AN ACT

Reforming the law on medical professional liability; providing for patient safety and reporting; establishing the Patient Safety Authority and the Patient Safety Trust Fund; abrogating regulations; providing for medical professional liability informed consent, damages, expert qualifications, limitations of actions and medical records; establishing the Interbranch Commission on Venue; providing for medical professional liability insurance; establishing the Medical Care Availability and Reduction of Error Fund; providing for medical professional liability claims; establishing the Joint Underwriting Association; regulating medical professional liability insurance; providing for medical licensure regulation; providing for administration; imposing penalties; and making repeals.

TABLE OF CONTENTS

The General Assembly of the Commonwealth of Pennsylvania hereby enacts as follows:

CHAPTER 1
PRELIMINARY PROVISIONS

Section 101. Short title.

This act shall be known and may be cited as the Medical Care Availability and Reduction of Error (Mcare) Act.

Section 102. Declaration of policy.

The General Assembly finds and declares as follows:

(1) It is the purpose of this act to ensure that medical care is available in this Commonwealth through a comprehensive and high-quality health care system.

(2) Access to a full spectrum of hospital services and to highly trained physicians in all specialties must be available across this Commonwealth.

(3) To maintain this system, medical professional liability insurance has to be obtainable at an affordable and reasonable cost in every geographic region of this Commonwealth.

(4) A person who has sustained injury or death as a result of medical negligence by a health care provider must be afforded a prompt determination and fair compensation.

(5) Every effort must be made to reduce and eliminate medical errors by identifying problems and implementing solutions that promote patient safety.

(6) Recognition and furtherance of all of these elements is essential to the public health, safety and welfare of all the citizens of Pennsylvania.

Section 103. Definitions.

The following words and phrases when used in this act shall have the meanings given to them in this section unless the context clearly indicates otherwise:

"Birth center." An entity licensed as a birth center under the act of July 19, 1979 (P.L.130, No.48), known as the Health Care Facilities Act.

"Claimant." A patient, including a patient's immediate family, guardian, personal representative or estate.

"Commissioner." The Insurance Commissioner of the Commonwealth.

"Guardian." A fiduciary who has the care and management of the estate or person of a minor or an incapacitated person.

"Health care provider." A primary health care center or a person, including a corporation, university or other educational institution licensed or approved by the Commonwealth to provide health care or professional medical services as a physician, a certified nurse midwife, a podiatrist, hospital, nursing home, birth center and, except as to section 711(a), an officer, employee or agent of any of them acting in the course and scope of employment.

"Hospital." An entity licensed as a hospital under the act of June 13, 1967 (P.L.31, No.21), known as the Public Welfare Code, or the act of July 19, 1979 (P.L.130, No.48), known as the Health Care Facilities Act.

"Immediate family." A parent, a spouse, a child or an adult sibling residing in the same household.

"Medical professional liability action." Any proceeding in which a medical professional liability claim is asserted, including an action in a court of law or an arbitration proceeding.

"Medical professional liability claim." Any claim seeking the recovery of damages or loss from a health care provider arising out of any tort or breach of contract causing injury or death resulting from the furnishing of health care services which were or should have been provided.

"Nursing home." An entity licensed as a nursing home under the act of July 19, 1979 (P.L.130, No.48), known as the Health Care Facilities Act.

"Patient." A natural person who receives or should have received health care from a health care provider.

"Personal representative." An executor or administrator of a patient's estate.

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

Section 104. Liability of nonqualifying health care providers.

Any person rendering services normally rendered by a health care provider who fails to qualify as a health care provider under this act is subject to liability under the law without regard to the provisions of this act.

Section 105. Provider not a warrantor or guarantor.

In the absence of a special contract in writing, a health care provider is neither a warrantor nor a guarantor of a cure.

CHAPTER 3
PATIENT SAFETY

Section 301. Scope.

This chapter relates to the reduction of medical errors for the purpose of ensuring patient safety.

Section 302. Definitions.

The following words and phrases when used in this chapter shall have the meanings given to them in this section unless the context clearly indicates otherwise:

"Ambulatory surgical facility." An entity defined as an ambulatory surgical facility under the act of July 19, 1979 (P.L.130, No.48), known as the Health Care Facilities Act.

"Authority." The Patient Safety Authority established in section 303.

"Board." The board of directors of the Patient Safety Authority.

"Department." The Department of Health of the Commonwealth.

"Fund." The Patient Safety Trust Fund established in section 305.

"Health care worker." An employee, independent contractor, licensee or other individual authorized to provide services in a medical facility.

"Incident." An event, occurrence or situation involving the clinical care of a patient in a medical facility which could have injured the patient but did not either cause an unanticipated injury or require the delivery of additional health care services to the patient. The term does not include a serious event.

"Infrastructure." Structures related to the physical plant and service delivery systems necessary for the provision of health care services in a medical facility.

"Infrastructure failure." An undesirable or unintended event, occurrence or situation involving the infrastructure of a medical facility or the discontinuation or significant disruption of a service which could seriously compromise patient safety.

"Licensee." An individual who is all of the following:

(1) Licensed or certified by the department or the Department of State to provide professional services in this Commonwealth.

(2) Employed by or authorized to provide professional services in a medical facility.

"Medical facility." An ambulatory surgical facility, birth center or hospital.

"Patient safety officer." An individual designated by a medical facility under section 309.

"Serious event." An event, occurrence or situation involving the clinical care of a patient in a medical facility that results in death or compromises patient safety and results in an unanticipated injury requiring the delivery of additional health care services to the patient. The term does not include an incident.

Section 303. Establishment of Patient Safety Authority.

(a) Establishment.--There is established a body corporate and politic to be known as the Patient Safety Authority. The powers and duties of the authority shall be vested in and exercised by a board of directors.

(b) Composition.--The board of the authority shall consist of 11 members composed and appointed in accordance with the following:

(1) The Physician General or a physician appointed by the Governor if there is no appointed Physician General.

(2) Four residents of this Commonwealth, one of whom shall be appointed by the President pro tempore of the Senate, one of whom shall be appointed by the Minority Leader of the Senate, one of whom shall be appointed by the Speaker of the House of Representatives and one of whom shall be appointed by the Minority Leader of the House of Representatives, who shall serve terms coterminous with their respective appointing

authorities.

(3) A health care worker residing in this Commonwealth who is a physician and is appointed by the Governor, who shall serve an initial term of three years.

(4) A health care worker residing in this Commonwealth who is licensed by the Department of State as a nurse and is appointed by the Governor, who shall serve an initial term of three years.

(5) A health care worker residing in this Commonwealth who is licensed by the Department of State as a pharmacist and is appointed by the Governor, who shall serve an initial term of two years.

(6) A health care worker residing in this Commonwealth who is employed by a hospital and is appointed by the Governor, who shall serve an initial term of two years.

(7) Two residents of this Commonwealth, one of whom is a health care worker and one of whom is not a health care worker, appointed by the Governor, who shall each serve a term of four years.

(c) Terms.--With the exception of paragraphs (1) and (2), members of the board shall serve for terms of four years after completion of the initial terms designated in subsection (b) and shall not be eligible to serve more than two full consecutive terms.

(d) Quorum.--A majority of the members of the board shall constitute a quorum. Notwithstanding any other provision of law, action may be taken by the board at a meeting upon a vote of the majority of its members present in person or through the use of amplified telephonic equipment if authorized by the bylaws of the board.

(e) Meetings.--The board shall meet at the call of the chairperson or as may be provided in the bylaws of the board. The board shall hold meetings at least quarterly, which shall be subject to the requirements of 65 Pa.C.S. Ch. 7 (relating to open meetings). Meetings of the board may be held anywhere within this Commonwealth.

(f) Chairperson.--The chairperson shall be the person appointed under subsection (b)(1).

(g) Formation.--The authority shall be formed within 60 days of the effective date of this section.

Section 304. Powers and duties.

(a) General rule.--The authority shall do all of the following:

(1) Adopt bylaws necessary to carry out the provisions of this chapter.

(2) Employ staff as necessary to implement this chapter.

(3) Make, execute and deliver contracts and other instruments.

(4) Apply for, solicit, receive, establish priorities for, allocate, disburse, contract for, administer and spend funds in the fund and other funds that are made available to the authority from any source consistent with the purposes of this chapter.

(5) Contract with a for-profit or registered nonprofit entity or entities, other than a health care provider, to do the following:

(i) Collect, analyze and evaluate data regarding reports of serious events and incidents, including the identification of performance indicators and patterns in frequency or severity at certain medical facilities or in certain regions of this Commonwealth.

(ii) Transmit to the authority recommendations for changes in health care practices and procedures which may be instituted for the purpose of reducing the number and severity of serious events and incidents.

(iii) Directly advise reporting medical facilities of immediate changes that can be instituted to reduce serious events and incidents.

(iv) Conduct reviews in accordance with subsection (b).

(6) Receive and evaluate recommendations made by the entity or entities contracted with in accordance with paragraph (5) and report those recommendations to the department, which shall have no more than 30 days to approve or disapprove the recommendations.

(7) After consultation and approval by the department, issue recommendations to medical facilities on a facility-specific or on a Statewide basis regarding changes, trends and improvements in health care practices and procedures for the purpose of reducing the number and severity of serious events and incidents. Prior

to issuing recommendations, consideration shall be given to the following factors that include expectation of improved quality care, implementation feasibility, other relevant implementation practices and the cost impact to patients, payors and medical facilities. Statewide recommendations shall be issued to medical facilities on a continuing basis and shall be published and posted on the department's and the authority's publicly accessible World Wide Web site.

(8) Meet with the department for purposes of implementing this chapter.

(b) Anonymous reports to the authority.--A health care worker who has complied with section 308(a) may file an anonymous report regarding a serious event with the authority. Upon receipt of the report, the authority shall give notice to the affected medical facility that a report has been filed. The authority shall conduct its own review of the report unless the medical facility has already commenced an investigation of the serious event. The medical facility shall provide the authority with the results of its investigation no later than 30 days after receiving notice pursuant to this subsection. If the authority is dissatisfied with the adequacy of the investigation conducted by the medical facility, the authority shall perform its own review of the serious event and may refer a medical facility and any involved licensee to the department for failure to report pursuant to section 313(e) and (f).

(c) Annual report to General Assembly.--

(1) The authority shall report no later than May 1, 2003, and annually thereafter to the department and the General Assembly on the authority's activities in the preceding year. The report shall include:

(i) A schedule of the year's meetings.

(ii) A list of contracts entered into pursuant to this section, including the amounts awarded to each contractor.

(iii) A summary of the fund receipts and expenditures, including a financial statement and balance sheet.

(iv) The number of serious events and incidents reported by medical facilities on a geographical basis.

(v) The information derived from the data collected, including any recognized trends concerning patient safety.

(vi) The number of anonymous reports filed and reviews conducted by the authority.

(vii) The number of referrals to licensure boards for failure to report under this chapter.

(viii) Recommendations for statutory or regulatory changes which may help improve patient safety in the Commonwealth.

