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THE GENERAL ASSEMBLY OF PENNSYLVANIA

HOUSE BILL

No. 1802 Session of 2001

INTRODUCED BY MICOZZIE, DeLUCA, ADOLPH, BEBKO-JONES, BUXTON, FICHTER, GANNON, GODSHALL, LAWLESS, McGILL, MELIO, PIPPY, SATHER, SCHRODER, WASHINGTON, ZUG, ALLEN, ARGALL, M. BAKER, BARD, BROWNE, BUTKOVITZ, CAPPELLI, CIVERA, L. I. COHEN, COLAFELLA, COLEMAN, CORRIGAN, COY, DALEY, DALLY, FAIRCHILD, FEESE, FRANKEL, GABIG, GORDNER, HARHAI, HASAY, HERMAN, HESS, HORSEY, JAMES, LAUGHLIN, LEH, LESCOVITZ, MACKERETH, MAHER, MARKOSEK, McCALL, McILHATTAN, McILHINNEY, S. MILLER, READSHAW, ROBINSON, ROHRER, RUBLEY, SAINATO, SAYLOR, SCHULER, SEMMEL, SHANER, SOLOBAY, STEIL, STERN, T. STEVENSON, E. Z. TAYLOR, THOMAS, TIGUE, TRICH, WATSON, J. WILLIAMS, WILT, WOGAN, M. WRIGHT, YOUNGBLOOD, FLICK, C. WILLIAMS, BENNINGHOFF, WOJNAROSKI, GEIST, ARMSTRONG, GEORGE, LEWIS, BASTIAN, ROBERTS AND TURZAI, JUNE 19, 2001

AS AMENDED ON THIRD CONSIDERATION, HOUSE OF REPRESENTATIVES, JANUARY 29, 2002

AN ACT

~~Amending the act of October 15, 1975 (P.L.390, No.111), entitled "An act relating to medical and health related malpractice insurance, prescribing the powers and duties of the Insurance Department; providing for a joint underwriting plan; the Arbitration Panels for Health Care, compulsory screening of claims; collateral sources requirement; limitation on contingent fee compensation; establishing a Catastrophe Loss Fund; and prescribing penalties," further providing for the payment of the unfunded liabilities of the Medical Professional Liability Catastrophe Loss Fund; repealing provisions related to the Medical Professional Liability Insurance Catastrophe Loss Fund Advisory Board; and creating the Pennsylvania Medical Professional Liability Catastrophe Loss Authority and providing for its governance and powers.~~ <—

AMENDING THE ACT OF OCTOBER 15, 1975 (P.L.390, NO.111), ENTITLED "AN ACT RELATING TO MEDICAL AND HEALTH RELATED MALPRACTICE INSURANCE, PRESCRIBING THE POWERS AND DUTIES OF THE INSURANCE DEPARTMENT; PROVIDING FOR A JOINT UNDERWRITING PLAN; THE ARBITRATION PANELS FOR HEALTH CARE, COMPULSORY SCREENING OF CLAIMS; COLLATERAL SOURCES REQUIREMENT; LIMITATION ON CONTINGENT FEE COMPENSATION; ESTABLISHING A CATASTROPHE LOSS <—

FUND; AND PRESCRIBING PENALTIES," FURTHER PROVIDING FOR DEFINITIONS AND FOR STATUTE OF LIMITATIONS; ESTABLISHING THE MEDICAL PROFESSIONAL LIABILITY CATASTROPHE LOSS FUND AUTHORITY AND THE MEDICAL PROFESSIONAL LIABILITY CATASTROPHE LOSS FUND; PROVIDING FOR JURISDICTION, FOR CHANGE OF VENUE, FOR CONTRACTS FOR LIMITATION OF NONECONOMIC DAMAGES, FOR JOINT AND SEVERAL LIABILITY, FOR EXPERT WITNESS QUALIFICATIONS, FOR LIABILITY FOR MISREPRESENTATION TO SEEK INFORMED CONSENT, FOR LOSS OF PLEASURES OF LIFE, FOR PRETRIAL DISPOSITION OF FRIVOLOUS MEDICAL PROFESSIONAL LIABILITY CLAIMS, FOR COLLATERAL SOURCES, FOR PERIODIC PAYMENT OF FUTURE DAMAGES, FOR PERMISSIBLE ARGUMENT AS TO DAMAGES AT TRIAL; FURTHER PROVIDING FOR MANDATORY REPORTING, FOR INVESTIGATIONS, FOR REPORTING TO LICENSURE BOARDS AND FOR DUTY TO NOTIFY LICENSING BOARD ABOUT CERTAIN ARRESTS; FURTHER PROVIDING FOR HEARINGS; PROVIDING FOR CONFIDENTIALITY OF CERTAIN RECORDS; FURTHER PROVIDING FOR REVIEW BY STATE LICENSING BOARDS; PROVIDING FOR CONTINUING MEDICAL EDUCATION, FOR BOARD-IMPOSED CIVIL PENALTIES AND FOR MANDATORY REFERRAL FOR CLAIMS HISTORY; ADDING PROVISIONS RELATING TO PATIENT SAFETY; ESTABLISHING THE PATIENT SAFETY AUTHORITY; AND PROVIDING FOR PRESERVATION AND ACCURACY OF MEDICAL RECORDS AND FOR THE POWERS AND DUTIES OF THE AUTHORITY AND THE DEPARTMENT OF HEALTH.

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

~~Section 1. The definition of "director" in section 103 of the act of October 15, 1975 (P.L.390, No.111), known as the Health Care Services Malpractice Act, amended November 26, 1996 (P.L.776, No.135), is amended and the section is amended by adding definitions to read:~~ <—

~~Section 103. Definitions.--As used in this act:~~

~~"Aggregate unfunded liability" means the costs of administering, paying, defending, settling, litigating, financing and estimating authority claims.~~

~~"Assessments" means the annual assessments levied by the authority pursuant to section 701.1(q)(2).~~

~~"Authority" means the Pennsylvania Medical Professional Liability Catastrophe Loss Authority created in Article VII.~~

~~"Authority buyout fund" means the fund established in section 701.2(h)(5).~~

"Authority claims" means those claims set forth in section 701.1(g).

"Basic insurance coverage" means the minimum professional liability insurance or self-insurance requirements as set forth in section 701(a).

"Board" or "governing board" means the governing board of the authority established under section 701.1(c).

"Bond" means and includes a note, bond, bond anticipation note, refunding note and bond, interim certificate, debenture and other evidence of indebtedness or obligation, other than a revenue anticipation note, which the authority is authorized to issue pursuant to this act.

"Bond or revenue anticipation note payment account" means the account or accounts established pursuant to section 701.2(h)(3).

* * *

"Debt service reserve fund" means the fund or funds established pursuant to section 701.2(h)(2).

[~~"Director" means the Director of the Medical Professional Liability Catastrophe Loss Fund.~~]

"Executive director" means the executive director of the authority appointed pursuant to section 701.1(h)(2).

"Financial plan" means the plan required to be adopted by the authority pursuant to section 701.1(n).

* * *

"Government agency" means the Governor, departments, boards, commissions, authorities and other officers and agencies of the Commonwealth, including, but not limited to, those which are not subject to the policy supervision and control of the Governor. The term does not include any court or other officer or agency of the unified judicial system or the General Assembly or its

officers and agencies.

* * *

"Medical Professional Liability Catastrophe Loss Fund" means the fund transferred to the authority by this act, the unfunded liability of which will, upon its termination pursuant to this act, be transferred to the authority and paid from the authority buyout fund.

"Minimum reserve fund requirement" means that amount defined as the minimum debt service reserve fund requirement for such fund or funds as specified in a resolution or resolutions of the authority authorizing the issuance of bonds.

* * *

"Political subdivision" means any county, city, borough, incorporated town, township, school district or vocational school district.

* * *

"Refund" means, together with its variations, with regard to bonds, the issuance and sale of bonds, the proceeds of which are used or are to be used, either now or in the future, after investment in an escrow account, for the payment of principal or interest on, or the redemption of, outstanding bonds of the authority either at maturity or upon prior redemption.

"Revenue anticipation notes" means notes issued by the authority pursuant to section 701.2(g) in anticipation of the receipt of revenues from assessments levied under section 701.1(g).

"Right-to-Know Law" means the act of June 21, 1957 (P.L.390, No.212), referred to as the Right-to-Know Law.

"Sunshine Act" means 65 Pa.C.S. Ch. 7 (relating to open meetings).

"Surplus assessment fund" means the fund or funds established pursuant to section 701.2(h)(6).

Section 2. Sections 605 and 701 of the act, amended November 26, 1996 (P.L.776, No.135), are amended to read:

Section 605. Statute of Limitations.--(a) All claims for recovery pursuant to this act must be commenced within the existing applicable statutes of limitation. In the event that any claim is made against a health care provider subject to the provisions of Article VII more than four years after the breach of contract or tort occurred which is filed within the statute of limitations, such claim shall be defended and paid by the [fund] authority if the [fund] authority has received a written request for indemnity and defense within 180 days of the date on which notice of the claim is given to the health care provider or his insurer. For these claims, the limit of liability of the authority shall be $1,000,000 for each occurrence for each health care provider. Where multiple treatments or consultations took place less than four years before the date on which the health care provider or his insurer received notice of the claim, the claim shall be deemed, for purposes of this section, to have occurred less than four years prior to the date of notice and shall be defended by the insurer pursuant to section 702(d). If such claim is made after four years because of the willful concealment by the health care provider or his insurer, the [fund] authority shall have the right of full indemnity including defense costs from such health care provider or his insurer. [A filing pursuant to section 401 shall toll the running of the limitations contained herein.]

(b) For policies issued or renewed in the calendar year 2007, and each year thereafter, the limit of liability of the

authority under this section shall be $0 for each occurrence, on or after the date of issue or renewal, for each health care provider and per annual aggregate for each health care provider and the authority shall not be responsible for defense of claims under this section.

Section 701. Professional Liability Insurance [and Fund].--(a) Every health care provider as defined in this act, practicing medicine or podiatry or otherwise providing health care services in the Commonwealth shall insure his professional liability only with an insurer licensed or approved by the Commonwealth of Pennsylvania, or provide proof of self-insurance in accordance with this section.

(1) (i) For policies issued or renewed in the calendar years 1997 [through] and 1998, a health care provider, other than hospitals, who conducts more than 50% of its health care business or practice within the Commonwealth of Pennsylvania shall annually insure or self-insure its professional liability in the amount of $300,000 per occurrence and $900,000 per annual aggregate, and hospitals located in the Commonwealth shall insure or self-insure their professional liability in the amount of $300,000 per occurrence, and $1,500,000 per annual aggregate, hereinafter known as ["basic coverage insurance"] basic insurance coverage, and they shall be entitled to participate in the [fund] authority.

(ii) For policies issued or renewed in the calendar years 1999 [through 2000] and 2000, the basic insurance coverage for a health care provider, other than hospitals, who conducts more than 50% of its health care business or practice within this Commonwealth shall [annually insure or self-insure its professional liability], on an annual basis, be in the amount of

~~$400,000 per occurrence and $1,200,000 per annual aggregate, and~~ ~~for~~ ~~hospitals located in this Commonwealth [shall insure or self-insure their professional liability]~~ ~~the basic, insurance coverage, on an annual basis, shall be~~ ~~in the amount of $400,000 per occurrence and $2,000,000 per annual aggregate~~, ~~and they shall be entitled to participate in the authority~~.

~~(iii) For policies issued or renewed in the calendar year 2001[, and each year thereafter,]~~ ~~and 2002, the basic insurance coverage for~~ ~~a health care provider, other than hospitals, who conducts more than 50% of its health care, business or practice within this Commonwealth shall [annually insure or self-insure its professional liability]~~, ~~on an annual basis, be~~ ~~in the amount of $500,000 per occurrence and $1,500,000 per annual aggregate, and~~ ~~for~~ ~~hospitals located in this Commonwealth [shall insure or self-insure their professional liability]~~ ~~the basic insurance coverage, on an annual basis, shall be~~ ~~in the amount of $500,000 per occurrence and $2,500,000 per annual aggregate[.]~~, ~~and they shall be entitled to participate in the authority.~~

~~(iv) For policies issued or renewed in the calendar year 2003 and 2004, the basic insurance coverage for a health care provider, other than hospitals, who conducts more than 50% of its health care business or practice within this Commonwealth shall, on an annual basis, be in the amount of $700,000 per occurrence, and $2,100,000 per annual aggregate, and for hospitals located in this Commonwealth the basic insurance coverage, on an annual basis, shall be in the amount of $700,000 per occurrence, and $3,100,000 per annual aggregate, and they shall be entitled to participate in the authority.~~

~~(v) For policies issued or renewed in the calendar year 2005~~

and 2006, the basic insurance coverage for a health care provider, other than hospitals, who conducts more than 50% of its health care business or practice within this Commonwealth shall, on an annual basis, be in the amount of $900,000 per occurrence, and $2,700,000 per annual aggregate, and for hospitals located in this Commonwealth the basic insurance coverage, on an annual basis, shall be in the amount of $900,000 per occurrence, and $3,700,000 per annual aggregate, and they shall be entitled to participate in the authority.

(vi) For policies issued or renewed in the calendar year 2007, and each year thereafter, the basic insurance coverage for a health care provider, other than hospitals, who conducts more than 50% of its health care business or practice within this Commonwealth shall, on an annual basis, be in the amount of $1,200,000 per occurrence, and $3,600,000 per annual aggregate, and for hospitals located in this Commonwealth the basic insurance coverage, on an annual basis, shall be in the amount of $1,200,000 per occurrence, and $4,600,000 per annual aggregate, and they shall be entitled to participate in the authority.

(2) (i) A health care provider who conducts 50% or less of its health care business or practice within the Commonwealth shall insure or self-insure its professional liability in the amounts listed in subparagraphs (ii)[, (iii) and (iv)] through (vii) and shall not be required to contribute to or be entitled to participate in the [fund] authority set forth in Article VII of this act or the plan set forth in Article VIII of this act.

(ii) For policies issued or renewed in calendar years 1997 through 1998, basic insurance coverage shall, on an annual basis, be in the amount of $300,000 per occurrence and $900,000

~~per annual aggregate.~~

~~(iii) For policies issued or renewed in calendar years 1999 through 2000, basic insurance coverage shall, on an annual basis, be in the amount of $400,000 per occurrence and $1,200,000 per annual aggregate.~~

~~(iv) For policies issued or renewed in calendar year 2001[, and each year thereafter] and 2002, basic insurance coverage shall, on an annual basis, be in the amount of $500,000 per occurrence and $1,500,000 per annual aggregate.~~

~~(v) For policies issued or renewed in calendar year 2003 and 2004, basic insurance coverage shall, on an annual basis, be in the amount of $700,000 per occurrence and $2,100,000 per annual aggregate.~~

~~(vi) For policies issued or renewed in calendar year 2005 and 2006, basic insurance coverage shall, on an annual basis, be in the amount of $900,000 per occurrence and $2,700,000 per annual aggregate.~~

~~(vii) For policies issued or renewed in the calendar year 2007, and each year thereafter, basic insurance coverage shall, on an annual basis, be in the amount of $1,000,000 per occurrence, and $3,000,000 per annual aggregate.~~

~~(3) For the purposes of this section, "health care business or practice" shall mean the number of patients to whom health care services are rendered by a health care provider within an annual period.~~

~~(4) All self-insurance plans shall be submitted with such information as the commissioner shall require for approval and shall be approved by the commissioner upon his finding that the plan constitutes protection equivalent to the insurance requirements of a health care provider.~~

~~(5) A fee shall be charged by the Insurance Department to all self-insurers for examination and approval of their plans.~~

~~(6) Self-insured health care providers and hospitals if exempt from this act shall submit the information required under section 809 to the commissioner.~~

~~(b) (1) No insurer providing professional liability insurance shall be liable for payment of any claim against a health care provider for any loss or damages awarded in a professional liability action in excess of the basic coverage insurance, as provided in subsection (a)(1) for each health care provider against whom an award is made unless the health care provider's professional liability policy or self-insurance plan provides for a higher annual aggregate limit.~~

~~(2) If a claim exceeds the aggregate limits of an insurer or a self-insurance plan, the [fund]~~ authority ~~shall be responsible for the payment of the claim up to the [fund]~~ authority ~~coverage limits.~~

~~(c) A government may satisfy its obligations pursuant to this act, as well as the obligations of its employees to the extent of their employment, by either purchasing insurance or assuming such obligation as a self-insurer and including the payment of all [surcharges]~~ assessments ~~under this act.~~

~~[(d) There is hereby created a contingency fund for the purpose of paying all awards, judgments and settlements for loss or damages against a health care provider entitled to participate in the fund as a consequence of any claim for professional liability brought against such health care provider as a defendant or an additional defendant to the extent such health care provider's share exceeds its basic coverage insurance in effect at the time of occurrence as provided in~~

~~subsection (a)(1). The limit of liability of the fund shall be as follows:~~

~~(1) For calendar years 1997 through 1998, the limit of liability of the fund shall be $900,000 for each occurrence for each health care provider and $2,700,000 per annual aggregate for each health care provider.~~

~~(2) For calendar years 1999 through 2000, the limit of liability of the fund shall be $800,000 for each occurrence for each health care provider and $2,400,000 per annual aggregate for each health care provider.~~

~~(3) For calendar year 2001, and each year thereafter, the limit of liability of the fund shall be $700,000 for each occurrence for each health care provider and $2,100,000 per annual aggregate for each health care provider.~~

~~(e) (1) After December 31, 1996, the fund shall be funded by the levying of an annual surcharge on or after January 1 of every year on all health care providers entitled to participate in the fund. The surcharge shall be determined by the fund, filed with the commissioner and communicated to all basic insurance coverage carriers and self-insured providers. The surcharge shall be based on the prevailing primary premium for each health care provider for maintenance of professional liability insurance and shall be the appropriate percentage thereof, necessary to produce an amount sufficient to reimburse the fund for the payment of final claims and expenses incurred during the preceding claims period and to provide an amount necessary to maintain an additional 15% of the final claims and expenses incurred during the preceding claims period.~~

~~(2) The Joint Underwriting Association shall file updated rates for all health care providers with the commissioner by May~~

~~1 of each year.~~

~~(3) The fund shall review and may adjust the prevailing primary premium in line with any applicable changes to the prevailing primary premium made in filings by the Joint Underwriting Association and approved by the commissioner.~~

~~(4) The fund may adjust the applicable prevailing primary premium of any hospital, including a hospital associated with a university or other education institution, through an increase or decrease in the individual hospital's prevailing primary premium not to exceed 20%. Any such 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. All premium adjustments pursuant to this subsection shall require the approval of the commissioner.~~

~~(5) For health care providers that do not engage in direct clinical practice on a full-time basis, the prevailing primary premium rate shall be adjusted by the fund to reflect the lower risk associated with the less-than-full-time direct clinical practice.~~

~~(6) The surcharge provided in paragraph (1) shall be reviewed by the commissioner within 30 days of submission. After review, the commissioner may only disapprove a surcharge if it is inadequate or excessive. If so disapproved, the fund shall make an adjustment to the next surcharge calculation to reflect the appropriate increase or decrease.~~

~~(7) When a health care provider changes the term of its professional liability coverage, the surcharge shall be calculated on an annual base and shall reflect the surcharge percentages in effect for all the surcharge periods over which~~

~~the policy is in effect.~~

~~(8) Health care providers having approved self-insurance plans shall be surcharged an amount equal to the surcharge imposed on a health care provider of like class, size, risk and kind as determined by the director. The fund and all income from the fund shall be held in trust, deposited in a segregated account, invested and reinvested by the director, and shall not become a part of the General Fund of the Commonwealth. All claims shall be computed on August 31 for all claims which became final between that date and September 1 of the preceding year. All such claims shall be paid on or before December 31 following the August 31 by which they became final, as provided above.~~

~~(9) Notwithstanding the above provisions relating to an annual surcharge, the commissioner shall have the authority, during September of each year, if the fund would be exhausted by the payment in full of all claims which have become final and the expenses of the fund, to determine and levy an emergency surcharge on all health care providers then entitled to participate in the fund. Such emergency surcharge shall be the appropriate percentage of the cost to each health care provider for maintenance of professional liability insurance necessary to produce an amount sufficient to allow the fund to pay in full all claims determined to be final as of August 31 of each year and the expenses of the fund as of December 31 of each year.~~

~~(10) The annual and emergency surcharges on health care providers and any income realized by investment or reinvestment shall constitute the sole and exclusive sources of funding for the fund. No claims or expenses against the fund shall be deemed to constitute a debt of the Commonwealth or a charge against the~~

~~General Fund of the Commonwealth.~~

~~(11) The director shall issue rules and regulations consistent with this section regarding the establishment and operation of the fund including all procedures and the levying, payment and collection of the surcharges except that the commissioner shall issue rules and regulations regarding the imposition of the emergency surcharge.~~

~~(12) Upon the effective date of this section, the fund shall immediately notify all insurers writing professional liability insurance of the schedule of occurrence rates approved by the commissioner and in effect for the Joint Underwriting Association.~~

~~(13) Within 20 days of the effective date of this section, the fund shall recalculate the surcharge for health care providers for the surcharge period beginning January 1, 1997, based upon the prevailing primary premium.~~

~~(14) A health care provider may elect to pay the annual surcharge in equal installments, not exceeding four, if the health care provider informs the primary carrier of the option to pay in installments and the entire annual surcharge is collected and remitted to the fund by December 10, with four equal installments commencing 60 days from the date of policy inception or renewal with payment due each 60 days thereafter until the full remittance is paid. This paragraph shall apply to surcharges for 1997. This paragraph shall expire January 1, 1998.~~

~~(f) The failure of any health care provider to comply with any of the provisions of this section or any of the rules and regulations issued by the director shall result in the suspension or revocation of the health care provider's license~~

by the licensure board.

(g) Any physician who exclusively practices the specialty of forensic pathology shall be exempt from the provisions of this act.

(h) All health care providers who are members of the Pennsylvania military forces are exempt from the provisions of this act while in the performance of their assigned duty in the Pennsylvania military forces under orders.]

Section 3. The act is amended by adding sections to read:

Section 701.1. Pennsylvania Medical Professional Liability Catastrophe Loss Authority.--(a) The Pennsylvania Medical Professional Liability Catastrophe Loss Fund shall be terminated on January 1, 2002. Upon appointment of the initial members of the board as provided in subsection (c)(1), the following shall occur:

(1) The operation, management and control of the fund until its termination date as set forth herein shall be vested in the authority.

