S T A T E O F N E W Y O R K

882

2011-2012 Regular Sessions

I N A S S E M B L Y

(PREFILED)

January 5, 2011

Introduced by M. of A. KELLNER -- read once and referred to the Committee on Codes

AN ACT to amend chapter 266 of the laws of 1986 amending the civil practice law and rules and other laws relating to malpractice and professional medical conduct; and to amend the state finance law, in relation to creating the health care access protection fund; and to amend the insurance law, in relation to the payment of medical malpractice insurance premiums

THE PEOPLE OF THE STATE OF NEW YORK, REPRESENTED IN SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

Section 1. Legislative Intent. The legislature finds and declares that access to quality health care is a critical element to achieving and sustaining a high quality of life for all New Yorkers, and that assuring an adequate supply of physicians in New York state is an essential component to ensuring access to quality health care. As a result of rapidly rising liability insurance premiums, physicians are being forced to limit the scope of their practice, increase the number of patients they have to see each day, leave New York, or leave the practice of medicine entirely, thereby compromising patient access and/or the quality of medical care to New Yorkers. The legislature further finds that the health insurance industry has generated enormous profits and reserves far beyond that required by law. Since the payers exercise absolute control over the revenue side of most physicians' practices, it is only right and proper that some of those reserves and profits be used to reduce the burden of physicians' medical liability premiums and to ensure that reimbursement rates adequately reflect future annual increases in medical malpractice premiums to be paid by physicians.

S 2. Paragraph (a) of subdivision 1 of section 18 of chapter 266 of the laws of 1986, amending the civil practice law and rules and other laws relating to malpractice and professional medical conduct, as

EXPLANATION--Matter in ITALICS (underscored) is new; matter in brackets [ ] is old law to be omitted.

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amended by section 23 of part B of chapter 58 of the laws of 2008, is amended to read as follows:

(a) The superintendent of insurance and the commissioner of health or their designee shall, from funds available in the hospital excess liability pool created pursuant to subdivision (5) of this section, purchase a policy or policies for excess insurance coverage, as authorized by paragraph (1) of subsection (e) of section 5502 of the insurance law; or from an insurer, other than an insurer described in section 5502 of the insurance law, duly authorized to write such coverage and actually writing medical malpractice insurance in this state; or shall purchase equivalent excess coverage in a form previously approved by the superintendent of insurance for purposes of providing equivalent excess coverage in accordance with section 19 of chapter 294 of the laws of 1985, for medical or dental malpractice occurrences between July 1, 1986 and June 30, 1987, between July 1, 1987 and June 30, 1988, between July 1, 1988 and June 30, 1989, between July 1, 1989 and June 30, 1990, between July 1, 1990 and June 30, 1991, between July 1, 1991 and June 30, 1992, between July 1, 1992 and June 30, 1993, between July 1, 1993 and June 30, 1994, between July 1, 1994 and June 30, 1995, between July 1, 1995 and June 30, 1996, between July 1, 1996 and June 30, 1997, between July 1, 1997 and June 30, 1998, between July 1, 1998 and June 30, 1999, between July 1, 1999 and June 30, 2000, between July 1, 2000 and June 30, 2001, between July 1, 2001 and June 30, 2002, between July 1, 2002 and June 30, 2003, between July 1, 2003 and June 30, 2004, between July 1, 2004 and June 30, 2005, between July 1, 2005 and June 30, 2006, between July 1, 2006 and June 30, 2007, between July 1, 2007 and June 30, 2008, between July 1, 2008 and June 30, 2009, between July 1, 2009 and June 30, 2010, and between July 1, 2010 and June 30, 2011 or reimburse the hospital where the hospital purchases equivalent excess coverage as defined in subparagraph (i) of paragraph (a) of subdivision (1-a) of this section for medical or dental malpractice occurrences between July 1, 1987 and June 30, 1988, between July 1, 1988 and June 30, 1989, between July 1, 1989 and June 30, 1990, between July 1, 1990 and June 30, 1991, between July 1, 1991 and June 30, 1992, between July 1, 1992 and June 30, 1993, between July 1, 1993 and June 30, 1994, between July 1, 1994 and June 30, 1995, between July 1, 1995 and June 30, 1996, between July 1, 1996 and June 30, 1997, between July 1, 1997 and June 30, 1998, between July 1, 1998 and June 30, 1999, between July 1, 1999 and June 30, 2000, between July 1, 2000 and June 30, 2001, between July 1, 2001 and June 30, 2002, between July 1, 2002 and June 30, 2003, between July 1, 2003 and June 30, 2004, between July 1, 2004 and June 30, 2005, between July 1, 2005 and June 30, 2006, between July 1, 2006 and June 30, 2007, between July 1, 2007 and June 30, 2008, between July 1, 2008 and June 30, 2009, between July 1, 2009 and June 30, 2010, and between July 1, 2010 and June 30, 2011 for physicians or dentists certified as eligible for each such period or periods pursuant to subdivision (2) of this section by a general hospital licensed pursuant to article 28 of the public health law; provided that no single insurer shall write more than fifty percent of the total excess premium for a given policy year; and provided, however, that such eligible physicians or dentists must have in force an individual policy, from an insurer licensed in this state of primary malpractice insurance coverage in amounts of no less than one million three hundred thousand dollars for each claimant and three million nine hundred thousand dollars for all claimants under that policy during the period of such excess coverage for such occurrences or be endorsed as additional insureds under a

