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THE GENERAL ASSEMBLY OF PENNSYLVANIA

HOUSE BILL

No. 158 Session of 2003

INTRODUCED BY MICOZZIE, DeLUCA, HENNESSEY, MANDERINO, PIPPY, SATHER, TANGRETTI, VANCE, WALKO, BISHOP, BROWNE, DAILEY, J. EVANS, FREEMAN, LEVDANSKY, MUNDY, STABACK, STEIL, SURRA, E. Z. TAYLOR, TIGUE, WASHINGTON AND YOUNGBLOOD, FEBRUARY 26, 2003

AS AMENDED ON THIRD CONSIDERATION, HOUSE OF REPRESENTATIVES, JUNE 9, 2003

AN ACT

Amending the act of March 20, 2002 (P.L.154, No.13), entitled "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," further providing for ~~reporting; and providing for~~ DECLARATION OF POLICY, FOR POWERS AND DUTIES OF THE AUTHORITY, FOR PATIENT SAFETY PLANS, FOR ADDITIONAL ADJUSTMENTS OF THE PREVAILING PRIMARY PREMIUM, FOR MEDICAL FACILITY REPORTS AND NOTIFICATION, FOR THE MEDICAL CARE AVAILABILITY AND REDUCTION OF ERROR FUND, FOR MEDICAL PROFESSIONAL LIABILITY INSURANCE BY THE JOINT UNDERWRITING ASSOCIATION, FOR APPROVAL OF MEDICAL PROFESSIONAL LIABILITY INSURERS, FOR ADMINISTRATIVE DEFINITIONS, FOR CLAIMS, FOR MEDICAL PROFESSIONAL LIABILITY INSURANCE, FOR CANCELLATION OF INSURANCE POLICY AND FOR REPORTING; PROVIDING FOR REPORTS BY HOSPITALS AND HEALTH CARE FACILITIES AND FOR VOLUNTARY CONTRACTUAL ARBITRATION; FURTHER PROVIDING FOR ANNUAL REPORT; FURTHER DEFINING "NONPARTICIPATING HEALTH CARE PROVIDER" AND "PARTICIPATING HEALTH CARE PROVIDER"; PROVIDING FOR public disclosure of information concerning physicians; EXTENDING

PATIENT SAFETY STANDARDS TO CERTAIN ABORTION FACILITIES; ESTABLISHING THE MCARE ASSESSMENT NEED PROGRAM; PROVIDING FOR FAIR MEDICAL BILL PAYMENTS TO CERTAIN HIGH RISK HEALTH CARE PROVIDERS AND ACUTE CARE INSTITUTIONS FOR CARE, TREATMENTS AND SERVICES COVERED UNDER HEALTH INSURANCE POLICIES; REQUIRING HEALTH INSURERS TO DISCLOSE FEE SCHEDULES AND ALL RULES AND ALGORITHMS RELATING THERETO; REQUIRING HEALTH INSURERS TO PROVIDE FULL PAYMENT TO PHYSICIANS WHEN MORE THAN ONE SURGICAL PROCEDURE IS PERFORMED ON THE PATIENT BY THE SAME PHYSICIAN DURING ONE CONTINUOUS OPERATING PROCEDURE; AND PROVIDING FOR FUNCTIONS OF THE DEPARTMENT OF HEALTH, FOR CAUSES OF ACTION AND FOR PENALTIES.

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

~~Section 1. Section 903 of the act of March 20, 2002 (P.L.154, No.13), known as the Medical Care Availability and Reduction of Error (Mcare) Act, is amended to read:~~ <—

SECTION 1. SECTION 102 OF THE ACT OF MARCH 20, 2002 (P.L.154, NO.13), KNOWN AS THE MEDICAL CARE AVAILABILITY AND REDUCTION OF ERROR (MCARE) ACT, IS AMENDED TO READ: <—

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.

(7) THE COST OF MEDICAL MALPRACTICE INSURANCE PREMIUMS ARE DIRECTLY IMPACTED BY MEDICAL ERRORS.

(8) HEALTH CARE PROVIDERS' COST OF POOR QUALITY IS ESTIMATED TO BE AS HIGH AS 30% TO 50% OF THE TOTAL AMOUNT PAID FOR HEALTH CARE.

(9) A 1999 STUDY BY THE INSTITUTE OF MEDICINE OF HARVARD UNIVERSITY REVEALED THAT, EACH YEAR, AS MANY AS 98,000 PEOPLE DIE AS A RESULT OF PREVENTABLE MEDICAL ERRORS WHICH COST THE NATION AN ESTIMATED $29,000,000,000. THE STUDY CITES MEDICAL ERRORS AS THE FIFTH LEADING CAUSE OF DEATH IN THE UNITED STATES.

(10) RESEARCH SHOWS THAT A VAST MAJORITY OF MEDICAL ERRORS ARE SYSTEMIC RATHER THAN HUMAN ERRORS.

(11) TOTAL QUALITY MANAGEMENT SYSTEMS IMPLEMENTED IN INDUSTRY AND, RECENTLY, BY THE UNITED STATES DEPARTMENT OF VETERANS AFFAIRS HOSPITAL SYSTEM HAVE SUCCESSFULLY REDUCED MEDICAL ERRORS.

(12) IT IS THE PURPOSE OF THIS ACT TO IMPROVE PATIENT SAFETY, IMPROVE HEALTH CARE QUALITY AND LOWER HEALTH CARE COSTS BY OFFERING MEDICAL MALPRACTICE PREMIUM DISCOUNTS TO HEALTH CARE PROVIDERS THAT INSTITUTE TOTAL QUALITY MANAGEMENT HEALTH CARE SYSTEMS.

SECTION 2. THE DEFINITION OF "MEDICAL FACILITY" IN SECTION 302 OF THE ACT IS AMENDED AND THE SECTION IS AMENDED BY ADDING A

DEFINITION TO READ:

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:

"ABORTION FACILITY." A FACILITY OR MEDICAL FACILITY AS DEFINED IN 18 PA.C.S. § 3203 (RELATING TO DEFINITIONS) WHICH IS SUBJECT TO THIS CHAPTER PURSUANT TO SECTION 315(B) OR (C) AND WHICH IS NOT SUBJECT TO LICENSURE UNDER THE HEALTH CARE FACILITIES ACT.

* * *

"MEDICAL FACILITY." AN AMBULATORY SURGICAL FACILITY, BIRTH CENTER [OR], HOSPITAL OR AN ABORTION FACILITY.

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SECTION 3. SECTIONS 304(B), 305(C), 306(B), 307(D), 310(A)(2), 311(F)(1) AND 313 OF THE ACT ARE AMENDED TO READ:

SECTION 304. POWERS AND DUTIES.

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(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).

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SECTION 305. PATIENT SAFETY TRUST FUND.

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(C) ASSESSMENT.--COMMENCING JULY 1, 2002, EACH MEDICAL FACILITY SHALL PAY THE DEPARTMENT [A SURCHARGE ON ITS LICENSING FEE] AN ASSESSMENT 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.

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SECTION 306. DEPARTMENT RESPONSIBILITIES.

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(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, AND, IN THE CASE OF ABORTION FACILITIES, AND FOR APPROVAL OR REVOCATION PURPOSES PURSUANT TO 28 PA. CODE § 29.43 (RELATING TO FACILITY APPROVAL), 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.

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(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[.] AND SPECIFICALLY DESIGNATE IN SUCH NOTIFICATION THE PROCESS THROUGH WHICH HEALTH CARE WORKERS WILL REPORT ANY SERIOUS EVENTS AND INCIDENTS AT THE MEDICAL FACILITY. THE DEPARTMENT SHALL ESTABLISH FOR USE BY MEDICAL FACILITIES A UNIFORM PROCEDURE FOR NOTIFYING HEALTH CARE WORKERS 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 310. PATIENT SAFETY COMMITTEE.

(A) COMPOSITION.--

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(2) AN AMBULATORY SURGICAL FACILITY'S, ABORTION 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, ABORTION FACILITY OR BIRTH CENTER WHO IS NOT AN AGENT, EMPLOYEE OR CONTRACTOR OF THE AMBULATORY SURGICAL FACILITY, ABORTION 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.

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SECTION 311. CONFIDENTIALITY AND COMPLIANCE.

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(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, APPROVAL 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.

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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.

(E.1) ADDITIONAL REPORTING.--IF A MEDICAL FACILITY IS NAMED IN A MEDICAL LIABILITY ACTION WHICH RESULTS IN A JUDGMENT AGAINST THE FACILITY OF $50,000 OR MORE, THE MEDICAL FACILITY SHALL, WITHIN 30 DAYS OF FINAL ADJUDICATION, REPORT THE JUDGMENT TO THE DEPARTMENT. THE REPORT SHALL CONTAIN A DESCRIPTION OF THE OCCURRENCE, THE LOCATION THE OCCURRENCE TOOK PLACE AND THE AMOUNT OF THE AWARD. THE DEPARTMENT SHALL MAKE SUCH REPORTS AVAILABLE TO THE GENERAL PUBLIC ON ITS WORLD WIDE WEB SITE.

(F) FAILURE TO REPORT OR NOTIFY.--FAILURE TO [REPORT A SERIOUS EVENT OR AN INFRASTRUCTURE FAILURE AS REQUIRED BY THIS SECTION] COMPLY WITH THE REPORTING REQUIREMENTS OF SUBSECTION (A), (B) OR (E.1) 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[.] AND, IN THE CASE OF AN ABORTION FACILITY, MAY BE A BASIS FOR REVOCATION OF APPROVAL PURSUANT TO 28 PA. CODE § 29.43 (RELATING TO FACILITY APPROVAL). IN ADDITION TO ANY PENALTY WHICH MAY BE IMPOSED UNDER THE HEALTH CARE FACILITIES ACT[,A] OR UNDER 18 PA.C.S. CH. 32 (RELATING TO ABORTION):

(1) 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.

(2) A MEDICAL FACILITY WHICH FAILS TO NOTIFY A PATIENT IN ACCORDANCE WITH SECTION 308(B) IS SUBJECT TO AN ADMINISTRATIVE PENALTY OF $5,000 IMPOSED BY THE DEPARTMENT.

SECTION 4. THE ACT IS AMENDED BY ADDING A SECTION TO READ:

SECTION 315. ABORTION FACILITIES.

(A) GENERAL.--THIS SECTION SHALL APPLY TO ABORTION FACILITIES.

(B) APPLICATION DURING CURRENT YEAR.--AN ABORTION FACILITY THAT PERFORMS 100 OR MORE ABORTIONS AFTER THE EFFECTIVE DATE OF THIS ACT DURING THE CALENDAR YEAR IN WHICH THIS SECTION TAKES EFFECT SHALL BE SUBJECT TO PROVISIONS OF THIS CHAPTER AT THE BEGINNING OF THE IMMEDIATELY FOLLOWING CALENDAR YEAR AND DURING EACH SUBSEQUENT CALENDAR YEAR UNLESS THE FACILITY GIVES THE DEPARTMENT WRITTEN NOTICE THAT IT WILL NOT BE PERFORMING 100 OR MORE ABORTIONS DURING SUCH FOLLOWING CALENDAR YEAR AND DOES NOT PERFORM 100 OR MORE ABORTIONS DURING THAT CALENDAR YEAR.

(C) APPLICATION IN SUBSEQUENT CALENDAR YEARS.--IN THE CALENDAR YEARS FOLLOWING THE EFFECTIVE DATE OF THIS ACT, THIS CHAPTER SHALL APPLY TO AN ABORTION FACILITY NOT SUBJECT TO SUBSECTION (B) ON THE DAY FOLLOWING THE PERFORMANCE OF ITS 100TH ABORTION AND FOR THE REMAINDER OF THAT CALENDAR YEAR AND DURING EACH SUBSEQUENT CALENDAR YEAR UNLESS THE FACILITY GIVES THE DEPARTMENT WRITTEN NOTICE THAT IT WILL NOT BE PERFORMING 100 OR MORE ABORTIONS DURING SUCH FOLLOWING CALENDAR YEAR AND DOES NOT PERFORM 100 OR MORE ABORTIONS DURING THAT CALENDAR YEAR.

(D) PATIENT SAFETY PLAN.--AN ABORTION FACILITY SHALL SUBMIT ITS PATIENT SAFETY PLAN UNDER SECTION 307(C) WITHIN 60 DAYS FOLLOWING THE APPLICATION OF THIS CHAPTER TO THE FACILITY.

(E) REPORTING.--AN ABORTION FACILITY SHALL BEGIN REPORTING SERIOUS EVENTS, INCIDENTS AND INFRASTRUCTURE FAILURES CONSISTENT WITH THE REQUIREMENTS OF SECTION 313 UPON THE SUBMISSION OF ITS PATIENT SAFETY PLAN TO THE DEPARTMENT.

(F) CONSTRUCTION.--NOTHING IN THIS CHAPTER SHALL BE CONSTRUED TO LIMIT THE PROVISIONS OF 18 PA.C.S. CH. 32 (RELATING TO ABORTION) OR ANY REGULATION ADOPTED UNDER 18 PA.C.S. CH. 32.

SECTION 5. THE DEFINITIONS OF "NONPARTICIPATING HEALTH CARE PROVIDER" AND "PARTICIPATING HEALTH CARE PROVIDER" IN SECTION 702 OF THE ACT ARE AMENDED TO READ:

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:

* * *

"NONPARTICIPATING HEALTH CARE PROVIDER." A HEALTH CARE PROVIDER AS DEFINED IN SECTION 103 THAT CONDUCTS [20%] 50% 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%] 50% OF ITS HEALTH CARE BUSINESS OR PRACTICE WITHIN THIS COMMONWEALTH OR A NONPARTICIPATING HEALTH CARE PROVIDER WHO CHOOSES TO PARTICIPATE IN THE FUND.

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SECTION 6. SECTIONS 712(G), 714(G), 732, 733, 741 AND 747 OF THE ACT ARE AMENDED TO READ:

SECTION 712. MEDICAL CARE AVAILABILITY AND REDUCTION OF ERROR FUND.

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(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.