(2) All allocations, appropriations, equipment, claims and other files, contracts, agreements, obligations and other materials which are used, employed or expended by the Pennsylvania Medical Professional Liability Catastrophe Loss Fund shall be and are hereby transferred to the authority as if these contracts, agreements and obligations had been incurred or entered into by the authority.

(3) The director of the Medical Professional Liability Catastrophe Loss Fund shall have no authority, duties or responsibilities pursuant to this act, shall continue to serve at the pleasure of the board and shall exercise only that authority and those duties or responsibilities specifically

assigned to him or her by the board. Upon termination of the Pennsylvania Medical Professional Liability Catastrophe Loss Fund, the authority shall assume and pay the unfunded liability of the fund pursuant to this act. Claim files transferred to the authority pursuant to this subsection shall be confidential and shall not be subject to the "Right-to-Know law."

(b) There is hereby created a body corporate and politic to be known as the Pennsylvania Medical Professional Liability Catastrophe Loss Authority for the purpose of paying all awards, judgments and settlements for loss or damages against a health care provider entitled to participate in the authority as a consequence of any claim for professional liability brought against such health care provider as a defendant or an additional defendant to the extent such health care provider's liability exceeds its basic insurance coverage as required in section 701(a)(1) and consistent with section 605 and subsection (d). The authority shall be a public authority and instrumentality of the Commonwealth, exercising public powers of the Commonwealth as an agency and instrumentality thereof. The exercise by the authority of the powers conferred by this act is hereby declared to be and shall for all purposes be deemed and held to be the performance of an essential public function.

(c) The following provisions shall apply to the governing board:

(1) The powers and duties of the authority shall be exercised by a governing board composed of five members to be appointed as follows:

(i) One member shall be appointed by the Governor.

(ii) Four members shall be appointed by the Majority Leader of the Senate, the Minority Leader of the Senate, the Majority

Leader of the House of Representatives, and the Minority Leader of the House of Representatives, each of whom shall make one appointment. Initial appointments to the board shall be made within ten days following the effective date of this section. Members of the governing board shall have qualifications or experience in banking, finance or insurance. No member of the board shall be an individual, or represent individuals or organizations, that participate in the authority. No member of the board shall be an attorney representing claimants or health care providers in medical malpractice litigation subject to the provisions of this act. No member of the board shall be an employee, or a representative, of a firm which represents claimants or health care providers in medical malpractice litigation subject to the provisions of this act. No member of the board shall seek or hold any position as any other public official within the Commonwealth or as any national, state, or local political party officer nor shall any member of the board seek election as a public official or as a national, state, or local political party officer for a period of one year following his or her service on the board.

(2) The term of a member of the board shall begin on the date of appointment. The member appointed by the Governor shall have an initial term of four years; members appointed by the majority leaders shall have an initial term of four years; and members appointed by the minority leaders shall have an initial term of two years. All subsequent appointments shall be for three-year terms. The member's term shall continue until his or her replacement is appointed, but in no event longer than six months from the expiration of the member's term. A board member may be reappointed to serve an additional term or terms.

Whenever a vacancy occurs prior to the end of a member's term, the appointing authority who originally appointed the board member whose seat has become vacant shall appoint a successor member within 30 days of the vacancy. A member appointed to fill a vacancy prior to the expiration of a term shall serve the unexpired term and shall subsequently be eligible for appointment to a full term.

(3) The appointee of the Governor shall set a date, time and place for the initial organizational meeting of the board within ten days of the appointment of all of the initial members of the board. The members shall elect from among themselves a chairperson, vice-chairperson, secretary, treasurer and such other officers as they, in their sole discretion, shall determine. A member may hold more than one office of the board at any time.

(4) The board shall meet as frequently as it deems appropriate but at least once during each quarter of the fiscal year. In addition, a meeting of the board shall be called by the chairperson if a request for a meeting is submitted to the chairperson in writing by at least two members of the board. A majority of the full board shall constitute a quorum for the purpose of conducting the business of the board and for all other purposes. A board member must be physically present to be counted toward the quorum. All actions of the board shall be taken by a simple majority of the board majority.

(5) Board members shall not receive compensation or remuneration for their service on the board, but shall be entitled to reimbursement for all reasonable and necessary actual expenses in connection with their attendance at meetings and the performance of their duties under this act.

~~(d) The limit of liability of the authority shall be as follows:~~

~~(1) For policies issued or renewed in the calendar years 1997 and 1998, the limit of liability of the authority shall be $900,000 for each occurrence, on or after the date of issue or renewal, for each health care provider and $2,700,000 per annual aggregate for each health care provider, in excess of the basic insurance coverage.~~

~~(2) For policies issued or renewed in the calendar years 1999 and 2000, the limit of liability of the authority shall be $800,000 for each occurrence, on or after the date of issue or renewal, for each health care provider and $2,400,000 per annual aggregate for each health care provider, in excess of the basic insurance coverage.~~

~~(3) For policies issued or renewed in the calendar years 2001 and 2002, the limit of liability of the authority shall be $700,000 for each occurrence, on or after the date of issue or renewal, for each health care provider and $2,100,000 per annual aggregate for each health care provider, in excess of the basic insurance coverage.~~

~~(4) For policies issued or renewed in the calendar years 2003 and 2004, the limit of liability of the authority shall be $500,000 for each occurrence, on or after the date of issue or renewal, for each health care provider and $1,500,000 per annual aggregate for each health care provider, in excess of the basic insurance coverage.~~

~~(5) For policies issued or renewed in the calendar years 2005 and 2006, the limit of liability of the authority shall be $300,000 for each occurrence, on or after the date of issue or renewal, for each health care provider and $900,000 per annual~~

aggregate for each health care provider, in excess of the basic insurance coverage.

(6) For policies issued or renewed in the calendar year 2007, and each year thereafter, the limit of liability of the authority shall be $0 for each occurrence, on or after the date of issue or renewal, for each health care provider and $0 per annual aggregate for each health care provider.

(e) With regard to disposition of authority claims, the board shall appoint a claims committee whose members shall be representatives of the health care provider classes entitled to participate in the authority in substantially the same proportion as those health care provider classes pay assessments to the authority, but in no case shall a provider class have less than one representative on the claims committee. The claims committee shall review and advise the authority on the disposition of all claims. Acting through the claims committee, the authority shall have the following rights, powers, duties and responsibilities, in addition to all other rights, powers, duties and responsibilities imposed by this act or other acts, rules or regulations applicable thereto:

(1) The executive director shall be promptly notified, in writing, by a basic insurance coverage carrier or by a self-insurance plan, of any case involving an authority claim where such insurance carrier or self-insurance plan reasonably believes that the value of the claim exceeds 50% of the basic insurer's coverage or self-insurance plan or falls under the provisions of section 605 or subsection (d). The executive director shall prescribe the form of such notification. Any and all information provided to the executive director pursuant to this paragraph shall be confidential and shall not be subject to

~~the "Right-to-Know Law."~~

~~(2) The basic insurance coverage carrier or self-insurance plan shall be responsible to provide a defense for authority claims, including defense of the authority buyout fund, except as provided in section 605 and subsection (d). In all instances where the executive director has received proper notice in accordance with paragraph (1), the authority may, but shall not be obligated to, join in the defense and be represented by counsel.~~

~~(3) In the event that the basic insurance coverage carrier or self-insurance plan enters into a settlement with the claimant to the full extent of its liability as provided above, it may obtain a release from the claimant to the extent of its payment, which payment shall not have any effect upon any claim against the authority buyout fund or the duty of the authority to continue the defense of the claim.~~

~~(4) The authority, acting through the executive director or any other authorized agent, is authorized, empowered and directed to do any and all acts and things as it may determine to be necessary to defend, litigate, settle or compromise any claim made against the authority buyout fund. A health care provider's basic insurance coverage carrier or self-insurance plan shall have the right to approve any settlement entered into by the authority on behalf of the insured health care provider; provided, however, that the settlement shall be deemed approved by the basic insurance coverage carrier or self-insurance plan if such carrier or plan fails to notify the executive director of its disapproval, in writing, within five days of the receipt of written notice from the executive director of intent to approve the settlement. In the event that more than one health~~

~~care provider is party to a settlement, each health care provider's basic insurance coverage carrier or self-insurance plan shall have the right to approve only that portion of the settlement which is contributed on behalf of its insured health care provider.~~

~~(5) The authority is hereby authorized and empowered to use all or any portion of moneys on deposit in the authority buyout fund, or otherwise available to the authority and not otherwise required for the payment of debt service requirements or operating expenses, to contract with one or more licensed insurers for the payment of any and all awards, judgments or settlements for loss or damage arising out of, and to administer, defend, settle, litigate or compromise, any authority claim.~~

~~(6) Nothing in this act shall preclude the authority from adjusting or paying for the adjustment of authority claims, provided that such payment or adjustment is consistent with the financial plan adopted by the authority and in place at such time.~~

~~(7) Upon the request of a party to a case within the authority buyout fund coverage limits, the authority 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 to any proceeding hereunder that mediation shall be binding, the parties shall be bound by the conclusions of the mediator. The authority shall promulgate such rules and regulations as are necessary, proper or desirable to implement this provision. Proceedings conducted under this subsection shall be confidential and shall not be subject to the "Sunshine Act" and information provided during or as a result of such~~

proceedings shall not be considered public information subject to disclosure under the "Right-to-Know Law."

(8) Delay damages and postjudgment interest applicable to the liability of the authority buyout fund may be paid by the authority from amounts on deposit in or allocable to the authority buyout fund and shall not be charged against the health care provider's annual aggregate limits. The basic insurance coverage carrier or self-insurance plan shall be responsible for its proportionate share of delay damages and postjudgment interest.

(9) The authority may authorize any health care provider to manage their claims.

(10) The executive director shall, at each meeting of the board, report in summary form on adjustments or settlements of claims under paragraphs (4), (5) and (6).

(f) Statutes applicable to authority.--Unless otherwise expressly provided in this act, the provisions of the following acts shall apply to the authority:

(1) the "Right-to-Know law";

(2) the "Sunshine Act";

(3) the act of July 19, 1957 (P.L.1017, No.451), known as the "State Adverse Interest Act"; and

(4) 65 Pa.C.S., Ch. 11 (relating to ethic standards and financial disclosure).

(g) The authority is established for the purposes, without limitation, by itself or by agreement and in cooperation with others, of providing reinsurance, management and financing and refinancing through purchase, sale or otherwise, of claims accrued or to be accrued against the Pennsylvania Medical Professional Liability Catastrophe Loss Fund through and

~~including December 31, 2006, and against the authority consistent with Section 605 and subsection (d). The authority shall have all powers necessary, proper or desirable to effect the purposes of this act, including, but not limited to, the following:~~

~~(1) To commission a study to reliably estimate the amount of moneys, including costs of administration, defense, financing, insurance, reinsurance, settlement, litigation and otherwise, which will be required to pay all awards, judgments and settlements for loss and damages against health care providers entitled to participate in the Medical Professional Liability Catastrophe Loss Fund as a consequence of any claim for professional liability which arises out of an occurrence occurring prior to January 1, 2007, to the extent that:~~

~~(i) such health care provider's liability exceeds its basic insurance coverage as provided in section 701(a)(1);~~

~~(ii) such award, judgment or settlement is within the limits of liability of the authority set forth in Section 605 and subsection (d); and~~

~~(iii) the claim for recovery which is the basis for such award, judgment or settlement is commenced within the existing applicable statute of limitations.~~

~~(2) To commission updates to such study, at least once every two years, to determine if the estimate of the aggregate unfunded liability is accurate and to adjust, as needed, such estimate to more accurately reflect the aggregate unfunded liability based on the information obtained since the initial study or previous update, as applicable. The initial study and each update conducted in accordance with this paragraph shall specify all relevant assumptions upon which the determinations~~

were based, and shall be submitted in a report to the Governor, the Majority and Minority Chairpersons of the Senate Banking and Insurance Committee and the Majority and Minority Chairpersons of the House Insurance Committee.

(3) To pay all awards, judgments and settlements for loss or damages against a health care provider entitled to participate in the authority as a consequence of any authority claim as they become final, such payment to be made solely from moneys on deposit in the authority buyout fund.

(4) To enter into any and all contracts, agreements or other instruments necessary, proper or desirable to conduct its business and fulfill its duties and obligations hereunder.

(5) To sue and be sued, implead and be impleaded, complain and defend in all courts.

(6) To adopt, use and alter at will a corporate seal.

(7) To adopt bylaws for the management and regulation of its affairs and to adopt rules and policies and to promulgate regulations in connection with the performance of its functions and duties which, notwithstanding any other provision of law to the contrary, shall be submitted as final-omitted regulations pursuant to the act of June 25, 1982 (P.L.633, No.181), known as the "Regulatory Review Act"; provided, however, that, at least ten days prior to submission of any final-omitted regulation, the authority shall provide each basic insurance coverage insurance carrier and self-insurance plan with a summary of the final-omitted regulation and a notice setting forth the subject of the final-omitted regulation and the date on which the final-omitted regulation will be submitted to the Independent Regulatory Review Commission and the standing committees, and cause a copy of the foregoing notice to be published in the

Pennsylvania Bulletin.

(8) To appoint officers, agents, employees and servants and to prescribe their duties and obligations and to fix their compensation as set forth herein or otherwise required to fulfill its duties and obligations hereunder.

(8.1) Any person who is an employee of the fund on the effective date of this section and who becomes an employee of the authority shall remain a member of and continue to be eligible to participate under the State Employees' Retirement System.

(9) To retain outside counsel, auditors and such other professional advisors and consultants as it may determine to be necessary, proper or desirable to render such professional and advisory services as the authority deems appropriate.

(10) To cooperate with any Federal or state agency.

(11) To acquire by gift or otherwise, purchase, hold, receive, lease, sublease and use any franchise, license or personal property or any interest therein. The authority shall not purchase real property and shall lease or sublease real property solely for the purpose of providing office space in which the authority will conduct its business.

(12) To sell, transfer, convey or otherwise dispose of any property or any interest therein.

(13) To enter into any contracts for group insurance and to contribute to retirement plans for the benefit of its employees and to enroll its employees in an existing retirement system of a government agency.

(14) To accept, purchase or borrow equipment, supplies, services or other things necessary, proper or desirable to the work of the authority from other government agencies, and all

government agencies are hereby authorized and empowered to contract with the authority for, and to sell, lend or grant to the authority, such equipment, supplies, services or other things necessary, proper or desirable to fulfill the duties of the authority hereunder.

(15) To borrow money for the purpose of fulfilling its duties and obligations hereunder and to evidence the same through the execution and delivery of bonds and revenue anticipation notes hereunder; to secure payment of such bonds, or any part thereof, by pledge of or security interest in all or any part of its revenues, receipts, accounts, tangible personal property and contract rights; to secure payment of such revenue anticipation notes as provided in section 701.2; to make such agreements with purchasers or holders of such bonds and revenue anticipation notes or with any other obligees of the authority, which agreements shall be in such form and contain such terms and conditions as shall be necessary, proper or desirable to effect the purposes of the authority hereunder, and shall constitute contracts with the holders of such bonds and revenue anticipation notes; to obtain such credit enhancement or liquidity facilities in connection with any such bond or revenue anticipation note as the authority shall determine to be advantageous; and in general, to provide for the security for any such bonds and revenue anticipation notes and the rights of the owners or holders thereof. The authority shall use the most cost-effective financing methods available.

(16) To negotiate the terms and conditions of, and to enter into any agreements with, insurance companies and others relating to the sale, transfer, assignment, payment and/or management of any claims or losses associated with any authority

claim, which terms, conditions and agreements shall be determined by the authority to be necessary, proper or desirable to effect the purposes of the authority hereunder.

(17) To invest any funds of the authority in investments approved by the board from time to time in accordance with the provisions of this act.

(18) To receive and hold assets, moneys and funds from any source, including, but not limited to, appropriations, grants, gifts and assessments made pursuant to the provisions of this act.

(19) To procure such insurance, reinsurance, guarantees, sureties and other insurance and financial products as the authority may determine to be necessary, proper or desirable to fulfill its purposes hereunder.

(20) To pledge the credit of the authority in the manner provided by this act.

(21) To do all acts and things necessary, proper or desirable to fulfill its duties and obligations hereunder.

(h) The following provisions shall apply to employees and agents of the authority:

(1) The board shall fix and determine the number of employees of the authority and their respective compensation and duties. The board may contract for or receive the loan of services of persons in the employ of other government agencies, and other government agencies shall be authorized to make such employees available. No employee of the authority, except for any person in the employment of another government agency who is made available to the authority pursuant to this paragraph, shall seek or hold any position as a public official within this Commonwealth or as any national, State or local political party

officer while in the service of the authority. Except as provided in paragraph (2) with regard to the executive director, employees of the authority may serve as appointive public officials at any time following their service with the authority.

(2) The board shall retain an executive director upon the vote of a majority of the full board. The board shall, upon the approval of a majority of the full board, delegate to the executive director such powers of the board as the board shall deem necessary, proper or desirable to carry out the purposes of the authority, subject in every case to the supervision and control of the board. Subject to any limitations imposed by the board, and consistent with the requirements of this act, the executive director: (i) shall administer all funds and accounts of the authority; (ii) may employ and fix the compensation of such clerical and other assistants as he or she may determine to be necessary, proper or desirable to fulfill the purposes of the authority hereunder; and (iii) may promulgate rules and shall not seek election as a public official or as a national, State or local party officer for a period of one year following his or her service with the authority.

(3) The board shall, by the vote of a majority of the full board, hire a general counsel to the authority. The board may employ such other counsel, in addition to the general counsel, as it, in its sole discretion, shall determine. For purposes of the general counsel and other counsel employed by the board, the authority shall not be considered either an executive agency or an independent agency for the purpose of the act of October 15, 1980 (P.L.950, No.164), known as the "Commonwealth Attorneys Act," but shall possess the same status for such purpose as the

~~Auditor General, State Treasurer and the Pennsylvania Public Utility Commission; except that the provisions of section 204(f) of the "Commonwealth Attorneys Act" shall not apply to the authority and that, notwithstanding the provisions of section 221(1) of the act of October 5, 1980 (P.L.693, No.142), known as the "JARA Continuation Act of 1980," the authority, through its legal counsel, shall defend actions brought against the authority or its members, officers, officials and employees when acting within the scope of their official duties.~~

~~(i) Notwithstanding any purpose or general or specific power granted to the authority by this act or any other act, whether express or implied:~~

~~(1) The authority shall have no power or authority to pledge the credit or taxing powers of the Commonwealth or any political subdivision, except the credit of the authority created by this act, nor shall any bonds or revenue anticipation notes of the authority be deemed a debt or liability of the Commonwealth or any political subdivision.~~

~~(2) The Commonwealth, any government agency, or any political subdivision shall not be liable for such payment of principal, interest, or premium on any authority bonds or revenue anticipation notes. Liability shall be the sole responsibility of the authority.~~

~~(3) Notwithstanding any provision of this or any other law to the contrary, or of any implication that may be drawn therefrom, the Commonwealth and its political subdivisions shall have no legal or moral obligation for the payment of any expenses or obligations of the authority, including, but not limited to, bond or revenue anticipation note principal and interest, the funding or refunding of any reserves and any~~

administrative or operating expenses whatsoever, other than for the appropriation of funds for initial operating expenses of the authority contained in subsection (q)(1).

(4) Bonds and revenue anticipation notes issued by the authority shall contain a prominent statement of the limitations set forth in this subsection and shall further recite that obligees of the authority shall have no recourse, either legal or moral, to the Commonwealth or to any political subdivision for any payment of any amounts with respect to such bonds or revenue anticipation notes.

(j) The authority shall have continuing existence and succession for a term not to exceed one year after final payment and discharge of all of its liabilities, including without limitation, its bonds and revenue anticipation notes. Upon the termination of the existence of the authority, all of its rights in and to any property, including any funds remaining in any debt service reserve fund, shall be repaid to those providers who:

(1) on the termination date of the authority are subject to this act; and

(2) have paid assessments for all or some portion of the last five full fiscal years of the authority in a manner and proportion to be determined by the authority consistent with the historic manner and average proportion by which such providers were assessed over the last five full fiscal years of the authority. Any determination made by the authority pursuant to this subsection shall be deemed to be final and conclusive absent a showing of gross negligence or fraud.

(k) The fiscal year of the authority shall be established by the authority by adoption of a resolution, and may be changed by

the authority in the same manner.

(1) The initial operating budget of the authority shall be adopted by the board within 120 days following the initial meeting of the board as convened pursuant to subsection (c). Thereafter, the board shall, at least 60 days prior to the beginning of each fiscal year, adopt an operating budget for the authority by the vote of a majority of the full board. Such operating budget shall set forth in reasonable detail the projected expenses of operation of the authority for the ensuing fiscal year including, without limitation, the salary and benefits of the executive director and any other employees of the authority, the cost and expenses of any legal and other professionals employed or retained by the authority, and the projected revenues of the authority to be derived from investment earnings and assessments and any other moneys of the authority which are reasonably estimated to be available to pay the operating expenses set forth in the operating budget. The following information shall be included in the authority's operating budget:

(i) the total amount of debt service to become due on authority bonds or revenue anticipation notes for such ensuing fiscal year, including payments of principal and interest, maturity value or sinking fund payments;

(ii) the amount, if any, due to any provider of any credit or liquidity facility representing payments made by such provider on behalf of the authority as set forth in the applicable resolution, credit or liquidity facility agreement or trust indenture as a result of any previous failure of the authority to make any such payment provided for in the applicable resolution, credit or liquidity facility agreement or

trust indenture, including any related reasonable interest, fees or charges in connection therewith;

(iii) the amount, if any, required to restore the debt service reserve fund to the level required under section 701.2(h)(2) and the resolutions of the authority adopted in connection with the issuance of any bonds or revenue anticipation notes; and

(iv) the amount, if any, required to be rebated to the United States to provide for continued Federal tax exemption, if applicable, with respect to any bonds or revenue anticipation notes.

Authority operating expenses shall be budgeted and paid first from the revenues derived from the investment income of the authority and then from other moneys of the authority as provided in the authority's annual operating budget. The authority shall repay the initial amounts allocated to the authority under subsection (q)(1) from such sources or from the proceeds of the initial issuance of bonds or revenue anticipation notes of the authority. The Commonwealth shall not be responsible for funding the annual operating budget of the authority.

