CHAPTER 243. MEDICAL MALPRACTICE AND HEALTH-RELATED SELF-INSURANCE PLANS

Sec.

Authority

The provisions of this Chapter 243 issued under The Insurance Company Law of 1921 (40 P.S. §§ 341—991); the Health Care Services Malpractice Act (40 P.S. §§ 1301.101—1301.1006); and sections 206, 506, 1501 and 1502 of The Administrative Code of 1929 (71 P.S. §§ 66, 186, 411 and 412), unless otherwise noted.

Source

The provisions of this Chapter 243 adopted July 1, 1977, effective July 2, 1977, 7 Pa.B. 1816; renumbered February 9, 1979, 9 Pa.B. 498, unless otherwise noted.

Cross References

This chapter cited in 49 Pa. Code § 18.20 (relating to professional liability insurance coverage for acupuncturists and practitioners of Oriental Medicine); 49 Pa. Code § 18.146 (relating to professional liability insurance coverage for licensed physician assistants); 49 Pa. Code § 18.611 (relating to professional liability insurance coverage for licensed perfusionists); 49 Pa. Code § 18.710 (relating to professional liability insurance coverage for genetic counselors); 49 Pa. Code § 18.864 (relating to professional liability insurance coverage for licensed prosthetist, orthotist, pedorthist or orthotic fitter); 49 Pa. Code § 25.164 (relating to professional liability insurance coverage for licensed physician assistants); 49 Pa. Code § 25.811 (relating to professional liability insurance coverage for licensed perfusionist); 49 Pa. Code § 25.910 (relating to professional liability insurance coverage for genetic counselors); 49 Pa. Code § 40.69 (relating to professional liability insurance); and 49 Pa. Code § 42.16 (relating to biennial renewal; inactive status; failure to renew).

§ 243.1. Purpose.

The purposes of this chapter are to provide a procedure for the approval of self-insurance plans, provide for the orderly transition between commercial insurance and self-insurance that provides continuous and adequate protection, encourage effective risk management in order to enhance patient care, and provide for adequate funding by a health care provider, thereby enhancing prompt payment of claims of those persons that may avail themselves of the services provided by the health care provider.

Authority

The provisions of this § 243.1 amended under The Insurance Department Act of 1921 (40 P.S. §§ 1—321); The Insurance Company Law of 1921 (40 P.S. §§ 341—991); and sections 206, 506, 1501 and 1502 of The Administrative Code of 1929 (71 P.S. §§ 66, 186, 411 and 412); and the Health Care Services Malpractice Act (40 P.S. §§ 1301.101—1301.1006).

Source

The provisions of this § 243.1 adopted July 1, 1977, effective July 2, 1977, 7 Pa.B. 1816; renumbered February 9, 1979, 9 Pa.B. 498; amended September 18, 1987, effective November 18, 1987, 17 Pa.B. 3742. Immediately preceding text appears at serial page (109902).

§ 243.2. 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).

Asserted claim—An incident about which the potential claimant has made a communication and which, after review of the circumstances, leads to the reasonable conclusion that the provider may have possible claim liability.

Commissioner—The Insurance Commissioner of the Commonwealth.

Department—The Insurance Department of the Commonwealth.

Effective date—The date on which the Commissioner initially approved a self-insurance plan, whether under this chapter or prior regulations.

Government—The government of the United States, a state, a political subdivision of a state, an instrumentality of one or more states or an agency, subdivision or department of these forms of government. The term includes a corporation or other association organized by a government for the execution of a government program and subject to control by a government or corporation or agency established under an interstate compact or international treaty.

Health care provider—A primary health center or person, corporation, 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, a surgeon, a certified nurse midwife, a podiatrist, hospital, nursing home, birth center and, except as to section 701(a) of the act (40 P.S. § 1301.701(a)), an officer, employe or agent of any of the providers acting in the course and scope of employment.

Plan of risk management—A plan established and maintained for the purpose of reducing, through loss prevention, loss reduction and other generally accepted risk management techniques, the frequency and severity of personal injuries arising out of the rendition of or failure to render professional services by a health care provider.