(5) A PARTICIPATING HEALTH CARE PROVIDER THAT IMPLEMENTS, TO THE SATISFACTION OF THE DEPARTMENT OF HEALTH, A TOTAL QUALITY MANAGEMENT HEALTH CARE SYSTEM APPROVED BY THE DEPARTMENT OF HEALTH SHALL BE ENTITLED TO A 20% DISCOUNT IN THE APPLICABLE PREVAILING PRIMARY PREMIUM FOR EACH FISCAL YEAR IN WHICH THE SYSTEM IS IMPLEMENTED.

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SECTION 714. MEDICAL PROFESSIONAL LIABILITY CLAIMS.

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(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. PROCEEDING 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).] MEDICAL MALPRACTICE SMALL CLAIMS DISPUTE RESOLUTION.--

(1) IF A CLAIMANT BELIEVES THAT HE IS A VICTIM OF MEDICAL MALPRACTICE, HE SHALL HAVE THE RIGHT TO REQUEST THAT THE CLAIM BE HEARD BY MEDICAL MALPRACTICE SMALL CLAIMS ARBITRATION, MEDICAL MALPRACTICE SMALL CLAIMS MEDIATION OR SUMMARY JURY TRIAL AS ALTERNATIVES TO FORMAL LITIGATION IN FEDERAL OR STATE COURT.

(2) (I) IN ORDER TO UTILIZE THE MEDICAL MALPRACTICE SMALL CLAIMS ARBITRATION PROCEDURE, ALL PARTIES MUST AGREE IN WRITING TO SUBMIT THE CLAIM TO MEDICAL MALPRACTICE SMALL CLAIMS ARBITRATION AND BE SUBJECT TO THE PROVISIONS OF THIS SUBSECTION. THE ARBITRATION PROCEDURE SHALL BE COMMENCED BY THE CLAIMANT SERVING THE DEFENDANT, VIA CERTIFIED OR REGISTERED MAIL, WITH A STATEMENT OF CLAIM AND NOTICE OF INTENT. THE STATEMENT OF CLAIM SHALL SET FORTH, WITH SUFFICIENT SPECIFICITY AS REQUIRED IN A FORMAL CIVIL COMPLAINT PURSUANT TO THE PENNSYLVANIA RULES OF CIVIL PROCEDURE, THE NATURE OF THE ALLEGED MALPRACTICE, THE RESULTING INJURIES AND THE DAMAGES SOUGHT. THE NOTICE OF INTENT SHALL STATE THAT THE CLAIMANT DESIRES TO HAVE THE CLAIM HEARD BY MEDICAL MALPRACTICE SMALL CLAIMS ARBITRATION AND INQUIRES WHETHER THE DEFENDANT DESIRES THE SAME. IF THE DEFENDANT DOES NOT RESPOND WITHIN 30 DAYS OF SERVICE OF THE STATEMENT OF CLAIM AND NOTICE OF INTENT, IT SHALL BE DEEMED THAT THE DEFENDANT DOES NOT AGREE TO HAVE THE CLAIM HEARD BY

MEDICAL MALPRACTICE SMALL CLAIMS ARBITRATION AND THE CLAIM SHALL NOT BE HEARD IN THAT MANNER. IF THE DEFENDANT DOES AGREE TO HAVE THE CLAIM HEARD IN THAT MANNER, AN AFFIRMATIVE RESPONSE SHALL BE SERVED UPON THE CLAIMANT WITHIN 30 DAYS OF INITIAL SERVICE ALONG WITH AN ANSWER TO THE STATEMENT OF CLAIM, AS WOULD BE FILED IN RESPONSE TO A FORMAL CIVIL COMPLAINT PURSUANT TO THE PENNSYLVANIA RULES OF CIVIL PROCEDURE. A DEFENDANT'S AGREEMENT, DISAGREEMENT OR LACK OF RESPONSE TO A MEDICAL MALPRACTICE SMALL CLAIMS ARBITRATION REQUEST SHALL IN NO WAY BE DEEMED AN ADMISSION OF LIABILITY.

(II) (A) NONPARTY TESTIMONY, WHETHER EXPERT TESTIMONY OR LAY TESTIMONY, CAN BE SUBMITTED WITHOUT STANDARD FORMALITIES BY MEANS OF AFFIDAVIT, OPINION LETTER, DEPOSITION TESTIMONY, CURRICULUM VITAE AND EXHIBITS INCLUDING, BUT NOT LIMITED TO, PHOTOGRAPHS, MEDICAL RECORDS, REPORTS AND BILLS, RADIOLOGY STUDIES, EMPLOYMENT RECORDS, WAGE INFORMATION, BUSINESS RECORDS, OFFICIAL RECORDS MAINTAINED BY THE COMMONWEALTH AND STANDARD U.S. GOVERNMENT LIFE EXPECTANCY TABLES, IF AT LEAST 30 DAYS' ADVANCE WRITTEN NOTICE WAS GIVEN TO THE OPPOSING PARTY ALONG WITH COPIES OF ALL MATERIALS THAT ARE TO BE SUBMITTED.

(B) ANY MATERIALS SUBMITTED MAY BE USED ONLY FOR PURPOSES WHICH WOULD BE PERMISSIBLE IF THE PERSON WHOSE TESTIMONY IS WAIVED WERE PRESENT AND TESTIFYING AT THE HEARING.

(C) THE PARTIES CAN TESTIFY LIVE, BY STANDARD DEPOSITION OR BY VIDEOTAPE DEPOSITION.

(D) EXCEPT AS PROVIDED FOR IN THIS SUBSECTION, THE PENNSYLVANIA RULES OF EVIDENCE SHALL BE APPLICABLE.

(E) ANY PARTY MAY HAVE A TRANSCRIPT AND RECORDING OF THE ARBITRATION PROCEEDING MADE AT HIS OR HER OWN EXPENSE.

(F) LEGAL MEMORANDA CAN BE SUBMITTED.

(G) THE ARBITRATORS ARE TO ENSURE THAT A FULL, FAIR AND IMPARTIAL HEARING AND REVIEW OF THE EVIDENCE IS CONDUCTED.

(H) THE HEARING MAY PROCEED IN THE ABSENCE OF A PARTY WHO, AFTER DUE NOTICE, FAILS TO APPEAR.

(I) UNLESS THE PARTIES AGREE OTHERWISE, THE HEARING IS TO BE HELD IN THE COUNTY WHERE THE CAUSE OF ACTION AROSE.

(III) THE FOLLOWING CRITERIA SHALL APPLY TO THE ARBITRATION PANEL:

(A) THERE SHALL BE THREE ARBITRATORS IN AN ARBITRATION PROCEEDING.

(B) EACH ARBITRATOR SHALL BE AN ATTORNEY LICENSED IN THIS COMMONWEALTH.

(C) EACH PARTY SHALL SELECT AN ARBITRATOR. THE SELECTED ARBITRATORS SHALL SELECT A CHAIR ARBITRATOR. IF A PARTY DOES NOT SELECT AN ARBITRATOR WITHIN 20 DAYS OF BEING REQUESTED TO DO SO, IF THE ARBITRATORS SELECTED CANNOT AGREE WITHIN 20 DAYS ON THE SELECTION OF A CHAIR ARBITRATOR OR IF THERE ARE MORE THAN TWO PARTIES INVOLVED AND THEY CANNOT AGREE WITHIN 20 DAYS OF BEING REQUESTED TO JOINTLY SELECT AN ARBITRATOR, EITHER PARTY MAY PETITION A COURT OF COMPETENT

JURISDICTION TO MAKE THE NECESSARY SELECTIONS.

(D) THE ARBITRATORS SHALL BE INDEPENDENT OF ALL PARTIES, WITNESSES AND LEGAL COUNSEL.

(E) EACH PARTY SHALL BE RESPONSIBLE FOR THE COMPENSATION OF THE ARBITRATOR SELECTED BY OR FOR THAT PARTY. THE COMPENSATION FOR THE CHAIR ARBITRATOR SHALL BE SHARED BY THE PARTIES.

(F) AFTER THE ARBITRATORS ARE SELECTED AND BEFORE AN AWARD IS MADE, THERE SHALL BE NO EX PARTE COMMUNICATION WITH THE ARBITRATORS BY THE PARTIES OR THEIR COUNSEL.

(G) THE ARBITRATORS SHALL CONSIDER ALL RELEVANT EVIDENCE THAT HAS BEEN PROPERLY SUBMITTED ALONG WITH ANY LEGAL MEMORANDA AND SHALL DECIDE THE ISSUES OF LIABILITY, AMOUNT OF DAMAGES AND APPORTIONMENT OF LIABILITY AMONG THE PARTIES.

(H) THE CHAIR ARBITRATOR, AT THE REQUEST OF A PARTY AND UPON GOOD CAUSE SHOWN, MAY SUBPOENA A PARTY OR INDIVIDUAL TO ATTEND THE HEARING OR A DEPOSITION AND, UNLESS OTHERWISE PROVIDED FOR IN THIS SUBSECTION, THE PARTY REQUESTING THE SUBPOENA SHALL PAY THE REASONABLE FEES AND COSTS OF THE PERSON BEING SUBPOENAED TO TESTIFY, INCLUDING A REASONABLE EXPERT WITNESS FEE IF APPLICABLE.

(I) THE CHAIR ARBITRATOR SHALL DETERMINE THE DATE, TIME AND PLACE OF THE HEARING AND SHALL PROVIDE THE OTHER ARBITRATORS AND PARTIES WITH AT LEAST 30 DAYS' ADVANCE NOTICE.

(J) THE CHAIR ARBITRATOR SHALL DECIDE ANY PREHEARING ISSUES THAT MAY ARISE.

(K) ISSUES THAT ARISE DURING THE HEARING SHALL BE HEARD BY THE ARBITRATORS AND SHALL BE DECIDED BY A MAJORITY OF THE ARBITRATORS.

(L) THE CHAIR ARBITRATOR SHALL HAVE THE AUTHORITY TO ADMINISTER OATHS OR AFFIRMATIONS TO WITNESSES AND TO ADJOURN AN UNCOMPLETED HEARING FROM DAY TO DAY.

(M) THE ARBITRATORS SHALL HAVE THE AUTHORITY TO DECIDE ALL ISSUES OF LAW AND FACT, DETERMINE LIABILITY AND AWARD DAMAGES.

(N) THE DECISION OF THE ARBITRATORS SHALL NOT BE USED AS EVIDENCE IN ANY FUTURE PROCEEDING.

(O) THE ARBITRATORS MAY NOT BE CALLED AS WITNESSES IN ANY FUTURE PROCEEDING.

(P) EXCEPT AS PROVIDED FOR IN THIS SUBSECTION, THE ARBITRATORS SHALL FOLLOW THE LAWS OF THIS COMMONWEALTH AND SHALL BE GUIDED BY THE PENNSYLVANIA RULES OF CIVIL PROCEDURE AND THE PENNSYLVANIA RULES OF EVIDENCE.

(IV) IF REQUESTED BY A DEFENDANT, THE CLAIMANT SHALL UNDERGO ONE PHYSICAL EXAMINATION, ONE MENTAL EXAMINATION AND ONE VOCATIONAL EXAMINATION. ALL EXPENSES ASSOCIATED WITH THE EXAMINATION SHALL BE BORNE BY THE REQUESTING PARTY. ALL EXAMINATIONS SHALL BE CONDUCTED IN THIS COMMONWEALTH. IF THE EXAMINATION TO BE CONDUCTED IS LOCATED MORE THAN 50 MILES FROM THE CLAIMANT'S RESIDENCE, ANY TRAVELING AND ASSOCIATED EXPENSES OF THE CLAIMANT ARE TO BE BORNE BY THE PARTY REQUESTING THE EXAMINATION. UPON A CLEAR SHOWING OF GOOD CAUSE AND SUBSTANTIAL NEED, THE CHAIR ARBITRATOR CAN ORDER ADDITIONAL EXAMINATIONS.

(V) EACH PARTY SHALL PROVIDE UP TO FIVE DEPOSITIONS WITHOUT ANY REQUEST TO BE COMPENSATED FOR LOST WAGES OR TRAVEL EXPENSES. IT IS UP TO THE PARTIES TO AGREE WHERE THE DEPOSITIONS ARE TO BE HELD WITH THE OBJECTIVE OF MINIMIZING THE EXPENSE AND INCONVENIENCE OF THE PARTIES AND WITNESSES. IF THE PARTIES CANNOT AGREE, THE CHAIR ARBITRATOR SHALL HAVE THE AUTHORITY TO DECIDE WHEN AND WHERE THE DEPOSITION WILL BE HELD. PARTIES SHALL BEAR THEIR OWN EXPENSES AND THOSE OF THEIR COUNSEL. THE PARTY REQUESTING THE DEPOSITION SHALL BEAR ANY COSTS OF THE WITNESS AND ANY STENOGRAPHIC AND VIDEO COSTS OF THE DEPOSITION.

(VI) OTHER THAN AS PROVIDED FOR IN THIS ACT, THE PARTIES MAY EXERCISE ALL DISCOVERY RIGHTS, REMEDIES AND PROCEDURES AVAILABLE AS IF THE CLAIM WERE PENDING IN A COURT OF COMMON PLEAS EXCEPT THAT THE CHAIR ARBITRATOR SHALL DECIDE ALL DISCOVERY ISSUES AND THERE SHALL BE NO RIGHT TO APPEAL THE CHAIR ARBITRATOR'S DECISION REGARDING DISCOVERY ISSUES.

(VII) THE TOTAL MONETARY AWARD, EXCLUDING ANY AWARD OF DELAY DAMAGES, THAT CAN BE RENDERED FOR ANY AND ALL DAMAGES PER CLAIM, WHETHER THE CLAIM INCLUDES ONE OR MORE INDIVIDUAL CLAIMANTS, CANNOT EXCEED $250,000.

(VIII) IF THE PARTIES STIPULATE OR OTHERWISE AGREE IN WRITING THAT THE ARBITRATION AWARD SHALL BE BINDING, THE CLAIMANT SHALL BE ENTITLED TO REASONABLE ATTORNEY FEES AND COSTS IF THE CLAIMANT IS THE PREVAILING PARTY AS DEFINED IN 42 U.S.C. § 1988 (PUBLIC LAW 94-559).