hospital professional liability policy which is offered through a voluntary attending physician ("channeling") program previously permitted by the superintendent of insurance during the period of such excess coverage for such occurrences. During such period, such policy for excess coverage or such equivalent excess coverage shall, when combined with the physician's or dentist's primary malpractice insurance coverage or coverage provided through a voluntary attending physician ("channeling") program, total an aggregate level of two million three hundred thousand dollars for each claimant and six million nine hundred thousand dollars for all claimants from all such policies with respect to occurrences in each of such years provided, however, if the cost of primary malpractice insurance coverage in excess of one million dollars, but below the excess medical malpractice insurance coverage provided pursuant to this act, exceeds the rate of nine percent per annum, then the required level of primary malpractice insurance coverage in excess of one million dollars for each claimant shall be in an amount of not less than the dollar amount of such coverage available at nine percent per annum; the required level of such coverage for all claimants under that policy shall be in an amount not less than three times the dollar amount of coverage for each claimant; and excess coverage, when combined with such primary malpractice insurance coverage, shall increase the aggregate level for each claimant by one million dollars and three million dollars for all claimants; and provided further, that, with respect to policies of primary medical malpractice coverage that include occurrences between April 1, 2002 and June 30, 2002, such requirement that coverage be in amounts no less than one million three hundred thousand dollars for each claimant and three million nine hundred thousand dollars for all claimants for such occurrences shall be effective April 1, 2002. PROVIDED FURTHER THAT, EFFECTIVE JULY 1, 2011, THE COST OF THE FIRST FIVE HUNDRED FIFTY THOUSAND DOLLARS OF AN ELIGIBLE PHYSICIAN'S PRIMARY MEDICAL MALPRACTICE COVERAGE SHALL BE PAID THROUGH THE HEALTH CARE ACCESS PROTECTION FUND CREATED PURSUANT TO SECTION 97-KKKK OF THE STATE FINANCE LAW.

S 3. The state finance law is amended by adding a new section 97-kkkk to read as follows:

S 97-KKKK. HEALTH CARE ACCESS PROTECTION FUND. FUNDS ACCUMULATED, INCLUDING INCOME FROM INVESTED FUNDS, FROM THE PAYMENTS SPECIFIED IN SECTIONS THREE THOUSAND TWO HUNDRED FORTY AND FOUR THOUSAND THREE HUNDRED TWENTY-EIGHT OF THE INSURANCE LAW SHALL BE DEPOSITED AND CREDITED TO A SPECIAL REVENUE FUND-OTHER FUND TO BE ESTABLISHED BY THE COMPTROLLER. TO THE EXTENT OF FUNDS APPROPRIATED THEREFOR, THE COMMISSIONER SHALL PROVIDE FUNDING FOR THE PURPOSES OF COVERING THE COST OF THE FIRST FIVE HUNDRED FIFTY THOUSAND DOLLARS OF PRIMARY MEDICAL MALPRACTICE COVERAGE OF A PHYSICIAN WHO IS ELIGIBLE TO OBTAIN EXCESS COVERAGE, AS SET FORTH PURSUANT TO PARAGRAPH (A) OF SUBDIVISION ONE OF SECTION EIGHTEEN OF CHAPTER TWO HUNDRED SIXTY-SIX OF THE LAWS OF NINETEEN HUNDRED EIGHTY-SIX.

S 4. The insurance law is amended by adding a new section 3240 to read as follows:

S 3240. LOSS RATIO PAYMENT. BEGINNING IN CALENDAR YEAR TWO THOUSAND NINE, IF THE LOSS RATIO FOR AN INDIVIDUAL HEALTH INSURANCE POLICY FORM, A SMALL GROUP HEALTH INSURANCE OR A LARGE GROUP HEALTH INSURANCE POLICY FORM IS LESS THAN EIGHTY-SEVEN PERCENT, AN INSURER SHALL PAY TO THE COMMISSIONER OF HEALTH OR SUCH COMMISSIONER'S DESIGNEE A PERCENT OF THE AGGREGATE PREMIUM COLLECTED FOR THE POLICY FORM IN THE PREVIOUS YEAR EQUAL TO THE DIFFERENCE BETWEEN THE MINIMUM LOSS RATIO FOR THE POLICY FORM STARTED IN THIS SECTION AND THE ACTUAL LOSS RATIO; PROVIDED, HOWEV-