(m) Annually, within 45 days of receipt of the audit required by this subsection, the authority shall file a report with the Governor, the Majority and Minority Chairpersons of the Appropriations Committee of the Senate, and the Majority and Minority Chairpersons of the Appropriations Committee of the House of Representatives, which shall make provision for the accounting of revenues and expenses for the fiscal year. The authority shall have its books, accounts and records audited annually in accordance with generally accepted auditing

standards by an independent auditor who shall be a certified public accountant and a copy of the audit report shall be attached to and made a part of the authority's annual report. A concise financial statement of the authority shall be published annually in the Pennsylvania Bulletin.

(n) Prior to the initial issuance of any bonds or revenue anticipation notes by the authority hereunder, the authority shall adopt a financial plan which will provide for the payment of:

(i) any authority claims;

(ii) any and all debt service requirements with respect to any bonds or revenue anticipation notes issued or to be issued by the authority to fund the program required by this act;

(iii) all administrative and financing costs and expenses, as well as liquidity and insurance costs, if any, associated with any bonds or revenue anticipation notes issued or to be issued by the authority; and

(iv) all operating costs of the authority as set forth in and required by the annual operating budget.

The financial plan of the authority shall be reviewed and updated at least annually in connection with the preparation and publication of the authority's annual operating budget and shall at all times provide for the payment of all amounts due and payable or to become due and payable by the authority to others.

(o) Members of the board shall not be liable personally on any obligations of the authority, including, without limitation, bonds and revenue anticipation notes of the authority. It is hereby declared to be the intent of the General Assembly that the authority created by this act and its members, officers, officials, agents and employees shall enjoy sovereign and

official immunity, as provided in 1 Pa.C.S. section 2310 (relating to sovereign immunity reaffirmed; specific waiver), and shall remain immune from suit except as provided by and subject to the provisions of 42 Pa.C.S. sections 8501 (relating to definitions) through 8528 (relating to limitations on damages).

(p) The authority shall comply in all respects with the nondiscrimination and contract compliance plans used by the Department of General Services to assure that all persons are accorded equality of opportunity in employment and contracting by the authority and its contractors, subcontractors, assignees, lessees, agents, vendors and suppliers.

(q) The following provisions shall apply to authorized funding:

(1) Upon the effective date of this act, all assets and liabilities of the Pennsylvania Medical Professional Liability Catastrophe Loss Fund become the assets and liabilities of the Pennsylvania Medical Professional Liability Catastrophe Loss Authority.

(2) After December 31, 2001, the authority shall be funded by the levying of an annual assessment on or after January 1 of every year on all health care providers, except those exempted under section 701(a)(2) and subsection (s). The assessment shall be determined by the authority, filed with the commissioner and communicated to all basic insurance coverage carriers and self-insurance plans. The assessment shall be based on the prevailing primary premium for each health care provider in effect during the calendar year 2000 for maintenance of professional liability insurance and shall be the appropriate percentage thereof, necessary to produce an amount sufficient to provide for the

payment of claims, any and all debt service requirements with respect to any bonds and revenue anticipation notes issued or to be issued by the authority, all operating, administrative and financing costs and expenses, as well as liquidity and insurance costs, if any, associated with any bonds and revenue anticipation notes issued or to be issued by the authority, under the financial plan adopted by the authority, provided, however, that in calendar years 2002 through 2008 the aggregate annual assessment shall not exceed 50 percent of the surcharge imposed for calendar year 2000.

(3) The Joint Underwriting Association shall file an updated schedule of occurrence rates for all health care providers with the commissioner by May 1 of each year.

(4) The authority shall:

(i) review and may adjust the prevailing primary premium in line with any applicable changes to the schedule of occurrence rates made in filings by the Joint Underwriting Association and approved by the commissioner; and

(ii) review and may adjust the applicable prevailing primary premium of any hospital, including a hospital associated with a university or other educational institution, through an increase or decrease in the individual hospital's prevailing primary premium not to exceed 20% for any one year. Any such adjustment shall be based on the frequency and severity of claims paid by the authority 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. All prevailing primary premium adjustments pursuant to this paragraph shall require the approval of the commissioner.

(5) For health care providers that do not engage in direct

clinical practice on a full-time basis, the prevailing primary premium shall be prorated, based on the proportionate share of direct clinical practice to non-clinical practice, by the authority to reflect the lower risk associated with the less than full-time direct clinical practice.

(6) The authority shall adjust the annual assessment downward for new physicians, certified nurse midwives and podiatrists who enter practice in this Commonwealth after December 31, 2006. The elimination or discount shall not increase the cost of the annual assessment to existing health care providers. The basic coverage for new physicians, certified nurse midwives and podiatrists shall be the same as all other health care providers as prescribed in section 701(a)(1)(vi).

(7) The assessment provided in paragraph (2) shall be reviewed by the commissioner within 30 days of submission. After review, the commissioner may only disapprove an assessment if it is inadequate or excessive under the financial plan adopted by the authority. If so disapproved, the authority shall make an adjustment to the assessment calculation to reflect the appropriate increase or decrease.

(8) When a health care provider changes the term of its basic insurance coverage, the assessment shall be calculated on an annual base and shall reflect the assessment percentages in affect for all the assessment periods over which the policy is in effect.

(9) Health care providers having approved self-insurance plans shall be assessed an amount equal to the assessment imposed on a health care provider of like class, size, risk and kind as determined by the authority.

(10) A11 claims shall be computed on August 31 for all

claims which became final between that date and September 1 of the preceding year. All such claims shall be paid on the last business day on or before December 31 following the August 31 by which they became final.

(11) The annual assessments on health care providers, any proceeds of any sale of bonds and revenue anticipation notes, and any income realized by investment or reinvestment shall constitute the sole and exclusive sources of funding for the authority. No claims or expenses against the authority shall be deemed to constitute a debt of the Commonwealth or a charge against the General Fund of the Commonwealth.

(12) The authority, within two years of the effective date of this act, must be empowered to and shall arrange for the separate retirement of the liabilities associated with the following classes of health care providers:

(i) primary health centers;

(ii) certified nurse midwives;

(iii) podiatrists;

(iv) nursing homes; and

(v) birth centers.

Such arrangements shall be on terms and conditions proportionate to the individual liability of each class of health care provider. Such arrangements may result in assessments for primary health centers, certified nurse midwives, podiatrists, nursing homes and birth centers different than provided for under section 701.1(q). Upon satisfaction of such arrangements, primary health centers, certified nurse midwives, podiatrists, nursing homes and birth centers shall not be required to contribute to or be entitled to participate in the authority set forth in Article VII. In cases where a provider class rejects

such an arrangement, the authority shall present to such provider class new term arrangements at least once in every two-year period.

(13) Notwithstanding the above provisions relating to an annual assessment, the commissioner shall have the authority, during September of each year, if the authority would be exhausted by the payment in full of all claims which have become final and the expenses of the authority, to determine and levy an emergency assessment on all health care providers then entitled to participate in the authority. Such emergency assessment shall be the appropriate percentage of the cost to each health care provider for maintenance of professional liability insurance necessary to produce an amount sufficient to allow the authority to pay in full all claims determined to be final as of August 31 of each year, debt service, and the expenses of the authority as of December 31 of each year.

(r) The failure of any health care provider to comply with any of the provisions of this act or any of the rules and regulations issued by the authority shall result in the suspension or revocation of the health care provider's license by the applicable licensure board.

(s) The following providers are exempt from the provisions of this act:

(1) any physician who exclusively practices the specialty of forensic pathology;

(2) retired licensed practitioners who provide care to immediate family members; and

(3) all health care providers who are members of the Pennsylvania military forces while in the performance of their assigned duty in the Pennsylvania military forces under orders.

Section 701.2. Bonds, Revenue Anticipation Notes and Funds of Authority.--

(a) Any bonds or revenue anticipation notes issued by the authority under this act shall be limited revenue obligations of the authority, payable solely from the funds and accounts of the authority, including the revenues pledged for the payment and security therefor. The authority shall not have any power or authority at any time or in any manner to pledge the credit or taxing power of the Commonwealth or any of its political subdivisions and no obligation of the authority shall be deemed to be an obligation of the Commonwealth or any of its political subdivisions. Neither the Commonwealth nor any of its political subdivisions shall be liable for the payment of any principal or interest, or any other amounts, with respect to any bonds or revenue anticipation notes of the authority. The issuance of bonds and revenue anticipation notes by the authority under the provisions of this act shall not directly or indirectly obligate the Commonwealth or any of its political subdivisions to levy or pledge any form of taxation whatever therefor or to make any appropriation for their payment, except as may be expressly permitted by this act. The authority's bonds and revenue anticipation notes shall not constitute a charge, lien or encumbrance, legal or equitable, upon any property of the Commonwealth or of its political subdivisions, except the authority buyout fund, the other funds and accounts established hereunder and under the provisions of any resolution or trust indenture authorizing any indebtedness, and the revenues pledged or otherwise encumbered under the provisions of such resolutions or trust indentures and for the purposes of issuing the bonds and revenue anticipation notes and fulfilling the purposes of

the authority hereunder. The substance of this limitation shall be plainly stated on the face of every bond and revenue anticipation note delivered by the authority. Bonds and revenue anticipation notes issued by the authority shall not be subject to any statutory limitation on the indebtedness of the Commonwealth nor shall they be included in computing the aggregate indebtedness of the Commonwealth in respect to, and to the extent of, any such limitation. All amounts necessary for the punctual payment of debt service requirements on the bonds and revenue anticipation notes shall be deemed appropriated, but only from the limited sources specifically pledged therefor pursuant to this act.

(b) The following provisions shall apply to the issuance of bonds or revenue anticipation notes:

(1) Any bonds or revenue anticipation notes issued by the authority and reciting in substance that such bond or revenue anticipation note has been issued by the authority to accomplish the public purposes of this act shall be conclusively deemed in any suit, action or proceeding involving the validity or enforceability of such bonds or revenue anticipation notes or any security therefor to have been issued for such purposes.

(2) The authority shall cause a copy of any resolution authorizing the issuance of bonds or revenue anticipation notes to be filed for public inspection at its principal place of business.

(3) After the issuance of bonds and revenue anticipation notes by the authority, all such bonds and revenue anticipation notes shall be conclusively presumed to be fully and properly authorized and issued in accordance with all laws of the Commonwealth, and any person shall be estopped from questioning

~~or challenging their authorization, sale, execution or delivery by the authority.~~

~~(c) Any pledge or grant of a security interest in revenues or property of the authority shall be valid and binding from the time when such pledge or grant is made; the revenues or other property so pledged and thereafter received by the authority shall immediately be subject to the lien of any such pledge or security interest without physical delivery thereof or further act, and the lien of any such pledge or security interest shall be valid and binding as against all parties having claims of any kind in tort, contract or otherwise against the authority irrespective of whether such parties have notice thereof. Neither the resolution nor any other instrument of the authority by which a pledge or security interest is created need be recorded or filed to perfect such pledge or security interest, but the authority shall nonetheless cause such recording or filing to be made as is usual and customary in such cases.~~

~~(d) The following provisions shall apply to the Commonwealth:~~

~~(1) The Commonwealth does hereby pledge to and agree with each and every owner of authority bonds that the Commonwealth will not limit or alter the rights hereby vested in the authority or otherwise created by this act in any manner which impairs or is inconsistent with the obligations of the authority to such bondholder until all such bonds, together with the interest thereon, shall have been fully paid and discharged.~~

~~(2) The Commonwealth does hereby pledge to and agree with each and every person who, as owner thereof, leases or subleases property, or rights to property, to or from the authority, that the Commonwealth will not limit or alter the rights hereby~~

vested in the authority or otherwise created by this act in any manner which impairs or is inconsistent with the obligations of the authority to such persons until all such obligations of the authority under the lease or sublease shall have been fully met, paid and discharged.

(3) If and to the extent that the authority pledges as security for any bonds or revenue anticipation notes any revenues to be derived from charges or assessments of health care providers, the Commonwealth does hereby pledge to and agree with each and every obligee of the authority acquiring bonds or revenue anticipation notes so secured, that, until all bonds or revenue anticipation notes secured by the pledge of the authority, and all interest thereon, are fully paid or provided for and until all liens created to secure such bonds or revenue anticipation notes shall have been fully paid and discharged, the Commonwealth itself will not, nor will it authorize any government agency making such assessment, to reduce the amount of such assessment beyond an amount that would provide moneys to the authority which, together with other moneys legally available to the authority, will permit the authority in any given fiscal year to pay all of the debt service on such bonds and revenue anticipation notes for such fiscal year.

(e) The holders of bonds and revenue anticipation notes of the authority shall have the right to enforce a pledge of or security interest in revenues of the authority securing payment of such bonds or revenue anticipation notes against all government agencies in possession of any such revenues at any time, which revenues may be collected directly from such officials upon notice by such obligees or a trustee for such obligees for application to the payment of such bonds or revenue

anticipation notes as when due or for deposit in any sinking, bond or debt service fund established by this act or established by resolution of the authority with such trustee at the times and in the amounts specified in such bonds or revenue anticipation notes or in the resolution or indenture or trust agreement securing such bonds or revenue anticipation notes. Any government agency in possession of any such revenues shall make payment against receipt and shall thereby be discharged from any further liability or responsibility for such revenues. If such payment shall be made to a holder of such bonds or revenue anticipation notes, it shall be made against surrender of such bonds or revenue anticipation notes to the payor for delivery to the authority in the case of payment in full; otherwise, it shall be made against production of such bonds or revenue anticipation notes for notation thereon of the amount of the payment. The provisions of this section with respect to the enforceability and collection of revenues which secure bonds or revenue anticipation notes shall supersede any contrary or inconsistent statutory provision or rule of law. This section shall be construed and applied to fulfill the legislative purpose of clarifying and facilitating the financing by the authority of the obligations of the Medical Professional Liability Catastrophe Loss Fund by assuring to the obligees of the authority the full and immediate benefit of the security for the bonds or revenue anticipation notes, without delay, diminution or interference based on any statute, decision, ordinance or administrative rule or practice.

(f) The following provisions shall apply to bonds:

(1) Any bonds of the authority shall be authorized by a resolution of the board by vote of a majority of the full board

and shall be of such series, bear such date or dates, bear or accrue interest at such rate or rates as shall be determined by the board as necessary to issue and sell in a public, private, invited or negotiated sale, be in such denominations, be in such form, either coupon or fully registered without coupons or in certificated or book-entry-only form, carry such registration, exchangeability and interchangeability privileges, be payable in such medium of payment and at such place or places, be subject to such terms of redemption and be entitled to such priorities of payment in the revenues or receipts of the authority as such resolution or resolutions of the board may provide. The bonds shall be signed by or shall bear the facsimile signatures of such officers as the board shall determine, and coupon bonds shall have attached thereto interest coupons bearing the facsimile signature of the treasurer of the authority, and all bonds shall be authenticated by an authenticating agent, fiscal agent or trustee, all as may be prescribed in such resolution or resolutions. Any such bonds may be issued and delivered notwithstanding that one or more of the officers whose facsimile signatures shall be upon such bonds, or the treasurer whose signature shall be upon the coupon, shall have ceased to be such officer at the time the bonds shall actually be issued or delivered.

(2) Bonds issued by the authority under the provisions of this act shall mature no later than 30 years from their respective dates of original issuance.

(3) Bonds issued by the authority under the provisions of this act may be sold by the authority at public, private, invited or negotiated sale for such price or prices and at such rate or rates of interest as the authority shall determine.

~~Bonds issued by the authority under the provisions of this act may be sold by the authority at a private sale by negotiation for such price or prices and at such rate or rates of interest as the authority shall determine. Pending the preparation of definitive bonds, interim receipts may be issued to the purchaser or purchasers of such bonds, and may contain such terms and conditions as the authority may determine.~~

~~(4) Bonds issued by the authority shall have the qualities of negotiable instruments under 13 Pa.C.S (relating to the commercial code).~~

~~(5) The proceeds of an issue of bonds issued by the authority pursuant to the provisions of this act may be used to:~~

~~(i) pay the costs of issuance of such bonds and to otherwise provide for the security therefor, including, without limitation, costs of liquidity and credit enhancement;~~

~~(ii) pay administrative costs and expenses of the authority associated with performing its duties and responsibilities hereunder;~~

~~(iii) fund required reserves for the bonds, or otherwise required by the authority to perform its duties and obligations hereunder, and to otherwise fulfill the legislative purposes of this act;~~

~~(iv) capitalize interest on such bonds for a period to be determined by the authority; and~~

~~(v) fund the program or programs contemplated by the financial plan of the authority.~~

~~Proceeds of the initial issue of bonds to be undertaken by the authority may be applied to reimburse the Commonwealth for the appropriation contained in section 701.1 (q)(1) and to fund up to $500,000 of initial operating expenses of the authority.~~

(6) Subject to the provisions of the outstanding bonds of the authority and the provisions of this act, the authority shall have the right and power to refund or otherwise refinance any outstanding bonds of the authority, whether such debt represents principal or interest, in whole or in part at any time. The term of any refunding bonds shall not extend to a final maturity date that could not have been included in the original issue of bonds being refunded. A refunding or refinancing may result in an increase in the total principal amount of outstanding indebtedness, but the total amount of principal and interest payments in any year may not be increased as a result of such refunding or refinancing except when refunding a variable rate obligation to a fixed rate financing.

(7) The effectuation of the authorized purposes of the authority shall and will be in all respects for the benefit of the people of this Commonwealth, for the increase of their commerce and prosperity and for the improvement of their health, safety, welfare and living conditions; and since the authority will, as a public instrumentality of the Commonwealth, be performing essential government functions in effectuating such purposes, the authority shall not be required to pay any taxes or assessments upon any property acquired or used or permitted to be used by the authority for such purposes; and the bonds issued by the authority, their transfer and the income therefrom, including any profits made on the sale thereof, shall, at all times, be free from State and local taxation within this Commonwealth. This exemption shall not extend to gift, estate, succession or inheritance taxes or any other taxes not levied directly on the bonds, the transfer thereof, the income therefrom or the realization of profits on the sale

thereof.

(8) In connection with the issuance of bonds and in order to secure the payment of such bonds, the authority, in addition to its other powers, but in all events, subject to the further limitations imposed by this act, shall have the right and power to:

(i) pledge or grant a security interest in all or any part of its gross or net revenues, including, specifically without limitation any and all amounts received or to be received with respect to assessments established pursuant to section 701.1 of this act;

(ii) grant a security interest in all or any part of its property then owned or thereafter acquired;

(iii) covenant against pledging or granting a security interest in all or any part of its revenues or all or any part of its property to which its right or title exists or may thereafter come into existence, or against permitting or suffering any lien on such revenues or property;

(iv) covenant as to which other or additional debts or obligations may be incurred by it;

(v) covenant as to the bonds to be issued, and as to the issuance of such bonds, in escrow or otherwise, and as to the use and disposition of the proceeds thereof;

(vi) provide for the replacement of lost, destroyed or mutilated bonds;

(vii) covenant against extending the time for the payment of bonds, or interest thereon, and to covenant for the redemption of any such bonds and to provide the terms and conditions thereof;

(viii) covenant as to the amount of revenues to be received

in each fiscal year or other period of time by the authority, as well as to the use and disposition to be made thereof, create or authorize the creation of special funds or reserves for debt service or other purposes and covenant as to the use and disposition of the moneys held in such funds;

(ix) prescribe the procedure, if any, by which the terms of any contract with bondholders may be amended or abrogated, and the amount of bonds the holders of which must consent thereto, and the manner in which such consent may be given;

(x) covenant as to the use of any or all of its property, warrant as to the authority's title to such property, and covenant as to the maintenance of its property, the replacement thereof, the insurance to be carried thereon and the use and disposition of insurance proceeds;

(xi) covenant as to the rights, liabilities, powers and duties arising upon the breach by it of any covenant, condition or obligation, provided that the authority shall not be permitted to covenant that upon such breach any or all of its bonds shall become or may be declared due before their stated maturity or scheduled prior mandatory redemption;

(xii) vest in a trustee or holders of bonds, or any proportion of them, the right to enforce the payment of the bonds, or to enforce any covenants securing or relating thereto;

(xiii) vest in a trustee the right, in the event of default in payments of interest or on principal of bonds of the authority, to take possession and use of any property of the authority and to collect the revenues and receipts of the authority and to dispose of such moneys in accordance with any obligation of the authority with or to a trustee pursuant to a resolution or trust indenture;

(xiv) provide for the powers and duties of a trustee and to limit the liabilities thereof, as well as to provide the terms and conditions upon which a trustee or holders of bonds, or any proportion thereof, may enforce any covenant or right securing or relating to the bonds;

(xv) enter into interest rate exchange agreements, interest rate cap and floor agreements and other similar agreements which in the judgment of the authority will assist the authority in managing its interest costs;

(xvi) obtain letters of credit, bond insurance and other facilities for credit enhancement and liquidity; and

(xvii) exercise all or any part or combination of the powers granted in this act, make covenants expressly authorized in this act, make such covenants and do any and all such acts and things as may be necessary or convenient or desirable in order to secure its bonds, or, in the absolute discretion of the authority, as will tend to accomplish the purposes of this act, by making the bonds more marketable, notwithstanding that such covenants, acts or things may not be specifically enumerated by this act.

The revenues of the authority and the property of the authority shall be pledged or otherwise encumbered only as expressly provided in this section and except to the extent necessary to effectuate such pledge or encumbrance, shall not be subject to attachment nor levied upon by execution or otherwise.

(9) Bondholders shall have the right, in addition to all other rights which may be conferred on such bondholders subject only to any binding contractual restrictions:

(i) by mandamus, suit, action or proceeding at law or in equity, to compel the authority and the members of the board,

officers, agents or employees thereof:

(A) to perform each and every term, provision and covenant contained in any bond, or any contract, agreement or trust indenture of the authority, which term, provision or covenant was for the benefit of such obligee;

(B) to require the carrying out of any or all such terms, provisions or covenants, and such bonds, contracts, agreements or trust indentures; and

(C) to require the fulfillment of all duties imposed upon the authority by this act.

(ii) by proceeding in equity, to obtain an injunction against any acts or things which may be unlawful or the violation of any of the rights of such bondholders.

(iii) to require the authority to account as if it were the trustee of an express trust for the bondholders for any pledged revenues received.