Primary health center—A community-based nonprofit corporation, meeting standards prescribed by the Department of Health, which provides preventative, diagnostic, therapeutic and basic emergency health care by licensed practitioners who are employes of the corporation or under contract to the corporation.

Professional liability insurance—Insurance against liability on the part of the health care provider arising out of a tort or breach of contract causing injury or death, resulting from the furnishing of medical services which were or should have been provided.

Self-insurance—The assumption by a health care provider of a professional liability risk arising out of a tort or breach of contract causing injury or death resulting from the furnishing of medical services which were or should have been provided.

Authority

The provisions of this § 243.2 amended under The Insurance Department Act of 1921 (40 P. S. §§ 1—321); The Insurance Company Law of 1921 (40 P. S. §§ 341—991); and sections 206, 506, 1501 and 1502 of The Administrative Code of 1929 (71 P. S. §§ 66, 186, 411 and 412); and the Health Care Services Malpractice Act (40 P. S. §§ 1301.101—1301.1006).

Source

The provisions of this § 243.2 adopted July 1, 1977, effective July 2, 1977, 7 Pa.B. 1816; renumbered February 9, 1979, 9 Pa.B. 498; amended September 18, 1987, effective November 18, 1987, 17 Pa.B. 3742. Immediately preceding text appears at serial pages (109902), (63282) and (39843).

§ 243.3. Standards for self-insurance plans.

For a plan of self-insurance to meet the standard of section 701(a)(4) of the act (40 P. S. § 1307.701(a)(4)) that it ''constitutes protection equivalent to the insurance requirements of a health care provider'', the plan shall do the following:

(1) Provide a fund, in a form approved by the Commissioner, to be held by a trustee in a segregated and independent account which shall be available only for the payment of claims covered by the basic insurance provided by the act. A separate segregated and independent account within the trust shall be used by the health care provider to pay for expenses such as trustee fees or commissions, legal expenses or other claims for liability other than the basic insurance provided in the act. The funding and reporting requirements only apply to the trust account for the payment of claims covered by the basic insurance provided by the act.

(2) Capitalize the fund for the payment of claims covered by the basic insurance provided by the act using only the following permissible assets:

(i) Direct obligations of the United States Government—United States Treasury bonds, bills or notes.

(ii) Obligations of Federal government agencies—bonds, debentures or notes such as the following:

(A) Federal Home Loan Bank.

(B) Small Business Administration.

(C) Federal Land Bank.

(D) Federal National Mortgage Association.

(E) Government National Mortgage Association.

(iii) Direct obligations of the Commonwealth—Commonwealth general obligation bonds, debentures or notes.

(iv) Obligations of Commonwealth agencies—bonds, debentures or notes for the following:

(A) General State Authority.

(B) Highway and Bridge Authority.

(C) Public School Building Authority.

(D) Higher Education Authority.

(E) State universities.

(v) An interest-bearing deposit or a certificate of deposit in a bank, bank and trust company or savings bank chartered in this Commonwealth which is protected by the Federal Deposit Insurance Corporation.

(vi) A savings account or certificate of deposit of a savings association chartered in this Commonwealth which is protected by the Federal Savings and Loan Insurance Corporation.

(vii) United States corporations' bonds or debentures rated in one of the three highest categories by a nationally recognized securities rating organization.

(viii) Corporate preferred or common stock or shares of a corporation incorporated under the laws of the United States rated in one of the three highest categories by a nationally recognized securities rating organization.

(ix) Short term investment funds managed by major commercial banks chartered in this Commonwealth. A detailed description or listing of the components of the short term investment fund shall be furnished upon application by the health care provider and on a yearly basis thereafter. Submission of details concerning the investment fund may coincide with the financial reporting requirements set forth under § 243.4 (relating to reporting requirements for self-insurance plans).

(x) Surety bonds issued by an insurance company authorized to write surety bonds in this Commonwealth, for which the policy holders' rating and financial rating for the company is not less than A and IX, respectively, by Best's Insurance Reports. The total face amount of surety bonds issued by the insurance company may not exceed 10% of the capital and surplus of the insurance company.