(2) The report shall be distributed to the Secretary of Health, the chair and minority chair of the Public Health and Welfare Committee of the Senate and the chair and minority chair of the Health and Human Services Committee of the House of Representatives.

(3) The annual report shall be made available for public inspection and shall be posted on the authority's publicly accessible World Wide Web site.

Section 305. Patient Safety Trust Fund.

(a) Establishment.--There is hereby established a separate account in the State Treasury to be known as the Patient Safety Trust Fund. The fund shall be administered by the authority. All interest earned from the investment or deposit of moneys accumulated in the fund shall be deposited in the fund for the same use.

(b) Funds.--All moneys deposited into the fund shall be held in trust and shall not be considered general revenue of the Commonwealth but shall be used only to effectuate the purposes of this chapter as determined by the authority.

(c) Assessment.--Commencing July 1, 2002, each medical facility shall pay the department a surcharge on its licensing fee as necessary to provide sufficient revenues to operate the authority. The total assessment for all medical facilities shall not exceed $5,000,000. The department shall transfer the total assessment amount to the fund within 30 days of receipt.

(d) Base amount.--For each succeeding calendar year, the department shall determine and assess each medical facility its proportionate share of the authority's budget. The total

assessment amount shall not exceed $5,000,000 in fiscal year 2002-2003 and shall be increased according to the Consumer Price Index in each succeeding fiscal year.

(e) Expenditures.--Moneys in the fund shall be expended by the authority to implement this chapter.

(f) Dissolution.--In the event that the fund is discontinued or the authority is dissolved by operation of law, any balance remaining in the fund, after deducting administrative costs of liquidation, shall be returned to the medical facilities in proportion to their financial contributions to the fund in the preceding licensing period.

(g) Failure to pay surcharge.--If, after 30 days' notice, a medical facility fails to pay a surcharge levied by the department under this chapter, the department may assess an administrative penalty of $1,000 per day until the surcharge is paid.

Section 306. Department responsibilities.

(a) General rule.--The department shall do all of the following:

(1) Review and approve patient safety plans in accordance with section 307.

(2) Receive reports of serious events and infrastructure failures under section 313.

(3) Investigate serious events and infrastructure failures.

(4) In conjunction with the authority, analyze and evaluate existing health care procedures and approve recommendations issued by the authority pursuant to section 304(a)(6) and (7).

(5) Meet with the authority for purposes of implementing this chapter.

(b) Department consideration.--The recommendations made to medical facilities pursuant to subsection (a)(4) may be considered by the department for licensure purposes under the act of July 19, 1979 (P.L.130, No.48), known as the Health Care Facilities Act, but shall not be considered mandatory unless adopted by the department as regulations pursuant to the act of June 25, 1982 (P.L.633, No.181), known as the Regulatory Review Act.

Section 307. Patient safety plans.

(a) Development and compliance.--A medical facility shall develop, implement and comply with an internal patient safety plan that shall be established for the purpose of improving the health and safety of patients. The plan shall be developed in consultation with the licensees providing health care services in the medical facility.

(b) Requirements.--A patient safety plan shall:

(1) Designate a patient safety officer as set forth in section 309.

(2) Establish a patient safety committee as set forth in section 310.

(3) Establish a system for the health care workers of a medical facility to report serious events and incidents which shall be accessible 24 hours a day, seven days a week.

(4) Prohibit any retaliatory action against a health care worker for reporting a serious event or incident in accordance with the act of December 12, 1986 (P.L.1559, No.169), known as the Whistleblower Law.

(5) Provide for written notification to patients in accordance with section 308(b).

(c) Approval.--Within 60 days from the effective date of this section, a medical facility shall submit its patient safety plan to the department for approval consistent with the requirements of this section. Unless the department approves or rejects the plan within 60 days of receipt, the plan shall be deemed approved.

(d) Employee notification.--Upon approval of the patient safety plan, a medical facility shall notify all health care workers of the medical facility of the patient safety plan. Compliance with the patient safety plan shall be required as a condition of employment or credentialing at the medical facility.

Section 308. Reporting and notification.

(a) Reporting.--A health care worker who reasonably believes that a serious event or incident has occurred shall report the serious event or incident according to the patient safety plan of the medical facility unless the health care worker knows that a report has already been made. The report shall be made immediately or as soon thereafter as reasonably practicable, but in no event later than 24 hours after the occurrence or discovery of a serious event or incident.

(b) Duty to notify patient.--A medical facility through an appropriate designee shall

provide written notification to a patient affected by a serious event or, with the consent of the patient, to an available family member or designee within seven days of the occurrence or discovery of a serious event. If the patient is unable to give consent, the notification shall be given to an adult member of the immediate family. If an adult member of the immediate family cannot be identified or located, notification shall be given to the closest adult family member. For unemancipated patients who are under 18 years of age, the parent or guardian shall be notified in accordance with this subsection. The notification requirements of this subsection shall not be subject to the provisions of section 311(a). Notification under this subsection shall not constitute an acknowledgment or admission of liability.

(c) Liability.--A health care worker who reports the occurrence of a serious event or incident in accordance with subsection (a) or (b) shall not be subject to any retaliatory action for reporting the serious event or incident and shall have the protections and remedies set forth in the act of December 12, 1986 (P.L.1559, No.169), known as the Whistleblower Law.

(d) Limitation.--Nothing in this section shall limit a medical facility's ability to take appropriate disciplinary action against a health care worker for failure to meet defined performance expectations or to take corrective action against a licensee for unprofessional conduct, including making false reports or failure to report serious events under this chapter.

Section 309. Patient safety officer.

A patient safety officer of a medical facility shall do all of the following:

(1) Serve on the patient safety committee.

(2) Ensure the investigation of all reports of serious events and incidents.

(3) Take such action as is immediately necessary to ensure patient safety as a result of any investigation.

(4) Report to the patient safety committee regarding any action taken to promote patient safety as a result of investigations commenced pursuant to this section.

Section 310. Patient safety committee.

(a) Composition.--

(1) A hospital's patient safety committee shall be composed of the medical facility's patient safety officer and at least three health care workers of the medical facility and two residents of the community served by the medical facility who are not agents, employees or contractors of the medical facility. No more than one member of the patient safety committee shall be a member of the medical facility's board of trustees. The committee shall include members of the medical facility's medical and nursing staff. The committee shall meet at least monthly.

(2) An ambulatory surgical facility's or birth center's patient safety committee shall be composed of the medical facility's patient safety officer and at least one health care worker of the medical facility and one resident of the community served by the ambulatory surgical facility or birth center who is not an agent, employee or contractor of the ambulatory surgical facility or birth center. No more than one member of the patient safety committee shall be a member of the medical facility's board of governance. The committee shall include members of the medical facility's medical and nursing staff. The committee shall meet at least quarterly.

(b) Responsibilities.--A patient safety committee of a medical facility shall do all of the following:

(1) Receive reports from the patient safety officer pursuant to section 309.

(2) Evaluate investigations and actions of the patient safety officer on all reports.

(3) Review and evaluate the quality of patient safety measures utilized by the medical facility. A review shall include the consideration of reports made under sections 304(a)(5) and (b), 307(b)(3) and 308(a).

(4) Make recommendations to eliminate future serious events and incidents.

(5) Report to the administrative officer and governing body of the medical facility on a quarterly basis regarding the number of serious events and incidents and

its recommendations to eliminate future serious events and incidents.

Section 311. Confidentiality and compliance.

(a) Prepared materials.--Any documents, materials or information solely prepared or created for the purpose of compliance with section 310(b) or of reporting under section 304(a)(5) or (b), 306(a)(2) or (3), 307(b)(3), 308(a), 309(4), 310(b)(5) or 313 which arise out of matters reviewed by the patient safety committee pursuant to section 310(b) or the governing board of a medical facility pursuant to section 310(b) are confidential and shall not be discoverable or admissible as evidence in any civil or administrative action or proceeding. Any documents, materials, records or information that would otherwise be available from original sources shall not be construed as immune from discovery or use in any civil or administrative action or proceeding merely because they were presented to the patient safety committee or governing board of a medical facility.

(b) Meetings.--No person who performs responsibilities for or participates in meetings of the patient safety committee or governing board of a medical facility pursuant to section 310(b) shall be allowed to testify as to any matters within the knowledge gained by the person's responsibilities or participation on the patient safety committee or governing board of a medical facility, provided, however, the person shall be allowed to testify as to any matters within the person's knowledge which was gained outside of the persons's responsibilities or participation on the patient safety committee or governing board of a medical facility pursuant to section 310(b).

(c) Applicability.--The confidentiality protections set forth in subsections (a) and (b) shall only apply to the documents, materials or information prepared or created pursuant to the responsibilities of the patient safety committee or governing board of a medical facility set forth in section 310(b).

(d) Received materials.--Except as set forth in subsection (f), any documents, materials or information received by the authority or department from the medical facility, health care worker, patient safety committee or governing board of a medical facility solely prepared or created for the purpose of compliance with section 310(b) or of reporting under section 304(a)(5) or (b), 306(a)(2) or (3), 307(b)(3), 308(a), 309(4), 310(b)(5) or 313 shall not be discoverable or admissible as evidence in any civil or administrative action or proceeding. Any records received by the authority or department from the medical facility, health care worker, patient safety committee or governing board of a medical facility pursuant to the requirements of this act shall not be discoverable from the department or the authority in any civil or administrative action or proceeding. Documents, materials, records or information may be used by the authority or department to comply with the reporting requirements under subsection (f) and section 304(a)(7) or (c) or 306(b).

(e) Document review.--

(1) Except as set forth in paragraph (2), no current or former employee of the authority, the department or the Department of State shall be allowed to testify as to any matters gained by reason of his or her review of documents, materials, records or information submitted to the authority by the medical facility or health care worker pursuant to the requirements of this act.

(2) Paragraph (1) does not apply to findings or actions by the department or the Department of State which are public records.

(f) Access.--

(1) The department shall have access to the information under section 313(a) or (c) and may use such information for the sole purpose of any licensure or corrective action against a medical facility. This exemption to use the information received pursuant to section 313(a) or (c) shall only apply to licensure or corrective actions and shall not be utilized to permit the disclosure of any information obtained under section 313(a) or (c) for any other purpose.

(2) The Department of State shall have access to the information under section 313(a) and may use such information for the sole purpose of any licensure or disciplinary action against a health care worker. This exemption to use the information received pursuant to section 313(a) shall only apply to licensure or disciplinary actions and shall not be utilized to permit the disclosure of any information obtained under section 313(a) for any other purpose.

(g) Original source document.--In the event an original source document as set forth in

subsection (a) is determined by a court of competent jurisdiction to be unavailable from the health care worker or medical facility in a civil action or proceeding, then in that circumstance alone the department may be required pursuant to a court order to release that original source document to the party identified in the court order.

(h) Right-to-know requests.--Any documents, materials or information made confidential by subsection (a) shall not be subject to requests under the act of June 21, 1957 (P.L.390, No.212), referred to as the Right-to-Know Law.