(10) Except as otherwise provided in any resolution of the authority authorizing or awarding bonds, the terms of such resolution and any agreement authorized by such resolution and the terms of this act as in effect when such bonds were authorized shall constitute a contract between the authority and the obligees from time to time of the authority, subject to modification by the affirmative vote of the holders of such amount of bonds as the resolution or applicable agreements or trust indentures shall provide.

(11) Bonds issued by the authority pursuant to this act are hereby made securities in which all government agencies, all insurance companies, trust companies, banking associations, banking corporations, savings banks, investment companies, executors, the trustees of any retirement, pension or annuity

fund or system of the Commonwealth or of any political subdivision, trustees and other fiduciaries may properly and legally invest funds, including capital, deposits or other funds in their control or belonging to them. Such bonds are hereby made securities which may properly and legally be deposited with and received by any government agency for any purpose for which the deposit of bonds or other obligations of the Commonwealth now or may hereafter be authorized by law.

(12) Subject to the requirements and conditions of this act, the first series of bonds issued by the authority shall be issued in such manner and time as shall be determined by the authority, so that net proceeds of the bonds will be available on or before December 15, 2001, or as soon as practicable thereafter, in an amount not less than the amount determined as necessary, proper or desirable by the authority to effectuate the purposes of this act and to implement the financial plan, though in no event in an amount greater than that provided for in paragraph (14).

(13) Subject to the requirements and conditions of this act, one or more additional series of bonds, other than temporary financing as provided for in subsection (g) and the initial issuance of bonds as provided in paragraph (12), shall be issued in such manner and time as shall be determined by the authority, so that net proceeds of the bonds will be available on or before the dates when such moneys are needed by the authority to effectuate the purposes of this act and to implement the financial plan adopted pursuant to this act. Except for a refunding permitted by paragraph (6), and for the issuance of temporary financing permitted by the provisions of subsection (g), no bonds shall be issued by the authority for any purpose

on a date later than December 31, 2031. The limitations of this section shall not apply to any bond to be issued by the authority to refund or refinance any other bond issued under this act, and to pay any costs and expenses associated with such refunding or refinancing.

(14) Except as expressly provided for in paragraph (5) or (6), the authority may not issue bonds in amounts that would cause the total amount of outstanding indebtedness to exceed, at the time of issuance, the most recent actuarial estimate of the aggregate unfunded liability, plus necessary reserves and contingencies, all as shall be set forth in the most recent financial plan of the authority.

(g) The following provisions shall apply to revenue anticipation notes:

(1) Notwithstanding any other provision of law, the authority shall have the power and authority, by resolution adopted by a majority of the full board, to borrow money from time to time in anticipation of the receipt of revenues from assessments, to evidence such indebtedness by issuance of revenue anticipation notes, and to authorize, issue and sell such notes in the manner and subject to the limitations set forth in this section. Any such notes authorized and issued in accordance with this section shall be designated revenue anticipation notes. The power set forth in this section to borrow from time to time shall include, but not be limited to, the power to make a single authorization and then issue and sell portions of such amount of authorized notes whenever desired or needed. This section shall be construed and applied to fulfill the legislative purpose of clarifying and facilitating temporary borrowings of the authority in anticipation of the receipt of

revenues from assessments, and to provide assurance to holders of such notes that they shall have the full and immediate benefit of the security therefor without delay, diminishment or interference based on any statute, court or administrative decision, ordinance or administrative rule or practice.

(2) The authority shall not, at any time, authorize or issue revenue anticipation notes which, when issued and delivered as provided herein, will, in the aggregate, together with all other revenue anticipation notes then issued and outstanding, exceed 85% of the amount of revenues certified by the authority in accordance with paragraph (6) to be collected or received during the remainder of the period during which the notes are to be issued and outstanding. In computing the aggregate amount of revenue anticipation notes outstanding at any time during the period for the purpose of the limitation imposed by this subsection, allowance shall be made for such notes as have already been paid and for amounts, if any, already paid into a sinking fund or trust fund established for payment of such notes.

(3) No revenue anticipation notes shall be stated to mature beyond twelve months after the date on which such revenue anticipation notes are issued. Interest on revenue anticipation notes from the date thereof shall be due and payable at the maturity of such notes or in installments at such earlier dates and at such annual rate or rates, fixed or variable, as shall be set forth in the resolution of the board authorizing their issuance.

(4) Revenue anticipation notes shall be issued in such denominations, shall be subject to such rights of prior redemption, shall have such privileges of interchange and

registration, shall be dated, shall be stated to mature on such dates and in such amounts, shall be in registered or bearer form with or without coupons or in certified or book-entry-only form, shall be payable in such medium of payment and shall be payable at such place or places, all as set forth in the resolution of the board authorizing their issuance.

(5) All revenue anticipation notes issued by the authority in a single fiscal year shall be equally and ratably secured by a pledge of, security interest in, and a lien and charge on, the revenues to be collected or received during the period when the notes will be outstanding. Such pledge, lien and charge shall be fully perfected against the authority, all creditors thereof and all third parties in accordance with the terms of the authorizing resolution from and after the filing of a financing statement or statements in accordance with 13 Pa.C.S. For the purpose of such filing, the sinking fund depositary or trustee of a trust fund for note payments, if any, or otherwise the fiscal agent or paying agent designated in the notes, may act as the representative of noteholders and, in such capacity, shall execute and file the financing statement and any continuation or termination statements as secured party. The authorizing resolution may establish one or more sinking funds or trust funds for payment of notes and provide for periodic or other deposits therein and may contain such covenants or other provisions as the authority may determine. No revenues pledged to secure bonds of the authority shall be pledged to secure revenue anticipation notes unless such pledge is, by its express terms, subordinate in all respects to the pledge of such revenues to secure such prior outstanding bonds. The holder of such subordinated notes, or a sinking fund depositary or trustee

acting on its behalf, shall have no right to enforce such pledge in the manner described in subsection (e) unless all payments due and payable with respect to such bonds shall have been made or provided for.

(6) Prior to each authorization of revenue anticipation notes, the authority shall certify its best estimate of the moneys to be received during the period when such notes will be outstanding. Such estimate of revenues shall take into account past and anticipated collection experience of the authority and current economic conditions as well as all other known facts. Such estimate shall be certified as of a date not more than thirty days prior to and no later than the date of the adoption of the resolution of the board authorizing the issuance and sale of such revenue anticipation notes, and shall be filed with the proceedings authorizing the revenue anticipation notes with the trustee for the notes of the authority, as provided in paragraph (8).

(7) Revenue anticipation notes may be sold at public, private, invited or negotiated sale and at such price or prices as the board, by a majority of all its members, shall determine. At the time of delivery of each issue, series or subseries of revenue anticipation notes, the authority, by its duly qualified officers and executive director, shall certify to the original purchasers thereof that the amount of all such notes to be outstanding will not exceed the limitations of paragraph (2) calculated from the date of such certificate to the respective maturity dates of all such notes to remain outstanding. Such certificate shall be retained by the authority until all revenue anticipation notes issued during the fiscal year shall have been paid in full.

(8) Prior to the delivery of any revenue anticipation notes to the original purchasers thereof, the authority shall file with the trustee for such revenue anticipation notes:

(i) the transcript of proceedings authorizing the issuance of the revenue anticipation notes, which proceedings shall include, without limitation, the resolution authorizing the revenue anticipation notes;

(ii) the certificate required by paragraph (6) as to the amount of revenues to be collected during the term of the revenue anticipation notes; and

(iii) the certificate required by paragraph (7) and a true copy of the accepted proposal for purchase of the revenue anticipation notes.

No approval of the trustee is required for the authority to issue such revenue anticipation notes.

(9) If the authority fails to pay principal or interest on any of its revenue anticipation notes as the same become due and payable whether at the stated maturity or upon a mandatory or unrevoked call for prior redemption and such failure shall continue for 30 days, the holder thereof shall, subject to the priorities created under this act and the provisions of any outstanding bonds of the authority, and subject to any limitation upon individual rights of action included in the resolution authorizing the revenue anticipation notes, have the right to recover the amount due in accordance with section 701.3. The judgment recovered shall have an appropriate priority upon the moneys next received by the authority.

(h) The following provisions shall apply to authority funds.

(1) All funds of the authority received from any source shall be delivered to or upon the order of the treasurer of the

authority or to such other agent of the authority as the board may designate. Such funds received by the authority shall be promptly deposited in a bank or banks in this Commonwealth as chosen by a majority of the full board. The moneys in such account or accounts may be paid by the treasurer of the authority or other designated agent of the authority on warrant of the treasurer of the authority or by such persons as the board may authorize to make such warrants. All such deposits of moneys may, if required by the authority, be secured by obligations of the United States or of the Commonwealth of a market value equal, determined at least weekly, to the amount of the deposit, and all banks and trust companies are authorized to give such security for such deposits.

Subject to the provisions of any agreements with obligees of the authority, all funds of the authority, including the proceeds of any bonds and revenue anticipation notes which are not required for immediate use, shall be invested by or on behalf of the authority in obligations of the Federal Government or of the Commonwealth or obligations which are legal investments for Commonwealth funds. All such investments shall be fully secured in such manner, and shall be made upon such terms and conditions, as shall be required from time to time for moneys of the Commonwealth.

The proceeds realized from any assessment made for authority purposes or made available for use by the authority to secure its bonds and revenue anticipation notes shall be transferred to the authority at the times provided by this act and otherwise by law, subject to any limitations or restrictions, and otherwise in the manner set forth in any resolution of the authority authorizing any bonds or revenue anticipation notes. Subject to

any limitations as may be provided for in this section or in any resolution authorizing the issuance of bonds or revenue anticipation notes, any such transfers shall be made first, to the bond or revenue anticipation note payment account established pursuant to paragraph (4), second, to any debt service reserve fund established pursuant to paragraph (2), third, to the authority for the payment of operating expenses in the amounts permitted pursuant to section 701.1(1), and finally to the surplus assessment fund established pursuant to paragraph (6).

(2) One or more debt service reserve funds into which it shall deposit, or cause to be deposited:

(i) the proceeds of any assessment made for authority purposes or made available for use by the authority in excess of amounts required to be deposited in the bond payment account pursuant to paragraph (4);

(ii) the proceeds of any sale of bonds to the extent provided in the resolution or resolutions authorizing such bonds; and

(iii) any other moneys made available to the authority from any source for such purpose.

All moneys at any time held in any debt service reserve fund, except as provided hereafter, shall be used when required solely for the payment of:

(A) the principal amount of any bonds secured in whole or in part by such fund;

(B) the sinking fund payments, if any, required with respect to such bonds;

(C) the purchase or redemption of such bonds;

(D) interest with respect to such bonds; or

(E) any redemption premium required to be paid with respect to any such bonds when they are redeemed prior to maturity.

Any debt service reserve fund established pursuant to this subsection shall be a trust fund held for the benefit and security of the obligees of the authority whose bonds are secured by such fund. Moneys in a debt service reserve fund shall not be withdrawn from the fund at any time in an amount that would reduce the amount of the fund to less than the minimum reserve fund requirement established for such fund in the resolution of the authority creating such fund, except for withdrawals for the purpose of making payments when due of principal, interest, redemption premium and sinking fund payments, if any, with respect to such bonds for the payment of which other moneys of the authority are not available. Any income or interest earned by, or increments to, any debt service reserve fund due to the investment thereof may be transferred by the authority to other funds or accounts of the authority to the extent that such transfer does not reduce the amount of the debt service reserve fund below the minimum reserve fund requirements established for such fund. Moneys transferred to other funds or accounts in accordance with this subsection may be used for whatever purposes the authority deems appropriate so long as such purposes are consistent with this act and the contracts of the authority with obligees of the authority.

(3) The authority shall not at any time issue bonds which would be secured in whole or in part by a debt service reserve fund if the issuance of such bonds would cause the amount in the debt service reserve fund to fall below the minimum reserve requirement for such fund, unless the authority at the time of the issuance of such bonds shall deposit in the debt service

reserve fund an amount, from the proceeds of such bonds to be issued or from other sources, which when added to the amount already on deposit in such fund will cause the total amount on deposit in such debt service reserve fund to equal or exceed the minimum reserve fund requirement.

(4) Pursuant to any resolution authorizing the issuance of bonds or revenue anticipation notes, the authority shall establish a bond or revenue anticipation note payment account, as applicable, to be used by the authority, or by a trustee acting on behalf of the authority, to make payments of principal, redemption premium, sinking fund payments, if any, and interest on any such bonds or revenue anticipation notes to be issued by the authority, or to make payments to banks or financial institutions to reimburse them for payments made by or on behalf of the authority with respect to such outstanding bonds or revenue anticipation notes. Revenues shall be deposited into the bond or revenue anticipation note payment account in the amounts, in the manner and at the times set forth in paragraph (1). All such deposits shall be made prior to any other payments or disbursements of such revenues to any other funds or for any other purposes.

The bond or revenue anticipation note payment account shall constitute a trust fund held for the exclusive and equal and ratable benefit of the holders of any bonds or revenue anticipation notes issued by the authority, in accordance with the terms and conditions of this act and the resolution or resolutions authorizing the issuance of such bonds or revenue anticipation notes. In connection with the issuance of any such bonds or revenue anticipation notes, the authority shall establish and file with the trustee for such bonds or revenue

anticipation notes, a schedule of debt service payments and a corresponding schedule of deposits of revenues to be made from moneys collected from the required assessments under this act. The authority, or the trustee acting on behalf of the authority, shall be authorized to withdraw moneys form the bond or revenue anticipation note payment account:

(A) at the times and in the manner and amounts sufficient to pay all debt service requirements with respect to the outstanding bonds or revenue anticipation notes, as set forth in such bonds or revenue anticipation notes and in the resolutions and agreements authorizing such indebtedness and by which it is secured; and

(B) with regard only to bonds, after such amounts have been paid or provided for debt service, any excess moneys shall be transferred, first, to any debt service reserve fund established for such bonds under paragraph (2), to the extent of any deficiency therein, second, to the authority for the payment of operating expenses subject to the provisions and limitations of section 701.1(1), and finally, to the surplus assessment fund established pursuant to paragraph (6) of this subsection.

(5) There is hereby established an authority buyout fund to be held, administered, invested and applied by the authority in accordance with the provisions of, and to further the purposes of, this act to pay or provide for the payment of all awards, judgments or settlements for loss or damages against a health care provider entitled to participate in the authority as a consequence of any authority claim. The authority buyout fund shall be funded by the authority with the net proceeds of one or more series of bonds issued by the authority in accordance with this act. The authority buyout fund may be divided into multiple

accounts to provide separate accounting for the payment of authority claims of health care providers which are tax-exempt organizations under Federal law and for the payment of authority claims of health care providers which are not tax-exempt organizations under Federal law. The authority may determine to issue separate series of bonds so that a separate accounting of the uses of such indebtedness can be made.

The authority buyout fund shall constitute a trust fund held for the exclusive and equal and ratable benefit of the holders of any bonds issued by the authority, in accordance with the terms and conditions of this act and the resolution or resolutions authorizing the issuance of such bonds. The investments and all moneys from time to time on deposit in the authority buyout fund shall be devoted to, and used exclusively for, the payment of the claims against the authority, as set forth herein, and to the extent not needed therefor, may be applied to the payment of debt service accruing on the bonds of the authority, as may be set forth in the resolution, indenture or trust instrument securing such bonds.

(6) Pursuant to any resolution authorizing the issuance of bonds, the authority shall establish a surplus assessment fund to be held, invested and applied by the authority, or by a trustee acting on behalf of the authority, to fulfill the provisions of this act. Revenues shall be deposited into the surplus assessment fund in the amounts, in the manner and at the times set forth in paragraph (1), or by or on behalf of the authority as set forth in paragraph (4). Amounts from time to time on deposit in the surplus assessment fund shall be invested in accordance with the provisions of this act. Amounts from time to time on deposit in the surplus assessment fund shall be

applied, as needed, first, to cure any deficiency in the bond or revenue anticipation note payment account required to permit the authority, or the trustee acting on behalf of the authority, to make any required payments of debt service with respect to outstanding bonds or revenue anticipation notes of the authority, second, to the debt service reserve fund established under paragraph (2), to the extent of any deficiency therein, and finally, to the authority for the payment of operating expenses subject to the provisions and limitations of section 701.1(1).

The authority shall create such other funds and accounts as it may determine to be necessary, proper or desirable to effectuate its corporate purposes and shall pay into each such fund or account any moneys of the authority available for such purpose or any moneys made available to the authority by another person for the purposes of such fund or account. No other provision of this act shall be construed to prohibit the authority from creating within any fund one or more accounts that may be used or pledged by the authority for a special purpose.

(7) Any moneys deposited by or on behalf of the authority into any fund or account created by the authority in accordance with the provisions of this act and to be used or available to pay debt service with respect to any issued bonds or revenue anticipation notes of the authority, including, without limitation, the bond or revenue anticipation note payment account, any debt service reserve fund or sinking fund, the surplus assessment fund, and all investments and proceeds of investments from time to time held therein or accountable thereto shall, without further action or filing, be subjected to

a perfected security interest for the obligees of the authority for whom such fund is held until such moneys or investments shall be properly disbursed by or on behalf of the authority in accordance with the provisions of this act and with the terms and conditions of the resolutions, trust indentures and other contracts or agreements with, or for the benefit of such obligees.

Section 701.3. Original and Exclusive Jurisdiction of Supreme Court.--The Pennsylvania Supreme Court shall have exclusive jurisdiction to hear any challenge to or to render a declaratory judgment concerning the constitutionality of this article, the contractual rights of the parties relating to bonds and revenue anticipation notes to be issued pursuant to this article, or any action of the authority in issuing or attempting to issue bonds and revenue anticipation notes, whether with respect to the validity of the bonds or revenue anticipation notes, proper authorization with respect thereto, or otherwise. The Supreme Court is authorized to take any action it deems appropriate, consistent with the Supreme Court retaining jurisdiction over such a matter, to find facts or to expedite a final judgment in connection with such a challenge or request for declaratory relief.

Section 701.4. No Impairment of Rights and Obligations.--Except as expressly set forth herein, nothing in this act shall limit the rights or impair the obligations of any person with respect to any obligation set forth in any contract, agreement, settlement or judgment in effect as of the effective date of this act.

Section 701.5. Construction of Act.--The provisions of this act providing for security for and rights and remedies of

~~obligees of the authority shall be liberally construed to achieve the purposes stated and provided for by this act.~~

~~Section 4. Section 702 of the act is repealed.~~

~~Section 5. Sections 705, 706, 803, 809, 811 and 841-A of the act, amended or added November 26, 1996 (P.L.776, No.135), are amended to read:~~

~~Section 705. Liability of Excess Carriers.--(a) No insurer providing excess professional liability insurance to any health care provider eligible for coverage under the [fund]~~ authority ~~shall be liable for payment of any claim against a health care provider for any loss or damages except those in excess of the [fund]~~ authority ~~coverage limits.~~

~~(b) No carrier providing excess professional liability insurance for a health care provider covered by the [fund]~~ authority ~~shall be liable for any loss resulting from the insolvency or dissolution of the [fund]~~ authority~~.~~

~~Section 706. Advisory Board.--(a) There is hereby established an advisory board of eleven members to be known as the [Medical Professional Liability Insurance Catastrophe Loss Fund]~~ Authority ~~Advisory Board.~~

~~(b) The~~ authority advisory ~~board shall be comprised of the following persons:~~

~~(1) The Insurance Commissioner.~~

~~(2) Four members, one each to be appointed by the President pro tempore of the Senate, the Minority Leader of the Senate, the Speaker of the House of Representatives and the Minority Leader of the House of Representatives. These members shall have experience in the areas of law, health care, liability insurance, finance or actuarial analysis.~~

~~(3) Six members appointed by the Governor as follows:~~

~~(i) One physician, who shall be appointed for a three-year term.~~

~~(ii) One representative of a hospital provider, who shall be appointed for a three-year term.~~

~~(iii) One representative of a casualty insurer with 1% or less share of the medical professional liability insurance market in this Commonwealth, who shall be appointed for a two-year term.~~

~~(iv) One podiatrist [or]~~ and ~~one representative of a nursing home, who shall be appointed for a three-year term. The podiatrist and the representative of a nursing home shall alternate terms.~~

~~(v) Two representatives of the public-at-large, one of whom shall be appointed for a two-year term and the other for a one-year term.~~

~~(c) After the initial terms under this paragraph have been completed, all terms shall be for a period of three years.~~

~~(d) The members of the~~ authority advisory ~~board shall serve without compensation, but shall be reimbursed for their actual and necessary traveling and other expenses in connection with attendance at meetings.~~

~~(e) The members of the~~ authority advisory ~~board shall [have the following powers and duties:~~

~~(1) To review procedures and operations of the fund.~~

~~(2) To commission audits to be paid for by the fund, not to exceed more than one every two years.~~

~~(3) To adopt reasonable standards for prompt investigation and settlement of claims arising under this act to include, but not be limited to:~~

~~(i) Prompt acknowledgment of pertinent communications with~~

~~respect to claims.~~

~~(ii) Reasonable standards for prompt investigation and settlement of claims.~~

~~(iii) Prompt and reasonable settlement of claims in which liability has become reasonably clear.~~

~~(iv) Fair settlement of all claims.~~

~~(v) Prevention of duplication in formal proof of loss and subsequent verification.~~

~~(vi) Provision of reasonable and accurate explanations of basis for claims denials or settlement offers.~~

~~(f) The board shall make annual reports to the Governor and the General Assembly which shall include recommendations regarding management and legislative changes.~~

~~(g) The board shall undertake a study of the operations and structure of the fund and shall report to the Governor and the General Assembly, not later than September 1, 1997, its recommendations concerning the future of the fund, including, but not limited to, an opt-out provision for doctors and hospitals, total elimination or phaseout of the fund and other provisions for providing adequate medical professional liability insurance, including evaluation of the unfunded liability and financing options to retire any unfunded liabilities. The report shall recommend measures to be taken by the General Assembly.~~

~~(h) As used in this section, the term "board" means the Medical Professional Liability Insurance Catastrophe Loss Fund Advisory Board.]~~ provide advice and make recommendations to the ~~authority board.~~

~~Section 803. Plan Operation, Rates and Deficits.--(a) Subject to the supervision and approval of the commissioner, insurers may consult and agree with each other and with other~~

~~appropriate persons as to the organization, administration and operation of the plan and as to rates and rate modifications for insurance coverages provided under the plan. Rates and rate modifications adopted or changed for insurance coverages provided under the plan shall be approved by the commissioner in accordance with the act of June 11, 1947 (P.L.538, No.246), known as "The Casualty and Surety Rate Regulatory Act," except as may be inconsistent with subsection (c).~~