(IX) ARBITRATORS SHALL HAVE THE AUTHORITY TO AWARD DELAY DAMAGES.

(X) ARBITRATORS SHALL RENDER AN AWARD WITHIN TEN DAYS FROM THE CONCLUSION OF THE HEARING. THE AWARD SHALL DISPOSE OF ALL CLAIMS AND BE SIGNED BY ALL ARBITRATORS OR BY A MAJORITY OF THEM. THE AWARD NEED NOT CONTAIN FACTUAL FINDINGS OR LEGAL CONCLUSIONS. ONCE SIGNED, THE AWARD SHALL BE IMMEDIATELY SENT TO ALL PARTIES AND FILED WITH THE PROTHONOTARY IN A COURT OF COMPETENT JURISDICTION WHERE THE ACTION COULD HAVE BEEN ORIGINALLY FILED HAD THE PARTIES NOT AGREED TO SMALL CLAIMS ARBITRATION.

(XI) UNLESS THE PARTIES STIPULATE OR OTHERWISE AGREE IN WRITING, EITHER PARTY SHALL HAVE THE RIGHT TO APPEAL THE AWARD FOR A TRIAL DE NOVO IN A COURT OF COMPETENT JURISDICTION. NO REFERENCE TO THE AGREEMENT OF MEDICAL MALPRACTICE SMALL CLAIMS ARBITRATION, THE HEARING, THE FINDINGS OR THE AWARD SHALL BE MADE DURING A SUBSEQUENT TRIAL, EXCEPT THAT TESTIMONY INTRODUCED AT THE ARBITRATION HEARING MAY BE USED FOR PURPOSES OTHERWISE PERMITTED UNDER THE LAWS OF THIS COMMONWEALTH. AN APPEAL BY ANY PARTY SHALL BE DEEMED AN APPEAL BY ALL PARTIES AS TO ALL ISSUES UNLESS OTHERWISE STIPULATED TO IN WRITING BY ALL PARTIES. THE APPEAL SHALL BE FILED IN ACCORDANCE WITH THE PENNSYLVANIA RULES OF CIVIL PROCEDURE.

(XII) UNLESS AN APPEAL IS PROPERLY FILED, A DEFENDANT SHALL, IF THERE WAS NO FINDING OF JOINT AND SEVERAL LIABILITY, IMMEDIATELY PAY ANY MONETARY ARBITRATION AWARD OR ITS RESPECTIVE PORTION OF THE AWARD. IF NO APPEAL HAS BEEN PROPERLY FILED AND THE ARBITRATION HAS NOT BEEN PAID BY THE 30TH DAY FROM THE DATE OF THE AWARD, INTEREST SHALL ACCRUE AT THE RATE OF 18% PER ANNUM FROM THE DATE OF THE AWARD. THE AWARD MAY BE ENFORCED

PURSUANT TO THE PENNSYLVANIA RULES OF CIVIL PROCEDURE.

(XIII) OTHER THAN AS PROVIDED FOR IN THIS SECTION, THE PROCEDURES THAT CAN BE UNDERTAKEN ONCE AN AWARD HAS BEEN RENDERED, INCLUDING, BUT NOT LIMITED TO, TRANSFERRING, RECORDING AND ENFORCING A JUDGMENT, SHALL BE GOVERNED BY THE PENNSYLVANIA RULES OF CIVIL PROCEDURE.

(XIV) THE SERVICE OF A STATEMENT OF CLAIM AND NOTICE OF INTENT SHALL TOLL THE STATUTE OF LIMITATIONS. ALL CLAIMS FOR RECOVERY PURSUANT TO THIS SECTION MUST BE COMMENCED WITHIN THE APPLICABLE STATUTE OF LIMITATIONS.

(3) (I) IN ORDER TO UTILIZE THE MEDICAL MALPRACTICE SMALL CLAIMS MEDIATION PROCEDURE SET FORTH IN THIS SUBSECTION, ALL PARTIES MUST AGREE IN WRITING TO THE PROCEDURE. THE MEDIATION PROCEDURE SHALL BE COMMENCED BY THE CLAIMANT SERVING THE DEFENDANT, VIA CERTIFIED OR REGISTERED MAIL, WITH A STATEMENT OF CLAIM AND NOTICE OF INTENT. THE STATEMENT OF CLAIM SHALL SET FORTH, WITH SUFFICIENT SPECIFICITY AS REQUIRED IN A FORMAL CIVIL COMPLAINT PURSUANT TO THE PENNSYLVANIA RULES OF CIVIL PROCEDURE, THE NATURE OF THE ALLEGED MALPRACTICE, THE RESULTING INJURIES AND THE DAMAGES SOUGHT. THE NOTICE OF INTENT SHALL STATE THAT THE CLAIMANT DESIRES TO HAVE THE CLAIM HEARD BY MEDICAL MALPRACTICE SMALL CLAIMS MEDIATION AND INQUIRES WHETHER THE DEFENDANT DESIRES THE SAME. IF THE DEFENDANT DOES NOT RESPOND WITHIN 30 DAYS OF SERVICE OF THE STATEMENT OF CLAIM AND NOTICE OF INTENT, IT SHALL BE DEEMED THAT THE DEFENDANT DOES NOT AGREE TO HAVE THE CLAIM HEARD BY MEDICAL MALPRACTICE SMALL CLAIMS MEDIATION AND THE CLAIM SHALL NOT BE HEARD IN THAT MANNER. IF THE DEFENDANT DOES AGREE TO HAVE THE CLAIM HEARD IN THAT

MANNER, AN AFFIRMATIVE RESPONSE SHALL BE SERVED UPON THE CLAIMANT WITHIN 30 DAYS OF INITIAL SERVICE ALONG WITH AN ANSWER TO THE STATEMENT OF CLAIM AS WOULD BE FILED IN RESPONSE TO A FORMAL CIVIL COMPLAINT PURSUANT TO THE PENNSYLVANIA RULES OF CIVIL PROCEDURE. A DEFENDANT'S AGREEMENT, DISAGREEMENT OR LACK OF RESPONSE TO A MEDICAL MALPRACTICE SMALL CLAIMS MEDIATION REQUEST SHALL IN NO WAY BE DEEMED AN ADMISSION OF LIABILITY.

(II) THE CONDUCT OF MEDICATION CONFERENCES SHALL BE AS FOLLOWS:

(A) TESTIMONY SHALL BE SUBMITTED BY AFFIDAVIT, OPINION LETTER, DEPOSITION TESTIMONY AND CURRICULUM VITAE AND EXHIBITS, INCLUDING, BUT NOT LIMITED TO, PHOTOGRAPHS, MEDICAL RECORDS, REPORTS AND BILLS, RADIOLOGY STUDIES, EMPLOYMENT RECORDS, WAGE INFORMATION, BUSINESS RECORDS, OFFICIAL RECORDS MAINTAINED BY THE COMMONWEALTH AND STANDARD U.S. GOVERNMENT LIFE EXPECTANCY TABLES CAN BE SUBMITTED IF AT LEAST 30 DAYS' ADVANCE WRITTEN NOTICE WAS GIVEN TO THE OPPOSING PARTY ALONG WITH COPIES OF ALL MATERIALS THAT ARE TO BE SUBMITTED.

(B) ANY MATERIALS SUBMITTED MAY BE USED ONLY FOR PURPOSES WHICH WOULD BE PERMISSIBLE IF THE PERSON WHOSE TESTIMONY IS WAIVED WERE PRESENT AND TESTIFYING AT THE HEARING.

(C) LEGAL MEMORANDA MAY BE SUBMITTED.

(D) THE MEDIATOR SHALL ENSURE THAT A FULL, FAIR AND IMPARTIAL MEDIATION AND REVIEW OF THE EVIDENCE IS CONDUCTED.

(E) OTHER THAN THE MEDIATOR, ONLY COUNSEL OF THE

PARTIES SHALL ATTEND THE MEDIATION CONFERENCE.

(F) UNLESS THE PARTIES AGREE OTHERWISE, THE MEDIATION CONFERENCE SHALL BE HELD IN THE COUNTY WHERE THE CAUSE OF ACTION AROSE.

(G) ANY DISCUSSIONS OR STATEMENTS MADE DURING THE MEDIATION CONFERENCE SHALL REMAIN CONFIDENTIAL, SHALL NOT BE DEEMED ADMISSIONS BY A PARTY AND SHALL NOT BE UTILIZED IN ANY FUTURE PROCEEDING.

(III) THE FOLLOWING CRITERIA SHALL APPLY TO MEDIATION CONFERENCES:

(A) THERE SHALL BE ONE MEDIATOR FOR EACH MEDIATION CONFERENCE.

(B) EACH MEDIATOR SHALL BE AN ATTORNEY LICENSED IN THE COMMONWEALTH, IN PRIVATE PRACTICE, WHO HAS AT LEAST TEN YEARS OF MEDICAL MALPRACTICE LITIGATION EXPERIENCE AND WHO HAS REPRESENTED BOTH CLAIMANTS AND PHYSICIANS IN MEDICAL MALPRACTICE CASES.

(C) THE PARTIES CAN AGREE ON A MEDIATOR OR THE COMMISSIONER SHALL SELECT A MEDIATOR IF THE PARTIES ARE UNABLE TO AGREE AND AT LEAST 60 DAYS HAVE PASSED SINCE THE PARTIES AGREED TO HAVE THE CLAIM DECIDED UNDER THIS SUBSECTION.

(D) THE MEDIATOR SHALL BE INDEPENDENT OF ALL PARTIES, WITNESSES AND LEGAL COUNSEL.

(E) THE COMPENSATION FOR THE MEDIATOR SHALL BE SHARED BY THE PARTIES.

(F) AFTER THE MEDIATOR IS SELECTED THERE SHALL BE NO EX PARTE COMMUNICATION WITH THE MEDIATOR BY THE PARTIES OR THEIR COUNSEL.

(G) THE MEDIATOR SHALL CONSIDER ALL RELEVANT

EVIDENCE THAT HAS BEEN PROPERLY SUBMITTED ALONG WITH ANY LEGAL MEMORANDA TO HELP THE PARTIES REACH A RESOLUTION OF THE CLAIM.

(H) THE MEDIATOR SHALL DETERMINE THE DATE, TIME AND PLACE OF THE CONFERENCE AND SHALL PROVIDE THE PARTIES WITH AT LEAST 30 DAYS' ADVANCE NOTICE.

(I) THE MEDIATOR SHALL NOT BE CALLED AS A WITNESS IN ANY FUTURE PROCEEDING.

(IV) EACH PARTY SHALL PROVIDE UP TO FIVE DEPOSITIONS WITHOUT ANY REQUEST TO BE COMPENSATED FOR LOST WAGES OR TRAVEL EXPENSES. ALL DEPOSITIONS SHALL BE HELD IN THIS COMMONWEALTH. THE PARTIES SHALL AGREE WHERE THE DEPOSITIONS ARE TO BE HELD WITH THE OBJECTIVE OF MINIMIZING THE EXPENSE AND INCONVENIENCE OF THE PARTIES AND WITNESSES. IF THE PARTIES CANNOT AGREE, THE MEDIATOR SHALL DECIDE WHEN AND WHERE THE DEPOSITION WILL BE HELD. PARTIES SHALL BEAR THEIR OWN EXPENSES AND THOSE OF THEIR COUNSEL. THE PARTY REQUESTING THE DEPOSITION SHALL BEAR ANY COSTS OF THE WITNESS AND ANY STENOGRAPHIC AND VIDEO COSTS OF THE DEPOSITION.

(V) EXCEPT AS PROVIDED FOR IN THIS ACT, THE PARTIES MAY EXERCISE ALL DISCOVERY RIGHTS, REMEDIES AND PROCEDURES AVAILABLE AS IF THE CLAIM WERE PENDING IN A COURT OF COMMON PLEAS EXCEPT THAT THE CHAIR ARBITRATOR SHALL DECIDE ALL DISCOVERY ISSUES AND THERE SHALL BE NO RIGHT TO APPEAL THE CHAIR ARBITRATOR'S DECISION REGARDING DISCOVERY ISSUES.

(VI) THE TOTAL DAMAGES, EXCLUDING ANY AWARD OF DELAY DAMAGES, THE MEDIATOR CAN RECOMMEND FOR ANY AND ALL DAMAGES PER CLAIM, WHETHER A CLAIM INCLUDES ONE OR MORE

INDIVIDUAL CLAIMANTS, CANNOT EXCEED $250,000.

(VII) IF THE PARTIES STIPULATE OR OTHERWISE AGREE IN WRITING THAT THE MEDIATOR'S RECOMMENDATION SHALL BE BINDING, THE CLAIMANT SHALL BE ENTITLED TO REASONABLE ATTORNEY FEES AND, IF APPLICABLE, COSTS AND DELAY DAMAGES IF THE CLAIMANT IS THE PREVAILING PARTY.

(VIII) UNLESS THE PARTIES STIPULATE OR OTHERWISE AGREE IN WRITING, THE RECOMMENDATIONS BY THE MEDIATOR SHALL NOT BE BINDING.

(IX) IF THE PARTIES RESOLVE THE CLAIM, ANY MONETARY SETTLEMENT SHALL BE PAID WITHIN 30 DAYS. IF THE SETTLEMENT AMOUNT HAS NOT BEEN PAID IN FULL BY THE 30TH DAY FROM THE DATE OF SETTLEMENT OF THE CLAIM, INTEREST SHALL ACCRUE AT THE RATE OF 18% PER ANNUM FROM THE DATE OF THE SETTLEMENT. IF A NONBREACHING PARTY HAS TO FILE AN ACTION WITH A COURT FOR BREACH OF CONTRACT OR TO OTHERWISE ENFORCE THE SETTLEMENT AGREEMENT, REASONABLE ATTORNEY FEES, COSTS AND A PENALTY OF 50% OF THE SETTLEMENT MAY BE IMPOSED ON THE BREACHING PARTY.

(X) THE SERVICE OF A STATEMENT OF CLAIM AND NOTICE OF INTENT WILL TOLL THE STATUTE OF LIMITATIONS. ALL CLAIMS FOR RECOVERY PURSUANT TO THIS SUBSECTION MUST BE COMMENCED WITHIN THE APPLICABLE STATUTE OF LIMITATIONS.