(xi) Clear, irrevocable and unconditional letters of credit which may only be utilized to fund asserted claims as defined in paragraph (6).

(3) Ensure that the total market value of assets comprising the account are sufficient to meet the financial requirements applicable to self-insurance.

(4) Secure the prior approval of the Commissioner before adding an asset to the fund that is not set forth in this section.

(5) Provide that the fund contains the following amounts:

(i) In the case of a hospital plan:

(A) Upon the effective date of the self-insurance plan approved by the Commissioner, the fund shall be capitalized at a minimum of $200,000 or an amount equal to the current annual premium charged by an insurer for an occurrence-based policy covering the employes of the hospital except licensed physicians, whichever amount is greater.

(B) On the second anniversary of the effective date of the plan, the capitalization of the fund shall be $325,000 or an amount equal to the current annual premium charged by an insurer for an occurrence-based policy covering the employes of the hospital except licensed physicians, whichever amount is greater.

(C) On the third anniversary of the effective date of the plan, the capitalization of the fund shall be $500,000 or an amount equal to the current annual premium charged by an insurer for an occurrence-based policy covering the employes of the hospital except licensed physicians, whichever amount is greater.

(D) On the sixth anniversary of the effective date of the plan, the capitalization of the fund shall be $1 million.

(ii) In the case of a hospital plan which includes physicians, the Fund's capitalization requirements of subparagraph (i)(A)—(D) shall be augmented by an amount equal to the total of the annual basic coverage premiums for the physicians that would be charged by a licensed, admitted insurance carrier. If no quote or certified quote equivalent is obtainable from a licensed admitted insurance carrier, the premiums set by the Pennsylvania Joint Underwriting Association may be used.

(iii) In the case of a plan for health care providers other than hospitals, $300,000 upon the effective date of the plan; however, the amount shall be $600,000 for health care providers who conduct 50% or less of their health care business or practice, as defined in section 701(a)(2) of the act (40 P. S. § 1301.701(a)(2)), within this Commonwealth.

(6) Provide that there shall be added to the capitalization of the fund amounts equal to the potential liability, within the limits of basic insurance coverage required by the act, as estimated by procedures established by the self-insurance plan for each asserted claim against the health care provider.

(7) Provide evidence of implementation of a plan of risk management acceptable to the Commissioner, or evidence that the health care provider has implemented a previously approved plan of risk management, which may be offered on a consulting basis by an insurer or risk management consulting firm.

(8) Provide for appropriate coverage if a health care provider terminates a self-insurance plan. After notification of termination to the Department by the health care provider, the fund shall be maintained for 4 years under paragraphs (5) and (6). At the end of the 4-year period, the trustee of the fund may return to the health care provider the amounts deposited under paragraph (5). Amounts deposited under paragraph (6) shall be maintained until final disposition of those claims.

(9) Provide for an agreement that books and records pertaining to a fund, as defined in this section, shall be open for inspection by the Commissioner at reasonable times.

(10) Confer upon the Commissioner the right to require, by order of the Department, compliance by the health care provider and trustee with the trust agreement, the act and current regulations.

(11) Establish a trustee reporting system as follows:

(i) Prior to the initiation of a program year, the health care provider, based on the funding strategy which it develops for that program year, shall

provide the trustee with a letter describing the amount of funding to be achieved during that calendar year and the payment plan by which it will be achieved. This subparagraph does not require the trustee to have responsibility for establishing the correctness of the funding level to be used for a program year.

(ii) If the health care provider deviates from the plan funding strategies, it is the duty of the trustee to notify the health care provider, whereupon the health care provider will present the trustee with a reason for having deviated and a plan for adherence to the established schedule. If a deficiency is not eliminated within 60 days of the deviation from adherence to the schedule, the trustee shall promptly notify the Commissioner.