ER, SUCH AMOUNTS SHALL BE OFFSET BY ANY AMOUNT REQUIRED TO BE RETURNED TO POLICY HOLDERS IN ACCORDANCE WITH SECTION THREE THOUSAND TWO HUNDRED THIRTY-ONE OF THIS ARTICLE. AMOUNTS DUE UNDER THIS SECTION SHALL BE PAID BY MAY FIRST OF THE YEAR FOLLOWING THE CALENDAR YEAR IN WHICH A LOSS RATIO REQUIREMENT WAS NOT SATISFIED. THE INSTRUCTIONS AND FORMAT FOR CALCULATING AND REPORTING LOSS RATIOS SHALL BE THE SAME AS THOSE THAT APPLY TO SECTION THREE THOUSAND TWO HUNDRED THIRTY-ONE OF THIS ARTICLE. THE SUPERINTENDENT SHALL HAVE AUTHORITY TO AUDIT DATA, IMPOSE PENALTIES FOR NONCOMPLIANCE WITH THIS SECTION CONSISTENT WITH AUTHORITY PROVIDED TO THE SUPERINTENDENT IN OTHER PROVISIONS OF THIS CHAPTER, AND PROMULGATE REGULATIONS TO IMPLEMENT THIS SECTION. SUCH SUMS SHALL BE DIRECTED TO THE HEALTH CARE ACCESS PROTECTION FUND SET FORTH PURSUANT TO SECTION NINETY-SEVEN-KKKK OF THE STATE FINANCE LAW. FOR THE PURPOSES OF THIS SECTION, THE TERM "LOSS RATIO" SHALL MEAN ALL FUNDS EXPENDED DIRECTLY FOR THE PURPOSES OF REIMBURSING MEDICAL CARE, INCLUDING CARE PROVIDED BY PHYSICIANS AND OTHER HEALTH CARE PROFESSIONALS, HOSPITALS, NURSING HOMES, HOME CARE, PRESCRIPTION DRUGS AND DURABLE MEDICAL EQUIPMENT, PROVIDED TO INSUREDS COVERED UNDER AN INDIVIDUAL HEALTH INSURANCE POLICY FORM, A SMALL GROUP HEALTH INSURANCE POLICY FORM OR A LARGE GROUP HEALTH INSURANCE POLICY FORM, AS A PERCENTAGE OF REVENUE DERIVED BY SUCH INSURER FOR SUCH POLICY FORM.

S 5. The insurance law is amended by adding a new section 4328 to read as follows:

S 4328. LOSS RATIO PAYMENT. BEGINNING IN CALENDAR YEAR TWO THOUSAND NINE, IF THE LOSS RATIO FOR AN INDIVIDUAL DIRECT PAYMENT CONTRACT FORM, A SMALL GROUP OR A SMALL GROUP REMITTANCE CONTRACT FORM OR A LARGE GROUP CONTRACT FORM IS LESS THAN EIGHTY-SEVEN PERCENT, A CORPORATION SUBJECT TO THE PROVISIONS OF THIS ARTICLE SHALL PAY TO THE COMMISSIONER OF HEALTH OR SUCH COMMISSIONER'S DESIGNEE A PERCENT OF THE AGGREGATE PREMIUMS EARNED FOR THE CONTRACT FORM IN THE PREVIOUS CALENDAR YEAR EQUAL TO THE DIFFERENCE BETWEEN THE MINIMUM LOSS RATIO FOR THE POLICY FORM AS STATED IN THIS SECTION AND THE ACTUAL LOSS RATIO; PROVIDED, HOWEVER, THAT SUCH AMOUNT SHALL BE OFFSET BY ANY AMOUNT REQUIRED TO BE RETURNED TO CONTRACT HOLDERS IN ACCORDANCE WITH SECTION FOUR THOUSAND THREE HUNDRED EIGHT OF THIS ARTICLE. AMOUNTS DUE UNDER THIS SECTION SHALL BE PAID BY MAY FIRST OF THE YEAR FOLLOWING THE CALENDAR YEAR IN WHICH THE LOSS RATIO REQUIREMENT WAS NOT SATISFIED. THE INSTRUCTIONS AND FORMAT FOR CALCULATING AND REPORTING LOSS RATIOS SHALL BE THE SAME AS THOSE THAT APPLY TO SECTION FOUR THOUSAND THREE HUNDRED EIGHT OF THIS ARTICLE. THE SUPERINTENDENT SHALL HAVE AUTHORITY TO AUDIT DATA, IMPOSE PENALTIES FOR NONCOMPLIANCE WITH THIS SECTION CONSISTENT WITH AUTHORITY PROVIDED TO THE SUPERINTENDENT IN OTHER PROVISIONS OF THIS CHAPTER, AND PROMULGATE REGULATIONS TO IMPLEMENT THIS SECTION. SUCH FUNDS SHALL BE DIRECTED TO THE HEALTH CARE ACCESS PROTECTION FUND ESTABLISHED PURSUANT TO SECTION NINETY-SEVEN-KKKK OF THE STATE FINANCE LAW. FOR THE PURPOSES OF THIS SECTION, THE TERM "LOSS RATIO" SHALL MEAN ALL FUNDS EXPENDED DIRECTLY FOR THE PURPOSES OF REIMBURSING MEDICAL CARE, INCLUDING CARE PROVIDED BY PHYSICIANS AND OTHER HEALTH CARE PROFESSIONALS, HOSPITALS, NURSING HOMES, HOME CARE, PRESCRIPTION DRUGS AND DURABLE MEDICAL EQUIPMENT, PROVIDED TO INSUREDS COVERED UNDER AN INDIVIDUAL DIRECT PAYMENT CONTRACT FORM, A SMALL GROUP OR SMALL GROUP REMITTANCE CONTRACT FORM OR A LARGE GROUP CONTRACT FORM, AS A PERCENTAGE OF REVENUE DERIVED BY SUCH INSURER FOR SUCH POLICY FORM.