(4) AFTER A WRIT OF SUMMONS OR COMPLAINT HAS BEEN PROPERLY FILED, THE PARTIES MAY AGREE, IF PERMITTED BY THE COURT IN WHICH THE SUMMONS OR COMPLAINT HAS BEEN FILED, TO HAVE THE CLAIM HEARD BY WAY OF SUMMARY JURY TRIAL. UNLESS THE COURT IN WHICH THE SUMMONS OR COMPLAINT WAS FILED PROVIDES OTHERWISE, THE SUMMARY JURY TRIAL PROCEDURE SHALL BE AS FOLLOWS:

(I) UNLESS OTHERWISE AGREED TO BY THE PARTIES, THE SUMMARY JURY TRIAL SHALL NOT BE BINDING.

(II) THE PARTIES, THEIR COUNSEL AND AN INDIVIDUAL WHO HAS SETTLEMENT AUTHORITY SHALL ATTEND THE SUMMARY JURY TRIAL.

(III) THE PARTIES SHALL AT ALL TIMES EXERCISE GOOD FAITH EFFORT TO AMICABLY RESOLVE THE CLAIM.

(IV) UNLESS OTHERWISE AGREED TO BY THE PARTIES, SUMMARY JURIES SHALL CONSIST OF 12 JURORS.

(V) EACH PARTY SHALL BE ENTITLED TO TWO PEREMPTORY CHALLENGES.

(VI) THE CLAIMANT SHALL PROCEED FIRST AND MAY SAVE A PORTION OF HIS ALLOTTED TIME FOR REBUTTAL.

(VII) COUNSEL FOR EACH PARTY SHALL BE ENTITLED TO A ONE-HALF HOUR PRESENTATION OF THE CASE. THE PRESENTATION MAY INVOLVE A COMBINATION OF ARGUMENT, A SUMMARY OF THE EVIDENCE TO BE PRESENTED AND A STATEMENT OF THE APPLICABLE LAW, IF NEEDED TO ANSWER ANY SPECIAL VERDICT QUESTIONS. COUNSEL MAY QUOTE FROM DEPOSITIONS AND MAY USE EXHIBITS. COUNSEL SHALL PROVIDE A LIST OF EXHIBITS HE INTENDS TO USE TO OPPOSING COUNSEL AT LEAST 30 DAYS PRIOR TO THE SUMMARY JURY TRIAL. COUNSEL SHALL PROVIDE PROPOSED JURY INSTRUCTIONS TO OPPOSING COUNSEL AND THE COURT AT LEAST 30 DAYS PRIOR TO THE SUMMARY JURY TRIAL. NOTHING DONE BY COUNSEL WITH REGARD TO THE SUMMARY JURY TRIAL WILL BE BINDING ON COUNSEL OR THE PARTIES OR SHALL CONSTITUTE A WAIVER.

(VIII) NO LIVE TESTIMONY SHALL BE PERMITTED.

(IX) THE CLAIM SHALL BE SUBMITTED TO THE JURY BY SPECIAL VERDICT QUESTIONS WHICH WILL BE PROVIDED BY THE

PARTIES.

(X) A MAJORITY VERDICT REPRESENTING 5/6 OF THE JURY SHALL BE REQUIRED WITH RESPECT TO EACH VERDICT QUESTION.

(XI) THE JURY SHALL DETERMINE LIABILITY AND DAMAGES.

(5) THE METHODS OF DISPUTE RESOLUTION IN THIS SUBSECTION SHALL NOT BE CONSTRUED AS A LIMITATION ON THE PARTIES' ABILITY TO AGREE ON ALTERNATIVE DISPUTE RESOLUTION METHODS OR TO AGREE TO MODIFY THE METHODS PROVIDED IN THIS SUBSECTION.

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SECTION 732. MEDICAL PROFESSIONAL LIABILITY INSURANCE.

(A) INSURANCE.--[THE] EXCEPT AS PROVIDED IN SUBSECTION (D), 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] EXCEPT AS PROVIDED IN SUBSECTION (D), 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] THE HEALTH CARE PROVIDERS IT INSURES TO SATISFY ITS INSURANCE REQUIREMENTS UNDER SECTION 711 ON REASONABLE AND NOT UNFAIRLY DISCRIMINATORY TERMS.

(5) PERMITS [A HEALTH CARE PROVIDER] THE HEALTH CARE PROVIDERS IT INSURES TO FINANCE ITS PREMIUM OR ALLOWS INSTALLMENT PAYMENT OF PREMIUMS SUBJECT TO CUSTOMARY TERMS AND CONDITIONS.

(C) CLAIMS-FREE CREDIT.--THE JOINT UNDERWRITING ASSOCIATION SHALL PROVIDE A DISCOUNT OF AT LEAST 15% ON THE APPLICABLE PREMIUM TO ANY NONINSTITUTIONAL FULL-TIME HEALTH CARE PROVIDER MAKING APPLICATION FOR INSURANCE COVERING A PERIOD OF AT LEAST SIX MONTHS, IF IT CAN BE DOCUMENTED THAT A HEALTH CARE PROVIDER HAS A CLAIMS-FREE EXPERIENCE. THIS SUBSECTION SHALL EXPIRE TEN YEARS AFTER THE EFFECTIVE DATE OF THIS SUBSECTION UNLESS MAINTAINING THE DISCOUNT IS PROVEN TO BE ACTUARILY JUSTIFIED. NO OTHER CREDIT FOR CLAIMS-FREE EXPERIENCE SHALL APPLY WHILE THIS SUBSECTION REMAINS IN FORCE.

(D) CERTAIN POLICIES PROHIBITED.--EXCEPT AS PROVIDED IN PARAGRAPH (5), THE JOINT UNDERWRITING ASSOCIATION SHALL NOT OFFER MEDICAL PROFESSIONAL LIABILITY INSURANCE TO ANY HEALTH CARE PROVIDER MAKING APPLICATION WHO DISCLOSES ANY OF THE FOLLOWING:

(1) THE HEALTH CARE PROVIDER'S MEDICAL LICENSE HAS BEEN REVOKED IN ANY STATE.

(2) THE HEALTH CARE PROVIDER'S LICENSE TO DISPENSE OR PRESCRIBE DRUGS OR MEDICATION HAS BEEN REVOKED IN THIS COMMONWEALTH OR ANY OTHER STATE.

(3) THE HEALTH CARE PROVIDER HAS HAD THREE OR MORE

MEDICAL LIABILITY CLAIMS IN THE PAST FIVE MOST RECENT YEARS IN WHICH THE JUDGMENT AGAINST THE PROVIDER OR SETTLEMENT ENTERED WAS $500,000 OR MORE FOR EACH CLAIM.

(4) THE HEALTH CARE PROVIDER HAS BEEN CONVICTED, OR ENTERED A PLEA OF GUILTY OR NO CONTEST FOR ANY OF THE FOLLOWING OFFENSES:

(I) A FELONY VIOLATION OF THE ACT OF APRIL 14, 1972 (P.L.233, NO.64), KNOWN AS THE CONTROLLED SUBSTANCE, DRUG, DEVICE AND COSMETIC ACT.

(II) 18 PA.C.S. CH. 25 (RELATING TO CRIMINAL HOMICIDE).

(III) 18 PA.C.S. § 2702 (RELATING TO AGGRAVATED ASSAULT).

(IV) 18 PA.C.S. § 2709.1 (RELATING TO STALKING).

(V) 18 PA.C.S. CH. 29 (RELATING TO KIDNAPPING).

(VI) 18 PA.C.S. CH. 31 (RELATING TO SEXUAL OFFENSES).

(VII) 18 PA.C.S. § 3301 (RELATING TO ARSON AND RELATED OFFENSES).

(VIII) 18 PA.C.S. § 3302 (RELATING TO CAUSING OR RISKING CATASTROPHE).

(IX) 18 PA.C.S. CH. 35 (RELATING TO BURGLARY AND OTHER CRIMINAL INTRUSION).

(X) 18 PA.C.S. CH. 37 (RELATING TO ROBBERY).

(XI) A FELONY VIOLATION UNDER 18 PA.C.S. CH. 39 (RELATING TO THEFT AND RELATED OFFENSES).

(XII) 18 PA.C.S. CH. 59 (RELATING TO PUBLIC INDECENCY).

(5) A HEALTH CARE PROVIDER WHO IS INELIGIBLE TO OBTAIN MEDICAL PROFESSIONAL LIABILITY INSURANCE UNDER PARAGRAPH (4)

MAY BECOME ELIGIBLE TO APPLY FOR SUCH INSURANCE WITH THE JOINT UNDERWRITING ASSOCIATION UPON A DETERMINATION BY THE HEALTH CARE PROVIDER'S STATE LICENSING BOARD THAT THE HEALTH CARE PROVIDER IS FIT TO PRACTICE MEDICINE. THE LICENSING BOARD SHALL MAKE SUCH A DETERMINATION UPON THE HEALTH CARE PROVIDER'S DEMONSTRATION TO THE LICENSING BOARD'S SATISFACTION THAT THE HEALTH CARE PROVIDER HAS BEEN REHABILITATED AND POSSESSES THE REQUISITE COMPETENCY, SKILL AND MORAL CHARACTER TO RETURN TO PRACTICE. THE HEALTH CARE PROVIDER SHALL NOT BE ELIGIBLE TO PETITION THE LICENSING BOARD FOR A DETERMINATION THAT HE IS FIT TO PRACTICE UNTIL AFTER THE RESOLUTION OF ANY DISCIPLINARY ACTION THAT MAY BE PENDING AGAINST THE HEALTH CARE PROVIDER BEFORE THE LICENSING BOARD.

(E) DEFINITIONS.--AS USED IN THIS SECTION, THE FOLLOWING WORDS AND PHRASES SHALL HAVE THE MEANINGS GIVEN TO THEM IN THIS SUBSECTION:

"CLAIMS-FREE EXPERIENCE." A DOCUMENTED PERIOD IN WHICH NO CLAIMS HAVE BEEN MADE AGAINST A HEALTH CARE PROVIDER OVER THE PAST FIVE MOST RECENT YEARS, AND THE HEALTH CARE PROVIDER HAS HAD CONTINUOUS INSURANCE COVERAGE IN FORCE FOR THE FIVE YEARS IMMEDIATELY PRECEDING THE PROPOSED EFFECTIVE DATE OF INSURANCE COVERAGE AND NO JOINT UNDERWRITING ASSOCIATION SURCHARGE APPLIES FOR THE FOLLOWING:

(1) LICENSING BOARD DISCIPLINARY PROCEDURES.

(2) HOSPITAL DISCIPLINARY PROCEEDINGS.

(3) MEDICARE AND MEDICAID ACTION.

(4) FEDERAL DRUG ENFORCEMENT ADMINISTRATION ACTION.

(5) THE CONTROLLED SUBSTANCE, DRUG, DEVICE AND COSMETIC ACT.

"FULL TIME." A HEALTH CARE PROVIDER WORKING MORE THAN 25 HOURS PER WEEK.

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]:

(1) 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).

(2) THERE IS A 20% DISCOUNT IN EACH PREMIUM FOR A HEALTH CARE PROVIDER THAT IMPLEMENTS, TO THE SATISFACTION OF THE DEPARTMENT OF HEALTH, A TOTAL QUALITY MANAGEMENT HEALTH CARE SYSTEM APPROVED BY THE DEPARTMENT OF HEALTH.

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] COMPLY WITH ALL OF THE FOLLOWING:

(1) 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.

(2) OFFER A 20% DISCOUNT IN THE PREMIUM FOR A HEALTH CARE PROVIDER THAT IMPLEMENTS, TO THE SATISFACTION OF THE DEPARTMENT OF HEALTH, A TOTAL QUALITY MANAGEMENT HEALTH CARE SYSTEM APPROVED BY THE DEPARTMENT OF HEALTH.

SECTION 747. CANCELLATION OF INSURANCE POLICY.

(A) TERMINATION.--A TERMINATION OF A MEDICAL PROFESSIONAL LIABILITY INSURANCE POLICY BY NONRENEWAL OR 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 NONRENEWAL OR CANCELLATION WAS [GIVEN WITHIN 60 DAYS AFTER THE ISSUANCE OF THE POLICY TO THE INSURED,] RECEIVED BY THE INSURED 120 DAYS PRIOR TO THE NONRENEWAL OR CANCELLATION AND NO NONRENEWAL OR CANCELLATION SHALL TAKE EFFECT UNLESS A WRITTEN NOTICE STATING THE REASONS FOR THE NONRENEWAL OR 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.

(B) PREMIUM INCREASE.--A PREMIUM INCREASE FOR A MEDICAL PROFESSIONAL LIABILITY INSURANCE POLICY SHALL NOT BE EFFECTIVE AGAINST THE INSURED UNLESS NOTICE OF THE PREMIUM INCREASE WAS RECEIVED BY THE INSURED 90 DAYS PRIOR TO THE PREMIUM INCREASE AND NO PREMIUM INCREASE SHALL TAKE EFFECT UNLESS A WRITTEN NOTICE STATING THE REASONS FOR THE PREMIUM INCREASE AND THE DATE AND TIME UPON WHICH THE PREMIUM INCREASE 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 7. THE ACT IS AMENDED BY ADDING CHAPTERS TO READ:

CHAPTER 8

VOLUNTARY CONTRACTUAL ARBITRATION

SECTION 801. SCOPE.

THIS CHAPTER RELATES TO VOLUNTARY CONTRACTUAL ARBITRATION OF CLAIMS OF PATIENTS ARISING FROM THE CARE AND TREATMENT OF HEALTH CARE PROVIDERS.

SECTION 802. 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:

"AGREEMENT." AN AGREEMENT TO SUBMIT ANY DISPUTE ARISING OUT OF OR RELATING TO MEDICAL TREATMENT OR MEDICAL SERVICES TO BINDING ARBITRATION, INCLUDING PROVISIONS RELATING TO FORUM, VENUE, PROCEDURES AND LIMITATIONS, IF ANY, ON DAMAGES RECOVERABLE AS LONG AS NO STATUTORY OR CONSTITUTIONAL PROVISION IS VIOLATED.