(iii) On a monthly basis, the health care provider shall provide the trustee with a report from an authorized representative of the health care provider stating the total of asserted claims reserves that should be established. It is the trustee's duty to compare the reserve levels with the corresponding amounts available in the fund for asserted claims reserves. If a deficiency exists in the amounts available, the trustee shall notify the health care provider promptly. Within 30 days, the health care provider shall in turn notify the trustee of the manner in which it intends to rectify the deficiency. If a deficiency is not eliminated within 60 days of the first notice, the trustee has the duty to notify the Commissioner.

(12) Establish a trustee investment policy to the effect that a trustee, in making or retaining investments, recognizes that the primary objective of the fund is to insure adequate liquidity of the fund for payment of professional liability claims.

(13) Provide in the trust agreement that the agreement may be amended only with the prior approval of the Department.

(14) Provide in the trust agreement that the trustee may resign only with the prior approval of the Department. The current trustee shall continue to assume the trustee duties under the trust agreement until the Department approves a successor trustee who shall assume the duties of the trust agreement.

Authority

The provisions of this § 243.3 amended under The Insurance Department Act of 1921 (40 P. S. §§ 1—321); The Insurance Company Law of 1921 (40 P. S. §§ 341—991); and sections 206, 506, 1501 and 1502 of The Administrative Code of 1929 (71 P. S. §§ 66, 186, 411 and 412); and the Health Care Services Malpractice Act (40 P. S. §§ 1301.101—1301.1006).

Source

The provisions of this § 243.3 adopted July 1, 1977, effective July 2, 1977, 7 Pa.B. 1816; renumbered February 9, 1979, 9 Pa.B. 498; amended April 13, 1979, effective April 14, 1979, 9 Pa.B. 1289; amended September 18, 1987, effective November 18, 1987, 17 Pa.B. 3742. Immediately preceding text appears at serial pages (39843) to (39845).

Cross References

This section cited in 31 Pa. Code § 243.9 (relating to government plan for self-insurance); and 31 Pa. Code § 243.11 (relating to compliance by existing self-insured hospitals).

§ 243.4. Reporting requirements for self-insurance plans.

A health care provider with an approved self-insurance plan shall report to the Commissioner not later than 6 months following the end of the hospital's fiscal year the experience of the prior fiscal year. The reports shall include the following:

(1) A certificate of acceptable audit of the self-insurance trust fund by a certified public accountant (CPA) and a copy of the CPA report.

(2) A balance sheet, an income and expense exhibit and other financial exhibits which the Commissioner may require.

(3) A comprehensive report of the risk management program of the self-insurance plan. A provider may substitute the proof of current 3-year accreditation by the Joint Commission on Accreditation of Hospitals and the current Department of Health audit showing a satisfactory status in place of the comprehensive report.

(4) Other information as the Commissioner may reasonably request.

Authority

The provisions of this § 243.4 amended under The Insurance Department Act of 1921 (40 P. S. §§ 1—321); The Insurance Company Law of 1921 (40 P. S. §§ 341—991); and sections 206, 506, 1501 and 1502 of The Administrative Code of 1929 (71 P. S. §§ 66, 186, 411 and 412); and the Health Care Services Malpractice Act (40 P. S. §§ 1301.101—1301.1006).

Source

The provisions of this § 243.4 adopted July 1, 1977, effective July 2, 1977, 7 Pa.B. 1816; renumbered February 9, 1979, 9 Pa.B. 498; amended September 18, 1987, effective November 18, 1987, 17 Pa.B. 3742. Immediately preceding text appears at serial page (39845).

Cross References

This section cited in 31 Pa. Code § 243.3 (relating to standards for self-insurance plans).

§ 243.5. Approval of risk management plan by Commissioner.

An insurance company, entity, association or other unit desiring to gain approval of a plan of risk management to which health care providers may subscribe in fulfillment of the requirements under this chapter shall submit the plan to the Commissioner for approval. Before the Commissioner will grant approval, a plan shall have the following:

(1) A complete risk management manual containing a detailed description of the operation of the plan.