(i) Liability.--Notwithstanding any other provision of law, no person providing information or services to the patient safety committee, governing board of a medical facility, authority or department shall be held by reason of having provided such information or services to have violated any criminal law, or to be civilly liable under any law, unless such information is false and the person providing such information knew or had reason to believe that such information was false and was motivated by malice toward any person directly affected by such action.

Section 312. Patient safety discount.

A medical facility may make application to the department for certification of any program that is recommended by the authority that results in the reduction of serious events at that facility. The department, in consultation with the Insurance Department, shall develop the criteria for such certification. Insurers shall file with the Insurance Department a discount in the rate or rates applicable for mandated basic insurance coverage to reflect the initiation of a certified program. The Insurance Department shall review all filings in accordance with the act of June 11, 1947 (P.L.538, No.246), known as The Casualty and Surety Rate Regulatory Act. A medical facility shall receive a discount in the rate or rates applicable for mandated basic insurance coverage required by law, consistent with the level of such discount approved by the Insurance Department. In reviewing filings under this section, the commissioner shall consider whether and the extent to which the program certified under this section is otherwise covered under a program of risk management offered by an insurance company or exchange or self-insurance plan providing medical professional liability coverage.

Section 313. Medical facility reports and notifications.

(a) Serious event reports.--A medical facility shall report the occurrence of a serious event to the department and the authority within 24 hours of the medical facility's confirmation of the occurrence of the serious event. The report to the department and the authority shall be in the form and manner prescribed by the authority in consultation with the department and shall not include the name of any patient or any other identifiable individual information.

(b) Incident reports.--A medical facility shall report the occurrence of an incident to the authority in a form and manner prescribed by the authority and shall not include the name of any patient or any other identifiable individual information.

(c) Infrastructure failure reports.--A medical facility shall report the occurrence of an infrastructure failure to the department within 24 hours of the medical facility's confirmation of the occurrence or discovery of the infrastructure failure. The report to the department shall be in the form and manner prescribed by the department.

(d) Effect of report.--Compliance with this section by a medical facility shall satisfy the reporting requirements of the act of July 19, 1979 (P.L.130, No.48), known as the Health Care Facilities Act.

(e) Notification to licensure boards.--If a medical facility discovers that a licensee providing health care services in the medical facility during a serious event failed to report the event in accordance with section 308(a), the medical facility shall notify the licensee's licensing board of the failure to report.

(f) Failure to report or notify.--Failure to report a serious event or an infrastructure failure as required by this section or to develop and comply with the patient safety plan in accordance with section 307 or to notify the patient in accordance with section 308(b) shall be a violation of the Health Care Facilities Act. In addition to any penalty which may be imposed under the Health Care Facilities Act, a medical facility which fails to report a serious event or an infrastructure failure or to notify a licensure board in accordance with this chapter may be subject to an administrative penalty of $1,000 per day imposed by the department.

(g) Report submission.--Within 30 days following notice published pursuant to section 5103, a medical facility shall begin reporting serious events, incidents and infrastructure failures consistent with the requirements of this section.

Section 314. Existing regulations.

The provisions of 28 Pa. Code § 51.3(f) and (g) (relating to notification) shall be abrogated with respect to a medical facility upon the reporting of a serious event, incident or infrastructure failure pursuant to section 313.

CHAPTER 5
MEDICAL PROFESSIONAL LIABILITY

Section 501. Scope.

This chapter relates to medical professional liability.

Section 502. Declaration of policy.

The General Assembly finds and declares that it is the purpose of this chapter to ensure a fair legal process and reasonable compensation for persons injured due to medical negligence in this Commonwealth. Ensuring the future availability of and access to quality health care is a fundamental responsibility that the General Assembly must fulfill as a promise to our children, our parents and our grandparents.

Section 503. Definitions.

The following words and phrases when used in this chapter shall have the meanings given to them in this section unless the context clearly indicates otherwise:

"Commission." The Interbranch Commission on Venue established in section 514.

"Department." The Insurance Department of the Commonwealth.

"Health care provider." A primary health care center, a personal care home licensed by the Department of Public Welfare pursuant to the act of June 13, 1967 (P.L.31, No.21), known as the Public Welfare Code, or a person, including a corporation, university or other educational institution licensed or approved by the Commonwealth to provide health care or professional medical services as a physician, a certified nurse midwife, a podiatrist, hospital, nursing home, birth center, and an officer, employee or agent of any of them acting in the course and scope of employment.

"Informed consent." The consent of a patient to the performance of a procedure in accordance with section 504.

Section 504. Informed consent.

(a) Duty of physicians.--Except in emergencies, a physician owes a duty to a patient to obtain the informed consent of the patient or the patient's authorized representative prior to conducting the following procedures:

(1) Performing surgery, including the related administration of anesthesia.

(2) Administering radiation or chemotherapy.

(3) Administering a blood transfusion.

(4) Inserting a surgical device or appliance.

(5) Administering an experimental medication, using an experimental device or using an approved medication or device in an experimental manner.

(b) Description of procedure.--Consent is informed if the patient has been given a description of a procedure set forth in subsection (a) and the risks and alternatives that a reasonably prudent patient would require to make an informed decision as to that procedure. The physician shall be entitled to present evidence of the description of that procedure and those risks and alternatives that a physician acting in accordance with accepted medical standards of medical practice would provide.

(c) Expert testimony.--Expert testimony is required to determine whether the procedure constituted the type of procedure set forth in subsection (a) and to identify the risks of that procedure, the alternatives to that procedure and the risks of these alternatives.

(d) Liability.--

(1) A physician is liable for failure to obtain the informed consent only if the patient proves that receiving such information would have been a substantial factor in the patient's decision whether to undergo a procedure set forth in subsection (a).

(2) A physician may be held liable for failure to seek a patient's informed consent if the physician knowingly misrepresents to the patient his or her professional

credentials, training or experience.

Section 505. Punitive damages.

(a) Award.--Punitive damages may be awarded for conduct that is the result of the health care provider's willful or wanton conduct or reckless indifference to the rights of others. In assessing punitive damages, the trier of fact can properly consider the character of the health care provider's act, the nature and extent of the harm to the patient that the health care provider caused or intended to cause and the wealth of the health care provider.

(b) Gross negligence.--A showing of gross negligence is insufficient to support an award of punitive damages.

(c) Vicarious liability.--Punitive damages shall not be awarded against a health care provider who is only vicariously liable for the actions of its agent that caused the injury unless it can be shown by a preponderance of the evidence that the party knew of and allowed the conduct by its agent that resulted in the award of punitive damages.

(d) Total amount of damages.--Except in cases alleging intentional misconduct, punitive damages against an individual physician shall not exceed 200% of the compensatory damages awarded. Punitive damages, when awarded, shall not be less than $100,000 unless a lower verdict amount is returned by the trier of fact.

(e) Allocation.--Upon the entry of a verdict including an award of punitive damages, the punitive damages portion of the award shall be allocated as follows:

(1) 75% shall be paid to the prevailing party; and

(2) 25% shall be paid to the Medical Care Availability and Reduction of Error Fund.

Section 506. Affidavit of noninvolvement.

(a) General provisions.--Any health care provider named as a defendant in a medical professional liability action may cause the action against that provider to be dismissed upon the filing of an affidavit of noninvolvement with the court. The affidavit of noninvolvement shall set forth with particularity the facts which demonstrate that the provider was misidentified or otherwise not involved, individually or through its servants or employees, in the care and treatment of the claimant and was not obligated, either individually or through its servants or employees, to provide for the care and treatment of the claimant.

(b) Statute of limitations.--The filing of an affidavit of noninvolvement by a health care provider shall have the effect of tolling the statute of limitations as to that provider with respect to the claim at issue as of the date of the filing of the original pleading.

(c) Challenge.--A codefendant or claimant shall have the right to challenge an affidavit of noninvolvement by filing a motion and submitting an affidavit which contradicts the assertions of noninvolvement made by the health care provider in the affidavit of noninvolvement.

(d) False or inaccurate filing or statement.--If the court determines that a health care provider named as a defendant falsely files or makes false or inaccurate statements in an affidavit of noninvolvement, the court upon motion or upon its own initiative shall immediately reinstate the claim against that provider. In any action where the health care provider is found by the court to have knowingly filed a false or inaccurate affidavit of noninvolvement, the court shall impose upon the person who signed the affidavit or represented the party, or both, an appropriate sanction, including, but not limited to, an order to pay to the other party or parties the amount of the reasonable expenses incurred because of the filing of the false affidavit, including a reasonable attorney fee.

Section 507. Advance payments.

No advance payment made by the health care provider or the provider's basic coverage insurance carrier to or for the claimant shall be construed as an admission of liability for injuries or damages suffered by the claimant. Notwithstanding section 508, evidence of an advance payment shall not be admissible by a claimant in a medical professional liability action.

Section 508. Collateral sources.

(a) General rule.--Except as set forth in subsection (d), a claimant in a medical professional liability action is precluded from recovering damages for past medical expenses or past lost earnings incurred to the time of trial to the extent that the loss is covered

by a private or public benefit or gratuity that the claimant has received prior to trial.

(b) Option.--The claimant has the option to introduce into evidence at trial the amount of medical expenses actually incurred, but the claimant shall not be permitted to recover for such expenses as part of any verdict except to the extent that the claimant remains legally responsible for such payment.

(c) No subrogation.--Except as set forth in subsection (d), there shall be no right of subrogation or reimbursement from a claimant's tort recovery with respect to a public or private benefit covered in subsection (a).

(d) Exceptions.--The collateral source provisions set forth in subsection (a) shall not apply to the following:

(1) Life insurance, pension or profit-sharing plans or other deferred compensation plans, including agreements pertaining to the purchase or sale of a business.

(2) Social Security benefits.

(3) Cash or medical assistance benefits which are subject to repayment to the Department of Public Welfare.

(4) Public benefits paid or payable under a program which under Federal statute provides for right of reimbursement which supersedes State law for the amount of benefits paid from a verdict or settlement.

Section 509. Payment of damages.

(a) General rule.--In a medical professional liability action, the trier of fact shall make a determination with separate findings for each claimant specifying the amount of all of the following:

(1) Except as provided for under section 508, past damages for:

(i) medical and other related expenses in a lump sum;

(ii) loss of earnings in a lump sum; and

(iii) noneconomic loss in a lump sum.

(2) Future damages for:

(i) medical and other related expenses by year;

(ii) loss of earnings or earning capacity in a lump sum; and

(iii) noneconomic loss in a lump sum.

(b) Future damages.--

(1) Except as set forth in paragraph (8), future damages for medical and other related expenses shall be paid as periodic payments after payment of the proportionate share of counsel fees and costs based upon the present value of the future damages awarded pursuant to this subsection. The trier of fact may vary the amount of periodic payments for future damages as set forth in subsection (a)(2)(i) from year to year for the expected life of the claimant to account for different annual expenditure requirements, including the immediate needs of the claimant. The trier of fact shall also provide for purchase and replacement of medically necessary equipment in the years that expenditures will be required as may be necessary.