"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) OF THE ACT OF MARCH 20, 2002 (P.L.154, NO.13), KNOWN AS THE MEDICAL CARE AVAILABILITY AND REDUCTION OF ERROR (MCARE) ACT, AN OFFICER, EMPLOYEE OR AGENT OF ANY OF THEM ACTING IN THE COURSE AND SCOPE OF EMPLOYMENT PROVIDING MEDICAL CARE.

"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.

"PATIENT." A PERSON RECEIVING CARE OR TREATMENT BY A HEALTH CARE PROVIDER, INCLUDING A PERSON'S NATURAL, LEGAL OR APPOINTED GUARDIAN. IF THE PERSON RECEIVING CARE OR TREATMENT IS A MINOR, THE TERM SHALL ALSO INCLUDE A PARENT, NATURAL, LEGAL OR APPOINTED GUARDIAN. IN THE CASE OF A PREGNANT WOMAN, THE TERM SHALL REFER TO THE MOTHER.

SECTION 803. VOLUNTARY ARBITRATION.

(A) AGREEMENT.--A PATIENT AND ANY HEALTH CARE PROVIDER MAY EXECUTE AN AGREEMENT TO SUBMIT TO BINDING ARBITRATION ANY DISPUTE, CONTROVERSY OR ISSUE ARISING OUT OF CARE OR TREATMENT BY THE HEALTH CARE PROVIDER DURING THE PERIOD THAT THE AGREEMENT IS IN FORCE OR THAT HAS ALREADY ARISEN BETWEEN THE PARTIES.

(B) FORM AND CONTENTS OF AGREEMENT.--EXECUTION OF AN AGREEMENT UNDER THIS ACT BY A PATIENT MAY NOT BE MADE A PREREQUISITE TO RECEIPT OF CARE OR TREATMENT BY THE HEALTH CARE PROVIDER. AN AGREEMENT TO ARBITRATE, EXECUTED BEFORE CARE OR TREATMENT IS PROVIDED, SHALL BE A SEPARATE DOCUMENT, WRITTEN IN PLAIN LANGUAGE AND MUST:

(1) CLEARLY PROVIDE IN BOLD PRINT IN AT LEAST 12-POINT BOLD TYPE ON THE FACE OF THE AGREEMENT THAT EXECUTION OF THE AGREEMENT BY THE PATIENT IS NOT A PREREQUISITE TO RECEIVING CARE OR TREATMENT.

(2) CLEARLY PROVIDE IN AT LEAST 12-POINT BOLD, UPPERCASE TYPE:

(I) NOTICE WITH REGARD TO ANY TERMS OR CONDITIONS OF THE AGREEMENT THAT CONSTITUTE WAIVERS AND RIGHTS AFFECTED UPON EXECUTION; AND

(II) NOTICE WITH REGARD TO THE MANNER OF SELECTION

OF THE ARBITRATORS.

(3) CONTAIN THE FOLLOWING NOTICE ABOVE THE SIGNATURE LINE OF THE AGREEMENT IN AT LEAST 12-POINT BOLD, UPPERCASE TYPE.

BY SIGNING THIS CONTRACT YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL.

(4) ACKNOWLEDGE THE PATIENT'S RECEIPT OF THE AGREEMENT AND SHALL BE DATED.

(C) VOIDABLE AGREEMENT.--IF A HEALTH CARE PROVIDER DOES NOT COMPLY WITH THIS SECTION, THE AGREEMENT TO ARBITRATE IS VOIDABLE AT THE OPTION OF THE PATIENT.

(D) REVOCATION OF AGREEMENT.--THE AGREEMENT MUST PROVIDE THAT THE PATIENT MAY DO ANY OF THE FOLLOWING TO REVOKE THE AGREEMENT:

(1) NOTIFY THE HEALTH CARE PROVIDER IN WRITING WITHIN SEVEN DAYS AFTER TREATMENT HAS BEEN COMPLETED.

(2) NOTIFY THE HEALTH CARE PROVIDER IN WRITING WITHIN SEVEN DAYS AFTER THE PATIENT HAS RECEIVED NOTICE OF A SERIOUS EVENT PURSUANT TO SECTION 308.

(3) NOTIFY THE HEALTH CARE PROVIDER IN WRITING WITHIN 30 DAYS AFTER RETAINING COUNSEL IF THE PATIENT WAS NOT NOTIFIED OF A SERIOUS EVENT PURSUANT TO SECTION 308.

(E) REEXECUTION OF AGREEMENT.--AN AGREEMENT TO ARBITRATE BETWEEN A PATIENT AND A HOSPITAL MUST BE REEXECUTED EACH TIME A PERSON IS ADMITTED TO A HOSPITAL. THE AGREEMENT MAY BE EXTENDED BY WRITTEN AGREEMENT OF ALL PARTIES TO APPLY TO CARE AFTER HOSPITALIZATION. A PERSON RECEIVING OUTPATIENT CARE FROM A HOSPITAL OR CLINIC OR A MEMBER OF A HEALTH MAINTENANCE ORGANIZATION MAY EXECUTE AN AGREEMENT FOR A CONTINUING PROGRAM OF TREATMENT OR DURING CONTINUED MEMBERSHIP, BUT SHALL NOT BE

EFFECTIVE UNLESS RENEWED IN THE SAME MANNER AS AN ORIGINAL AGREEMENT AT LEAST ONCE EVERY 12 MONTHS.

(F) CONSTRUCTION OF AGREEMENT.--AN AGREEMENT TO ARBITRATE IS NOT A CONTRACT OF ADHESION, NOR UNCONSCIONABLE, NOR OTHERWISE IMPROPER, WHERE IT COMPLIES WITH THE PROVISIONS OF THIS ACT.

(G) ARBITRATION PROCEDURE.--THE PROCEDURE FOR ARBITRATION SHALL BE AS FOLLOWS:

(1) ARBITRATORS SHALL BE SELECTED IN THE SAME MANNER AS ARBITRATORS ARE SELECTED PURSUANT TO 42 PA.C.S. § 7361(A) (RELATING TO COMPULSORY ARBITRATION).

(2) ARBITRATION SHALL BE CONDUCTED IN ACCORDANCE WITH THE PROVISIONS OF 42 PA.C.S. CH. 73 SUBCH. A (RELATING TO STATUTORY ARBITRATION), EXCEPT AS FURTHER PROVIDED IN THIS SUBSECTION.

(3) AN ARBITRATOR SHALL BE SELECTED BY EACH PARTY AND THE TWO ARBITRATORS SHALL SELECT A THIRD ARBITRATOR. IF THE TWO ARBITRATORS SELECTED BY THE PARTIES CANNOT AGREE ON A THIRD ARBITRATOR WITHIN 30 DAYS OF THEIR SELECTION, EITHER ARBITRATOR MAY REQUEST THAT THE SELECTION BE MADE BY THE COURT HAVING JURISDICTION.

(4) EACH PARTY SHALL:

(I) BEAR THE EXPENSES INCURRED BY THE ARBITRATOR THEY SELECTED; AND

(II) EQUALLY BEAR THE EXPENSES INCURRED BY THE THIRD ARBITRATOR.

(5) ARBITRATION SHALL TAKE PLACE IN THE COUNTY IN WHICH THE PATIENT LIVES, UNLESS OTHERWISE AGREED TO BY BOTH PARTIES. LOCAL RULES OF PROCEDURE AND EVIDENCE SHALL APPLY TO THE PROCEEDINGS.

(6) A DECISION AGREED TO BY TWO OF THE ARBITRATORS SHALL

BE BINDING ON THE PARTIES.

CHAPTER 8-A

MCARE ASSESSMENT NEED PROGRAM

SECTION 801-A. SCOPE.

THIS CHAPTER RELATES TO THE MCARE ASSESSMENT NEED PROGRAM.

SECTION 802-A. 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:

"ASSESSMENT." THE ASSESSMENT LEVIED BY THE INSURANCE DEPARTMENT ON HEALTH CARE PROVIDERS, ESTABLISHED UNDER THIS ACT.

"ELIGIBLE APPLICANT." A PHYSICIAN LICENSED IN GOOD STANDING BY THE LICENSING BOARD, PRACTICING IN THIS COMMONWEALTH, WHO MEETS THE CRITERIA ESTABLISHED BY THE PROGRAM ADMINISTRATOR PURSUANT TO THIS CHAPTER AND WHO IS NOT DISQUALIFIED UNDER SECTION 803-A(D).

"LICENSING BOARD." THE STATE BOARD OF MEDICINE, THE STATE BOARD OF OSTEOPATHIC MEDICINE OR THE STATE BOARD OF PODIATRY.

"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.

"PHYSICIAN." AN INDIVIDUAL LICENSED OR CERTIFIED UNDER THE LAWS OF THIS COMMONWEALTH BY THE STATE BOARD OF MEDICINE, THE STATE BOARD OF OSTEOPATHIC MEDICINE OR THE STATE BOARD OF PODIATRY. THE TERM SHALL INCLUDE A LICENSED NURSE MIDWIFE.

"PROGRAM." THE MCARE ASSESSMENT NEED PROGRAM ESTABLISHED UNDER SECTION 803-A(A).

"PROGRAM ADMINISTRATOR." THE STATE AGENCY, BUREAU,

DEPARTMENT OR OFFICE DESIGNATED BY THE GOVERNOR TO ADMINISTER THE MCARE ASSESSMENT NEED PROGRAM.

SECTION 803-A. MCARE ASSESSMENT NEED PROGRAM.

(A) PROGRAM ESTABLISHED.--THE MCARE ASSESSMENT NEED PROGRAM IS HEREBY ESTABLISHED TO PROVIDE ASSESSMENT REDUCTIONS TO ELIGIBLE APPLICANTS. THE PROGRAM SHALL APPLY TO POLICIES DUE ON OR AFTER JANUARY 1, 2003.

(B) RESTRICTED RECEIPTS ACCOUNT.--THERE IS HEREBY ESTABLISHED IN THE TREASURY DEPARTMENT A NONLAPSING RESTRICTED RECEIPTS ACCOUNT, TO BE KNOWN AS THE MCARE ASSESSMENT NEED PROGRAM ACCOUNT, FOR THE PURPOSE OF FUNDING ASSESSMENT REDUCTIONS FOR ELIGIBLE APPLICANTS.

(C) ELIGIBILITY.--TO BE ELIGIBLE FOR AN ASSESSMENT REDUCTION UNDER THE PROGRAM, A PHYSICIAN MUST SUBMIT DOCUMENTATION INCLUDING, BUT NOT LIMITED TO, THE FOLLOWING:

(1) STATEMENT OF EARNED AND UNEARNED INCOME;

(2) FEDERAL AND STATE TAX RETURNS AND SUPPORTING DOCUMENTATION;

(3) DOCUMENTATION OF PAID MEDICAL PROFESSIONAL LIABILITY INSURANCE PAYMENT, INCLUDING THE PRIMARY COVERAGE AND THE ASSESSMENT;

(4) OTHER INFORMATION AS THE PROGRAM ADMINISTRATOR MAY REQUIRE; AND

(5) FEDERAL AND STATE TAX RETURNS AND SUPPORTING DOCUMENTATION OF THE THIRD PARTY, IF THE PHYSICIAN'S PREMIUMS OR SURCHARGES ARE PAID BY A THIRD PARTY.

(D) PROHIBITIONS.--A PHYSICIAN SHALL NOT BE ELIGIBLE FOR PARTICIPATION IN THE PROGRAM IF ANY OF THE FOLLOWING APPLY:

(1) THE PHYSICIAN'S MEDICAL LICENSE HAS BEEN REVOKED IN ANY STATE.

(2) THE PHYSICIAN'S LICENSE TO DISPENSE OR PRESCRIBE DRUGS OR MEDICATION HAS BEEN REVOKED IN THIS COMMONWEALTH OR ANY OTHER STATE.

(3) THE PHYSICIAN HAS HAD THREE OR MORE MEDICAL LIABILITY CLAIMS IN THE PAST FIVE MOST RECENT YEARS IN WHICH THE JUDGMENT AGAINST THE PROVIDER OR SETTLEMENT ENTERED WAS $500,000 OR MORE FOR EACH CLAIM.

(4) THE PHYSICIAN HAS BEEN CONVICTED OR ENTERED A PLEA OF GUILTY OR NO CONTEST FOR ANY OF THE FOLLOWING OFFENSES:

(I) A FELONY VIOLATION OF THE ACT OF APRIL 14, 1972 (P.L.233, NO.64), KNOWN AS THE CONTROLLED SUBSTANCE, DRUG, DEVICE AND COSMETIC ACT.

(II) 18 PA.C.S. CH. 25 (RELATING TO CRIMINAL HOMICIDE).

(III) 18 PA.C.S. § 2702 (RELATING TO AGGRAVATED ASSAULT).

(IV) 18 PA.C.S. § 2709.1 (RELATING TO STALKING).

(V) 18 PA.C.S. CH. 29 (RELATING TO KIDNAPPING).

(VI) 18 PA.C.S. CH. 31 (RELATING TO SEXUAL OFFENSES).

(VII) 18 PA.C.S. § 3301 (RELATING TO ARSON AND RELATED OFFENSES).

(VIII) 18 PA.C.S. § 3302 (RELATING TO CAUSING OR RISKING CATASTROPHE).

(IX) 18 PA.C.S. CH. 35 (RELATING TO BURGLARY AND OTHER CRIMINAL INTRUSION).

(X) 18 PA.C.S. CH. 37 (RELATING TO ROBBERY).

(XI) A FELONY VIOLATION UNDER 18 PA.C.S. CH. 39 (RELATING TO THEFT AND RELATED OFFENSES).

(XII) 18 PA.C.S. CH. 59 (RELATING TO PUBLIC

INDECENCY).

(E) PROGRAM ADMINISTRATOR DUTIES.--THE PROGRAM ADMINISTRATOR SHALL:

(1) ADMINISTER THE PROGRAM AND ESTABLISH PROCEDURES AND FORMS AS MAY BE NECESSARY TO IMPLEMENT THE PROGRAM.