~~(b) In the event that the Joint Underwriting Association suffers a deficit in any calendar year, the board of directors of the Joint Underwriting Association shall so certify to the~~ executive ~~director of the [fund]~~ authority ~~and the commissioner. Such certification shall be subject to the review and approval of the commissioner. Within 60 days following such certification and approval the~~ executive ~~director of the [fund]~~ authority ~~shall make sufficient payment to the Joint Underwriting Association to compensate for said deficit. A deficit shall exist whenever the sum of the earned premiums collected by the Joint Underwriting Association and the investment income therefrom is exhausted by virtue of payment of or allocation for the Joint Underwriting Association's necessary administrative expenses, taxes, losses, loss adjustment expenses and reserves, including reserves for: (1) losses incurred, (2) losses incurred but not reported, (3) loss adjustment expenses, (4) unearned premiums.~~

~~(c) Within 60 days following the certification that the Joint Underwriting Association has suffered a deficit, as set forth in subsection (b), the board of directors of the Joint Underwriting Association shall file with the commissioner. The commissioner shall approve a premium increase sufficient to~~

~~generate the requisite income to:~~

~~(1) reimburse the [fund] authority for any payment made by the [fund] authority to compensate for said deficit; and~~

~~(2) increase premiums to a level actuarially sufficient to avoid an operating deficit by the Joint Underwriting Association during the following 12 months.~~

~~The Joint Underwriting Association shall reimburse the [fund] authority with interest at a rate equal to that earned by the [fund] authority on its invested assets within one year of any payment made by the [fund] authority as compensation for any deficit incurred by the Joint Underwriting Association.~~

~~(d) Upon dissolution of the authority, the authority shall no longer be obligated to make payment to the Joint Underwriting Association in the event that the Joint Underwriting Association suffers a deficit.~~

~~Section 809. Reports to Commissioner and Claims Information.--(a) By October 15 of each year, basic coverage insurance carriers and self-insured providers shall report to the [fund] authority the claims information specified in subsection (b).~~

~~(b) Sixty days after the end of any calendar year, the [fund] authority shall prepare a report for the commissioner. The report shall contain the total amount of claims paid and expenses incurred therewith, the total amount of reserve set aside for future claims, the date and place in which each claim arose, the amounts paid, if any, and the disposition of each claim, judgment of court, settlement or otherwise, and such additional information as the commissioner shall require. For final claims at the end of any calendar year, the report shall include details by basic coverage insurance carriers and self-~~

~~insured providers of the amount of [surcharge]~~ assessment ~~collected, the number of reimbursements paid and the amount of reimbursements paid.~~

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

~~Section 811. Professional Corporations, Professional Associations and Partnerships.--(a) The Joint Underwriting Association shall offer [basic coverage insurance]~~ basic ~~insurance coverage~~ ~~to such professional corporations, professional associations and partnerships entirely owned by health care providers who cannot conveniently obtain insurance through ordinary methods at rates not in excess of those applicable to similarly situated professional corporations, professional associations and partnerships.~~

~~(b) In the event that a professional corporation, professional association or partnership entirely owned by health care providers elects to be covered by [basic coverage insurance]~~ basic insurance coverage ~~and upon payment of the annual [surcharge]~~ assessments ~~as required by section [701(e)]~~ 701.1(g), ~~the professional corporation, professional association or partnership shall be entitled to such excess coverage from the [fund]~~ authority ~~as is provided in this act.~~

~~(c) Any professional corporation, professional association, or partnership which acquires [basic coverage insurance]~~ basic ~~insurance coverage~~ ~~from the Joint Underwriting Association pursuant to subsection (a) or from an insurer licensed or approved by the Commonwealth [of Pennsylvania] shall be required~~

~~to participate in and contribute to the [fund]~~ authority ~~as provided in this act.~~

~~(d) Any professional corporation, professional association or partnership which participates in or contributes to the [fund]~~ authority ~~shall be subject to all other provisions of this act.~~

~~Section 841-A. Mandatory Reporting.--(a) Each malpractice insurer, including the [Medical Professional Liability Catastrophe Loss Fund]~~ authority ~~established by this act, which makes payment under a policy of insurance in settlement, or in partial settlement of, or in satisfaction of a judgment in a medical malpractice action or claim shall provide to the appropriate licensure board a true and correct copy of the report required to be filed with the Federal Government by section 421 of the Health Care Quality Improvement Act of 1986 (Public Law 99-660, 42 U.S.C. § 11131). The copy of the report required by this section shall be filed simultaneously with the report required by section 421 of the Health Care Quality Improvement Act of 1986. The Insurance Department shall monitor and enforce compliance with this section. The Bureau of Professional and Occupational Affairs and the licensure boards shall have access to information pertaining to compliance.~~

~~(b) A malpractice insurer or person who reports under subsection (a) in good faith and without malice shall be immune from civil or criminal liability arising from the report.~~

~~(c) Information received under this subsection shall not be considered public information for the purposes of the [act of June 21, 1957 (P.L.390, No.212), referred to as the] Right-to-Know Law or [the act of July 3, 1986 (P.L.388, No.84), known as the "Sunshine Act,"]~~ 65 Pa.C.S. Ch. 7 (relating to open

meetings) until used in a formal disciplinary proceeding.

(d) Each licensure board shall submit a report not later than March 1 of each year to the chairman and the minority chairman of the Consumer Protection and Professional Licensure Committee of the Senate and to the chairman and minority chairman of the Professional Licensure Committee of the House of Representatives. The report shall include, but not be limited to, the number of reports received under subsection (a), the status of the investigations of those reports, any disciplinary action which has been taken and the length of time from the receipt of each report to final licensure board action.

Section 6. Any person who is an employee of the Medical Professional Liability Catastrophe Loss Fund on the effective date of this act shall be given priority consideration for employment to fill vacancies with executive agencies under the Governor's jurisdiction.

Section 7. Existing regulations of the Medical Professional Liability Catastrophe Loss Fund shall remain in full force and effect until amended or repealed by the Pennsylvania Medical Professional Liability Catastrophe Loss Authority.

Section 8. A health care provider covered under this act may make application to the Insurance Department for certification of any established patient safety plan which includes participation in a regional, state or national program developed for the purpose of a reduction in medical errors and promotion of error prevention. The department shall develop the criteria for such certification. Upon receipt of the certification by the department, a health care provider shall receive a discount in the rate or the rates applicable for both basic coverage and the authority's assessment for the next applicable policy year, with

~~the level of such discount to be determined by the department.~~

~~Section 9. This act shall take effect immediately.~~

SECTION 1. THE TITLE OF THE ACT OF OCTOBER 15, 1975 <—
(P.L.390, NO.111), KNOWN AS THE HEALTH CARE SERVICES MALPRACTICE ACT, IS AMENDED TO READ:

AN ACT

RELATING TO MEDICAL AND HEALTH RELATED MALPRACTICE INSURANCE, PRESCRIBING THE POWERS AND DUTIES OF THE INSURANCE DEPARTMENT; PROVIDING FOR A JOINT UNDERWRITING PLAN; THE ARBITRATION PANELS FOR HEALTH CARE, COMPULSORY SCREENING OF CLAIMS; COLLATERAL SOURCES REQUIREMENT; LIMITATION ON CONTINGENT FEE COMPENSATION; ESTABLISHING [A] MEDICAL PROFESSIONAL LIABILITY CATASTROPHE LOSS AUTHORITY FUND; ESTABLISHING THE MEDICAL PROFESSIONAL LIABILITY CATASTROPHE LOSS AUTHORITY; ADDING PROVISIONS RELATING TO PATIENT SAFETY; ESTABLISHING THE PATIENT SAFETY AUTHORITY AND PATIENT SAFETY TRUST FUND; AND PROVIDING FOR THE POWERS AND DUTIES OF THE DEPARTMENT OF HEALTH; AND PRESCRIBING PENALTIES.

SECTION 2. SECTIONS 103 AND 605 OF THE ACT, AMENDED NOVEMBER 26, 1996 (P.L.776, NO.135), ARE AMENDED TO READ:

SECTION 103. DEFINITIONS.--AS USED IN THIS ACT:

"BIRTH CENTER" MEANS AN ENTITY LICENSED UNDER THE ACT OF JULY 19, 1979 (P.L.130, NO.48), KNOWN AS THE "HEALTH CARE FACILITIES ACT," AS A BIRTH CENTER.

"CLAIMANT" MEANS A PATIENT AND INCLUDES A PATIENT'S IMMEDIATE FAMILY, GUARDIAN, PERSONAL REPRESENTATIVE OR ESTATE.

"CLAIMS MADE" MEANS [A POLICY OF] MEDICAL PROFESSIONAL LIABILITY INSURANCE THAT [WOULD LIMIT OR RESTRICT THE LIABILITY OF THE INSURER UNDER THE POLICY TO ONLY] INSURES THOSE CLAIMS MADE OR REPORTED DURING THE [CURRENCY OF THE POLICY PERIOD AND

WOULD EXCLUDE] PERIOD WHICH IS INSURED AND EXCLUDES COVERAGE FOR [CLAIMS] A CLAIM REPORTED SUBSEQUENT TO THE [TERMINATION EVEN WHEN SUCH CLAIMS RESULTED FROM OCCURRENCES DURING THE CURRENCY OF THE POLICY] PERIOD EVEN IF THE CLAIM RESULTED FROM AN OCCURRENCE DURING THE PERIOD WHICH WAS INSURED.

"CLAIMS PERIOD" MEANS THE PERIOD FROM SEPTEMBER 1 TO THE FOLLOWING AUGUST 31.

"COMMISSIONER" MEANS THE INSURANCE COMMISSIONER OF THIS COMMONWEALTH.

"DEPARTMENT" MEANS THE INSURANCE DEPARTMENT OF THE COMMONWEALTH.

["DIRECTOR" MEANS THE DIRECTOR OF THE MEDICAL PROFESSIONAL LIABILITY CATASTROPHE LOSS FUND.]

"FUND" MEANS THE MEDICAL PROFESSIONAL LIABILITY CATASTROPHE LOSS FUND [CREATED IN ARTICLE VII] ESTABLISHED IN SECTION 702-A.

"FUND COVERAGE LIMITS" MEANS THE COVERAGE PROVIDED BY THE [MEDICAL PROFESSIONAL LIABILITY CATASTROPHE LOSS FUND UNDER SECTION 701(A)] FUND UNDER SECTION 702-A.

"GOVERNMENT" MEANS THE GOVERNMENT OF THE UNITED STATES, ANY STATE, ANY POLITICAL SUBDIVISION OF A STATE, ANY INSTRUMENTALITY OF ONE OR MORE STATES, OR ANY AGENCY, SUBDIVISION, OR DEPARTMENT OF ANY SUCH GOVERNMENT, INCLUDING ANY CORPORATION OR OTHER ASSOCIATION ORGANIZED BY A GOVERNMENT FOR THE EXECUTION OF A GOVERNMENT PROGRAM AND SUBJECT TO CONTROL BY A GOVERNMENT, OR ANY CORPORATION OR AGENCY ESTABLISHED UNDER AN INTERSTATE COMPACT OR INTERNATIONAL TREATY.

"GUARDIAN" MEANS A FIDUCIARY WHO HAS THE CARE AND MANAGEMENT OF THE ESTATE OR PERSON OF A MINOR OR AN INCAPACITATED PERSON.

"HEALTH CARE BUSINESS OR PRACTICE" MEANS THE NUMBER OF PATIENTS TO WHOM HEALTH CARE SERVICES ARE RENDERED BY A HEALTH

CARE PROVIDER WITHIN AN ANNUAL PERIOD.

"HEALTH CARE PROVIDER" MEANS A PRIMARY HEALTH CENTER OR A PERSON, INCLUDING A CORPORATION, UNIVERSITY OR OTHER EDUCATIONAL INSTITUTION, [FACILITY, INSTITUTION OR OTHER ENTITY] 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 [701(A)] 701-A, AN OFFICER, EMPLOYEE OR AGENT OF ANY OF THEM ACTING IN THE COURSE AND SCOPE OF EMPLOYMENT.

"HOSPITAL" MEANS AN ENTITY LICENSED UNDER THE ACT OF JULY 19, 1979 (P.L.130, NO.48), KNOWN AS THE "HEALTH CARE FACILITIES ACT," AS A HOSPITAL.

"IMMEDIATE FAMILY" MEANS A PARENT, SPOUSE OR CHILD OR AN ADULT SIBLING RESIDING IN THE SAME HOUSEHOLD.

"INFORMED CONSENT" MEANS FOR THE PURPOSES OF THIS ACT AND OF ANY PROCEEDINGS ARISING UNDER THE PROVISIONS OF THIS ACT, THE CONSENT OF A PATIENT TO THE PERFORMANCE OF A PROCEDURE IN ACCORDANCE WITH SECTION 811-A.

"INTEREST" MEANS INTEREST AT THE RATE PRESCRIBED IN SECTION 806 OF THE ACT OF APRIL 9, 1929 (P.L.343, NO.176), KNOWN AS "THE FISCAL CODE."

"LICENSURE BOARD" MEANS THE STATE BOARD OF MEDICINE, THE STATE BOARD OF OSTEOPATHIC MEDICINE, THE STATE BOARD OF PODIATRY, THE DEPARTMENT OF PUBLIC WELFARE AND THE DEPARTMENT OF HEALTH.

"MEDICAL PROFESSIONAL LIABILITY INSURANCE" MEANS THE SAME AS PROFESSIONAL LIABILITY INSURANCE.

"NONRESIDENT HEALTH CARE PROVIDER" MEANS A HEALTH CARE PROVIDER THAT CONDUCTS 20% OR LESS OF ITS HEALTH CARE BUSINESS

OR PRACTICE WITHIN THIS COMMONWEALTH.

"NURSING HOME" MEANS AN ENTITY LICENSED UNDER THE ACT OF JULY 19, 1979 (P.L.130, NO.48), KNOWN AS THE "HEALTH CARE FACILITIES ACT," AS A NURSING HOME.

"PATIENT" MEANS A NATURAL PERSON WHO RECEIVES OR SHOULD HAVE RECEIVED HEALTH CARE FROM A HEALTH CARE PROVIDER.

"PERSONAL REPRESENTATIVE" MEANS AN EXECUTOR OR ADMINISTRATOR OF A PATIENT'S ESTATE.

"PREVAILING PRIMARY PREMIUM" MEANS THE SCHEDULE OF OCCURRENCE RATES APPROVED BY THE [INSURANCE COMMISSIONER] COMMISSIONER FOR THE JOINT UNDERWRITING ASSOCIATION.

"PRIMARY HEALTH CENTER" MEANS A COMMUNITY-BASED NONPROFIT CORPORATION MEETING STANDARDS PRESCRIBED BY THE DEPARTMENT OF HEALTH, WHICH PROVIDES PREVENTIVE, DIAGNOSTIC, THERAPEUTIC, AND BASIC EMERGENCY HEALTH CARE BY LICENSED PRACTITIONERS WHO ARE EMPLOYEES OF THE CORPORATION OR UNDER CONTRACT TO THE CORPORATION.

"PAYABLE CLAIMS" MEANS A CLAIM WHICH ARISES FROM AN OCCURRENCE WHICH OCCURS ON OR BEFORE DECEMBER 31, 2002, OR A CLAIM REPORTED TO THE INSURANCE DEPARTMENT ON OR BEFORE DECEMBER 31, 2008.

"PROFESSIONAL LIABILITY INSURANCE" MEANS 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.

"RESIDENT HEALTH CARE PROVIDER" MEANS A HEALTH CARE PROVIDER THAT CONDUCTS MORE THAN 20% OF ITS HEALTH CARE BUSINESS OR PRACTICE WITHIN THIS COMMONWEALTH.

SECTION 605. STATUTE OF LIMITATIONS.--(A) ALL CLAIMS FOR

RECOVERY PURSUANT TO THIS ACT MUST BE COMMENCED WITHIN THE EXISTING APPLICABLE STATUTES OF LIMITATION. A FILING PURSUANT TO SECTION 401 SHALL TOLL THE RUNNING OF THE LIMITATIONS CONTAINED IN THIS SECTION.

(B) IF A [IN THE EVENT THAT ANY] CLAIM IS MADE AGAINST A HEALTH CARE PROVIDER [SUBJECT TO THE PROVISIONS OF ARTICLE VII] REQUIRED TO PARTICIPATE IN THE FUND MORE THAN FOUR YEARS AFTER THE BREACH OF CONTRACT OR TORT OCCURRED [WHICH] AND THE CLAIM IS FILED WITHIN THE APPLICABLE STATUTE OF LIMITATIONS, [SUCH] THE CLAIM SHALL BE DEFENDED [AND PAID BY THE FUND IF THE FUND HAS] BY THE DEPARTMENT IF THE DEPARTMENT RECEIVED A WRITTEN REQUEST FOR INDEMNITY AND DEFENSE WITHIN 180 DAYS OF THE DATE ON WHICH NOTICE OF THE CLAIM IS GIVEN TO THE HEALTH CARE PROVIDER OR HIS INSURER. WHERE MULTIPLE TREATMENTS OR CONSULTATIONS TOOK PLACE LESS THAN FOUR YEARS BEFORE THE DATE ON WHICH THE HEALTH CARE PROVIDER OR HIS INSURER RECEIVED NOTICE OF THE CLAIM, THE CLAIM SHALL BE DEEMED, FOR PURPOSES OF THIS SECTION, TO HAVE OCCURRED LESS THAN FOUR YEARS PRIOR TO THE DATE OF NOTICE AND SHALL BE DEFENDED BY THE INSURER [PURSUANT TO SECTION 702(D). IF SUCH CLAIM IS MADE AFTER FOUR YEARS BECAUSE OF THE WILLFUL CONCEALMENT BY THE HEALTH CARE PROVIDER OR HIS INSURER, THE FUND SHALL HAVE THE RIGHT OF FULL INDEMNITY INCLUDING DEFENSE COSTS FROM SUCH HEALTH CARE PROVIDER OR HIS INSURER. A FILING PURSUANT TO SECTION 401 SHALL TOLL THE RUNNING OF THE LIMITATIONS CONTAINED HEREIN.] IN ACCORDANCE WITH ARTICLE VII-A.

(C) IF A HEALTH CARE PROVIDER IS FOUND LIABLE FOR A CLAIM DEFENDED BY THE DEPARTMENT IN ACCORDANCE WITH SUBSECTION (B), THE CLAIM SHALL BE PAID BY THE FUND UP TO THE LIMIT OF LIABILITY OF THE FUND. THE LIMIT OF LIABILITY OF THE FUND FOR A CLAIM DEFENDED BY THE DEPARTMENT UNDER SUBSECTION (B) SHALL BE

$1,000,000 FOR EACH OCCURRENCE.

(D) IF A CLAIM IS DEFENDED BY THE DEPARTMENT UNDER SUBSECTION (B) OR PAID UNDER SUBSECTION (C), AND THE CLAIM IS MADE AFTER FOUR YEARS BECAUSE OF THE WILLFUL CONCEALMENT BY THE HEALTH CARE PROVIDER OR HIS INSURER, THE FUND SHALL HAVE THE RIGHT OF FULL INDEMNITY INCLUDING THE DEPARTMENT'S DEFENSE COSTS FROM THE HEALTH CARE PROVIDER OR HIS INSURER.

(E) NOTWITHSTANDING SUBSECTIONS (B), (C) AND (D), ALL PROFESSIONAL LIABILITY INSURANCE POLICIES PROVIDING COVERAGE IN ACCORDANCE WITH ARTICLE VII-A WHICH ARE ISSUED ON OR AFTER JANUARY 1, 2003, SHALL PROVIDE A DEFENSE OF AND INSURANCE COVERAGE FOR CLAIMS ASSERTED AGAINST A HEALTH CARE PROVIDER REQUIRED TO PARTICIPATE IN THE FUND MORE THAN FOUR YEARS AFTER A BREACH OF CONTRACT OR TORT OCCURS IF THE BREACH OF CONTRACT OR TORT OCCURS AFTER DECEMBER 31, 2002.

SECTION 3. ARTICLE VII OF THE ACT IS REPEALED.

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

ARTICLE VII-A

MEDICAL PROFESSIONAL LIABILITY INSURANCE

SECTION 701-A. MEDICAL PROFESSIONAL LIABILITY INSURANCE.

(A) A HEALTH CARE PROVIDER PROVIDING HEALTH CARE SERVICES IN THIS COMMONWEALTH SHALL:

(1) PURCHASE MEDICAL PROFESSIONAL LIABILITY INSURANCE FROM AN INSURER WHICH IS LICENSED OR APPROVED BY THE DEPARTMENT; OR

(2) PROVIDE SELF-INSURANCE.

(B) A HEALTH CARE PROVIDER REQUIRED BY SUBSECTION (A) TO PURCHASE MEDICAL PROFESSIONAL LIABILITY INSURANCE OR PROVIDE SELF-INSURANCE SHALL SUBMIT PROOF OF INSURANCE OR SELF-INSURANCE TO THE DEPARTMENT WITHIN 60 DAYS OF THE POLICY BEING ISSUED.

(C) IF A HEALTH CARE PROVIDER FAILS TO SUBMIT THE PROOF OF INSURANCE OR SELF-INSURANCE REQUIRED BY SUBSECTION (B), THE DEPARTMENT SHALL, AFTER PROVIDING THE HEALTH CARE PROVIDER WITH NOTICE, NOTIFY THE HEALTH CARE PROVIDER'S LICENSING AUTHORITY. A HEALTH CARE PROVIDER'S LICENSE SHALL BE SUSPENDED OR REVOKED BY ITS LICENSURE BOARD OR AGENCY IF THE HEALTH CARE PROVIDER FAILS TO COMPLY WITH ANY OF THE PROVISIONS OF THIS ACT.

(D) A HEALTH CARE PROVIDER SHALL INSURE OR SELF-INSURE MEDICAL PROFESSIONAL LIABILITY IN ACCORDANCE WITH THE FOLLOWING:

(1) FOR POLICIES ISSUED OR RENEWED IN CALENDAR YEAR 2002, THE BASIC INSURANCE COVERAGE SHALL BE:

(I) $500,000 PER OCCURRENCE OR CLAIM AND $1,500,000 PER ANNUAL AGGREGATE FOR A HEALTH CARE PROVIDER THAT IS NOT A HOSPITAL, CONDUCTS MORE THAN 50% OF ITS HEALTH CARE BUSINESS OR PRACTICE WITHIN THIS COMMONWEALTH AND PARTICIPATES IN THE FUND.

