now owned in the name of the Fund and hereafter purchased by the Fund under section 1 of the act of April 25, 1929 (P. L. 723, No. 315) (72 P. S. § 3603) to be held in the shortened name of ''Medcat & Co.'' Such name will constitute the sole name under which the Director may invest funds. The Director will give notice to all parties with whom he deals in pursuit of his investment responsibilities, by citation of this section, of the existence of the Fund as the real party in interest in Medcat & Co. transactions.

Source

The provisions of this § 242.19 adopted October 7, 1977, effective October 8, 1977, 7 Pa.B. 2893.

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 Cas. Group of Ins. Companies v. Argonaut Ins. Co.*, 525 A.2d 1195, 1197 (Pa. 1987).

§ 242.20. Formal and informal complaints; procedure.

Under 1 Pa. Code § 31.1 (relating to scope of part), 1 Pa. Code Part II (relating to general rules of administrative practice and procedure) is applicable to the activities of and proceedings before the fund. These provisions will govern the procedure to be followed in handling formal and informal complaints addressed to the Fund.

Authority

The provisions of this § 242.20 issued under sections 206 and 506 of The Administrative Code of 1929 (71 P. S. §§ 66 and 186); section 701(e)(4) of the Health Care Services Malpractice Act (40 P. S. § 1301.701(e)(4)); and 2 Pa.C.S. § 102(a).

Source

The provisions of this § 242.20 adopted August 7, 1981, effective August 8, 1981, 11 Pa.B. 2760.

Notes of Decisions

Doctrine of exhaustion of administrative remedies was inapplicable where question was whether Medical Professional Liability Catastrophe Loss Fund was liable over to malpractice defendant's excess insurer since the key question of whether there was one or two occurrences of medical malpractice was not within the Fund's specialized knowledge since the Fund regulations, 31 Pa. Code §§ 242.1—242.20 do not address the claims and since the Health Care Services Malpractice Act makes no specific provision regarding claims between insurance companies and the Fund but does contemplate the Fund's involvement in litigation concerning the claims (40 P. S. § 1301.702(f)). *Ohio Cas. Group of Ins. Companies v. Argonaut Ins. Co.*, 500 A.2d 191 (Pa. Cmwlth. 1985).

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 Cas. Group of Ins. Companies v. Argonaut Ins. Co.*, 525 A.2d 1195 (Pa. 1987).

[Next page is 243-1.]