(2) ESTABLISH CRITERIA TO IDENTIFY ASSESSMENT REDUCTION RECIPIENTS FROM AMONG ALL PHYSICIANS WHO QUALIFY AND APPLY FOR A REDUCTION AND THE AMOUNT OF EACH REDUCTION. THE CRITERIA SHALL INCLUDE THE AMOUNT OF FUNDS ALLOCATED TO THE PROGRAM, THE APPLICANT'S ACTUAL FINANCIAL NEED, THE COMMUNITY-BASED NEED FOR THE APPLICANT'S SERVICES AND THE APPLICANT'S SPECIALTY CLASSIFICATION. THE PROGRAM ADMINISTRATOR MAY ESTABLISH ANY OTHER CRITERIA NECESSARY TO ENSURE ACCESS TO QUALITY HEALTH CARE IN ALL REGIONS OF THIS COMMONWEALTH.

(3) AWARD REDUCTIONS IN ASSESSMENTS TO ELIGIBLE APPLICANTS BY NO LATER THAN 90 DAYS AFTER THE PRECEDING CALENDAR YEAR FOR WHICH THE NECESSARY DOCUMENTATION IS REQUIRED.

(4) REQUIRE ASSESSMENT REDUCTION RECIPIENTS TO MAINTAIN ALL NECESSARY INFORMATION IN A FORMAT SPECIFIED BY THE PROGRAM ADMINISTRATOR.

(5) PROMULGATE REGULATIONS TO IMPLEMENT THIS CHAPTER.

(6) REPORT TO THE GOVERNOR AND 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 ON THE REDUCTIONS AWARDED, THE IMPACT ON THE RECIPIENTS AND THE AMOUNT DISBURSED BY THE PROGRAM. IN ADDITION TO THE CONTENT SPECIFIED IN THIS PARAGRAPH, THE REPORT SHALL INCLUDE ANY

OTHER INFORMATION NECESSARY TO ACCURATELY INFORM THE PUBLIC ABOUT THE PROGRAM, DEMOGRAPHICS OF ELIGIBLE APPLICANTS AND ASSESSMENT REDUCTION RECIPIENTS, THE FINANCIAL CONDITION OF HEALTH CARE PROVIDERS IN THIS COMMONWEALTH AND PATIENTS' ACCESS TO HEALTH CARE IN THIS COMMONWEALTH. THE REPORT SHALL BE DUE NOVEMBER 30 OF EACH YEAR AND SHALL BE MADE AVAILABLE FOR PUBLIC INSPECTION AND POSTED ON THE PROGRAM ADMINISTRATOR'S PUBLICLY ACCESSIBLE WORLD WIDE WEB SITE.

(F) CONFIDENTIAL INFORMATION.--THE DOCUMENTATION SPECIFIED IN SUBSECTION (C) SHALL BE CONFIDENTIAL AND SHALL NOT BE RELEASED TO ANYONE.

(G) EXPIRATION.--THIS SECTION SHALL EXPIRE JANUARY 1, 2014.

SECTION 804-A. PROGRAM FUNDING.

(A) DEPOSIT.--

(1) NOTWITHSTANDING THE PROVISIONS OF 75 PA.C.S. § 6506(B) (RELATING TO SURCHARGE) AND SECTION 712(M) TO THE CONTRARY, 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 MCARE ASSESSMENT NEED PROGRAM ACCOUNT.

(2) 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.

(B) TRANSFER OF FUNDS.--AMOUNTS DEPOSITED IN THE MEDICAL CARE AVAILABILITY AND RESTRICTION OF ERROR FUND IN ACCORDANCE WITH SECTION 712(M) AFTER DECEMBER 31, 2002, AND BEFORE THE EFFECTIVE DATE OF THIS SECTION SHALL BE TRANSFERRED BY THE STATE TREASURER TO THE MCARE ASSESSMENT NEED PROGRAM ACCOUNT.

(C) USE OF FUNDS.--AMOUNTS DEPOSITED OR TRANSFERRED INTO THE MCARE ASSESSMENT NEED PROGRAM ACCOUNT SHALL BE USED BY THE

PROGRAM ADMINISTRATOR TO PROVIDE ASSESSMENT REDUCTIONS TO ELIGIBLE APPLICANTS AS DETERMINED UNDER SECTION 3.

(D) EXPIRATION.--EXCEPT FOR SUBSECTION (A)(2), THIS SECTION SHALL EXPIRE JANUARY 1, 2014.

SECTION 805-A. INTERIM REGULATIONS.

THE PROGRAM ADMINISTRATOR SHALL PROMULGATE INTERIM REGULATIONS TO IMPLEMENT THE PROGRAM WITHIN 90 DAYS OF THE EFFECTIVE DATE OF THIS SECTION. THE INTERIM REGULATIONS SHALL EXPIRE AFTER TWO YEARS OR UPON THE ADOPTION OF FINAL REGULATIONS, WHICHEVER IS EARLIER. THE INTERIM REGULATIONS SHALL NOT BE SUBJECT TO SECTION 201 OR 205 OF THE ACT OF JULY 31, 1968 (P.L.769, NO.240), REFERRED TO AS THE COMMONWEALTH DOCUMENTS LAW.

CHAPTER 8-B

HEALTH CARE PROVIDER REIMBURSEMENTS

SECTION 801-B. SCOPE.

THIS CHAPTER RELATES TO HEALTH INSURANCE REIMBURSEMENTS FOR HIGH RISK HEALTH CARE PROVIDERS AND INSTITUTIONS.

SECTION 802-B. FINDINGS.

THE GENERAL ASSEMBLY OF THE COMMONWEALTH OF PENNSYLVANIA FINDS THAT:

(1) MANY HIGH RISK HEALTH CARE PROVIDERS AND INSTITUTIONS IN THIS COMMONWEALTH ARE RECEIVING REIMBURSEMENTS EVEN LESS THAN MEDICARE RATES FOR SERVICES THEY PROVIDE FOR COVERED CARE.

(2) HIGH RISK HEALTH CARE PROVIDERS AND INSTITUTIONS ARE CURRENTLY BEING UNDERCOMPENSATED FOR TREATMENTS AND SERVICES PROPERLY COVERED UNDER HEALTH INSURANCE POLICIES.

(3) THE CONTINUING LOW REIMBURSEMENT RATES TO THESE PROVIDERS THREATEN THE HEALTH, SAFETY AND WELFARE OF THE

CITIZENS OF THIS COMMONWEALTH BECAUSE HIGH RISK HEALTH CARE PROVIDERS AND INSTITUTIONS MAY LEAVE THIS COMMONWEALTH OR CLOSE DOWN IF THE LOW REIMBURSEMENTS CONTINUE SIMILAR TO WHAT HAS HAPPENED IN THE STATE OF CALIFORNIA.

(4) FAIR REIMBURSEMENTS MUST BE ESTABLISHED FOR HIGH RISK HEALTH CARE PROVIDERS AND INSTITUTIONS FOR SERVICES PROVIDED TO INDIVIDUALS FOR CARE, TREATMENTS AND SERVICES COVERED UNDER HEALTH INSURANCE POLICIES.

SECTION 803-B. 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:

"HEALTH INSURANCE POLICY." AN INDIVIDUAL OR GROUP HEALTH INSURANCE POLICY, CONTRACT OR PLAN WHICH PROVIDES MEDICAL, MENTAL, DENTAL, OPTICAL, PSYCHOLOGICAL OR HEALTH CARE COVERAGE BY ANY HEALTH CARE FACILITY OR LICENSED HEALTH CARE PROVIDER ON AN EXPENSE INCURRED, SERVICE OR PREPAID BASIS WHICH IS OFFERED BY OR IS GOVERNED UNDER ANY OF THE FOLLOWING:

(1) THE ACT OF MAY 17, 1921 (P.L.682, NO.284), KNOWN AS THE INSURANCE COMPANY LAW OF 1921.

(2) THE ACT OF JUNE 13, 1967 (P.L.31, NO.21), KNOWN AS THE PUBLIC WELFARE CODE.

(3) THE ACT OF DECEMBER 29, 1972 (P.L.1701, NO.364), KNOWN AS THE HEALTH MAINTENANCE ORGANIZATION ACT.

(4) THE ACT OF MAY 18, 1976 (P.L.123, NO.54), KNOWN AS THE INDIVIDUAL ACCIDENT AND SICKNESS INSURANCE MINIMUM STANDARDS ACT.

(5) A NONPROFIT CORPORATION SUBJECT TO 40 PA.C.S. CHS. 61 (RELATING TO HOSPITAL PLAN CORPORATIONS) AND 63 (RELATING TO PROFESSIONAL HEALTH SERVICES PLAN CORPORATIONS).

"HIGH RISK INSTITUTION." ANY LEVEL I OR LEVEL II TRAUMA CENTER ACCREDITED BY THE PENNSYLVANIA TRAUMA SYSTEMS FOUNDATION UNDER THE ACT OF JULY 3, 1985 (P.L.164, NO.45), KNOWN AS THE EMERGENCY MEDICAL SERVICES ACT.

"HIGH RISK PROVIDER." A MEDICAL PROVIDER WHO PAYS MEDICAL MALPRACTICE PREMIUMS IN THIS COMMONWEALTH IN ONE OF THE FOUR HIGHEST CLASSES.

"INSURER." AN ENTITY THAT INSURES AN INDIVIDUAL OR GROUP HEALTH INSURANCE POLICY, CONTRACT OR PLAN DESCRIBED UNDER A HEALTH INSURANCE POLICY.

SECTION 804-B. FAIR REIMBURSEMENTS FOR HIGH RISK HEALTH CARE PROVIDERS AND INSTITUTIONS.

(A) GENERAL RULE.--SUBJECT TO SUBSECTION (B), EVERY HEALTH INSURANCE POLICY THAT PROVIDES COVERAGE TO AN INDIVIDUAL AND IS EFFECTIVE, DELIVERED, ISSUED, EXECUTED OR RENEWED IN THIS COMMONWEALTH ON OR AFTER THE EFFECTIVE DATE OF THIS CHAPTER SHALL PROVIDE PAYMENT TO ANY HIGH RISK HEALTH CARE PROVIDER OR HIGH RISK INSTITUTION PROVIDING ANY CARE COVERED UNDER A HEALTH INSURANCE POLICY FOR ALL CARE INCLUDING TREATMENT, ACCOMMODATION, PRODUCTS, OR SERVICES TO A COVERED INDIVIDUAL FOR TREATMENTS AT A MINIMUM OF 110% OF THE APPLICABLE FEE SCHEDULE, THE RECOMMENDED FEE OR THE INFLATION INDEX CHARTS; OR 110% OF THE DIAGNOSTIC-RELATED GROUPS (DRG) PAYMENT; WHICHEVER PERTAINS TO THE SPECIALTY SERVICE INVOLVED, DETERMINED TO BE APPLICABLE IN THIS COMMONWEALTH UNDER THE MEDICARE PROGRAM AND ITS REGULATIONS FOR COMPARABLE SERVICES AT THE TIME THE SERVICES WERE RENDERED OR AT THE PROVIDER'S USUAL AND CUSTOMARY CHARGE, WHICHEVER IS LESS.

(B) MEDICARE ALLOWANCE MODIFICATIONS.--

(1) THE GENERAL ASSEMBLY FINDS THAT THE REIMBURSEMENT

ALLOWANCE APPLICABLE IN THIS COMMONWEALTH UNDER THE MEDICARE PROGRAM IS AN APPROPRIATE BASIS TO CALCULATE PAYMENTS FOR CARE INCLUDING TREATMENTS, ACCOMMODATIONS, PRODUCTS OR SERVICES FOR CARE AND TREATMENT.

(2) FUTURE CHANGES OR ADDITIONS TO THE MEDICARE ALLOWANCES SHALL APPLY TO THIS SECTION. IF THE INSURANCE COMMISSIONER DETERMINES THAT AN ALLOWANCE UNDER MEDICARE IS NOT REASONABLE, THE INSURANCE COMMISSIONER MAY ADOPT A DIFFERENT ALLOWANCE BY REGULATION, WHICH ALLOWANCE SHALL BE APPLIED AGAINST A PERCENTAGE LIMITATION IN THIS SECTION.

(3) IF A PREVAILING CHARGE, FEE SCHEDULE, RECOMMENDED FEE, INFLATION INDEX CHARGE OR DRG PAYMENT IS NOT BEING CALCULATED UNDER THE MEDICARE PROGRAM FOR A PARTICULAR TREATMENT, ACCOMMODATION, PRODUCT OR SERVICE, THE REIMBURSEMENT MAY NOT BE LESS THAN 80% OF THE PROVIDER'S USUAL AND CUSTOMARY CHARGE.

(4) IF ACUTE CARE IS PROVIDED IN AN ACUTE CARE FACILITY TO A PATIENT WITH IMMEDIATE LIFE-THREATENING OR URGENT INJURY BY A LEVEL I OR LEVEL II TRAUMA CENTER, ACCREDITED BY THE PENNSYLVANIA TRAUMA SYSTEMS FOUNDATION UNDER THE ACT OF JULY 3, 1985 (P.L.164, NO.45), KNOWN AS THE EMERGENCY MEDICAL SERVICES ACT, OR TO A MAJOR BURN INJURY PATIENT BY A BURN FACILITY WHICH MEETS ALL OF THE SERVICE STANDARDS OF THE AMERICAN BURN ASSOCIATION, THE REIMBURSEMENT MAY NOT BE LESS THAN THE USUAL OR CUSTOMARY CHARGE WHILE THE PATIENT IS STILL AT AN IMMEDIATE LIFE-THREATENING OR URGENT INJURY LEVEL.

SECTION 805-B. DIRECT BILLING TO INSUREDS PROHIBITED.

NO HIGH RISK PROVIDER OR HIGH RISK INSTITUTION SUBJECT TO THIS ACT MAY:

(1) BILL AN INSURED DIRECTLY, BUT MUST BILL THE INSURER

FOR DETERMINATION OF THE AMOUNT PAYABLE.

(2) IF RECEIVING FAIR PAYMENTS UNDER THIS CHAPTER, BILL OR OTHERWISE ATTEMPT TO COLLECT FROM AN INSURED THE DIFFERENCE BETWEEN THE PROVIDER'S OR INSTITUTION'S FULL CHARGE AND THE FAIR AMOUNT PAID BY THE INSURER, UNLESS REQUIRED BY A COPAYMENT UNDER THE HEALTH INSURANCE POLICY.

