CHAPTER 247. COVERAGE AND CLAIMS ISSUES—STATEMENT OF POLICY

Source

The provisions of this Chapter 247 adopted June 27, 1997, effective June 28, 1997, 27 Pa.B. 3061, unless otherwise noted.

§ 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 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 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.

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