Bill Summary

COMMITTEE:	Banking and Insurance	**DATE:**	6/6/13
PRIME SPONSOR:	Rafferty	**BILL NO:**	SB878
PREPARED BY:	Allison Dutrey	**PRINTER'S NO:**	971

A. Synopsis:

SB878 amends the Medical Care Availability and Reduction of Error (MCARE) Act to lock in future basic insurance coverage requirements for participating and non-participating health care providers, and hospitals.

B. Summary:

Basic insurance coverage will be as follows for policies issued/renewed in 2003 and thereafter:

- $500,000 per occurrence or claim, and $1,500,000 per annual aggregate for a health care provider that is not a hospital
- $1,000,000 per occurrence or claim, and $3,000,000 per annual aggregate for a nonparticipating health care provider
- $500,000 per occurrence or claim, and $2,500,000 per annual aggregate for a hospital

Limit of liability for the above is $500,000 per occurrence, and $1,500,000 per annual aggregate.

In 2019 and thereafter, if additional basic insurance coverage capacity is not available, basic coverage shall be:

- $750,000 per occurrence or claim, and $2,250,000 per annual aggregate for a health care provider that is not a hospital
- $1,000,000 per occurrence or claim, and $3,000,000 per annual aggregate for a nonparticipating health care provider
- $750,000 per occurrence or claim, and $3,750,000 per annual aggregate for a hospital

If basic coverage requirement is increased, the limit of liability for the above will be $250,000 per occurrence, and $750,000 per annual aggregate.

Unless the commissioner finds that additional basic insurance coverage capacity is not available, for policies issued/renewed three calendar years after the increase in coverage limits and for each calendar year thereafter, basic insurance coverage shall be:

- $1,000,000 per occurrence or claim, and $3,000,000 per annual aggregate for a health care provider that is not a hospital

- $1,000,000 per occurrence or claim, and $3,000,000 per annual aggregate for a nonparticipating health care provider

- $1,000,000 per occurrence or claim, and $4,500,000 per annual aggregate for a hospital

Limit of liability for the above: zero

The commissioner shall conduct a study every two years if basic coverage capacity is not available, and increase basic coverage if necessary.

The fund will be funded by an assessment on each participating health care provider. The assessment will be based on the prevailing primary premium for each participating health care provider and shall produce a sufficient amount. No assessment receipts or fund balances may be transferred from the fund for other purposes. Fund assessment receipts and fund balances may only be used to pay claims against the fund, administrative costs, or assessment credits. This will not be construed to validate or refute any position prior to the effective date.

The department is required to notify all basic insurance coverage insurers and self insured participating health care providers of the assessment by Nov. 1 for the succeeding calendar year. A discount on surcharges and assessments is established.

Actuarial data is compiled and required under this bill. After the filing is complete, the commissioner must submit findings to the Chairs of the Senate Banking and Insurance Committee, and the Chairs of the House Insurance Committee. The study will include an estimate of the total charge in medical professional liability insurance loss-cost resulting from this Act. Additional studies may be required if additional basic insurance coverage capacity is found and limits are increased.