(2) The trier of fact may incorporate into any future medical expense award adjustments to account for reasonably anticipated inflation and medical care improvements as presented by competent evidence.

(3) Future damages as set forth in subsection (a)(2)(i) shall be paid in the years that the trier of fact finds they will accrue. Unless the court orders or approves a different schedule for payment, the annual amounts due must be paid in equal quarterly installments rounded to the nearest dollar. Each installment is due and payable on the first day of the month in which it accrues.

(4) Interest does not accrue on a periodic payment before payment is due. If the payment is not made on or before the due date, the legal rate of interest accrues as of that date.

(5) Liability to a claimant for periodic payments not yet due for medical expenses terminates upon the claimant's death.

(6) Each party liable for all or a portion of the judgment shall provide funding for the awarded periodic payments, separately or jointly with one or more others, by means of an annuity contract, trust or other qualified funding plan which is approved by the court. The commissioner shall annually publish a list of insurers

designated by the commissioner as qualified to participate in the funding of periodic payment judgments. No annuity contractor may be placed on the commissioner's list of insurers unless the insurer has received the highest rating for claims paying ability by two independent financial services within the last 12 months.

(7) If an insurer defaults on a required periodic payment due to insolvency, the claimant shall be entitled to receive the payment from the Medical Care Availability and Reduction of Error Fund or, if the fund has ceased operations, from the Pennsylvania Life and Health Insurance Guaranty Association or the Property and Casualty Insurance Guaranty Association, whichever is applicable.

(8) Future damages for medical and other related expenses shall not be awarded in periodic payments if the claimant objects and stipulates that the total amount of the future damages for medical and other related expenses, without reduction to present value, does not exceed $100,000.

(c) Effect of full funding.--If full funding of an award pursuant to this section has been provided, the judgment is discharged, and any outstanding liens as a result of the judgment are released.

(d) Retained jurisdiction.--The court which enters judgment shall retain jurisdiction to enforce the judgment and to resolve related disputes.

Section 510. Reduction to present value.

Future damages for loss of earnings or earning capacity in a medical professional liability action shall be reduced to present value based upon the return that the claimant can earn on a reasonably secure fixed income investment. These damages shall be presented with competent evidence of the effect of productivity and inflation over time. The trier of fact shall determine the applicable discount rate based upon competent evidence.

Section 511. Preservation and accuracy of medical records.

(a) Timing.--Entries in patient charts concerning care rendered shall be made contemporaneously or as soon as practicable. Except as otherwise provided for in this section, it shall be considered unprofessional conduct and a violation of the applicable licensing statute to make alterations to a patient's chart.

(b) Corrections and disposal of records.--It shall not be considered unprofessional conduct or a violation of the applicable licensing statute for a health care provider to:

(1) Correct information on a patient's chart where information has been entered erroneously or where it is necessary to clarify entries made on the chart, provided that such corrections or additions shall be clearly identified as subsequent entries by a date and time.

(2) Add information to a patient's chart where it was not available at the time the record was first created, provided that:

(i) Such additions shall be clearly dated as subsequent entries.

(ii) A health care provider may add supplemental information within a reasonable time.

(3) Routinely dispose of medical records as permitted by law.

(c) Alteration of records.--In any medical professional liability action in which the claimant proves by a preponderance of the evidence that there has been an intentional alteration or destruction of medical records, the court in its discretion may instruct the jury to consider whether such intentional alteration or destruction constitutes an adverse inference.

(d) Licensure sanction.--Alteration or destruction of medical records for the purpose of eliminating information that would give rise to a medical professional liability action on the part of a health care provider shall constitute a ground for suspension. A health care provider who is aware of alteration or destruction in violation of this section shall report any party suspected of such conduct to the appropriate licensure board.

Section 512. Expert qualifications.

(a) General rule.--No person shall be competent to offer an expert medical opinion in a medical professional liability action against a physician unless that person possesses sufficient education, training, knowledge and experience to provide credible, competent testimony and fulfills the additional qualifications set forth in this section as applicable.

(b) Medical testimony.--An expert testifying on a medical matter, including the

standard of care, risks and alternatives, causation and the nature and extent of the injury, must meet the following qualifications:

(1) Possess an unrestricted physician's license to practice medicine in any state or the District of Columbia.

(2) Be engaged in or retired within the previous five years from active clinical practice or teaching. Provided, however, the court may waive the requirements of this subsection for an expert on a matter other than the standard of care if the court determines that the expert is otherwise competent to testify about medical or scientific issues by virtue of education, training or experience.

(c) Standard of care.--In addition to the requirements set forth in subsections (a) and (b), an expert testifying as to a physician's standard of care also must meet the following qualifications:

(1) Be substantially familiar with the applicable standard of care for the specific care at issue as of the time of the alleged breach of the standard of care.

(2) Practice in the same subspecialty as the defendant physician or in a subspecialty which has a substantially similar standard of care for the specific care at issue, except as provided in subsection (d) or (e).

(3) In the event the defendant physician is certified by an approved board, be board certified by the same or a similar approved board, except as provided in subsection (e).

(d) Care outside specialty.--A court may waive the same subspecialty requirement for an expert testifying on the standard of care for the diagnosis or treatment of a condition if the court determines that:

(1) the expert is trained in the diagnosis or treatment of the condition, as applicable; and

(2) the defendant physician provided care for that condition and such care was not within the physician's specialty or competence.

(e) Otherwise adequate training, experience and knowledge.--A court may waive the same specialty and board certification requirements for an expert testifying as to a standard of care if the court determines that the expert possesses sufficient training, experience and knowledge to provide the testimony as a result of active involvement in or full-time teaching of medicine in the applicable subspecialty or a related field of medicine within the previous five-year time period.

Section 513. Statute of repose.

(a) General rule.--Except as provided in subsection (b) or (c), no cause of action asserting a medical professional liability claim may be commenced after seven years from the date of the alleged tort or breach of contract.

(b) Injuries caused by foreign object.--If the injury is or was caused by a foreign object unintentionally left in the individual's body, the limitation in subsection (a) shall not apply.

(c) Injuries of minors.--No cause of action asserting a medical professional liability claim may be commenced by or on behalf of a minor after seven years from the date of the alleged tort or breach of contract or after the minor attains the age of 20 years, whichever is later.

(d) Death or survival actions.--If the claim is brought under 42 Pa.C.S. § 8301 (relating to death action) or 8302 (relating to survival action), the action must be commenced within two years after the death in the absence of affirmative misrepresentation or fraudulent concealment of the cause of death.

(e) Applicability.--No cause of action barred prior to the effective date of this section shall be revived by reason of the enactment of this section.

(f) Definition.--For purposes of this section, a "minor" is an individual who has not yet attained the age of 18 years.

Section 514. Interbranch Commission on Venue.

(a) Declaration of policy.--The General Assembly further recognizes that recent changes in the health care delivery system have necessitated a revamping of the corporate structure for various medical facilities and hospitals across this Commonwealth. This has unduly expanded the reach and scope of existing venue rules. Training of new physicians in many geographic regions has also been severely restricted by the resultant expansion of venue

applicability rules. These physicians and health care institutions are essential to maintaining the high quality of health care that our citizens have come to expect.

(b) Establishment of Interbranch Commission on Venue.--The Interbranch Commission on Venue for actions relating to medical professional liability is established as follows:

(1) The commission shall consist of the following members:

(i) The Chief Justice of the Supreme Court or a designee of the Chief Justice.

(ii) The chairperson of the Civil Procedural Rules Committee, who shall serve as the chairperson of the commission.

(iii) A judge of a court of common pleas appointed by the Chief Justice.

(iv) The Attorney General or a designee of the Attorney General.

(v) The General Counsel.

(vi) Two attorneys at law appointed by the Governor.

(vii) Four individuals, one each appointed by the:

(A) President pro tempore of the Senate;

(B) Minority Leader of the Senate;

(C) Speaker of the House of Representatives; and

(D) Minority Leader of the House of Representatives.

(2) The commission has the following functions:

(i) To review and analyze the issue of venue as it relates to medical professional liability actions filed in this Commonwealth.

(ii) To report, by September 1, 2002, to the General Assembly and the Supreme Court on the results of the review and analysis. The report shall include recommendations for such legislative action or the promulgation of rules of court on the issue of venue as the commission shall determine to be appropriate.

(3) The commission shall expire September 1, 2002.

Section 515. Remittitur.

(a) General rule.--In any case in which a defendant health care provider challenges a verdict on grounds of excessiveness, the trial court shall, in deciding a motion for remittitur, consider evidence of the impact, if any, upon availability or access to health care in the community if the defendant health care provider is required to satisfy the verdict rendered by the jury.

(b) Factors and evidence.--A trial court denying a motion for remittitur shall specifically set forth the factors and evidence it considered with respect to the impact of the verdict upon availability or access to health care in the community.

(c) Abuse of discretion.--An appellate court reviewing a lower court's denial of remittitur may find an abuse of discretion if evidence of the impact of paying the verdict upon availability and access to health care in the community has not been adequately considered by the lower court.

(d) Limit of security.--A trial court or appellate court may limit or reduce the amount of security that a defendant health care provider must post to prevent execution if the court finds that requiring a bond in excess of the limits of available insurance coverage would effectively deny the right to appeal.

Section 516. Ostensible agency.

(a) Vicarious liability.--A hospital may be held vicariously liable for the acts of another health care provider through principles of ostensible agency only if the evidence shows that:

(1) a reasonably prudent person in the patient's position would be justified in the belief that the care in question was being rendered by the hospital or its agents; or

(2) the care in question was advertised or otherwise represented to the patient as care being rendered by the hospital or its agents.

(b) Staff privileges.--Evidence that a physician holds staff privileges at a hospital shall be insufficient to establish vicarious liability through principles of ostensible agency unless the claimant meets the requirements of subsection (a)(1) or (2).

CHAPTER 7

SUBCHAPTER A
PRELIMINARY PROVISIONS

Compiler's Note: Section 4(a) of Act 44 of 2003 provided that Subchapter A is repealed insofar as it relates to health care providers that conduct less than 50% of their health care business or practice within this Commonwealth.

Section 701. Scope.

This chapter relates to medical professional liability insurance.

Section 702. Definitions.

The following words and phrases when used in this chapter shall have the meanings given to them in this section unless the context clearly indicates otherwise:

"Basic insurance coverage." The limits of medical professional liability insurance required under section 711(d).

"Claims made." Medical professional liability insurance that insures those claims made or reported during a period which is insured and excludes coverage for a claim reported subsequent to the period even if the claim resulted from an occurrence during the period which was insured.

"Claims period." The period from September 1 to the following August 31.

"Deficit." A joint underwriting association loss which exceeds the sum of earned premiums collected by the joint underwriting association and investment income.

"Department." The Insurance Department of the Commonwealth.

"Fund." The Medical Care Availability and Reduction of Error (Mcare) Fund established in section 712.

"Fund coverage limits." The coverage provided by the Medical Care Availability and Reduction of Error Fund under section 712.

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

"Health care business or practice." The number of patients to whom health care services are rendered by a health care provider within an annual period.