(II) $500,000 PER OCCURRENCE OR CLAIM AND $1,500,000 PER ANNUAL AGGREGATE FOR A HEALTH CARE PROVIDER THAT IS NOT A HOSPITAL AND CONDUCTS 50% OR LESS OF ITS HEALTH CARE BUSINESS OR PRACTICE WITHIN THIS COMMONWEALTH.

(III) $500,000 PER OCCURRENCE OR CLAIM AND $2,500,000 PER ANNUAL AGGREGATE FOR A HEALTH CARE PROVIDER WHICH IS A HOSPITAL LOCATED IN THIS COMMONWEALTH AND PARTICIPATES IN THE FUND.

(2) FOR POLICIES ISSUED OR RENEWED IN THE CALENDAR YEAR 2003 AND THEREAFTER, THE BASIC INSURANCE COVERAGE SHALL BE:

(I) $500,000 PER OCCURRENCE OR CLAIM AND $1,500,000 PER ANNUAL AGGREGATE FOR A RESIDENT HEALTH CARE PROVIDER THAT IS NOT A HOSPITAL LOCATED IN THIS COMMONWEALTH.

(II) $1,000,000 PER OCCURRENCE OR CLAIM AND

$3,000,000 PER ANNUAL AGGREGATE FOR A NONRESIDENT HEALTH CARE PROVIDER.

(III) $500,000 PER OCCURRENCE OR CLAIM AND $2,500,000 PER ANNUAL AGGREGATE FOR A RESIDENT HEALTH CARE PROVIDER WHICH IS A HOSPITAL LOCATED IN THIS COMMONWEALTH.

(3) BY JULY 1, 2005, THE COMMISSIONER SHALL STUDY THE AVAILABILITY OF MEDICAL PROFESSIONAL LIABILITY INSURANCE IN THIS COMMONWEALTH TO DETERMINE IF THE BASIC INSURANCE COVERAGE REQUIREMENT SHOULD BE INCREASED. IF THE COMMISSIONER DETERMINES THAT ADDITIONAL BASIC INSURANCE COVERAGE CAPACITY EXISTS AT AN AFFORDABLE COST, THE COMMISSIONER SHALL PLACE NOTICE THEREOF IN THE PENNSYLVANIA BULLETIN AND REQUIRE THE BASIC INSURANCE COVERAGE FOR POLICIES ISSUED OR RENEWED IN CALENDAR YEAR 2006 AND EACH YEAR THEREAFTER TO BE:

(I) $750,000 PER OCCURRENCE OR CLAIM AND $2,050,000 PER ANNUAL AGGREGATE FOR A RESIDENT HEALTH CARE PROVIDER THAT IS NOT A HOSPITAL LOCATED IN THIS COMMONWEALTH.

(II) $1,000,000 PER OCCURRENCE OR CLAIM AND $3,000,000 PER ANNUAL AGGREGATE FOR A NONRESIDENT HEALTH CARE PROVIDER.

(III) $750,000 PER OCCURRENCE OR CLAIM AND $3,650,000 PER ANNUAL AGGREGATE FOR A RESIDENT HEALTH CARE PROVIDER WHICH IS A HOSPITAL LOCATED IN THIS COMMONWEALTH.

IF THE COMMISSIONER DETERMINES THAT ADDITIONAL BASIC INSURANCE COVERAGE MAY NOT BE PURCHASED AT AN AFFORDABLE COST, THE COMMISSIONER SHALL CONDUCT ADDITIONAL STUDIES EVERY TWO YEARS UNTIL THE COMMISSIONER DETERMINES THAT ADDITIONAL BASIC INSURANCE COVERAGE MAY BE PURCHASED AT AN AFFORDABLE

COST, AT WHICH TIME THE COMMISSIONER SHALL INCREASE THE REQUIRED BASIC INSURANCE COVERAGE IN ACCORDANCE WITH THIS PARAGRAPH.

(4) TWO YEARS FOLLOWING THE NOTICE IN THE PENNSYLVANIA BULLETIN REQUIRED BY PARAGRAPH (3), THE COMMISSIONER SHALL STUDY THE AVAILABILITY OF MEDICAL PROFESSIONAL LIABILITY INSURANCE IN THIS COMMONWEALTH TO DETERMINE IF THE BASIC INSURANCE COVERAGE REQUIREMENT SHOULD BE INCREASED. IF THE COMMISSIONER DETERMINES THAT ADDITIONAL BASIC INSURANCE COVERAGE CAPACITY EXISTS AT AN AFFORDABLE COST, THE COMMISSIONER SHALL PLACE NOTICE THEREOF IN THE PENNSYLVANIA BULLETIN AND REQUIRE THE BASIC INSURANCE COVERAGE FOR POLICIES ISSUED OR RENEWED IN THE NEXT SUCCEEDING CALENDAR YEAR TO BE:

(I) $1,000,000 PER OCCURRENCE OR CLAIM AND $3,000,000 PER ANNUAL AGGREGATE FOR A RESIDENT HEALTH CARE PROVIDER THAT IS NOT A HOSPITAL LOCATED IN THIS COMMONWEALTH.

(II) $1,000,000 PER OCCURRENCE OR CLAIM AND $3,000,000 PER ANNUAL AGGREGATE FOR A NONRESIDENT HEALTH CARE PROVIDER.

(III) $1,000,000 PER OCCURRENCE OR CLAIM AND $4,500,000 PER ANNUAL AGGREGATE FOR A RESIDENT HEALTH CARE PROVIDER WHICH IS A HOSPITAL LOCATED IN THIS COMMONWEALTH.

IF THE COMMISSIONER DETERMINES THAT ADDITIONAL BASIC INSURANCE COVERAGE MAY NOT BE PURCHASED AT AN AFFORDABLE COST, THE COMMISSIONER SHALL CONDUCT ADDITIONAL STUDIES EVERY TWO YEARS UNTIL THE COMMISSIONER DETERMINES THAT ADDITIONAL BASIC INSURANCE COVERAGE MAY BE PURCHASED AT AN AFFORDABLE

COST, AT WHICH TIME THE COMMISSIONER SHALL INCREASE THE REQUIRED BASIC INSURANCE COVERAGE IN ACCORDANCE WITH THIS PARAGRAPH.

(E) A RESIDENT HEALTH CARE PROVIDER SHALL PARTICIPATE IN THE FUND.

(F) (1) IF A HEALTH CARE PROVIDER SELF-INSURES ITS MEDICAL PROFESSIONAL LIABILITY, THE HEALTH CARE PROVIDER SHALL SUBMIT ITS SELF-INSURANCE PLAN, SUCH ADDITIONAL INFORMATION AS THE DEPARTMENT MAY REQUIRE AND THE EXAMINATION FEE TO THE DEPARTMENT FOR APPROVAL.

(2) THE DEPARTMENT SHALL APPROVE THE PLAN IF IT DETERMINES THAT THE PLAN CONSTITUTES PROTECTION EQUIVALENT TO THE INSURANCE REQUIRED OF A HEALTH CARE PROVIDER UNDER SUBSECTION (D).

(G) (1) AN INSURER PROVIDING MEDICAL PROFESSIONAL LIABILITY INSURANCE SHALL NOT BE LIABLE FOR PAYMENT OF A CLAIM AGAINST A HEALTH CARE PROVIDER FOR ANY LOSS OR DAMAGES AWARDED IN A MEDICAL PROFESSIONAL LIABILITY ACTION IN EXCESS OF THE BASIC INSURANCE COVERAGE REQUIRED BY SUBSECTION (D) UNLESS THE HEALTH CARE PROVIDER'S MEDICAL PROFESSIONAL LIABILITY POLICY OR SELF-INSURANCE PLAN PROVIDES FOR A HIGHER ANNUAL AGGREGATE LIMIT.

(2) IF A CLAIM EXCEEDS THE LIMITS OF A BASIC COVERAGE INSURER OR A SELF-INSURANCE PLAN, THE FUND SHALL BE RESPONSIBLE FOR PAYMENT OF THE CLAIM UP TO THE FUND LIABILITY LIMITS.

(H) (1) NO INSURER PROVIDING EXCESS MEDICAL PROFESSIONAL LIABILITY INSURANCE TO A HEALTH CARE PROVIDER REQUIRED TO PARTICIPATE IN THE FUND SHALL BE LIABLE FOR PAYMENT OF A CLAIM AGAINST A HEALTH CARE PROVIDER FOR A LOSS OR DAMAGES IN

A MEDICAL PROFESSIONAL LIABILITY ACTION, EXCEPT THE LOSSES AND DAMAGES IN EXCESS OF THE FUND COVERAGE LIMITS.

(2) NO CARRIER PROVIDING EXCESS MEDICAL PROFESSIONAL LIABILITY INSURANCE FOR A HEALTH CARE PROVIDER REQUIRED TO PARTICIPATE IN THE FUND SHALL BE LIABLE FOR ANY LOSS RESULTING FROM THE INSOLVENCY OR DISSOLUTION OF THE FUND.

(I) A GOVERNMENTAL ENTITY MAY SATISFY ITS OBLIGATIONS UNDER THIS ACT, AS WELL AS THE OBLIGATIONS OF ITS EMPLOYEES TO THE EXTENT OF THEIR EMPLOYMENT, BY EITHER PURCHASING INSURANCE OR ASSUMING AN OBLIGATION AS A SELF-INSURER AND INCLUDING THE PAYMENT OF ALL ASSESSMENTS UNDER THIS ACT.

(J) THE FOLLOWING HEALTH CARE PROVIDERS SHALL BE EXEMPT FROM THIS ACT:

(1) A PHYSICIAN WHO EXCLUSIVELY PRACTICES THE SPECIALTY OF FORENSIC PATHOLOGY.

(2) A HEALTH CARE PROVIDER WHO IS A MEMBER OF THE PENNSYLVANIA MILITARY FORCES WHILE IN THE PERFORMANCE OF THAT MEMBER'S ASSIGNED DUTY IN THE PENNSYLVANIA MILITARY FORCES UNDER ORDERS.

(3) A RETIRED LICENSED HEALTH CARE PROVIDER WHO PROVIDES CARE ONLY TO THAT PROVIDER OR TO THAT PROVIDER'S IMMEDIATE FAMILY MEMBERS.

SECTION 702-A. MEDICAL PROFESSIONAL LIABILITY CATASTROPHE LOSS FUND.

(A) THERE IS HEREBY ESTABLISHED WITHIN THE STATE TREASURY A SPECIAL FUND TO BE KNOWN AS THE MEDICAL PROFESSIONAL LIABILITY CATASTROPHE LOSS FUND. THE FUND SHALL BE A CONTINUATION OF THE FUND ESTABLISHED UNDER FORMER ARTICLE VII. MONEYS IN THE FUND SHALL BE USED TO PAY CLAIMS AGAINST HEALTH CARE PROVIDERS REQUIRED TO PARTICIPATE IN THE FUND FOR LOSSES OR DAMAGES

AWARDED IN MEDICAL PROFESSIONAL LIABILITY ACTIONS IN EXCESS OF THE BASIC INSURANCE COVERAGE REQUIRED BY SECTION 701-A(D) AND FOR THE ADMINISTRATION OF THE FUND.

(B) THE LIMIT OF LIABILITY OF THE FUND FOR EACH HEALTH CARE PROVIDER REQUIRED TO PARTICIPATE UNDER SECTION 701-A(E) SHALL BE AS FOLLOWS:

(1) FOR CALENDAR YEAR 2002, THE LIMIT OF LIABILITY OF THE FUND SHALL BE $700,000 FOR EACH OCCURRENCE AND $2,100,000 PER ANNUAL AGGREGATE.

(2) FOR CALENDAR YEARS 2003 AND EACH YEAR THEREAFTER, THE LIMIT OF LIABILITY OF THE FUND SHALL BE $500,000 FOR EACH CLAIM AND $1,500,000 PER ANNUAL AGGREGATE.

(3) IF THE BASIC INSURANCE COVERAGE REQUIREMENT IS INCREASED IN ACCORDANCE WITH SECTION 701-A(D)(3) AND, NOTWITHSTANDING PARAGRAPH (2), FOR EACH CALENDAR YEAR FOLLOWING THE INCREASE IN THE BASIC INSURANCE COVERAGE REQUIREMENT, THE LIMIT OF LIABILITY OF THE FUND SHALL BE $250,000 FOR EACH CLAIM AND $950,000 PER ANNUAL AGGREGATE.

(4) IF THE BASIC INSURANCE COVERAGE REQUIREMENT IS INCREASED IN ACCORDANCE WITH SECTION 701-A(D)(4) AND, NOTWITHSTANDING PARAGRAPHS (2) AND (3), FOR EACH CALENDAR YEAR FOLLOWING THE INCREASE IN THE BASIC INSURANCE COVERAGE REQUIREMENT, THE FUND SHALL NOT BE LIABLE FOR EACH CLAIM.

(C) (1) FOR CALENDAR YEARS 1997 THROUGH 2002, THE FUND SHALL BE FUNDED BY A SURCHARGE ON THE BASIC INSURANCE COVERAGE OF EACH HEALTH CARE PROVIDER REQUIRED TO PARTICIPATE IN THE FUND. SURCHARGES SHALL BE LEVIED ON OR AFTER JANUARY 1 OF EACH YEAR.

(2) THE SURCHARGE SHALL BE BASED ON THE PREVAILING PRIMARY PREMIUM FOR EACH HEALTH CARE PROVIDER FOR MAINTENANCE

OF MEDICAL PROFESSIONAL LIABILITY INSURANCE AND SHALL BE THE APPROPRIATE PERCENTAGE THEREOF, NECESSARY TO:

(I) PRODUCE AN AMOUNT SUFFICIENT TO REIMBURSE THE FUND FOR THE PAYMENT OF FINAL CLAIMS AND EXPENSES INCURRED DURING THE PRECEDING CLAIMS PERIOD; AND

(II) PROVIDE AN AMOUNT NECESSARY TO MAINTAIN AN ADDITIONAL 15% OF THE FINAL CLAIMS AND EXPENSES INCURRED DURING THE PRECEDING CLAIMS PERIOD.

(3) THE SURCHARGE SHALL BE DETERMINED BY THE FUND AND FILED WITH THE DEPARTMENT. THE DEPARTMENT SHALL REVIEW THE SURCHARGE WITHIN 30 DAYS OF THE FILING.

(4) AFTER REVIEW, THE COMMISSIONER SHALL APPROVE THE SURCHARGE UNLESS IT IS INADEQUATE OR EXCESSIVE. IF THE SURCHARGE IS DISAPPROVED, THE FUND SHALL MAKE AN ADJUSTMENT TO THE NEXT SURCHARGE CALCULATION TO REFLECT THE APPROPRIATE INCREASE OR DECREASE.

(5) UPON RECEIPT OF THE COMMISSIONER'S APPROVAL OF THE SURCHARGE, THE FUND SHALL COMMUNICATE THE SURCHARGE TO ALL BASIC INSURANCE COVERAGE CARRIERS AND SELF-INSURED PROVIDERS TO BE LEVIED.

(6) ANY APPEAL OF THE SURCHARGE MUST BE FILED WITH THE COMMISSIONER.

(D) (1) FOR CALENDAR YEAR 2003 AND EACH YEAR THEREAFTER, THE FUND SHALL BE FUNDED BY AN ASSESSMENT ON EACH HEALTH CARE PROVIDER REQUIRED TO PARTICIPATE IN THE FUND. ASSESSMENTS SHALL BE LEVIED BY THE DEPARTMENT ON OR AFTER JANUARY 1 OF EACH YEAR. THE ASSESSMENT SHALL BE BASED ON THE PREVAILING PRIMARY PREMIUM FOR EACH HEALTH CARE PROVIDER FOR MAINTENANCE OF MEDICAL PROFESSIONAL LIABILITY INSURANCE AND SHALL BE THE APPROPRIATE PERCENTAGE THEREOF, NECESSARY TO PRODUCE AN

AMOUNT SUFFICIENT TO DO ALL OF THE FOLLOWING:

(I) REIMBURSE THE FUND FOR THE PAYMENT OF PAYABLE CLAIMS WHICH BECAME FINAL.

(II) PAY EXPENSES OF THE FUND INCURRED DURING THE PRECEDING CLAIMS PERIOD.

(III) PAY PRINCIPAL AND INTEREST ON OBLIGATIONS, IF ANY, ISSUED BY THE AUTHORITY.

(IV) PROVIDE A RESERVE THAT SHALL BE 10% OF THE PAYABLE CLAIMS THAT BECAME FINAL, EXPENSES AND PRINCIPAL AND INTEREST PAYMENT ON AUTHORITY OBLIGATIONS INCURRED DURING THE PRECEDING CLAIMS PERIOD.

(2) THE DEPARTMENT SHALL NOTIFY ALL BASIC INSURANCE COVERAGE CARRIERS AND SELF-INSURED PROVIDERS OF THE ASSESSMENT BY NOVEMBER 1 FOR THE SUCCEEDING CALENDAR YEAR.

(3) ANY APPEAL OF THE ASSESSMENT SHALL BE FILED WITH THE DEPARTMENT.

(E) IN CALENDAR YEARS 2002 THROUGH 2004, THE AGGREGATE ANNUAL ASSESSMENT SHALL NOT EXCEED 70% OF THE SURCHARGE IMPOSED FOR CALENDAR YEAR 2001. THE DISCOUNT IN THE ANNUAL SURCHARGE UNDER THIS SUBSECTION MAY BE FUNDED PURSUANT TO SECTION 703-A(B) OR (C).

(F) THE JOINT UNDERWRITING ASSOCIATION SHALL FILE UPDATED RATES FOR ALL HEALTH CARE PROVIDERS WITH THE COMMISSIONER BY MAY 1 OF EACH YEAR. THE DEPARTMENT SHALL REVIEW AND MAY ADJUST THE PREVAILING PRIMARY PREMIUM IN LINE WITH ANY APPLICABLE CHANGES WHICH HAVE BEEN APPROVED BY THE COMMISSIONER.

(G) THE DEPARTMENT MAY ADJUST THE APPLICABLE PREVAILING PRIMARY PREMIUM IN ACCORDANCE WITH THE FOLLOWING:

(1) THE APPLICABLE PREVAILING PRIMARY PREMIUM OF A HEALTH CARE PROVIDER WHICH IS NOT A HOSPITAL MAY BE ADJUSTED

THROUGH AN INCREASE IN THE INDIVIDUAL 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 HEALTH CARE PROVIDER DURING THE PAST FIVE MOST RECENT CLAIMS PERIODS AND SHALL BE IN ACCORDANCE WITH THE FOLLOWING:

(I) IF A SINGLE CLAIM HAS BEEN PAID DURING THE PAST FIVE MOST RECENT CLAIMS PERIODS BY THE FUND, A 10% INCREASE SHALL BE CHARGED.

(II) IF TWO 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 HEALTH CARE PROVIDER NOT ENGAGED IN DIRECT CLINICAL PRACTICE ON A FULL-TIME BASIS MAY BE ADJUSTED THROUGH A DECREASE IN THE INDIVIDUAL 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.

(3) THE APPLICABLE PREVAILING PRIMARY PREMIUM OF A HOSPITAL MAY BE ADJUSTED THROUGH AN INCREASE OR DECREASE IN THE INDIVIDUAL HOSPITAL'S PREVAILING PRIMARY PREMIUM NOT TO EXCEED 20%. ANY ADJUSTMENT SHALL BE BASED UPON THE FREQUENCY AND SEVERITY OF CLAIMS PAID BY THE FUND ON BEHALF OF OTHER HOSPITALS OF SIMILAR CLASS, SIZE, RISK AND KIND WITHIN THE SAME DEFINED REGION DURING THE PAST FIVE MOST RECENT CLAIMS PERIODS.

(H) A HEALTH CARE PROVIDER THAT HAS AN APPROVED SELF-INSURANCE PLAN SHALL BE SURCHARGED OR ASSESSED AN AMOUNT EQUAL TO THE SURCHARGE OR ASSESSMENT IMPOSED ON A HEALTH CARE PROVIDER

OF LIKE CLASS, SIZE, RISK AND KIND AS DETERMINED BY THE DEPARTMENT.

(I) IF A HEALTH CARE PROVIDER CHANGES THE TERM OF ITS MEDICAL PROFESSIONAL LIABILITY COVERAGE, THE SURCHARGE OR ASSESSMENT SHALL BE CALCULATED ON AN ANNUAL BASE AND SHALL REFLECT THE SURCHARGE OR ASSESSMENT PERCENTAGES IN EFFECT FOR THE PERIOD OVER WHICH THE POLICIES ARE IN EFFECT.

(J) PAYABLE CLAIMS SHALL BE COMPUTED ON AUGUST 31 FOR CLAIMS WHICH BECAME FINAL BETWEEN THAT DATE AND SEPTEMBER 1 OF THE PRECEDING YEAR. PAYABLE CLAIMS SHALL BE PAID ON OR BEFORE DECEMBER 31 FOLLOWING THE AUGUST 31 BY WHICH THEY BECAME FINAL.

(K) UPON SATISFACTION OF ALL PAYABLE CLAIMS AGAINST AND ALL LIABILITIES OF THE FUND, THE FUND SHALL TERMINATE. ANY BALANCE REMAINING IN THE FUND UPON SUCH TERMINATION SHALL BE RETURNED BY THE DEPARTMENT TO THE HEALTH CARE PROVIDERS WHO PARTICIPATED IN THE FUND IN PROPORTION TO THEIR ASSESSMENTS IN THE PRECEDING CALENDAR YEAR.

(L) THE SURCHARGES AND ASSESSMENTS ON HEALTH CARE PROVIDERS AND ANY INCOME REALIZED BY INVESTMENT OR REINVESTMENT SHALL CONSTITUTE THE SOLE AND EXCLUSIVE SOURCES OF FUNDING FOR THE FUND. A CLAIM AGAINST OR A LIABILITY OF THE FUND SHALL NOT BE DEEMED TO CONSTITUTE A DEBT OR LIABILITY OF THE COMMONWEALTH OR A CHARGE AGAINST THE GENERAL FUND.

(M) (1) A PRIMARY CARRIER AS DEFINED IN THE ACT OF MAY 17, 1921 (P.L.682, NO.284), KNOWN AS THE INSURANCE COMPANY LAW OF 1921, WHICH FAILS TO SETTLE A CLAIM BY ACTING IN BAD FAITH MAY BE HELD LIABLE FOR THE CONSEQUENCES OF ITS ACTIONS BY ITS INSURED, BY THE FUND, OR A PARTY WHO LAWFULLY SUCCEEDS TO THE RIGHTS OF ITS INSURED.