(2) An established broad-based risk management committee. The committee shall at least include the risk manager, the chief executive officer or a designee from administration, the president of the medical staff or a designee who

is a member of the medical staff, the director of nursing or a designee who is a registered nurse and a member of the medical records department.

(3) A subscription to a hospital utilization project or its equivalent.

(4) A risk management monitoring system to include self audits done on a scheduled basis.

(5) An operational set of medical staff bylaws approved by the Joint Commission on Accreditation of Hospitals or the Department of Health.

Authority

The provisions of this § 243.5 amended under The Insurance Department Act of 1921 (40 P. S. §§ 1—321); The Insurance Company Law of 1921 (40 P. S. §§ 341—991); and sections 206, 506, 1501 and 1502 of The Administrative Code of 1929 (71 P. S. §§ 66, 186, 411 and 412); and the Health Care Services Malpractice Act (40 P. S. §§ 1301.101—1301.1006).

Source

The provisions of this § 243.5 adopted July 1, 1977, effective July 2, 1977, 7 Pa.B. 1816; renumbered February 9, 1979, 9 Pa.B. 498; amended September 18, 1987, effective November 18, 1987, 17 Pa.B. 3742. Immediately preceding text appears at serial page (39845).

§ 243.6. Standards for institutional plan of risk management for hospitals and nursing homes.

(a) A hospital plan of risk management shall provide for certification by the management to be made to the Commissioner of satisfactory compliance with the following:

(1) The Medical Practice Act of 1985 (63 P. S. §§ 422.1—422.45), the Osteopathic Medical Practice Act (63 P. S. §§ 271.1—271.18) or the Podiatry Practice Act (63 P. S. §§ 42.1—42.21c).

(2) The provisions for professional standards review in section 1160 of the Social Security Act (42 U.S.C.A. § 1320c-9).

(3) A 3-year accreditation by the Joint Commission on Accreditation of Hospitals.

(4) The continuing education requirements of the Pennsylvania Medical Society, the Pennsylvania Osteopathic Medical Association, the Pennsylvania Podiatry Association or their equivalent.

(b) A plan of risk management for nursing homes shall provide for certification by the management to be made to the Commissioner of satisfactory compliance with the following:

(1) Licensure provisions for long-term care facilities at 28 Pa. Code Part IV, Subpart C (relating to long term care facilities).

(2) American National Standards Institute specifications for buildings and facilities accessible to and used by the physicially handicapped and the Pennsylvania standards and specifications applicable to facilities constructed with Commonwealth funds set by sections 1—3.1 of the act of September 1, 1965

(P. L. 459, No. 235) (71 P. S. §§ 1455.1—1455.3a) and 34 Pa. Code §§ 47.111—47.131 (relating to facilities for handicapped).

Authority

The provisions of this § 243.6 amended under The Insurance Department Act of 1921 (40 P. S. §§ 1—321); The Insurance Company Law of 1921 (40 P. S. §§ 341—991); and sections 206, 506, 1501 and 1502 of The Administrative Code of 1929 (71 P. S. §§ 66, 186, 411 and 412); and the Health Care Services Malpractice Act (40 P. S. §§ 1301.101—1301.1006).

Source

The provisions of this § 243.6 adopted July 1, 1977, effective July 2, 1977, 7 Pa.B. 1816; renumbered February 9, 1979, 9 Pa.B. 498; amended April 13, 1979, effective April 14, 1979, 9 Pa.B. 1289; amended September 18, 1987, effective November 18, 1987, 17 Pa.B. 3742. Immediately preceding text appears at serial pages (39845) to (39846).

Cross References

This section cited in 22 Pa. Code § 243.7 (relating to standards for noninstitutional plan of risk management).

§ 243.7. Standards for noninstitutional plan of risk management.

For noninstitutional plans of risk management, § 243.6 (relating to standards for institutional plan of risk management for hospitals and nursing homes) applies, except for subsection (a)(3).