"Health care provider." A participating health care provider or nonparticipating health care provider.

"Joint underwriting association." The Pennsylvania Professional Liability Joint Underwriting Association established in section 731.

"Joint underwriting association loss." The sum of the administrative expenses, taxes, losses, loss adjustment expenses, unearned premiums and reserves, including reserves for losses incurred and losses incurred but not reported, of the joint underwriting association.

"Licensure authority." The State Board of Medicine, the State Board of Osteopathic Medicine, the State Board of Podiatry, the Department of Public Welfare and the Department of Health.

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

"Nonparticipating health care provider." A health care provider as defined in section 103 that conducts 20% or less of its health care business or practice within this Commonwealth.

"Participating health care provider." A health care provider as defined in section 103 that conducts more than 20% of its health care business or practice within this Commonwealth or a nonparticipating health care provider who chooses to participate in the fund.

"Prevailing primary premium." The schedule of occurrence rates approved by the commissioner for the joint underwriting association.

SUBCHAPTER B FUND

Compiler's Note: Section 4(a) of Act 44 of 2003 provided that Subchapter B is repealed insofar as it relates to health care providers that conduct less than 50% of their health care business or practice within this Commonwealth.

Section 711. Medical professional liability insurance.

(a) Requirement.--A health care provider providing health care services in this Commonwealth shall:

(1) purchase medical professional liability insurance from an insurer which is licensed or approved by the department; or

(2) provide self-insurance.

(b) Proof of insurance.--A health care provider required by subsection (a) to purchase medical professional liability insurance or provide self-insurance shall submit proof of insurance or self-insurance to the department within 60 days of the policy being issued.

(c) Failure to provide proof of insurance.--If a health care provider fails to submit the proof of insurance or self-insurance required by subsection (b), the department shall, after providing the health care provider with notice, notify the health care provider's licensing authority. A health care provider's license shall be suspended or revoked by its licensure board or agency if the health care provider fails to comply with any of the provisions of this chapter.

(d) Basic coverage limits.--A health care provider shall insure or self-insure medical professional liability in accordance with the following:

(1) For policies issued or renewed in the calendar year 2002, the basic insurance coverage shall be:

(i) $500,000 per occurrence or claim and $1,500,000 per annual aggregate for a health care provider who conducts more than 50% of its health care business or practice within this Commonwealth and that is not a hospital.

(ii) $500,000 per occurrence or claim and $1,500,000 per annual aggregate for a health care provider who conducts 50% or less of its health care business or practice within this Commonwealth.

(iii) $500,000 per occurrence or claim and $2,500,000 per annual aggregate for a hospital.

(2) For policies issued or renewed in the calendar years 2003, 2004 and 2005, the basic insurance coverage shall be:

(i) $500,000 per occurrence or claim and $1,500,000 per annual aggregate for a participating health care provider that is not a hospital.

(ii) $1,000,000 per occurrence or claim and $3,000,000 per annual aggregate for a nonparticipating health care provider.

(iii) $500,000 per occurrence or claim and $2,500,000 per annual aggregate for a hospital.

(3) Unless the commissioner finds pursuant to section 745(a) that additional basic insurance coverage capacity is not available, for policies issued or renewed in calendar year 2006 and each year thereafter subject to paragraph (4), the basic insurance coverage shall be:

(i) $750,000 per occurrence or claim and $2,250,000 per annual aggregate for a participating health care provider that is not a hospital.

(ii) $1,000,000 per occurrence or claim and $3,000,000 per annual aggregate for a nonparticipating health care provider.

(iii) $750,000 per occurrence or claim and $3,750,000 per annual aggregate for a hospital.

If the commissioner finds pursuant to section 745(a) that additional basic insurance coverage capacity is not available, the basic insurance coverage requirements shall remain at the level required by paragraph (2); and the commissioner shall conduct a study every two years until the commissioner finds that additional basic insurance coverage capacity is available, at which time the commissioner shall increase the required basic insurance coverage in accordance with this paragraph.

(4) Unless the commissioner finds pursuant to section 745(b) that additional basic insurance coverage capacity is not available, for policies issued or renewed three years after the increase in coverage limits required by paragraph (3) and

for each year thereafter, the basic insurance coverage shall be:

(i) $1,000,000 per occurrence or claim and $3,000,000 per annual aggregate for a participating health care provider that is not a hospital.

(ii) $1,000,000 per occurrence or claim and $3,000,000 per annual aggregate for a nonparticipating health care provider.

(iii) $1,000,000 per occurrence or claim and $4,500,000 per annual aggregate for a hospital.

If the commissioner finds pursuant to section 745(b) that additional basic insurance coverage capacity is not available, the basic insurance coverage requirements shall remain at the level required by paragraph (3); and the commissioner shall conduct a study every two years until the commissioner finds that additional basic insurance coverage capacity is available, at which time the commissioner shall increase the required basic insurance coverage in accordance with this paragraph.

(e) Fund participation.--A participating health care provider shall be required to participate in the fund.

(f) Self-insurance.--

(1) If a health care provider self-insures its medical professional liability, the health care provider shall submit its self-insurance plan, such additional information as the department may require and the examination fee to the department for approval.

(2) The department shall approve the plan if it determines that the plan constitutes protection equivalent to the insurance required of a health care provider under subsection (d).

(g) Basic insurance liability.--

(1) An insurer providing medical professional liability insurance shall not be liable for payment of a claim against a health care provider for any loss or damages awarded in a medical professional liability action in excess of the basic insurance coverage required by subsection (d) unless the health care provider's medical professional liability insurance policy or self-insurance plan provides for a higher limit.

(2) If a claim exceeds the limits of a participating health care provider's basic insurance coverage or self-insurance plan, the fund shall be responsible for payment of the claim against the participating health care provider up to the fund liability limits.

(h) Excess insurance.--

(1) No insurer providing medical professional liability insurance with liability limits in excess of the fund's liability limits to a participating health care provider shall be liable for payment of a claim against the participating health care provider for a loss or damages in a medical professional liability action except the losses and damages in excess of the fund coverage limits.

(2) No insurer providing medical professional liability insurance with liability limits in excess of the fund's liability limits to a participating health care provider shall be liable for any loss resulting from the insolvency or dissolution of the fund.

(i) Governmental entities.--A governmental entity may satisfy its obligations under this chapter, as well as the obligations of its employees to the extent of their employment, by either purchasing medical professional liability insurance or assuming an obligation as a self-insurer, and paying the assessments under this chapter.

(j) Exemptions.--The following participating health care providers shall be exempt from this chapter:

(1) A physician who exclusively practices the specialty of forensic pathology.

(2) A participating health care provider who is a member of the Pennsylvania military forces while in the performance of the member's assigned duty in the Pennsylvania military forces under orders.

(3) A retired licensed participating health care provider who provides care only to the provider or the provider's immediate family members.

Section 712. Medical Care Availability and Reduction of Error Fund.

(a) Establishment.--There is hereby established within the State Treasury a special fund to be known as the Medical Care Availability and Reduction of Error Fund. Money in the fund shall be used to pay claims against participating health care providers for losses or damages awarded in medical professional liability actions against them in excess of the basic insurance coverage required by section 711(d), liabilities transferred in accordance with subsection (b) and for the administration of the fund.

(b) Transfer of assets and liabilities.--

(1) (i) The money in the Medical Professional Liability Catastrophe Loss Fund established under section 701(d) of the former act of October 15, 1975 (P.L.390, No.111), known as the Health Care Services Malpractice Act, is transferred to the fund.

(ii) The rights of the Medical Professional Liability Catastrophe Loss Fund established under section 701(d) of the former Health Care Services Malpractice Act are transferred to and assumed by the fund.

(2) The liabilities and obligations of the Medical Professional Liability Catastrophe Loss Fund established under section 701(d) of the former Health Care Services Malpractice Act are transferred to and assumed by the fund.

(c) Fund liability limits.--

(1) For calendar year 2002, the limit of liability of the fund created in section 701(d) of the former Health Care Services Malpractice Act for each health care provider that conducts more than 50% of its health care business or practice within this Commonwealth and for each hospital shall be $700,000 for each occurrence and $2,100,000 per annual aggregate.

(2) The limit of liability of the fund for each participating health care provider shall be as follows:

(i) For calendar year 2003 and each year thereafter, the limit of liability of the fund shall be $500,000 for each occurrence and $1,500,000 per annual aggregate.

(ii) If the basic insurance coverage requirement is increased in accordance with section 711(d)(3) and, notwithstanding subparagraph (i), for each calendar year following the increase in the basic insurance coverage requirement, the limit of liability of the fund shall be $250,000 for each occurrence and $750,000 per annual aggregate.

(iii) If the basic insurance coverage requirement is increased in accordance with section 711(d)(4) and, notwithstanding subparagraphs (i) and (ii), for each calendar year following the increase in the basic insurance coverage requirement, the limit of liability of the fund shall be zero.

(d) Assessments.--

(1) For calendar year 2003 and for each year thereafter, the fund shall be funded by an assessment on each participating health care provider. Assessments shall be levied by the department on or after January 1 of each year. The assessment shall be based on the prevailing primary premium for each participating health care provider and shall, in the aggregate, produce an amount sufficient to do all of the following:

(i) Reimburse the fund for the payment of reported claims which became final during the preceding claims period.

(ii) Pay expenses of the fund incurred during the preceding claims period.

(iii) Pay principal and interest on moneys transferred into the fund in accordance with section 713(c).

(iv) Provide a reserve that shall be 10% of the sum of subparagraphs (i), (ii) and (iii).

(2) The department shall notify all basic insurance coverage insurers and self-insured participating health care providers of the assessment by November 1 for the succeeding calendar year.

(3) Any appeal of the assessment shall be filed with the department.

(e) Discount on surcharges and assessments.--

(1) For calendar year 2002, the department shall discount the aggregate surcharge imposed under section 701(e)(1) of the Health Care Services Malpractice Act by

5% of the aggregate surcharge imposed under that section for calendar year 2001 in accordance with the following:

(i) Fifty percent of the aggregate discount shall be granted equally to hospitals and to participating health care providers that were surcharged as members of one of the four highest rate classes of the prevailing primary premium.

(ii) Notwithstanding subparagraph (i), 50% of the aggregate discount shall be granted equally to all participating health care providers.

(iii) The department shall issue a credit to a participating health care provider who, prior to the effective date of this section, has paid the surcharge imposed under section 701(e)(1) of the former Health Care Services Malpractice Act for calendar year 2002 prior to the effective date of this section.

(2) For calendar years 2003 and 2004, the department shall discount the aggregate assessment imposed under subsection (d) for each calendar year by 10% of the aggregate surcharge imposed under section 701(e)(1) of the former Health Care Services Malpractice Act for calendar year 2001 in accordance with the following:

(i) Fifty percent of the aggregate discount shall be granted equally to hospitals and to participating health care providers that were assessed as members of one of the four highest rate classes of the prevailing primary premium.

(ii) Notwithstanding subparagraph (i), 50% of the aggregate discount shall be granted equally to all participating health care providers.