(2) THE FUND MAY BE HELD LIABLE FOR THE CONSEQUENCES OF

ITS ACTIONS IF IT FAILS TO SETTLE A CLAIM BY ACTING IN BAD FAITH, BY ITS INSURED, OR A PARTY WHO LAWFULLY SUCCEEDS TO THE RIGHTS OF ITS INSURED, BUT ONLY IF THE FOLLOWING CONDITIONS ARE MET:

(I) THE PRIMARY CARRIER HAS TENDERED ITS LIMITS OF COVERAGE FOR THE INSURED TO THE FUND.

(II) A JUDGE PRESIDING OVER TRIAL OR PRETRIAL PROCEEDINGS HAS CERTIFIED TO THE FUND THE COURT'S RECOMMENDATION THAT THE CASE BE SETTLED FOR A SPECIFIC SUM WITHIN OR EQUAL TO THE APPLICABLE LIMITS OF COVERAGE.

(III) THE FUND REFUSES TO ACCEPT THE PRESIDING JUDGE'S RECOMMENDATION AND SUBSEQUENTLY THERE IS A VERDICT IN EXCESS OF THE LIMITS OF COVERAGE PROVIDED BY THE FUND.

(IV) IT IS SUBSEQUENTLY DETERMINED BY A FINDER OF FACT THAT THE FUND'S REFUSAL TO ACCEPT THE COURT'S RECOMMENDATION CONSTITUTED A BREACH OF ITS OBLIGATION TO ACT REASONABLY IN PROTECTING THE INTEREST OF THE INSURED HEALTH CARE PROVIDER.

(N) A HEALTH CARE PROVIDER WHO WAIVES THE RIGHT TO CONSENT TO A SETTLEMENT IN A POLICY FOR MEDICAL PROFESSIONAL LIABILITY INSURANCE SHALL BE ENTITLED TO A 5% REDUCTION IN PREMIUM FOR THE POLICY AND A CORRESPONDING 5% REDUCTION IN THE FUND SURCHARGE.

(O) A MEDICAL PROFESSIONAL LIABILITY INSURER SHALL NOT ASSESS ANY PREMIUM INCREASE TO A HEALTH CARE PROVIDER, OTHER THAN ANY BASE RATE MODIFICATIONS:

(1) FOR ANY CLAIM SUCCESSFULLY DEFENDED BY THE INSURER OR THE HEALTH CARE PROVIDER;

(2) FOR ANY CLAIM AGAINST THE PROVIDER THAT IS DISMISSED OR ABANDONED PRIOR TO FINAL ADJUDICATION; OR

(3) FOR ANY POTENTIAL CLAIM OF WHICH THE INSURER IS PUT ON NOTICE BUT WHICH IS NOT ASSERTED AGAINST THE HEALTH CARE PROVIDER.

SECTION 703-A. ADMINISTRATION OF FUND.

(A) THE FUND SHALL BE ADMINISTERED BY THE DEPARTMENT. THE ASSETS OF THE FUND ARE TRANSFERRED TO THE DEPARTMENT. THE DEPARTMENT SHALL CONTRACT WITH AN ENTITY OR ENTITIES FOR THE ADMINISTRATION OF CLAIMS AGAINST THE FUND IN ACCORDANCE WITH 62 PA.C.S. (RELATING TO PROCUREMENT) AND, TO THE FULLEST EXTENT PRACTICABLE, THE DEPARTMENT SHALL CONTRACT WITH ENTITIES THAT:

(1) ARE NOT WRITING OR UNDERWRITING MEDICAL PROFESSIONAL LIABILITY INSURANCE FOR HEALTH CARE PROVIDERS PERFORMING MEDICAL SERVICES IN THIS COMMONWEALTH.

(2) HAVE DEMONSTRABLE KNOWLEDGE OF AND EXPERIENCE IN THE HANDLING AND ADJUSTING OF MEDICAL PROFESSIONAL LIABILITY OR OTHER CATASTROPHIC CLAIMS IN THIS COMMONWEALTH OR OTHER JURISDICTIONS.

(3) HAVE DEVELOPED, INSTITUTED AND UTILIZED BEST PRACTICE STANDARDS FOR THE HANDLING AND ADJUSTING OF MEDICAL PROFESSIONAL LIABILITY OR OTHER CATASTROPHIC CLAIMS.

(4) HAVE DEMONSTRABLE KNOWLEDGE OF AND EXPERIENCE WITH THE HEALTH CARE PROVIDERS OF THIS COMMONWEALTH, THE MEDICAL PROFESSIONAL LIABILITY MARKETPLACE AND THE JUDICIAL SYSTEMS OF THIS COMMONWEALTH.

(5) HAVE DEMONSTRABLE KNOWLEDGE AND EXPERIENCE WITH THE COMPENSATION NEEDS OF PERSONS HARMED BY THE MEDICAL PROFESSIONAL LIABILITY OF HEALTH CARE PROVIDERS, AS WELL AS THE NEED TO ENSURE AFFORDABLE AND AVAILABLE MEDICAL PROFESSIONAL LIABILITY INSURANCE FOR THE HEALTH CARE PROVIDERS OF THIS COMMONWEALTH.

(B) THE DEPARTMENT MAY PURCHASE, ON BEHALF OF AND IN THE NAME OF THE FUND, AS MUCH INSURANCE OR REINSURANCE AS IS NECESSARY TO PRESERVE THE FUND OR RETIRE THE LIABILITIES OF THE FUND.

(C) THE DEPARTMENT MAY REQUEST THE AUTHORITY TO BORROW SUCH MONEY AS IS NECESSARY IN ORDER TO PAY THE LIABILITIES OF THE FUND UNTIL SUFFICIENT REVENUES ARE REALIZED BY THE FUND. IF THE DEPARTMENT REQUESTS THE AUTHORITY TO BORROW MONEY, THE DEPARTMENT SHALL ANNUALLY ASSESS HEALTH CARE PROVIDERS AND PAY TO THE AUTHORITY AN AMOUNT SUFFICIENT TO PAY PRINCIPAL AND INTEREST ON THE OBLIGATIONS ISSUED BY THE AUTHORITY.

(D) AN OBLIGATION OR DEBT ISSUED UNDER THIS ACT SHALL NOT BE DEEMED AN OBLIGATION OR DEBT OF THE COMMONWEALTH, NOR SHALL THE COMMONWEALTH BE LIABLE TO PAY PRINCIPAL AND INTEREST ON THE OBLIGATION OR TO OFFSET ANY LOSS OF PRINCIPAL AND INTEREST EARNINGS ON INVESTMENTS MADE BY THE DEPARTMENT OR RECOMMENDED BY THE DEPARTMENT PURSUANT TO THIS ACT.

SECTION 704-A. MEDICAL PROFESSIONAL LIABILITY CATASTROPHE LOSS FUND AUTHORITY.

(A) THERE IS HEREBY ESTABLISHED A BODY CORPORATE AND POLITIC TO BE KNOWN AS THE MEDICAL PROFESSIONAL LIABILITY CATASTROPHE LOSS FUND AUTHORITY. THE POWERS AND DUTIES OF THE AUTHORITY SHALL BE VESTED IN AND EXERCISED BY A BOARD OF DIRECTORS. THE BOARD OF THE AUTHORITY SHALL CONSIST OF THREE MEMBERS TO BE APPOINTED BY THE GOVERNOR. THE GOVERNOR SHALL ADDITIONALLY APPOINT ONE MEMBER AS CHAIRPERSON. MEMBERS OF THE BOARD SHALL SERVE FOR TERMS OF FOUR YEARS. NO APPOINTED MEMBER SHALL BE ELIGIBLE TO SERVE MORE THAN TWO FULL CONSECUTIVE TERMS. A MAJORITY OF THE MEMBERS OF THE BOARD SHALL CONSTITUTE A QUORUM. NOTWITHSTANDING ANY OTHER PROVISION OF LAW, ACTION MAY BE TAKEN

BY THE BOARD AT A MEETING UPON A VOTE OF THE MAJORITY OF ITS MEMBERS PRESENT IN PERSON OR THROUGH THE USE OF AMPLIFIED TELEPHONIC EQUIPMENT IF AUTHORIZED BY THE BYLAWS OF THE BOARD. THE BOARD SHALL MEET AT THE CALL OF THE CHAIRPERSON OR AS MAY BE PROVIDED IN THE BYLAWS OF THE BOARD. MEETINGS OF THE BOARD MAY BE HELD ANYWHERE WITHIN THIS COMMONWEALTH.

(B) THE AUTHORITY SHALL HAVE THE FOLLOWING POWERS AND DUTIES:

(1) ADOPT BYLAWS NECESSARY TO CARRY OUT THE PROVISIONS OF THIS ACT.

(2) EMPLOY STAFF AS NECESSARY TO IMPLEMENT THIS ACT.

(3) MAKE, EXECUTE AND DELIVER CONTRACTS AND OTHER INSTRUMENTS.

(4) BORROW, AT THE REQUEST OF THE DEPARTMENT, MONEYS IN THE NAME OF THE FUND, TO BE DEPOSITED IN THE FUND.

(5) MAKE PAYMENTS ON OBLIGATIONS OF THE AUTHORITY FROM ASSESSMENTS LEVIED AND COLLECTED BY THE DEPARTMENT.

(6) WITHIN TWO YEARS OF THE EFFECTIVE DATE OF THIS ARTICLE, ARRANGE FOR THE SEPARATE RETIREMENT OF THE LIABILITIES ASSOCIATED WITH THE PODIATRISTS.

SUCH ARRANGEMENTS SHALL BE ON TERMS AND CONDITIONS PROPORTIONATE TO THE INDIVIDUAL LIABILITY OF SUCH CLASS OF HEALTH CARE PROVIDER. SUCH ARRANGEMENTS MAY RESULT IN ASSESSMENTS FOR PODIATRISTS DIFFERENT THAN PROVIDED FOR UNDER SECTION 702-A(D)(1). UPON SATISFACTION OF THE ARRANGEMENTS, PODIATRISTS SHALL NOT BE REQUIRED TO CONTRIBUTE TO OR BE ENTITLED TO PARTICIPATE IN THE AUTHORITY SET FORTH IN THIS ARTICLE. IN CASES WHERE THE CLASS REJECTS SUCH AN ARRANGEMENT, THE AUTHORITY SHALL PRESENT TO THE PROVIDER CLASS NEW TERM ARRANGEMENTS AT LEAST ONCE IN EVERY TWO-YEAR PERIOD.

(C) NOTWITHSTANDING ANY OTHER PROVISION OF LAW, THE AUTHORITY SHALL NOT PLEDGE THE CREDIT OR TAXING POWERS OF THE COMMONWEALTH. AN OBLIGATION OR DEBT ISSUED UNDER THIS ACT SHALL NOT BE DEEMED AN OBLIGATION OR DEBT OF THE COMMONWEALTH, NOR SHALL THE COMMONWEALTH BE LIABLE TO PAY PRINCIPAL AND INTEREST ON THE OBLIGATION OR TO OFFSET ANY LOSS OF PRINCIPAL AND INTEREST EARNINGS ON INVESTMENTS MADE BY THE AUTHORITY OR RECOMMENDED BY THE AUTHORITY PURSUANT TO THIS ACT.

SECTION 705-A. MEDICAL PROFESSIONAL LIABILITY CLAIMS.

(A) A BASIC COVERAGE INSURER OR SELF-INSURED HEALTH CARE PROVIDER SHALL PROMPTLY NOTIFY THE DEPARTMENT IN WRITING OF ANY MEDICAL PROFESSIONAL LIABILITY CLAIM.

(B) IF A BASIC COVERAGE INSURER OR SELF-INSURED HEALTH CARE PROVIDER FAILS TO NOTIFY THE DEPARTMENT AS REQUIRED UNDER SUBSECTION (A) AND THE DEPARTMENT HAS BEEN PREJUDICED BY THE FAILURE OF NOTICE, THE INSURER OR PROVIDER SHALL BE SOLELY RESPONSIBLE FOR THE PAYMENT OF THE ENTIRE AWARD OR VERDICT THAT RESULTS FROM THE MEDICAL PROFESSIONAL LIABILITY CLAIM.

(C) A BASIC COVERAGE INSURER OR SELF-INSURED HEALTH CARE PROVIDER SHALL PROVIDE A DEFENSE TO A MEDICAL PROFESSIONAL LIABILITY CLAIM, INCLUDING A DEFENSE OF ANY POTENTIAL LIABILITY OF THE FUND, EXCEPT AS PROVIDED FOR IN SECTION 605. THE DEPARTMENT MAY JOIN IN THE DEFENSE AND BE REPRESENTED BY COUNSEL.

(D) (1) THE DEPARTMENT MAY DEFEND, LITIGATE, SETTLE OR COMPROMISE ANY MEDICAL PROFESSIONAL LIABILITY CLAIM PAYABLE BY THE FUND. A HEALTH CARE PROVIDER'S BASIC COVERAGE INSURER SHALL HAVE THE RIGHT TO APPROVE ANY SETTLEMENT ENTERED INTO BY THE DEPARTMENT ON BEHALF OF ITS INSURED HEALTH CARE PROVIDER. IF THE BASIC COVERAGE INSURER DOES NOT DISAPPROVE A

SETTLEMENT PRIOR TO EXECUTION BY THE DEPARTMENT, IT SHALL BE DEEMED APPROVED BY THE BASIC COVERAGE INSURER.

(2) IN THE EVENT THAT MORE THAN ONE HEALTH CARE PROVIDER IS PARTY TO A SETTLEMENT, THE HEALTH CARE PROVIDER'S BASIC COVERAGE INSURER SHALL HAVE THE RIGHT TO APPROVE ONLY THE PORTION OF THE SETTLEMENT WHICH IS CONTRIBUTED ON BEHALF OF ITS INSURED HEALTH CARE PROVIDER.

(E) IN THE EVENT THAT A BASIC COVERAGE INSURER OR SELF-INSURED HEALTH CARE PROVIDER ENTERS INTO A SETTLEMENT WITH A CLAIMANT TO THE FULL EXTENT OF ITS LIABILITY AS PROVIDED IN THIS ARTICLE, IT MAY OBTAIN A RELEASE FROM THE CLAIMANT TO THE EXTENT OF ITS PAYMENT, WHICH PAYMENT SHALL HAVE NO EFFECT UPON ANY EXCESS CLAIM AGAINST THE FUND OR ITS DUTY TO CONTINUE THE DEFENSE OF THE CLAIM.

(F) THE DEPARTMENT MAY ADJUST CLAIMS.

(G) UPON THE REQUEST OF A PARTY TO A MEDICAL PROFESSIONAL LIABILITY CLAIM WITHIN THE FUND COVERAGE LIMITS, THE DEPARTMENT MAY PROVIDE FOR A MEDIATOR IN INSTANCES WHERE MULTIPLE CARRIERS DISAGREE ON THE DISPOSITION OR SETTLEMENT OF A CASE. UPON THE CONSENT OF ALL PARTIES, THE MEDIATION SHALL BE BINDING. PROCEEDINGS CONDUCTED AND INFORMATION PROVIDED IN ACCORDANCE WITH THIS SECTION SHALL BE CONFIDENTIAL AND SHALL NOT BE CONSIDERED PUBLIC INFORMATION SUBJECT TO DISCLOSURE UNDER THE ACT OF JUNE 21, 1957 (P.L.390, NO.212), REFERRED TO AS THE RIGHT-TO-KNOW LAW AND 65 PA.C.S. CH. 7 (RELATING TO OPEN MEETINGS).

(H) DELAY DAMAGES AND POSTJUDGMENT INTEREST APPLICABLE TO THE FUND'S LIABILITY ON A MEDICAL PROFESSIONAL LIABILITY CLAIM SHALL BE PAID BY THE FUND AND SHALL NOT BE CHARGED AGAINST THE INSURED'S ANNUAL AGGREGATE LIMITS. THE BASIC COVERAGE INSURER OR

SELF-INSURER HEALTH CARE PROVIDER SHALL BE RESPONSIBLE FOR ITS PROPORTIONATE SHARE OF DELAY DAMAGES AND POSTJUDGMENT INTEREST APPLICABLE TO THE FUND'S LIABILITY ON A MEDICAL PROFESSIONAL LIABILITY SHALL BE PAID BY THE FUND AND SHALL NOT BE CHARGED AGAINST THE INSURED'S ANNUAL AGGREGATE LIMITS. THE BASIC COVERAGE INSURER OR SELF-INSURER HEALTH CARE PROVIDER SHALL BE RESPONSIBLE FOR ITS PROPORTIONATE SHARE OF DELAY DAMAGES AND POSTJUDGMENT INTEREST.

(I) INFORMATION PROVIDED TO THE DEPARTMENT OR MAINTAINED BY THE DEPARTMENT REGARDING A CLAIM SHALL BE CONFIDENTIAL, NOTWITHSTANDING THE RIGHT-TO-KNOW LAW AND 65 PA.C.S. CH. 7.

SECTION 5. THE ACT IS AMENDED BY ADDING SECTIONS TO READ:

SECTION 802-A. DEFINITIONS.--AS USED IN THIS ACT:

"MEDICAL PROFESSIONAL LIABILITY ACTION" MEANS ANY PROCEEDING IN WHICH A MEDICAL PROFESSIONAL LIABILITY CLAIM IS ASSERTED, INCLUDING, BUT NOT LIMITED TO, AN ACTION IN A COURT OF LAW OR AN ARBITRATION PROCEEDING.

"MEDICAL PROFESSIONAL LIABILITY CLAIM" MEANS ANY CLAIM BROUGHT BY OR ON BEHALF OF AN INDIVIDUAL SEEKING DAMAGES FOR LOSS SUSTAINED BY THE INDIVIDUAL AS A RESULT OF AN INJURY OR WRONG TO THE INDIVIDUAL OR ANOTHER INDIVIDUAL ARISING FROM A HEALTH CARE PROVIDER'S PROVISION OF OR FAILURE TO PROVIDE HEALTH CARE, INCLUDING, BUT NOT LIMITED TO, MEDICAL TREATMENT, DIAGNOSIS, OR CONSULTATION, REGARDLESS OF THE THEORY OF LIABILITY. THE POTENTIAL THEORIES OF LIABILITY INCLUDE, BUT ARE NOT LIMITED TO, NEGLIGENCE, LACK OF INFORMED CONSENT, BREACH OF CONTRACT, MISREPRESENTATION OR FRAUD. THE TERM ALSO INCLUDES A CLAIM SEEKING TO HOLD A THIRD PARTY LIABLE FOR THE CONDUCT OF A HEALTH CARE PROVIDER, INCLUDING, BUT NOT LIMITED TO, A CLAIM ASSERTING VICARIOUS LIABILITY OR CORPORATE NEGLIGENCE.

SECTION 803-A. JURISDICTION.--(A) EXCEPT AS PROVIDED IN SUBSECTION (B), A MEDICAL PROFESSIONAL LIABILITY CLAIM SHALL BE BROUGHT ONLY IN A COUNTY IN WHICH THE ALLEGED ACTS OR OMISSIONS GIVING RISE TO THE CLAIM PREDOMINATELY OCCURRED AND MAY BE SUBJECT TO REASSIGNMENT UNDER SECTION 804-A(C).

(B) EXCEPT AS PROVIDED IN SUBSECTION (C), IN AN ACTION IN WHICH THE PLAINTIFF HAS ESTABLISHED PROPER JURISDICTION IN A COURT FOR A MEDICAL PROFESSIONAL LIABILITY CLAIM AGAINST A DEFENDANT UNDER SUBSECTION (A), THE COURT ALSO HAS JURISDICTION FOR ALL CLAIMS AGAINST DEFENDANTS WHO ARE ALLEGED TO BE JOINTLY LIABLE WITH THE DEFENDANT FOR WHOM JURISDICTION HAS BEEN ESTABLISHED.

(C) IF ALL OF THE PROFESSIONAL LIABILITY CLAIMS FOR WHICH A COURT HAS JURISDICTION UNDER SUBSECTION (A) ARE DISMISSED OR WITHDRAWN PRIOR TO THE COMMENCEMENT OF THE TRIAL, THE COURT SHALL TRANSFER THE ACTION TO A COURT THAT HAS JURISDICTION AGAINST THE REMAINING DEFENDANTS UNDER SUBSECTION (A) OR (B).

(D) IN THE CASE OF A CLAIM ASSERTING VICARIOUS LIABILITY, ONLY THE ACTS AND OMISSIONS SUPPORTING THE UNDERLYING CLAIM SHALL BE CONSIDERED FOR PURPOSES OF ESTABLISHING JURISDICTION UNDER SUBSECTION (A). IN THE CASE OF A CLAIM ASSERTING CORPORATE LIABILITY OR A SIMILAR THEORY OF LIABILITY IN WHICH THE DEFENDANT IS ALLEGEDLY LIABLE FOR FAILURE TO EXERCISE REASONABLE CARE IN THE SELECTION OR SUPERVISION OF A HEALTH CARE PROVIDER WHO ALLEGEDLY PROVIDED DEFICIENT HEALTH CARE, ONLY THE ALLEGEDLY DEFICIENT HEALTH CARE OF THE HEALTH CARE PROVIDER SHALL BE CONSIDERED FOR PURPOSES OF ESTABLISHING JURISDICTION UNDER SUBSECTION (A).

SECTION 804-A. CHANGE OF VENUE.--(A) UPON THE PETITION OF A PARTY DEFENDANT, A COURT THAT HAS JURISDICTION FOR AN ACTION

ASSERTING A MEDICAL PROFESSIONAL LIABILITY CLAIM AGAINST ANY DEFENDANT UNDER SECTION 803-A SHALL TRANSFER THE ACTION TO THE COURT OF ANY OTHER COUNTY WHERE THE CLAIM COULD ORIGINALLY HAVE BEEN BROUGHT UNDER SECTION 803-A IF THE STANDARDS IN SUBSECTION (B) ARE SATISFIED.