SECTION 806-B. REPEALS.

ALL ACTS AND PARTS OF ACTS ARE REPEALED INSOFAR AS THEY ARE INCONSISTENT WITH THIS CHAPTER.

CHAPTER 8-C

HEALTH INSURANCE PAYERS

SECTION 801-C. SCOPE.

THIS CHAPTER RELATES TO HEALTH INSURANCE FEE SCHEDULES AND PROVIDER REIMBURSEMENTS.

SECTION 802-C. LEGISLATIVE FINDINGS.

THE GENERAL ASSEMBLY FINDS THAT:

(1) A MAJORITY OF PHYSICIANS IN THIS COMMONWEALTH ARE REIMBURSED FOR THEIR SERVICES TO PATIENTS BY THIRD-PARTY PAYORS. IN SOME CASES, THIS CONTRACTUAL RELATIONSHIP BETWEEN PHYSICIAN AND INSURER HAS EXISTED FOR YEARS WITHOUT THE PHYSICIAN RECEIVING FROM THE INSURER A FORMAL CONTRACT OR AN ACCURATE OR COMPLETE FEE SCHEDULE DETAILING FEES OR THE RULES OR ALGORITHMS THAT ACTUALLY DEFINE THE RATES AT WHICH PHYSICIANS ARE COMPENSATED FOR THE SERVICES THEY RENDER TO THE PAYORS' INSUREDS. MOST HEALTH CARE INSURERS IN THIS COMMONWEALTH REFUSE TO FULLY AND ACCURATELY DISCLOSE THEIR FEE SCHEDULES TO PARTICIPATING PHYSICIANS; THEREFORE, DOCTORS DO NOT KNOW AND CANNOT FIND OUT WHAT THEY WILL RECEIVE IN COMPENSATION PRIOR TO PERFORMING A SERVICE. THIS INSURER POLICY IS MANIFESTLY UNFAIR TO PHYSICIANS; IT IS A BREACH OF

THE PHYSICIANS' CONTRACTS; AND IT FACILITATES FURTHER BREACHES OF SUCH CONTRACTS BY MAKING IT IMPOSSIBLE FOR PHYSICIANS TO ENFORCE THEIR RIGHT TO FULL PAYMENT FOR SERVICES RENDERED.

(2) DURING THE COURSE OF A SINGLE OPERATIVE SESSION, A SURGEON MAY PERFORM MULTIPLE SURGICAL PROCEDURES ON THE PATIENT. THESE MULTIPLE SURGICAL PROCEDURES ARE SEPARATE AND DISTINCT OPERATIONS IN LAYMAN'S TERMS AND AS DEFINED BY THE CURRENT PROCEDURE TERMINOLOGY CODING SYSTEM CREATED BY THE AMERICAN MEDICAL ASSOCIATION AND OTHER PROFESSIONAL MEDICAL SOCIETIES. THE GENERAL ASSEMBLY FURTHER FINDS THAT THE CURRENT PROCEDURAL TERMINOLOGY (CPT) CODING SYSTEM IS UTILIZED BY ALL PHYSICIANS TO IDENTIFY TO PAYORS THE SERVICES RENDERED BY PHYSICIANS AND THAT PAYORS PURPORT TO ADOPT THE SAME CPT CODING SYSTEM IN DEFINING THE SERVICES FOR WHICH THEY COMPENSATE SUCH PHYSICIANS. THE GENERAL ASSEMBLY ALSO FINDS, HOWEVER, THAT, CONTRARY TO THE DICTATES OF THE CPT CODING SYSTEM AND WITHOUT DISCLOSING ANY SUCH DEVIATION TO THE PHYSICIANS WITH WHOM THEY CONTRACT, A NUMBER OF HEALTH CARE INSURERS IN THIS COMMONWEALTH COMPENSATE PHYSICIANS AS IF THE PROCEDURES PERFORMED IN ADDITION TO THE PRIMARY PROCEDURE WERE MERELY INCIDENTAL TO THE PRIMARY PROCEDURE AND THEREFORE SUCH PAYORS WILL COMPENSATE THE SURGEON FOR ONLY ONE PROCEDURE. THIS INSURER POLICY IS INCONSISTENT WITH THE MEDICAL JUDGMENTS UPON WHICH THE CPT CODING SYSTEM IS BASED, IT IS NOT ACCURATELY DISCLOSED TO PHYSICIANS, IT IS MANIFESTLY UNFAIR TO SURGEONS, IT LEADS TO A LACK OF ACCESS TO QUALITY HEALTH CARE SERVICES FOR PATIENTS, AND IT ADDS TO THE EXCESS PROFITS INSURERS TAKE FROM THE HEALTH CARE DELIVERY SYSTEM.

SECTION 803-C. DECLARATION OF INTENT.

THE GENERAL ASSEMBLY HEREBY DECLARES THAT IT IS THE POLICY OF THIS COMMONWEALTH THAT PHYSICIANS SHOULD RECEIVE FROM HEALTH CARE INSURERS A COMPLETE AND ACCURATE SCHEDULE OF THE REIMBURSEMENT FEES, INCLUDING ANY RULES OR ALGORITHMS UTILIZED BY THE PAYOR TO DETERMINE THE AMOUNT A PHYSICIAN WILL BE COMPENSATED IF MORE THAN ONE PROCEDURE IS PERFORMED DURING A SINGLE TREATMENT SESSION. THE GENERAL ASSEMBLY FURTHER DECLARES THAT IT IS THE POLICY OF THIS COMMONWEALTH THAT INSURERS MUST COMPLY WITH THEIR CONTRACTUAL OBLIGATIONS AND THAT SURGEONS SHOULD BE FAIRLY AND JUSTLY COMPENSATED FOR ALL SURGICAL PROCEDURES THEY PERFORM IN A SINGLE OPERATIVE SESSION.

SECTION 804-C. 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:

"FEE SCHEDULE." THE GENERALLY APPLICABLE MONETARY ALLOWANCE PAYABLE TO A PARTICIPATING PHYSICIAN FOR SERVICES RENDERED AS PROVIDED FOR BY AGREEMENT BETWEEN THE PARTICIPATING PHYSICIAN AND THE INSURER, INCLUDING, BUT NOT LIMITED TO, A LIST OF HEALTHCARE COMMON PROCEDURE CODING SYSTEM (HCPCS) LEVEL I CURRENT PROCEDURAL TERMINOLOGY (CPT) CODES, HCPCS LEVEL II NATIONAL CODES AND HCPCS LEVEL III LOCAL CODES AND THE FEES ASSOCIATED THEREIN; AND A DELINEATION OF THE PRECISE METHODOLOGY USED FOR DETERMINING THE GENERALLY APPLICABLE MONETARY ALLOWANCES, INCLUDING, BUT NOT LIMITED TO, FOOTNOTES DESCRIBING FORMULAS, ALGORITHMS, RULES AND CALCULATIONS ASSOCIATED WITH DETERMINATION OF THE INDIVIDUAL ALLOWANCES.

"HCPCS." HCFA (HEALTH CARE FINANCING ADMINISTRATION) COMMON PROCEDURAL CODING SYSTEM, A UNIFORM METHOD FOR HEALTH CARE

PROVIDERS AND MEDICAL SUPPLIERS TO REPORT PROFESSIONAL SERVICES, PROCEDURES, PHARMACEUTICALS AND SUPPLIES.

"HCPCS LEVEL I CPT CODES." THE DESCRIPTIVE TERMS AND IDENTIFYING CODES USED IN REPORTING SUPPLIES AND PHARMACEUTICALS USED BY AND SERVICES AND PROCEDURES PERFORMED BY PARTICIPATING PHYSICIANS AS LISTED IN THE AMERICAN MEDICAL ASSOCIATION'S PHYSICIAN'S CURRENT PROCEDURAL TERMINOLOGY (CPT).

"HCPCS LEVEL II NATIONAL CODES." DESCRIPTIVE TERMS AND IDENTIFYING CODES USED IN REPORTING SUPPLIES AND PHARMACEUTICALS USED BY AND SERVICES AND PROCEDURES PERFORMED BY PARTICIPATING PHYSICIANS.

"HCPCS LEVEL III LOCAL CODES." DESCRIPTIVE TERMS AND IDENTIFYING CODES USED IN REPORTING SUPPLIES AND PHARMACEUTICALS USED BY AND SERVICES AND PROCEDURES PERFORMED BY PARTICIPATING PHYSICIANS WHICH ARE ASSIGNED AND MAINTAINED BY PENNSYLVANIA'S CENTERS FOR MEDICARE AND MEDICAID SERVICES CARRIER.

"INSURER." ANY INSURANCE COMPANY, ASSOCIATION OR EXCHANGE AUTHORIZED TO TRANSACT THE BUSINESS OF INSURANCE IN THIS COMMONWEALTH. THIS SHALL ALSO INCLUDE ANY ENTITY OPERATING UNDER ANY OF THE FOLLOWING:

(1) SECTION 630 OF THE ACT OF MAY 17, 1921 (P.L.682, NO.284), KNOWN AS THE INSURANCE COMPANY LAW OF 1921.

(2) ARTICLE XXIV OF THE ACT OF MAY 17, 1921 (P.L.682, NO.284), KNOWN AS THE INSURANCE COMPANY LAW OF 1921.

(3) THE ACT OF DECEMBER 29, 1972 (P.L.1701, NO.364), KNOWN AS THE HEALTH MAINTENANCE ORGANIZATION ACT.

(4) 40 PA.C.S. CH. 61 (RELATING TO HOSPITAL PLAN CORPORATIONS).

(5) 40 PA.C.S. CH. 63 (RELATING TO PROFESSIONAL HEALTH SERVICES PLAN CORPORATIONS).

(6) 40 PA.C.S. CH. 67 (RELATING TO BENEFICIAL SOCIETIES).

"PARTICIPATING PHYSICIAN." AN INDIVIDUAL LICENSED UNDER THE LAWS OF THIS COMMONWEALTH TO ENGAGE IN THE PRACTICE OF 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 IN THE PRACTICE OF OSTEOPATHIC MEDICINE WITHIN THE SCOPE OF THE ACT OF OCTOBER 5, 1978 (P.L.1109, NO.261), KNOWN AS THE OSTEOPATHIC MEDICAL PRACTICE ACT, WHO BY AGREEMENT PROVIDES SERVICES TO AN INSURER'S SUBSCRIBERS.

SECTION 805-C. DISCLOSURE OF FEE SCHEDULES.

WITHIN 30 DAYS OF THE EFFECTIVE DATE OF THIS CHAPTER, INSURERS SHALL PROVIDE THEIR PARTICIPATING PHYSICIANS WITH A COPY OF THEIR FEE SCHEDULE, INCLUDING ALL APPLICABLE RULES AND ALGORITHMS UTILIZED BY THE INSURER TO DETERMINE THE AMOUNT ANY SUCH PHYSICIAN WILL BE COMPENSATED FOR PERFORMING ANY SINGLE PROCEDURE AND ANY GROUP OF PROCEDURES DURING A SINGLE TREATMENT SESSION, WHICH ARE APPLICABLE ON JULY 1, 2002, AND ANNUALLY THEREAFTER. INSURERS SHALL ALSO PROVIDE PARTICIPATING PHYSICIANS WITH UPDATES TO THE FEE SCHEDULE AS MODIFICATIONS OCCUR.

SECTION 806-C. PROCEDURE FOR PAYMENT OF MULTIPLE SURGICAL PROCEDURES.

WHEN A PARTICIPATING PHYSICIAN PERFORMS MORE THAN ONE SURGICAL PROCEDURE ON THE SAME PATIENT AND AT THE SAME OPERATIVE SESSION, INSURERS SHALL PAY THE PARTICIPATING PHYSICIAN THE GREATER OF THE AMOUNT CALCULATED ON THE BASIS OF THE APPLICABLE INSURER FEE SCHEDULE AND:

(1) ANY RULES, ALGORITHMS, CODES OR MODIFIERS INCLUDED THEREIN, GOVERNING REIMBURSEMENT FOR MULTIPLE SURGICAL PROCEDURES; OR

(2) THE PRINCIPLES GOVERNING REIMBURSEMENT FOR MULTIPLE SURGICAL PROCEDURES SET FORTH AND ESTABLISHED BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES WITHIN THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, INCLUDING THE RULE MANDATING PAYMENT TO THE PHYSICIAN OF:

(I) ONE HUNDRED PERCENT OF THE GENERALLY APPLICABLE MAXIMUM MONETARY ALLOWANCE FOR THE PROCEDURE WHICH HAS THE HIGHEST MONETARY ALLOWANCE.

(II) FIFTY PERCENT OF THE GENERALLY APPLICABLE MAXIMUM MONETARY ALLOWANCE FOR THE SECOND THROUGH FIFTH PROCEDURES WITH THE NEXT HIGHEST VALUES.

(III) PROCEDURES IN EXCESS OF FIVE REQUIRE SUBMISSION OF DOCUMENTATION AND INDIVIDUAL REVIEW TO DETERMINE PAYMENT AMOUNT.

SECTION 807-C. CONTRACT PROVISIONS.

ANY PROVISION IN ANY CONTRACT, INSURER POLICY OR FEE SCHEDULE THAT IS INCONSISTENT WITH ANY PROVISION OF THIS CHAPTER IS HEREBY DECLARED TO BE CONTRARY TO THE PUBLIC POLICY OF THE COMMONWEALTH AND IS VOID AND UNENFORCEABLE.

SECTION 808-C. VIOLATIONS.

AN INSURER VIOLATES:

(1) SECTION 805-C IF THE INSURER FAILS TO PROVIDE A PARTICIPATING PHYSICIAN WITH A COPY OF THE FEE SCHEDULE AND UPDATES TO THE FEE SCHEDULE IN THE TIME FRAME PROVIDED IN SECTION 805-C.

(2) SECTION 806-C IF THE INSURER FAILS TO ADHERE TO THE POLICY FOR PAYMENT OF MULTIPLE SURGERIES AS SET FORTH AND ESTABLISHED BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES WITHIN THE DEPARTMENT OF HEALTH AND HUMAN SERVICES.