(3) For calendar years 2005 and thereafter, if the basic insurance coverage requirement is increased in accordance with section 711(d)(3) or (4), the department may discount the aggregate assessment imposed under subsection (d) by an amount not to exceed the aggregate sum to be deposited in the fund in accordance with subsection (m).

(f) Updated rates.--The joint underwriting association shall file updated rates for all health care providers with the commissioner by May 1 of each year. The department shall review and may adjust the prevailing primary premium in line with any applicable changes which have been approved by the commissioner.

(g) Additional adjustments of the prevailing primary premium.--The department shall adjust the applicable prevailing primary premium of each participating health care provider in accordance with the following:

(1) The applicable prevailing primary premium of a participating health care provider which is not a hospital may be adjusted through an increase in the individual participating health care provider's prevailing primary premium not to exceed 20%. Any adjustment shall be based upon the frequency of claims paid by the fund on behalf of the individual participating health care provider during the past five most recent claims periods and shall be in accordance with the following:

(i) If three claims have been paid during the past five most recent claims periods by the fund, a 10% increase shall be charged.

(ii) If four or more claims have been paid during the past five most recent claims periods by the fund, a 20% increase shall be charged.

(2) The applicable prevailing primary premium of a participating health care provider which is not a hospital and which has not had an adjustment under paragraph (1) may be adjusted through an increase in the individual participating health care provider's prevailing primary premium not to exceed 20%. Any adjustment shall be based upon the severity of at least two claims paid by the fund on behalf of the individual participating health care provider during the past five most recent claims periods.

(3) The applicable prevailing primary premium of a participating health care provider not engaged in direct clinical practice on a full-time basis may be adjusted through a decrease in the individual participating health care provider's prevailing primary premium not to exceed 10%. Any adjustment shall be based upon the lower risk associated with the less-than-full-time direct clinical practice.

(4) The applicable prevailing primary premium of a hospital may be adjusted through an increase or decrease in the individual hospital's prevailing primary premium

not to exceed 20%. Any adjustment shall be based upon the frequency and severity of claims paid by the fund on behalf of other hospitals of similar class, size, risk and kind within the same defined region during the past five most recent claims periods.

(h) Self-insured health care providers.--A participating health care provider that has an approved self-insurance plan shall be assessed an amount equal to the assessment imposed on a participating health care provider of like class, size, risk and kind as determined by the department.

(i) Change in basic insurance coverage.--If a participating health care provider changes the term of its medical professional liability insurance coverage, the assessment shall be calculated on an annual basis and shall reflect the assessment percentages in effect for the period over which the policies are in effect.

(j) Payment of claims.--Claims which became final during the preceding claims period shall be paid on or before December 31 following the August 31 on which they became final.

(k) Termination.--Upon satisfaction of all liabilities of the fund, the fund shall terminate. Any balance remaining in the fund upon such termination shall be returned by the department to the participating health care providers who participated in the fund in proportion to their assessments in the preceding calendar year.

(l) Sole and exclusive source of funding.--Except as provided in subsection (m), the surcharges imposed under section 701(e)(1) of the Health Care Services Malpractice Act and assessments on participating health care providers and any income realized by investment or reinvestment shall constitute the sole and exclusive sources of funding for the fund. Nothing in this subsection shall prohibit the fund from accepting contributions from nongovernmental sources. A claim against or a liability of the fund shall not be deemed to constitute a debt or liability of the Commonwealth or a charge against the General Fund.

(m) Supplemental funding.--Notwithstanding the provisions of 75 Pa.C.S. § 6506(b) (relating to surcharge) to the contrary, beginning January 1, 2004, and for a period of nine calendar years thereafter, all surcharges levied and collected under 75 Pa.C.S. § 6506(a) by any division of the unified judicial system shall be remitted to the Commonwealth for deposit in the Medical Care Availability and Restriction of Error Fund. These funds shall be used to reduce surcharges and assessments in accordance with subsection (e). Beginning January 1, 2014, and each year thereafter, the surcharges levied and collected under 75 Pa.C.S. § 6506(a) shall be deposited into the General Fund.

(n) Waiver of right to consent to settlement.--A participating health care provider may maintain the right to consent to a settlement in a basic insurance coverage policy for medical professional liability insurance upon the payment of an additional premium amount.

Compiler's Note: Section 4(a) of Act 44 of 2003 provided that subsection (e)(2) and (3) are repealed insofar as it relates to physicians and certified nurse midwives.

Section 713. Administration of fund.

(a) General rule.--The fund shall be administered by the department. The department shall contract with an entity or entities for the administration of claims against the fund in accordance with 62 Pa.C.S. (relating to procurement), and, to the fullest extent practicable, the department shall contract with entities that:

(1) Are not writing, underwriting or brokering medical professional liability insurance for participating health care providers; however, the department may contract with a subsidiary or affiliate of any writer, underwriter or broker of medical professional liability insurance.

(2) Are not trade organizations or associations representing the interests of participating health care providers in this Commonwealth.

(3) Have demonstrable knowledge of and experience in the handling and adjusting of professional liability or other catastrophic claims.

(4) Have developed, instituted and utilized best practice standards and systems for the handling and adjusting of professional liability or other catastrophic claims.

(5) Have demonstrable knowledge of and experience with the professional liability marketplace and the judicial systems of this Commonwealth.

(b) Reinsurance.--The department may purchase, on behalf of and in the name of the

fund, as much insurance or reinsurance as is necessary to preserve the fund or retire the liabilities of the fund.

(c) Transfers.--The Governor may transfer to the fund from the Catastrophic Loss Benefits Continuation Fund, or such other funds as may be appropriate, such money as is necessary in order to pay the liabilities of the fund until sufficient revenues are realized by the fund. Any transfer made under this subsection shall be repaid with interest pursuant to section 2 of the act of August 22, 1961 (P.L.1049, No.479), entitled "An act authorizing the State Treasurer under certain conditions to transfer sums of money between the General Fund and certain funds and subsequent transfers of equal sums between such funds, and making appropriations necessary to effect such transfers."

(d) Confidentiality.--Information provided to the department or maintained by the department regarding a claim or adjustments to an individual participating health care provider's assessment shall be confidential, notwithstanding the act of June 21, 1957 (P.L.390, No.212), referred to as the Right-to-Know Law, or 65 Pa.C.S. Ch. 7 (relating to open meetings).

Section 714. Medical professional liability claims.

(a) Notification.--A basic coverage insurer or self-insured participating health care provider shall promptly notify the department in writing of any medical professional liability claim.

(b) Failure to notify.--If a basic coverage insurer or self-insured participating health care provider fails to notify the department as required under subsection (a) and the department has been prejudiced by the failure of notice, the insurer or provider shall be solely responsible for the payment of the entire award or verdict that results from the medical professional liability claim.

(c) Defense.--A basic coverage insurer or self-insured participating health care provider shall provide a defense to a medical professional liability claim, including a defense of any potential liability of the fund, except as provided for in section 715. The department may join in the defense and be represented by counsel.

(d) Responsibilities.--In accordance with section 713, the department may defend, litigate, settle or compromise any medical professional liability claim payable by the fund.

(e) Releases.--In the event that a basic coverage insurer or self-insured participating health care provider enters into a settlement with a claimant to the full extent of its liability as provided in this chapter, it may obtain a release from the claimant to the extent of its payment, which payment shall have no effect upon any claim against the fund or its duty to continue the defense of the claim.

(f) Adjustment.--The department may adjust claims.

(g) Mediation.--Upon the request of a party to a medical professional liability claim within the fund coverage limits, the department may provide for a mediator in instances where multiple carriers disagree on the disposition or settlement of a case. Upon the consent of all parties, the mediation shall be binding. Proceedings conducted and information provided in accordance with this section shall be confidential and shall not be considered public information subject to disclosure under the act of June 21, 1957 (P.L.390, No.212), referred to as the Right-to-Know Law, or 65 Pa.C.S. Ch. 7 (relating to open meetings).

(h) Delay damages and postjudgment interest.--Delay damages and postjudgment interest applicable to the fund's liability on a medical professional liability claim shall be paid by the fund and shall not be charged against the participating health care provider's annual aggregate limits. The basic coverage insurer or self-insured participating health care provider shall be responsible for its proportionate share of delay damages and postjudgment interest.

Section 715. Extended claims.

(a) General rule.--If a medical professional liability claim against a health care provider who was required to participate in the Medical Professional Liability Catastrophe Loss Fund under section 701(d) of the act of October 15, 1975 (P.L.390, No.111), known as the Health Care Services Malpractice Act, is made more than four years after the breach of contract or tort occurred and if the claim is filed within the applicable statute of limitations, the claim shall be defended by the department if the department received a written request for indemnity and defense within 180 days of the date on which notice of the

claim is first given to the participating health care provider or its insurer. Where multiple treatments or consultations took place less than four years before the date on which the health care provider or its insurer received notice of the claim, the claim shall be deemed for purposes of this section to have occurred less than four years prior to the date of notice and shall be defended by the insurer in accordance with this chapter.

(b) Payment.--If a health care provider is found liable for a claim defended by the department in accordance with subsection (a), the claim shall be paid by the fund. The limit of liability of the fund for a claim defended by the department under subsection (a) shall be $1,000,000 per occurrence.

(c) Concealment.--If a claim is defended by the department under subsection (a) or paid under subsection (b) and the claim is made after four years because of the willful concealment by the health care provider or its insurer, the fund shall have the right to full indemnity, including the department's defense costs, from the health care provider or its insurer.

(d) Extended coverage required.--Notwithstanding subsections (a), (b) and (c), all medical professional liability insurance policies issued on or after January 1, 2006, shall provide indemnity and defense for claims asserted against a health care provider for a breach of contract or tort which occurs four or more years after the breach of contract or tort occurred and after December 31, 2005.

Section 716. Podiatrist liability.

Within two years of the effective date of this chapter, the department shall calculate the amount necessary to arrange for the separate retirement of the fund's liabilities associated with podiatrists. Any arrangement shall be on terms and conditions proportionate to the individual liability of the class of health care provider. The arrangement may result in assessments for podiatrists different from the assessments for other health care providers. Upon satisfaction of the arrangement, podiatrists shall not be required to contribute to or be entitled to participate in the fund. In cases where the class rejects an arrangement, the department shall present to the provider class new term arrangements at least once in every two-year period. All costs and expenses associated with the completion and implementation of the arrangement shall be paid by podiatrists and may be charged in the form of an addition to the assessment.

SUBCHAPTER C
JOINT UNDERWRITING ASSOCIATION

Section 731. Joint underwriting association.

(a) Establishment.--There is established a nonprofit joint underwriting association to be known as the Pennsylvania Professional Liability Joint Underwriting Association. The joint underwriting association shall consist of all insurers authorized to write insurance in accordance with section 202(c)(4) and (11) of the act of May 17, 1921 (P.L.682, No.284), known as The Insurance Company Law of 1921, and shall be supervised by the department. The powers and duties of the joint underwriting association shall be vested in and exercised by a board of directors.