Authority

The provisions of this § 243.7 amended under The Insurance Department Act of 1921 (40 P. S. §§ 1—321); The Insurance Company Law of 1921 (40 P. S. §§ 341—991); and sections 206, 506, 1501 and 1502 of The Administrative Code of 1929 (71 P. S. §§ 66, 186, 411 and 412); and the Health Care Services Malpractice Act (40 P. S. §§ 1301.101—1301.1006).

Source

The provisions of this § 243.7 adopted July 1, 1977, effective July 2, 1977, 7 Pa.B. 1816; renumbered February 9, 1979, 9 Pa.B. 498; amended September 18, 1987, effective November 18, 1987, 17 Pa.B. 3742. Immediately preceding text appears at serial page (39846).

§ 243.8. [Reserved].

Source

The provisions of this § 243.8 adopted July 1, 1977, effective July 2, 1977, 7 Pa.B. 1816; renumbered February 9, 1979, 9 Pa.B. 498; reserved September 18, 1987, effective November 18, 1987, 17 Pa.B. 3742. Immediately preceding text appears at serial page (39847).

§ 243.9. Government plan for self-insurance.

A government plan of self-insurance shall meet the financial standards of this chapter for a health care provider. However, the Commissioner may waive the provisions of § 243.3 (relating to standards for self-insurance plans) upon satisfactory evidence that the elements of a sound self-insurance plan are operational,

including but not limited to the elements of financial viability, claims handling capability and plan of risk management.

Authority

The provisions of this § 243.9 issued under The Insurance Company Law of 1921 (40 P. S. §§ 341—991); and sections 206, 506, 1501 and 1502 of The Administrative Code of 1929 (71 P. S. §§ 66, 186, 411 and 412); and the Health Care Services Malpractice Act (40 P. S. §§ 1301.101—1301.1006).

Source

The provisions of this § 243.9 adopted July 1, 1977, effective July 2, 1977, 7 Pa.B. 1816; renumbered February 9, 1979, 9 Pa.B. 498.

§ 243.10. Fees and examination.

(a) A health care provider submitting an application for approval of a self-insurance plan shall reimburse the Department for actual costs incurred in the examination or approval, or both, of the plan.

(b) The health care provider is responsible for reimbursing the Department for actual costs incurred in subsequent reexamination of the self-insurance plan. The examination may be required as deemed appropriate by the Commissioner.

Authority

The provisions of this § 243.10 amended under The Insurance Department Act of 1921 (40 P. S. §§ 1—321); The Insurance Company Law of 1921 (40 P. S. §§ 341—991); and sections 206, 506, 1501 and 1502 of The Administrative Code of 1929 (71 P. S. §§ 66, 186, 411 and 412); and the Health Care Services Malpractice Act (40 P. S. §§ 1301.101—1301.1006).

Source

The provisions of this § 243.10 adopted July 1, 1977, effective July 2, 1977, 7 Pa.B. 1816; renumbered February 9, 1979, 9 Pa.B. 498; amended September 18, 1987, effective November 18, 1987, 17 Pa.B. 3742. Immediately preceding text appears at serial page (39847).

§ 243.11. Compliance by existing self-insured hospitals.

A health care provider currently operating under an approved self-insurance plan shall comply with the capitalization requirements of § 243.3 (relating to standards for self-insurance plans) by November 18, 1987. Compliance shall be attained by meeting the capitalization levels set for the corresponding years the current self-insurance plans have been in existence. For example, a self-insurance plan approved by the Commissioner in 1986 shall have at least $200,000 in its trust fund by November 18, 1987, or a plan approved in 1985 shall have at least $325,000 by November 18, 1987.

Authority

The provisions of this § 243.11 amended under The Insurance Department Act of 1921 (40 P. S. §§ 1—321); The Insurance Company Law of 1921 (40 P. S. §§ 341—991); and sections 206, 506, 1501 and 1502 of The Administrative Code of 1929 (71 P. S. §§ 66, 186, 411 and 412); and the Health Care Services Malpractice Act (40 P. S. §§ 1301.101—1301.1006).

Source

The provisions of this § 243.11 adopted September 18, 1987, effective November 18, 1987, 17 Pa.B. 3742.

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