S 6. The insurance law is amended by adding a new section 3224-d to read as follows:

S 3224-D. PHYSICIAN REIMBURSEMENT. (A) IF THE SUPERINTENDENT APPROVES AN INCREASE IN THE COST OF MEDICAL MALPRACTICE INSURANCE COVERAGE FOR PHYSICIANS AND SURGEONS, BY SEPTEMBER FIRST OF EACH YEAR IN WHICH SUCH INCREASE IS APPROVED, A HEALTH PLAN SHALL INCREASE ITS FEE SCHEDULE FOR PHYSICIAN REIMBURSEMENT BY A PERCENTAGE EQUAL TO OR GREATER THAN A PERCENTAGE AS DETERMINED BY THE SUPERINTENDENT TO BE THE INCREASE IN PHYSICIAN OFFICE EXPENSE ALLOCABLE TO THE INCREASE IN THE COST OF A MEDICAL MALPRACTICE INSURANCE POLICY APPROVED BY THE SUPERINTENDENT FOR THE POLICY YEAR BEGINNING THE PREVIOUS JULY FIRST. THE SUPERINTENDENT SHALL HAVE THE AUTHORITY TO ESTABLISH SEPARATE PERCENTAGES BASED UPON REGION OR SPECIALTY OF PRACTICE.

(B) AN INSURER'S, ORGANIZATION'S OR CORPORATION'S PURPOSEFUL OR KNOWING FAILURE TO INCLUDE SUCH INCREASE IN ITS FEE SCHEDULE FOR EACH PHYSICIAN FOR THE CONTRACT CYCLE NEXT FOLLOWING OR FAILURE TO INCLUDE SUCH INCREASE IN FUTURE REIMBURSEMENT FOR OUT OF NETWORK SERVICES WILL BE ASSESSED A MONETARY PENALTY OF ONE MILLION DOLLARS FOR EACH AFFECTED PHYSICIAN.

(C) NOTHING IN THIS SECTION SHALL BE CONSTRUED: (1) TO PREVENT A HEALTH PLAN FROM INCREASING ITS FEE SCHEDULE IN A PERCENTAGE GREATER THAN THE PERCENTAGE AS DETERMINED BY THE SUPERINTENDENT TO BE THE INCREASE IN PHYSICIAN OFFICE EXPENSE ALLOCABLE TO THE INCREASE IN THE COST OF A MEDICAL MALPRACTICE INSURANCE POLICY APPROVED BY THE SUPERINTENDENT FOR THE POLICY YEAR BEGINNING THE PREVIOUS JULY FIRST; OR

(2) TO REQUIRE THE IMPOSITION OF A DECREASE IN PHYSICIAN REIMBURSEMENT AS A RESULT OF AN AVERAGE RATE DECREASE FOR MEDICAL MALPRACTICE INSURANCE COVERAGE APPROVED BY THE SUPERINTENDENT.

(D) FOR THE PURPOSES OF THIS SECTION, A "HEALTH PLAN" SHALL BE DEFINED AS AN INSURER THAT IS LICENSED TO WRITE ACCIDENT AND HEALTH INSURANCE, OR THAT IS LICENSED PURSUANT TO ARTICLE FORTY-THREE OF THIS CHAPTER OR IS CERTIFIED PURSUANT TO ARTICLE FORTY-FOUR OF THE PUBLIC HEALTH LAW.

S 7. This act shall take effect immediately; provided that the amendments to chapter 266 of the laws of 1986 made by section one of this act shall apply to physician malpractice insurance policies issued on or after July 1, 2011.