(b) Duties.--The joint underwriting association shall do all of the following:

(1) Submit a plan of operation to the commissioner for approval.

(2) Submit rates and any rate modification to the department for approval in accordance with the act of June 11, 1947 (P.L.538, No.246), known as The Casualty and Surety Rate Regulatory Act.

(3) Offer medical professional liability insurance to health care providers in accordance with section 732.

(4) File with the department the information required in section 712.

(c) Liabilities.--A claim against or a liability of the joint underwriting association shall not be deemed to constitute a debt or liability of the Commonwealth or a charge against the General Fund.

Section 732. Medical professional liability insurance.

(a) Insurance.--The joint underwriting association shall offer medical professional liability insurance to health care providers and professional corporations, professional associations and partnerships which are entirely owned by health care providers who cannot conveniently obtain medical professional liability insurance through ordinary methods at

rates not in excess of those applicable to similarly situated health care providers, professional corporations, professional associations or partnerships.

(b) Requirements.--The joint underwriting association shall ensure that the medical professional liability insurance it offers does all of the following:

(1) Is conveniently and expeditiously available to all health care providers required to be insured under section 711.

(2) Is subject only to the payment or provisions for payment of the premium.

(3) Provides reasonable means for the health care providers it insures to transfer to the ordinary insurance market.

(4) Provides sufficient coverage for a health care provider to satisfy its insurance requirements under section 711 on reasonable and not unfairly discriminatory terms.

(5) Permits a health care provider to finance its premium or allows installment payment of premiums subject to customary terms and conditions.

Section 733. Deficit.

(a) Filing.--In the event the joint underwriting association experiences a deficit in any calendar year, the board of directors shall file with the commissioner the deficit.

(b) Approval.--Within 30 days of receipt of the filing, the commissioner shall approve or deny the filing. If approved, the joint underwriting association is authorized to borrow funds sufficient to satisfy the deficit.

(c) Rate filing.--Within 30 days of receiving approval of its filing in accordance with subsection (b), the joint underwriting association shall file a rate filing with the department. The commissioner shall approve the filing if the premiums generate sufficient income for the joint underwriting association to avoid a deficit during the following 12 months and to repay principal and interest on the money borrowed in accordance with subsection (b).

SUBCHAPTER D
REGULATION OF MEDICAL PROFESSIONAL LIABILITY INSURANCE

Section 741. Approval.

In order for an insurer to issue a policy of medical professional liability insurance to a health care provider or to a professional corporation, professional association or partnership which is entirely owned by health care providers, the insurer must be authorized to write medical professional liability insurance in accordance with the act of May 17, 1921 (P.L.682, No.284), known as The Insurance Company Law of 1921.

Section 742. Approval of policies on "claims made" basis.

The commissioner shall not approve a medical professional liability insurance policy written on a "claims made" basis by any insurer doing business in this Commonwealth unless the insurer shall guarantee to the commissioner the continued availability of suitable liability protection for a health care provider subsequent to the discontinuance of professional practice by the health care provider or the termination of the insurance policy by the insurer or the health care provider for so long as there is a reasonable probability of a claim for injury for which the health care provider may be held liable.

Section 743. Reports to commissioner and claims information.

(a) Duty to report.--By October 15 of each year, basic insurance coverage insurers and self-insured participating health care providers shall report to the department the claims information specified in subsection (b).

(b) Department report.--Sixty days after the end of each calendar year, the department shall prepare a report. The report shall contain the total amount of claims paid and expenses incurred during the preceding calendar year, the total amount of reserve set aside for future claims, the date and place in which each claim arose, the amounts paid, if any, and the disposition of each claim, judgment of court, settlement or otherwise. For final claims at the end of any calendar year, the report shall include details by basic insurance coverage insurers and self-insured participating health care providers of the amount of assessment collected, the number of reimbursements paid and the amount of reimbursements paid.

(c) Submission of report.--A copy of the report prepared pursuant to this section shall be submitted to the chairman and minority chairman of the Banking and Insurance Committee of the Senate and the chairman and minority chairman of the Insurance Committee of the House of Representatives.

Section 744. Professional corporations, professional associations and partnerships.

A professional corporation, professional association or partnership which is entirely owned by health care providers and which elects to purchase basic insurance coverage in accordance with section 711 from the joint underwriting association or from an insurer licensed or approved by the department shall be required to participate in the fund and, upon payment of the assessment required by section 712, be entitled to coverage from the fund.

Section 745. Actuarial data.

(a) Initial study.--The following shall apply:

(1) No later than April 1, 2005, each insurer providing medical professional liability insurance in this Commonwealth shall file loss data as required by the commissioner. For failure to comply, the commissioner shall impose an administrative penalty of $1,000 for every day that this data is not provided in accordance with this paragraph.

(2) By July 1, 2005, the commissioner shall conduct a study regarding the availability of additional basic insurance coverage capacity. The study shall include an estimate of the total change in medical professional liability insurance loss-cost resulting from implementation of this act prepared by an independent actuary. The fee for the independent actuary shall be borne by the fund. In developing the estimate, the independent actuary shall consider all of the following:

(i) The most recent accident year and ratemaking data available.

(ii) Any other relevant factors within or outside this Commonwealth in accordance with sound actuarial principles.

(b) Additional study.--The following shall apply:

(1) Three years following the increase of the basic insurance coverage requirement in accordance with section 711(d)(3), each insurer providing medical professional liability insurance in this Commonwealth shall file loss data with the commissioner upon request. For failure to comply, the commissioner shall impose an administrative penalty of $1,000 for every day that this data is not provided in accordance with this paragraph.

(2) Three months following the request made under paragraph (1), the commissioner shall conduct a study regarding the availability of additional basic insurance coverage capacity. The study shall include an estimate of the total change in medical professional liability insurance loss-cost resulting from implementation of this act prepared by an independent actuary. The fee for the independent actuary shall be borne by the fund. In developing the estimate, the independent actuary shall consider all of the following:

(i) The most recent accident year and ratemaking data available.

(ii) Any other relevant factors within or outside this Commonwealth in accordance with sound actuarial principles.

Section 746. Mandatory reporting.

(a) General provisions.--Each medical professional liability insurer and each self-insured health care provider, including the fund established by this chapter, which makes payment in settlement or in partial settlement of or in satisfaction of a judgment in a medical professional liability action or claim shall provide to the appropriate licensure board a true and correct copy of the report required to be filed with the Federal Government by section 421 of the Health Care Quality Improvement Act of 1986 (Public Law 99-660, 42 U.S.C. § 11131). The copy of the report required by this section shall be filed simultaneously with the report required by section 421 of the Health Care Quality Improvement Act of 1986. The department shall monitor and enforce compliance with this section. The Bureau of Professional and Occupational Affairs and the licensure boards shall have access to information pertaining to compliance.

(b) Immunity.--A medical professional liability insurer or person who reports under

subsection (a) in good faith and without malice shall be immune from civil or criminal liability arising from the report.

(c) Public information.--Information received under this section shall not be considered public information for the purposes of the act of June 21, 1957 (P.L.390, No.212), referred to as the Right-to-Know Law, or 65 Pa.C.S. Ch. 7 (relating to open meetings) until used in a formal disciplinary proceeding.

Section 747. Cancellation of insurance policy.

A termination of a medical professional liability insurance policy by cancellation, except for suspension or revocation of the insured's license or for reason of nonpayment of premium, is not effective against the insured unless notice of cancellation was given within 60 days after the issuance of the policy to the insured, and no cancellation shall take effect unless a written notice stating the reasons for the cancellation and the date and time upon which the termination becomes effective has been received by the commissioner. Mailing of the notice to the commissioner at the commissioner's principal office address shall constitute notice to the commissioner.

Section 748. Regulations.

The commissioner may promulgate regulations to implement and administer this chapter.

CHAPTER 9
ADMINISTRATIVE PROVISIONS

Section 901. Scope.

(a) General rule.--

(1) Except as set forth in subsection (b), this chapter is in pari materia with:

(i) the act of October 5, 1978 (P.L.1109, No.261), known as the Osteopathic Medical Practice Act; and

(ii) the act of December 20, 1985 (P.L.457, No.112), known as the Medical Practice Act of 1985.

(2) No duplication of procedure is required between this chapter and either:

(i) the Osteopathic Medical Practice Act; or

(ii) the Medical Practice Act of 1985.

(b) Conflict.--This chapter shall prevail if there is a conflict between this chapter and either:

(1) the Osteopathic Medical Practice Act; or

(2) the Medical Practice Act of 1985.

Section 902. Definitions.

The following words and phrases when used in this chapter shall have the meanings given to them in this section unless the context clearly indicates otherwise:

"Licensure board." Either or both of the following, depending on the licensure of the affected individual:

(1) The State Board of Medicine.

(2) The State Board of Osteopathic Medicine.

"Physician." An individual licensed under the laws of this Commonwealth to engage in the practice of:

(1) medicine and surgery in all its branches within the scope of the act of December 20, 1985 (P.L.457, No.112), known as the Medical Practice Act of 1985; or

(2) osteopathic medicine and surgery within the scope of the act of October 5, 1978 (P.L.1109, No.261), known as the Osteopathic Medical Practice Act.

Section 903. Reporting.

A physician shall report to the State Board of Medicine or the State Board of Osteopathic Medicine, as appropriate, within 60 days of the occurrence of any of the following:

(1) Notice of a complaint in a medical professional liability action that is filed against the physician. The physician shall provide the docket number of the case, where the case is filed and a description of the allegations in the complaint.

(2) Information regarding disciplinary action taken against the physician by a health care licensing authority of another state.

(3) Information regarding sentencing of the physician for an offense as provided in section 15 of the act of October 5, 1978 (P.L.1109, No.261), known as the Osteopathic Medical Practice Act, or section 41 of the act of December 20, 1985 (P.L.457, No.112), known as the Medical Practice Act of 1985.

(4) Information regarding an arrest of the physician for any of the following offenses in this Commonwealth or another state:

(i) 18 Pa.C.S. Ch. 25 (relating to criminal homicide);

(ii) 18 Pa.C.S. § 2702 (relating to aggravated assault); or

(iii) 18 Pa.C.S. Ch. 31 (relating to sexual offenses).

(iv) A violation of the act of April 14, 1972 (P.L.233, No.64), known as The Controlled Substance, Drug, Device and Cosmetic Act.

Section 904. Commencement of investigation and action.

(a) Investigations by licensure board.--With regard to notices of complaints received pursuant to section 903(1) or a complaint filed with the licensure board, the licensure board shall develop criteria and standards for review based on the frequency and severity of complaints filed against a physician. Any investigation of a physician based upon a complaint must be commenced no more than four years from the date notice of the complaint is received under section 903(1).

(b) Action by licensure board.--Unless an investigation has already been initiated pursuant to subsection (a), an action against a physician must be commenced by the licensure board no more than four years from the time the licensure board receives the earliest of any of the following:

(1) Notice that a payment against the physician has been reported to the National Practitioner Data Bank.