SECTION 809-C. CAUSE OF ACTION.

IN ADDITION TO ALL STATUTORY, COMMON LAW AND EQUITABLE CAUSES OF ACTION WHICH ALREADY EXIST, A PARTICIPATING PHYSICIAN SHALL HAVE A PRIVATE CAUSE OF ACTION FOR ANY VIOLATION OF ANY PROVISION OF THIS CHAPTER TO ENFORCE THE PROVISIONS OF THIS CHAPTER. A PARTICIPATING PHYSICIAN SHALL BE ENTITLED TO RECOVER FROM AN INSURER ANY LEGAL FEES AND COSTS ASSOCIATED WITH ANY SUIT BROUGHT UNDER THIS SECTION.

SECTION 810-C. TERMINATION OF AGREEMENT.

IN ADDITION TO OTHER REMEDIES PROVIDED IN THIS CHAPTER, A PARTICIPATING PHYSICIAN MAY TERMINATE HIS AGREEMENT IF AN INSURER VIOLATES THE PROVISIONS OF THIS CHAPTER. THE PHYSICIAN MAY CONTINUE TO PROVIDE SERVICES TO THE INSURER'S INSUREDS AND SHALL RECEIVE COMPENSATION AS AN OUT-OF-NETWORK PROVIDER.

SECTION 811-C. PENALTIES.

VIOLATIONS OF THIS CHAPTER SHALL BE CONSIDERED VIOLATIONS OF THE ACT OF MAY 17, 1921 (P.L.682, NO.284), KNOWN AS THE INSURANCE COMPANY LAW OF 1921, AND ARE SUBJECT TO THE PENALTIES AND SANCTIONS OF SECTION 2182 OF THE INSURANCE COMPANY LAW OF 1921.

SECTION 8. SECTIONS 902 AND 903 OF THE ACT ARE AMENDED TO READ:

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:

"DEPARTMENT." THE DEPARTMENT OF HEALTH OF THE COMMONWEALTH.

"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) Duty of physician to report.--A physician shall report to the State Board of Medicine or the State Board of Osteopathic Medicine, as appropriate, within [60] 30 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.

~~(b) Duty of prothonotary.--The prothonotary in any county in which a complaint in a medical professional liability action is filed against a physician shall report the filing to the State Board of Medicine or the State Board of Osteopathic Medicine within 30 days of the filing. The report shall include the~~

(B) FILING OF COMPLAINTS.--WITHIN 60 DAYS OF FILING A COMPLAINT IN A MEDICAL PROFESSIONAL LIABILITY ACTION AGAINST A PHYSICIAN, THE PLAINTIFF MUST DO ALL OF THE FOLLOWING:

(1) REPORT THE FILING TO THE STATE BOARD OF MEDICINE, THE STATE BOARD OF OSTEOPATHIC MEDICINE OR THE DEPARTMENT OF HEALTH, AS APPROPRIATE. THE REPORT UNDER THIS PARAGRAPH MUST INCLUDE THE docket number of the case, where the case is filed and a description of the allegations in the complaint.

(2) CERTIFY TO THE PROTHONOTARY THAT THE REPORT UNDER PARAGRAPH (1) HAS BEEN MADE.

(c) Penalties.--In addition to any other penalty provided in this act, a physician who fails to comply with the requirements of this section shall be subject to a fine by the licensing board in the following amount: $500 for a first offense, $1,000 for any second offense; and $2,500 for any third or subsequent offense.

Section ~~2.~~ 9. The act is amended by adding a section to read: <—

SECTION 904.1. REPORTS BY HOSPITALS AND HEALTH CARE FACILITIES. <—

(A) ACTION REPORT.--ANY HOSPITAL OR HEALTH CARE FACILITY LICENSED UNDER THE ACT OF JULY 19, 1979 (P.L.130, NO.48), KNOWN AS THE HEALTH CARE FACILITIES ACT, SHALL REPORT TO THE APPROPRIATE LICENSURE BOARD IF THE HOSPITAL OR FACILITY DENIES, RESTRICTS, REVOKES OR FAILS TO RENEW STAFF PRIVILEGES OR ACCEPTS THE RESIGNATION OF A PHYSICIAN FOR ANY REASON RELATED TO THE PHYSICIAN'S COMPETENCE TO PRACTICE MEDICINE OR FOR ANY VIOLATION OF LAW, REGULATION, RULE OR BYLAW OF THE HOSPITAL OR FACILITY. THE REPORT SHALL BE FILED WITHIN 30 DAYS OF THE OCCURRENCE OF THE REPORTABLE ACTION AND INCLUDE DETAILS REGARDING THE NATURE AND CIRCUMSTANCES OF THE ACTION, ITS DATE AND THE REASONS FOR IT.

(B) LIABILITY.--NO HOSPITAL, HEALTH CARE FACILITY OR PERSON THAT REPORTS INFORMATION TO A LICENSURE BOARD UNDER THIS SECTION SHALL BE LIABLE TO THE PHYSICIAN REFERENCED IN THE REPORT FOR MAKING THE REPORT, PROVIDED THAT THE REPORT IS MADE IN GOOD FAITH AND WITHOUT MALICE.

SECTION 10. SECTION 909 OF THE ACT IS AMENDED TO READ:

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 AND THE SPECIFIC REASONS FOR THE SANCTIONS.

(4) THE NUMBER OF AND SPECIFIC REASONS FOR 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 11. THE ACT IS AMENDED BY ADDING SECTIONS TO READ:

Section 911. Public disclosure.

(a) Data repository established.--There shall be jointly established between the State Board of Medicine and the State Osteopathic Board of Medicine a data repository which shall annually collect information to create individual profiles on each physician licensed in the Commonwealth. The information shall be collected on a form prescribed by the licensing board and shall be made available to the general public on the Department of State's publicly accessible World Wide Web site.

(b) Required information.--By July 1, 2003, and every year thereafter, each physician shall submit to the licensing board on the prescribed form the following:

(1) Information regarding the sentencing of a 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.

(2) Information regarding the conviction of a physician or a plea of guilty or no contest by a physician WITHIN THE TEN MOST RECENT YEARS 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).

(iii) A FELONY VIOLATION UNDER 18 Pa.C.S. § 2709.1 (relating to stalking). <—

(iv) A FELONY VIOLATION UNDER 18 Pa.C.S. Ch. 29 (relating to kidnapping). <—

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

(vi) A FELONY VIOLATION UNDER 18 Pa.C.S. § 3301 (relating to arson and related offenses). <—

(vii) 18 Pa.C.S. § 3302 (relating to causing or risking catastrophe).

(viii) A FELONY VIOLATION UNDER 18 Pa.C.S. Ch. 35 (relating to burglary and other criminal intrusion). <—

(ix) 18 Pa.C.S. Ch. 37 (relating to robbery).

(x) A felony violation under 18 Pa.C.S. Ch. 39 (relating to theft and related offenses).

(xi) A FELONY VIOLATION UNDER 18 Pa.C.S. Ch. 59 (relating to public indecency). <—

(XII) 75 PA.C.S. § 3731 (RELATING TO DRIVING UNDER INFLUENCE OF ALCOHOL OR CONTROLLED SUBSTANCE). <—

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

(3) A description of any final disciplinary actions taken against a physician by the licensing board in the Commonwealth or a health care licensing authority in another state within the ten most recent years.

(4) A description of any FINAL revocation or involuntary restriction of hospital privileges for reasons related to competency or character taken by a hospital's governing body or any other official of a hospital after procedural due process has been afforded, or the resignation from or nonrenewal of medical staff membership or the resignation of privileges at a hospital in lieu of or in settlement of a pending disciplinary case related to competence or character of the physician in that hospital in the ten most recent years. <—

(5) All medical malpractice judgments ~~or settlements~~ in which a payment of $50,000 or more is awarded to a complaining party within the ten most recent years. Disposition of paid claims shall be reported in a minimum of three graduated categories indicating the level of significance of the judgment ~~or settlement~~. Information involving paid malpractice claims shall be put in context by the repository by showing a comparison between a physician's judgment awards ~~and settlements~~ to the experience of other physicians within the same specialty classification ~~and within the same rating territory as established by the Joint~~ <— <— <—

~~Underwriting Association. Information concerning all settlements shall be accompanied by the following statement:~~

~~Settlement of a malpractice claim may occur for a variety of reasons which do not necessarily reflect negatively on the professional competence or conduct of a physician. A payment in settlement of a malpractice claim should not be construed as creating a presumption that medical malpractice has occurred.~~

~~Nothing in this paragraph shall be construed to limit or prevent the licensing board from providing further information about the significance of categories in which settlements are reported.~~ AND WITHIN THE SAME COUNTY. NO <—
INFORMATION REGARDING ANY PENDING MEDICAL LIABILITY ACTION AGAINST A PHYSICIAN SHALL BE DISCLOSED BY THE LICENSING BOARD TO THE GENERAL PUBLIC.

(6) Names of medical schools attended, graduate medical education obtained and dates of graduation.

(7) Specialty board certification.

(8) Number of years in practice.

(9) Names of hospitals at which privileges are attained.

(10) Appointments to medical school faculties.

(11) Information on published articles in peer review literature.

(12) The location and telephone number of the physician's primary practice setting.

(13) An indication as to whether the physician participates in the Medicare or State medical assistance program.

(c) Explanation.--Physicians may provide an explanation of any information disclosed pursuant to subsection (b) which shall

be included by the licensing board in the profile.

(d) Initial profile.--The licensing board shall provide physicians with a copy of their initial profile prior to its release to the general public. Physicians shall have no more than 30 days from the date of receipt of this profile to correct any factual inaccuracies that appear in the profile and return it to the licensing board at which time the initial profile shall be published.

(e) Revision or correction.--The licensing board shall establish a process through which each physician may revise or correct any information contained in the profile, provided however, that revisions to information disclosed under subsection (b)(1), (2), (3), (4), (5) and (6) shall be made within 30 days of any conviction, plea of guilty or no contest, sentencing or other final action taken against a physician.

(f) Penalties.--In addition to any other penalty provided for in this act, the licensing board shall impose a civil penalty for any violations of the provisions of this section in the following manner: $1,000 for a first offense, $2,500 for any second offense; and $5,000 for any third or subsequent offenses.

(G) TELEPHONE HOTLINE.--THE STATE BOARD OF MEDICINE AND THE <—
STATE BOARD OF OSTEOPATHIC MEDICINE SHALL ESTABLISH A TELEPHONE NUMBER WHICH SHALL BE OPERATIONAL ON EVERY BUSINESS DAY BETWEEN THE HOURS OF 9 A.M. AND 6 P.M. LOCAL TIME FOR THE PURPOSE OF DISSEMINATING INFORMATION PURSUANT TO THIS SECTION TO ANY INQUIRY.

SECTION 912. DEPARTMENT OF HEALTH.

(A) TOTAL QUALITY MANAGEMENT HEALTH CARE SYSTEM APPROVAL.--

(1) A TOTAL QUALITY MANAGEMENT HEALTH CARE SYSTEM MAY APPLY TO THE DEPARTMENT FOR APPROVAL. THE APPLICATION MUST BE

ON A FORM PRESCRIBED BY THE DEPARTMENT OF HEALTH AND MUST BE ACCOMPANIED BY A FEE SET BY REGULATION.

(2) WITHIN 30 DAYS OF RECEIPT OF AN APPLICATION UNDER PARAGRAPH (1), THE DEPARTMENT SHALL DO ONE OF THE FOLLOWING:

(I) IF THE DEPARTMENT DETERMINES THAT THE SYSTEM WILL SUCCESSFULLY REDUCE MEDICAL ERRORS BY A HEALTH CARE PROVIDER, APPROVE THE APPLICATION.

(II) IF THE DEPARTMENT DETERMINES THAT THE SYSTEM WILL NOT SUCCESSFULLY REDUCE MEDICAL ERRORS BY A HEALTH CARE PROVIDER, DENY THE APPLICATION. THIS SUBPARAGRAPH IS SUBJECT TO 2 PA.C.S. CH. 7 SUBCH. A (RELATING TO JUDICIAL REVIEW OF COMMONWEALTH AGENCY ACTION).

(3) FAILURE TO ACT WITHIN THE TIME SPECIFIED IN PARAGRAPH (2) SHALL BE DEEMED APPROVAL OF THE APPLICATION.

(B) TOTAL QUALITY MANAGEMENT HEALTH CARE SYSTEM IMPLEMENTATION.--THE DEPARTMENT SHALL PROVIDE HEALTH CARE PROVIDERS WITH CERTIFICATION OF IMPLEMENTATION OF TOTAL QUALITY MANAGEMENT HEALTH CARE SYSTEMS AS REQUIRED BY SECTIONS 712(G)(5), 733(C)(2) AND 741(2).

(C) REGULATIONS.--THE DEPARTMENT MAY PROMULGATE REGULATIONS TO IMPLEMENT THIS SECTION.

SECTION 12. ALL ACTS AND PARTS OF ACTS PROVIDING FOR NONRENEWAL, CANCELLATION OR PREMIUM INCREASE NOTICE ARE REPEALED INSOFAR AS THEY ARE INCONSISTENT WITH SECTION 747 OF THE ACT OF MARCH 20, 2002 (P.L.154, NO.13), KNOWN AS THE MEDICAL CARE AVAILABILITY AND REDUCTION OF ERROR (MCARE) ACT.

~~SECTION 3. THIS ACT SHALL TAKE EFFECT IMMEDIATELY.~~ <—

SECTION 13. THIS ACT SHALL TAKE EFFECT AS FOLLOWS:

(1) THE ADDITION OF CHAPTER 8-A OF THE ACT SHALL TAKE EFFECT JANUARY 1, 2004.

(2) THE AMENDMENT OR ADDITION OF SECTIONS 102, 302, 305(C), 306(B), 310(A)(2), 311(F)(1), 315, 712(G), 732, 733, 741, 902 AND 912 OF THE ACT SHALL TAKE EFFECT IN 60 DAYS.

(3) THE REMAINDER OF THIS ACT SHALL TAKE EFFECT IMMEDIATELY.