(2) Notice that a payment in a medical professional liability action against the physician has been reported to the licensure board by an insurer.

(3) Notice of a report made pursuant to section 903(2), (3) or (4).

(c) Laches.--The defense of laches is unavailable if the licensure board complies with this section.

(d) Applicability.--This section shall apply to actions against a physician initiated on or after the effective date of this chapter.

Section 905. Action on negligence.

If the licensure board determines, based on actions taken pursuant to section 904, that a physician has practiced negligently, the licensure board may impose disciplinary sanctions or corrective measures.

Section 906. Confidentiality agreements.

(a) Confidentiality agreements.--Upon settlement of a medical professional liability action containing a confidentiality agreement or upon a court order sealing the settlement and related records for purposes of confidentiality, the agreement or order shall not be operable against the licensure board to obtain copies of medical records of the patient on whose behalf the action is commenced. Prior to obtaining medical records under this subsection, the licensure board must obtain the consent of the patient or the patient's legal representative.

(b) Applicability.--The addition of subsection (a) shall apply to settlements entered into and court orders issued on or after the effective date of this chapter.

Section 907. Confidentiality of records of licensure boards.

(a) General rule.--All documents, materials or information utilized solely for an investigation undertaken by the State Board of Medicine or State Board of Osteopathic Medicine or concerning a complaint filed with the State Board of Medicine or State Board of Osteopathic Medicine shall be confidential and privileged. No person who has investigated or has access to or custody of documents, materials or information which are confidential and privileged under this subsection shall be required to testify in any judicial or administrative proceeding without the written consent of the State Board of Medicine or State Board of Osteopathic Medicine. This subsection shall not preclude or limit introduction of the contents of an investigative file or related witness testimony in a hearing or proceeding held before the State Board of Medicine or State Board of Osteopathic Medicine. This subsection shall not apply to letters to a licensee that disclose the final outcome of an investigation or to final adjudications or orders issued by the licensure

board.

(b) Certain disclosure permitted.--Except as provided in subsection (a), this section shall not prevent disclosure of any documents, materials or information pertaining to the status of a license, permit or certificate issued or prepared by the State Board of Medicine or State Board of Osteopathic Medicine or relating to a public disciplinary proceeding or hearing.

Section 908. Licensure board-imposed civil penalty.

In addition to any other civil remedy or criminal penalty provided for in this act, the act of December 20, 1985 (P.L.457, No.112), known as the Medical Practice Act of 1985, or the act of October 5, 1978 (P.L.1109, No.261), known as the Osteopathic Medical Practice Act, the State Board of Medicine and the State Board of Osteopathic Medicine, by a vote of the majority of the maximum number of the authorized membership of each board as provided by law or by a vote of the majority of the duly qualified and confirmed membership or a minimum of five members, whichever is greater, may levy a civil penalty of up to $10,000 on any current licensee who violates any provision of this act, the Medical Practice Act of 1985 or the Osteopathic Medical Practice Act or on any person who practices medicine or osteopathic medicine without being properly licensed to do so under the Medical Practice Act of 1985 or the Osteopathic Medical Practice Act. The boards shall levy this penalty only after affording the accused party the opportunity for a hearing as provided in 2 Pa.C.S. (relating to administrative law and procedure).

Section 909. Licensure board report.

(a) Annual report.--Each licensure board shall submit a report not later than March 1 of each year to the chair and the minority chair of the Consumer Protection and Professional Licensure Committee of the Senate and to the chair and minority chair of the Professional Licensure Committee of the House of Representatives. The report shall include:

(1) The number of complaint files against board licensees that were opened in the preceding five calendar years.

(2) The number of complaint files against board licensees that were closed in the preceding five calendar years.

(3) The number of disciplinary sanctions imposed upon board licensees in the preceding five calendar years.

(4) The number of revocations, automatic suspensions, immediate temporary suspensions and stayed and active suspensions imposed, voluntary surrenders accepted, license applications denied and license reinstatements denied in the preceding five calendar years.

(5) The range of lengths of suspensions, other than automatic suspensions and immediate temporary suspensions, imposed during the preceding five calendar years.

(b) Posting.--The report shall be posted on each licensure board's publicly accessible World Wide Web site.

Section 910. Continuing medical education.

(a) Rules and regulations.--Each licensure board shall promulgate and enforce regulations consistent with the act of October 5, 1978 (P.L.1109, No.261), known as the Osteopathic Medical Practice Act, or the act of December 20, 1985 (P.L.457, No.112), known as the Medical Practice Act of 1985, as appropriate, in establishing requirements of continuing medical education for individuals licensed to practice medicine and surgery without restriction as a condition for renewal of their licenses. Such regulations shall include any fees necessary for the licensure board to carry out its responsibilities under this section.

(b) Required completion.--Beginning with the licensure period commencing January 1, 2003, and following written notice to licensees by the licensure board, individuals licensed to practice medicine and surgery without restriction shall be required to enroll and complete 100 hours of mandatory continuing education during each two-year licensure period. As part of the 100-hour requirement, the licensure board shall establish a minimum number of hours that must be completed in improving patient safety and risk management subject areas.

(c) Review.--The licensure board shall review and approve continuing medical education providers or accrediting bodies who shall be certified to offer continuing medical education credit hours.

(d) Exemption.--Licensees shall be exempt from the provisions of this section as

follows:

(1) An individual applying for licensure in this Commonwealth for the first time shall be exempt from the continuing medical education requirement for the biennial renewal period following initial licensure.

(2) An individual holding a current temporary training license shall be exempt from the continuing medical education requirement.

(3) A retired physician who provides care only to immediate family members shall be exempt from the continuing medical education requirement.

(e) Waiver.--The licensure board may waive all or a portion of the continuing education requirement for biennial renewal to a licensee who shows to the satisfaction of the licensure board that he or she was unable to complete the requirements due to serious illness, military service or other demonstrated hardship. A waiver request shall be made in writing, with appropriate documentation, and shall include a description of circumstances sufficient to show why compliance is impossible. A waiver request shall be evaluated by the licensure board on a case-by-case basis. The licensure board shall send written notification of its approval or denial of a waiver request.

(f) Reinstatement.--A licensee seeking to reinstate an inactive or lapsed license shall show proof of compliance with the continuing education requirement for the preceding biennium.

(g) Board approval.--An individual shall retain official documentation of attendance for two years after renewal and shall certify completed courses on a form provided by the licensure board for that purpose to be filed with the biennial renewal form. Official documentation proving attendance shall be produced upon licensure board demand pursuant to random audits of reported credit hours. Electronic submission of documentation is permissible to prove compliance with this subsection. Noncompliance with the requirements of this section may result in disciplinary proceedings.

(h) Regulations.--The licensure board shall promulgate regulations necessary to carry out the provisions of this section within six months of the effective date of this section.

CHAPTER 51
MISCELLANEOUS PROVISIONS

Section 5101. Oversight.

(a) General rule.--The Insurance Department has the authority and shall assume oversight of the Medical Professional Liability Catastrophe Loss Fund established in section 701(d) of the act of October 15, 1975 (P.L.390, No.111), known as the Health Care Services Malpractice Act. As part of its responsibilities, the department shall do all of the following:

(1) Make all administrative decisions, including staffing requirements, on behalf of that fund.

(2) Approve the adjustment, defense, litigation, settlement or compromise of any claim payable by that fund.

(3) Collect the surcharges imposed in accordance with section 701(e)(1) of the Health Care Services Malpractice Act.

(b) Expiration.--This section shall expire October 1, 2002.

Section 5102. Prior fund.

(a) Administration.--Employees of the Medical Professional Liability Catastrophe Loss Fund on the effective date of this section shall continue to administer that fund subject to the authority and oversight of the Insurance Department. This subsection shall expire October 1, 2002.

(b) Employees.--If an employee of that fund on the effective date of this section is subsequently furloughed and the employee held a position not covered by a collective bargaining agreement, the employee shall be given priority consideration for employment to fill vacancies with executive agencies under the Governor's jurisdiction.

Section 5103. Notice.

When the authority has established a Statewide reporting system, the notice shall be transmitted to the Legislative Reference Bureau for publication in the Pennsylvania Bulletin.

Section 5104. Repeals.

(a) Specific.--

(1) Section 6506(c) of Title 75 of the Pennsylvania Consolidated Statutes is repealed.

(2) Except as set forth in paragraphs (3), (4) and (5), the act of October 15, 1975 (P.L.390, No.111), known as the Health Care Services Malpractice Act, is repealed.

(3) Section 103 of the Health Care Services Malpractice Act is repealed.

(4) Except as provided in paragraph (5), Article VII of the Health Care Services Malpractice Act is repealed.

(5) Section 701(e)(1) of the Health Care Services Malpractice Act is repealed.

(b) Inconsistent.--

(1) Section 6506(b) of Title 75 of the Pennsylvania Consolidated Statutes is repealed insofar as it is inconsistent with section 712(m).

(2) All other acts and parts of acts are repealed insofar as they are inconsistent with this act.

Section 5105. Applicability.

(a) Patient safety discount.--Section 312 shall apply to policies issued or renewed after December 31, 2002.

(b) Actions.--Sections 504(d)(2), 505(e), 508, 509, 510, 513 and 516 shall apply to causes of action which arise on or after the effective date of this section.

Section 5106. Expiration.

Section 312 shall expire on December 31, 2007.

Section 5107. Continuation.

(a) Orders and regulations.--Orders and regulations which were issued or promulgated under the former act of October 15, 1975 (P.L.390, No.111), known as the Health Care Services Malpractice Act, and which are in effect on the effective date of this section shall remain applicable and in full force and effect until modified under this act.

(b) Administration and construction.--To the extent possible under Subchapter C of Chapter 7, the joint underwriting association is authorized to administer Subchapter C of Chapter 7 as a continuation of the former Article VIII of the Health Care Services Malpractice Act.

Section 5108. Effective date.

This act shall take effect as follows:

(1) The following provisions shall take effect immediately:

(i) Chapter 1.
(ii) Section 501.
(iii) Section 502.
(iv) Section 503.
(v) Section 504.
(vi) Section 505.
(vii) Section 506.
(viii) Section 507.
(ix) Section 508.
(x) Section 509.
(xi) Section 510.
(xii) Section 513.
(xiii) Section 514.
(xiii.1) Section 515.
(xiii.2) Section 516.
(xiv) Except as provided in paragraph (3)(i), Chapter 7.
(xv) Section 5101.
(xvi) Section 5102.
(xvii) Section 5103.
(xviii) Section 5104(a)(1) and (2) and (b)(2).
(xix) Section 5105.
(xx) Section 5106.
(xxi) Section 5107.

(xxii) This section.

(2) The following provisions shall take effect 30 days after publication of the notice under section 5103:

(i) Section 313.

(ii) Section 314.

(3) The following provisions shall take effect October 1, 2002:

(i) Section 712(b) and (c)(1).

(ii) Section 5104(a)(4).

(4) Section 5104(a)(3) and (5) and (b)(1) shall take effect January 1, 2004.

(5) The remainder of this act shall take effect in 60 days.