(B) THE COURT SHALL GRANT A REQUEST FOR A CHANGE IN VENUE UNDER SUBSECTION (A) IF THE ALLEGEDLY DEFICIENT MEDICAL CARE OF ALL THE DEFENDANTS CONSIDERED TOGETHER PREDOMINATELY OCCURRED IN THE NEW COUNTY OR THE COURT OTHERWISE DETERMINES THAT A CHANGE IN VENUE IS APPROPRIATE. A DEFENDANT SHALL NOT BE REQUIRED TO ESTABLISH THAT THE PLAINTIFF'S CHOICE OF FORUM IS OPPRESSIVE OR VEXATIOUS TO OBTAIN A CHANGE IN VENUE.

(C) (1) IN ANY COUNTY WHERE THE JURY VENIRE POOL EXCEEDS 20% OF INDIVIDUALS EMPLOYED BY THE HEALTH CARE INDUSTRY, SUCH CASE AT THE REQUEST OF ANY PARTY SHALL BE TRANSFERRED TO ANOTHER COUNTY IN ACCORDANCE WITH A ROTATION SYSTEM DEVELOPED IN ACCORDANCE WITH PARAGRAPH (2).

(2) THE ADMINISTRATIVE OFFICE OF THE PENNSYLVANIA COURTS SHALL DEVELOP A LIST OF COUNTIES WITH JURY VENIRE POOLS WHICH EXCEED THE PERCENTAGES SET FORTH IN PARAGRAPH (1) EVERY FIVE YEARS OR IN SUCH OTHER FREQUENCY LESS THAN SAID PERIOD AS MAY BE DECIDED AT THE DISCRETION OF THE ADMINISTRATIVE OFFICE OF THE PENNSYLVANIA COURTS. A RANDOM SELECTION SYSTEM SHALL BE DEVELOPED BY THE COURTS FOR TRANSFERRING CASES TO A COUNTY WHOSE COURT OF COMMON PLEAS IS ORDINARILY NO MORE THAN 50 MILES FROM THE COURT OF COMMON PLEAS OF THE TRANSFERRING COUNTY UNLESS UNUSUAL CIRCUMSTANCES EXIST.

(3) AS USED IN THIS SUBSECTION, "HEALTH CARE INDUSTRY" MEANS HOSPITALS, PHYSICIANS, HEALTH CARE INSURANCE PROVIDERS AND PHARMACEUTICAL COMPANIES.

SECTION 805-A. STATUTE OF LIMITATIONS.--(A) EXCEPT AS PROVIDED IN SUBSECTION (B) OR (C), AN ACTION ASSERTING A MEDICAL PROFESSIONAL LIABILITY CLAIM MUST BE COMMENCED WITHIN TWO YEARS OF THE DATE THE INJURED INDIVIDUAL KNEW, OR SHOULD HAVE KNOWN BY USING REASONABLE DILIGENCE, OF THE INJURY AND ITS CAUSE OR WITHIN FOUR YEARS FROM THE DATE OF THE BREACH OF DUTY OR OTHER EVENT CAUSING THE INJURY, WHICHEVER IS EARLIER.

(B) IF THE INJURY IS, OR WAS, CAUSED BY A FOREIGN OBJECT LEFT IN THE INDIVIDUAL'S BODY, THE FOUR-YEAR LIMITATION IN SUBSECTION (A) SHALL NOT APPLY.

(C) IF THE INJURED INDIVIDUAL IS A MINOR UNDER 14 YEARS OF AGE, THE ACTION MUST BE COMMENCED WITHIN FOUR YEARS AFTER THE MINOR'S PARENT OR GUARDIAN KNEW, OR SHOULD HAVE KNOWN BY USING REASONABLE DILIGENCE, OF THE INJURY AND ITS CAUSE OR WITHIN FOUR YEARS FROM THE MINOR'S 14TH BIRTHDAY, WHICHEVER IS EARLIER.

(D) IF THE CLAIM IS BROUGHT UNDER 42 PA.C.S. § 8301 (RELATING TO DEATH ACTION) OR 8302 (RELATING TO SURVIVAL ACTION), THE ACTION MUST BE COMMENCED WITHIN THE TIME PERIOD SET FORTH IN SUBSECTIONS (A), (B) AND (C) OR WITHIN TWO YEARS AFTER THE DEATH, WHICHEVER IS EARLIER.

(E) NO CAUSE OF ACTION BARRED PRIOR TO THE EFFECTIVE DATE OF THIS SECTION SHALL BE REVIVED BY REASON OF THE ENACTMENT OF THIS SECTION.

SECTION 814-A. CONTRACTS FOR LIMITATION OF NONECONOMIC DAMAGES.--(A) AN AGREEMENT LIMITING NONECONOMIC DAMAGES THAT MAY BE AWARDED IN A MEDICAL PROFESSIONAL LIABILITY ACTION IS CONSISTENT WITH THE PUBLIC POLICY OF THIS COMMONWEALTH, SHALL BE VALID AND LEGALLY ENFORCEABLE, AND SHALL NOT BE DEEMED TO BE UNCONSCIONABLE OR OTHERWISE IMPROPER.

(B) A HEALTH CARE PROVIDER SHALL BE PERMITTED TO CONDITION

INITIAL OR CONTINUED ACCEPTANCE OF AN INDIVIDUAL AS A PATIENT ON THE INDIVIDUAL, OR AN AUTHORIZED LEGAL REPRESENTATIVE OF THE INDIVIDUAL, CONSENTING TO A LIMITATION ON NONECONOMIC DAMAGES OF NOT LESS THAN $250,000 THAT MAY BE AWARDED IN A MEDICAL PROFESSIONAL LIABILITY ACTION, AND NO HEALTH CARE INSURER OR OTHER PERSON THAT CONTRACTS OR ARRANGES FOR THE PROVISION OF MEDICAL SERVICES SHALL PROHIBIT A HEALTH CARE PROVIDER FROM IMPOSING SUCH A CONDITION.

(C) AN AGREEMENT THAT LIMITS NONECONOMIC DAMAGES IN A MEDICAL PROFESSIONAL LIABILITY ACTION INVOLVING MEDICAL SERVICES RENDERED TO A MINOR SHALL NOT BE SUBJECT TO DISAFFIRMANCE IF THE AGREEMENT IS SIGNED BY THE MINOR'S PARENT, LEGAL GUARDIAN OR OTHER LEGAL REPRESENTATIVE. AN AGREEMENT THAT LIMITS NONECONOMIC DAMAGES IN A MEDICAL PROFESSIONAL LIABILITY ACTION INVOLVING MEDICAL SERVICES RENDERED TO AN INDIVIDUAL WHO IS INCOMPETENT SHALL NOT BE SUBJECT TO DISAFFIRMANCE PROVIDED THAT THE AGREEMENT IS SIGNED BY THE INDIVIDUAL WHILE COMPETENT OR A LEGAL REPRESENTATIVE FOR THE INDIVIDUAL.

(D) AN AGREEMENT THAT LIMITS NONECONOMIC DAMAGES IN A MEDICAL PROFESSIONAL LIABILITY ACTION SHALL BE BINDING ON THE ESTATE OF THE INDIVIDUAL WHO SIGNED THE AGREEMENT, OR ON WHOSE BEHALF A LEGAL REPRESENTATIVE SIGNED THE AGREEMENT, AND ON ANY OTHER INDIVIDUAL WHOSE CLAIM IS DERIVATIVE OF THE SIGNER INDIVIDUAL'S CLAIM.

(E) A LIMITATION ON NONECONOMIC DAMAGES IN AN AGREEMENT PERMITTED BY SUBSECTION (A) SHALL BE DEEMED TO APPLY TO THE TOTAL NONECONOMIC DAMAGES AWARDED IN THE ACTION, REGARDLESS OF WHETHER ALL OF THE DEFENDANTS ARE PARTIES TO SUCH AN AGREEMENT, UNLESS THE AGREEMENT PROVIDES OTHERWISE.

(F) AN AGREEMENT PERMITTED BY SUBSECTION (A) MAY EXTEND THE

BENEFIT OF THE LIMITATION ON NONECONOMIC DAMAGES TO ANY HEALTH CARE PROVIDER OR OTHER PERSON REASONABLY IDENTIFIED BY NAME OR CATEGORY, INCLUDING, BUT NOT LIMITED TO, EMPLOYEES AND AGENTS OF A HEALTH CARE PROVIDER, A PERSON HELD VICARIOUSLY LIABLE FOR THE CONDUCT OF A HEALTH CARE PROVIDER AND THE MEDICAL STAFF OF A HEALTH CARE PROVIDER.

(G) IN THE EVENT THAT A HEALTH CARE PROVIDER IS REQUIRED BY LAW TO PROVIDE MEDICAL CARE TO AN INDIVIDUAL OR PROVIDES EMERGENCY MEDICAL CARE TO AN INDIVIDUAL, NONECONOMIC DAMAGES IN A MEDICAL PROFESSIONAL LIABILITY ACTION ARISING OUT OF THAT CARE SHALL BE LIMITED TO $250,000. FOR THE PURPOSES OF THE STATUTORY LIMITATION ON NONECONOMIC DAMAGES IMPOSED IN THIS SUBSECTION, THE LIMITATION ALSO SHALL APPLY TO CARE PROVIDED AFTER THE LEGAL OBLIGATION OR EMERGENCY CEASES, PROVIDED THAT THE INDIVIDUAL, OR A KNOWN LEGAL REPRESENTATIVE FOR THE INDIVIDUAL, IS ADVISED IN WRITING OF THE LIMITATION ON NONECONOMIC DAMAGES WITHIN A REASONABLE TIME.

(H) CONSIDERATION SHALL NOT BE REQUIRED FOR AN AGREEMENT PERMITTED BY SUBSECTION (A), PROVIDED THAT THE AGREEMENT PROVIDES THAT THE SIGNER AGREES TO BE LEGALLY BOUND.

SECTION 815-A. NONBINDING MEDIATION.--(A) AN AGREEMENT PROVIDING FOR NONBINDING MEDIATION OF A MEDICAL PROFESSIONAL LIABILITY CLAIM IS CONSISTENT WITH THE PUBLIC POLICY OF THE COMMONWEALTH AND IS VALID AND ENFORCEABLE. AN AGREEMENT WHICH MANDATES NONBINDING MEDIATION OF A MEDICAL PROFESSIONAL LIABILITY CLAIM SHALL NOT BE DEEMED TO BE UNCONSCIONABLE OR OTHERWISE IMPROPER.

(B) A HEALTH CARE PROVIDER MAY CONDITION INITIAL OR CONTINUED ACCEPTANCE OF AN INDIVIDUAL AS A PATIENT ON THE PATIENT OR AN AUTHORIZED LEGAL REPRESENTATIVE OF THE PATIENT

CONSENTING TO NONBINDING MEDIATION OF A MEDICAL PROFESSIONAL LIABILITY CLAIM; AND NO HEALTH CARE INSURER SHALL PROHIBIT A HEALTH CARE PROVIDER FROM IMPOSING SUCH A CONDITION.

(C) AN AGREEMENT THAT PROVIDES FOR NONBINDING MEDIATION OF A MEDICAL PROFESSIONAL LIABILITY CLAIM MAY INCLUDE TERMS DEFINING THE CONDUCT OF THE PROCEEDINGS.

(D) AN AGREEMENT WHICH MANDATES NONBINDING MEDIATION OF A MEDICAL PROFESSIONAL LIABILITY CLAIM INVOLVING MEDICAL SERVICES RENDERED TO A MINOR SHALL NOT BE SUBJECT TO DISAFFIRMANCE IF THE AGREEMENT IS SIGNED BY THE MINOR'S PARENT, LEGAL GUARDIAN OR LEGAL REPRESENTATIVE. AN AGREEMENT WHICH MANDATES NONBINDING MEDIATION OF A MEDICAL PROFESSIONAL LIABILITY CLAIM INVOLVING MEDICAL SERVICES RENDERED TO A PATIENT WHO IS INCOMPETENT SHALL NOT BE SUBJECT TO DISAFFIRMANCE IF THE AGREEMENT IS SIGNED BY A LEGAL REPRESENTATIVE FOR THE PATIENT.

(E) AN AGREEMENT WHICH MANDATES NONBINDING MEDIATION OF A MEDICAL PROFESSIONAL LIABILITY CLAIM SHALL BE BINDING ON THE ESTATE OF THE PATIENT AND ON ANY OTHER INDIVIDUAL WHOSE CLAIM IS DERIVATIVE OF THE PATIENT'S CLAIM.

(F) A PERSON, CORPORATION OR ENTITY NOT A SIGNATORY TO AN AGREEMENT TO PARTICIPATE IN NONBINDING MEDIATION OF A MEDICAL PROFESSIONAL LIABILITY CLAIM MAY JOIN IN THE MEDIATION AT THE REQUEST OF ANY PARTY WITH ALL THE RIGHTS AND OBLIGATIONS OF THE ORIGINAL PARTY. NO SIGNATORY MAY REFUSE TO MEDIATE BECAUSE OF THE PARTICIPATION OF AN ADDITIONAL PARTY. IN ORDER TO BE TREATED AS A PARTY, AN ADDITIONAL PARTICIPANT MUST SIGN A WRITTEN STATEMENT TO PARTICIPATE IN THE MEDIATION PROCEEDINGS AND THE AGREEMENT OR MUST SIGN THE AGREEMENT.

(G) THE EMPLOYEES OF A HEALTH CARE PROVIDER SHALL BE DEEMED TO BE PARTIES TO EVERY AGREEMENT PROVIDING FOR NONBINDING

MEDIATION OF A MEDICAL PROFESSIONAL LIABILITY CLAIM WHICH IS SIGNED BY THEIR EMPLOYER.

SECTION 816-A. JOINT AND SEVERAL LIABILITY.--(A) WHERE RECOVERY IS ALLOWED IN A MEDICAL PROFESSIONAL LIABILITY ACTION AGAINST MORE THAN ONE DEFENDANT, EACH DEFENDANT SHALL BE LIABLE FOR THAT PROPORTION OF THE TOTAL DOLLAR AMOUNT AWARDED AS DAMAGES IN THE RATIO OF THE AMOUNT OF HIS CAUSAL NEGLIGENCE TO THE AMOUNT OF CAUSAL NEGLIGENCE ATTRIBUTED TO ALL DEFENDANTS AGAINST WHOM RECOVERY IS ALLOWED.

(B) THE LIABILITY OF EACH DEFENDANT FOR DAMAGES SHALL BE SEVERAL ONLY AND SHALL NOT BE JOINT. EACH DEFENDANT SHALL BE LIABLE ONLY FOR THE AMOUNT OF DAMAGES ALLOCATED TO THAT DEFENDANT IN DIRECT PROPORTION TO THAT DEFENDANT'S PERCENTAGE OF FAULT, AND A SEPARATE JUDGMENT SHALL BE RENDERED AGAINST THE DEFENDANT FOR THAT AMOUNT. TO DETERMINE THE AMOUNT OF JUDGMENT TO BE ENTERED AGAINST EACH DEFENDANT, THE COURT, WITH REGARD TO EACH DEFENDANT, SHALL MULTIPLY THE TOTAL AMOUNT OF DAMAGES RECOVERABLE BY THE PLAINTIFF BY THE PERCENTAGE OF EACH DEFENDANT'S FAULT, AND THAT AMOUNT SHALL BE THE MAXIMUM RECOVERABLE AGAINST THAT DEFENDANT.

(C) IN ASSESSING PERCENTAGES OF FAULT, THE TRIER OF FACT SHALL CONSIDER THE FAULT OF ALL PERSONS WHO CONTRIBUTED TO THE DEATH OR INJURY TO PERSON OR PROPERTY, REGARDLESS OF WHETHER THE PERSON WAS OR COULD HAVE BEEN NAMED AS A PARTY TO THE ACTION, EXCEPT THAT NEGLIGENCE OR FAULT OF A NONPARTY MAY BE CONSIDERED ONLY IF THE PLAINTIFF ENTERED INTO A SETTLEMENT AGREEMENT WITH THE NONPARTY OR IF THE DEFENDING PARTY GIVES NOTICE AS PRESCRIBED BY GENERAL RULE THAT A NONPARTY WAS WHOLLY OR PARTIALLY AT FAULT. THE NOTICE SHALL INCLUDE THE NONPARTY'S NAME AND LAST KNOWN ADDRESS OR THE BEST IDENTIFICATION OF THE

NONPARTY WHICH IS POSSIBLE UNDER THE CIRCUMSTANCES, TOGETHER WITH A BRIEF STATEMENT OF THE BASIS FOR BELIEVING THE NONPARTY TO BE AT FAULT.

(D) NOTHING IN THIS SECTION SHALL BE CONSTRUED TO ELIMINATE OR DIMINISH ANY DEFENSES OR IMMUNITIES UNDER EXISTING LAW, EXCEPT AS EXPRESSLY NOTED IN THIS SECTION. ASSESSMENTS OF PERCENTAGES OF FAULT FOR NONPARTIES ARE USED ONLY AS A VEHICLE FOR ACCURATELY DETERMINING THE FAULT OF NAMED PARTIES. WHERE FAULT IS ASSESSED AGAINST NONPARTIES, THE FINDINGS OF FAULT SHALL NOT SUBJECT ANY NONPARTY TO LIABILITY IN THE ACTION OR ANY OTHER ACTION OR BE INTRODUCED AS EVIDENCE OF LIABILITY IN ANY ACTION.

(E) JOINT LIABILITY SHALL BE IMPOSED ON ALL WHO CONSCIOUSLY AND DELIBERATELY PURSUE A COMMON PLAN OR DESIGN TO COMMIT A TORTIOUS ACT OR ACTIVELY TAKE PART IN IT. ANY PERSON HELD JOINTLY LIABLE UNDER THIS SECTION SHALL HAVE A RIGHT OF CONTRIBUTION FROM THAT PERSON'S FELLOW DEFENDANTS ACTING IN CONCERT. A DEFENDANT SHALL BE HELD RESPONSIBLE ONLY FOR THE PORTION OF FAULT ASSESSED TO THOSE WITH WHOM THE DEFENDANT ACTED IN CONCERT UNDER THIS SECTION.

(F) THE BURDEN OF ALLEGING AND PROVING FAULT SHALL BE UPON THE PERSON WHO SEEKS TO ESTABLISH THE FAULT.

(G) NOTHING IN THIS SECTION SHALL BE CONSTRUED TO CREATE A CAUSE OF ACTION. NOTHING IN THIS SECTION SHALL BE CONSTRUED, IN ANY WAY, TO ALTER THE IMMUNITY OF ANY PERSON.

SECTION 817-A. LIABILITY FOR MISREPRESENTATION TO SEEK INFORMED CONSENT.--A HEALTH CARE PROVIDER MAY BE HELD LIABLE FOR FAILURE TO SEEK A PATIENT'S INFORMED CONSENT IF THE PROVIDER MAKES A KNOWING, WILLFUL AND AFFIRMATIVE MISREPRESENTATION TO THE PATIENT AS TO THE PHYSICIAN'S PROFESSIONAL CREDENTIALS,

TRAINING, OR EXPERIENCE WITH THE PROCEDURE AT ISSUE.

SECTION 818-A. LOSS OF PLEASURES OF LIFE.--IN ANY SURVIVAL ACTION BASED UPON A MEDICAL PROFESSIONAL LIABILITY ACTION IN WHICH THE CLAIMANT'S ESTATE CANNOT OR ELECTS NOT TO CLAIM SPECIAL DAMAGES AND THE DEFENDANT HEALTH CARE PROVIDER IS FOUND LIABLE FOR CAUSING THE DEATH OF THE CLAIMANT, THE ESTATE MAY RECOVER DAMAGES FOR THE DECEDENT'S LOSS OF THE PLEASURES OF LIFE.

SECTION 828-A. EXPERT WITNESS QUALIFICATIONS.--(A) AN EXPERT WITNESS IN A MEDICAL PROFESSIONAL LIABILITY ACTION AGAINST A PHYSICIAN MUST POSSESS SUFFICIENT EDUCATION, TRAINING, KNOWLEDGE, AND EXPERIENCE TO PROVIDE CREDIBLE, COMPETENT TESTIMONY, AND MEET THE QUALIFICATIONS SET FORTH IN SUBSECTION (B), (C), (D), (E) OR (F), AS APPLICABLE.

(B) AN EXPERT WITNESS TESTIFYING ON A MEDICAL MATTER, INCLUDING THE STANDARD OF CARE, RISKS AND ALTERNATIVES, CAUSATION AND NATURE AND EXTENT OF INJURY, MUST BE:

(1) A PHYSICIAN WITH AN UNRESTRICTED LICENSE TO PRACTICE IN ANY STATE OR THE DISTRICT OF COLUMBIA; AND

(2) ENGAGED IN ACTIVE CLINICAL PRACTICE OR TEACHING AND EXPERIENCED IN THE MEDICAL CARE AT ISSUE.

(C) AN EXPERT WITNESS TESTIFYING AS TO A PHYSICIAN'S STANDARD OF CARE MUST BE:

(1) SUBSTANTIALLY FAMILIAR WITH THE APPLICABLE STANDARD OF CARE FOR THE SPECIFIC CARE AT ISSUE AS OF THE TIME OF THE ALLEGED MALPRACTICE;

(2) IN THE SAME SPECIALTY AS THE DEFENDANT PHYSICIAN OR A SPECIALTY WHICH HAS A SUBSTANTIALLY SIMILAR STANDARD OF CARE FOR THE SPECIFIC CARE AT ISSUE; AND

(3) IF THE DEFENDANT PHYSICIAN IS CERTIFIED BY AN APPROVED

BOARD, CERTIFIED BY THE SAME OR A SIMILAR APPROVED BOARD.

(D) IN A CASE IN WHICH IT IS ALLEGED THAT A HEALTH CARE PROVIDER ENGAGED IN THE PROCESS OF DIAGNOSIS OR TREATMENT FOR A CONDITION WHICH WAS NOT WITHIN THE HEALTH CARE PROVIDER'S SPECIALTY OR COMPETENCE, A SPECIALIST FOUND BY THE COURT TO BE TRAINED IN TREATMENT OR DIAGNOSIS FOR SUCH CONDITION SHALL BE CONSIDERED COMPETENT TO RENDER AN EXPERT OPINION.

(E) AN EXPERT WITNESS SHALL NOT BE PRECLUDED FROM OFFERING TESTIMONY AS TO THE STANDARD OF CARE UNDER SUBSECTION (C) IF THE COURT MAKES A SPECIFIC FINDING THAT THE PROPOSED EXPERT POSSESSES SUFFICIENT TRAINING, EXPERIENCE AND KNOWLEDGE AS A RESULT OF PRACTICE OR TEACHING IN THE SPECIALTY OF THE DEFENDANT OR PRACTICE OR TEACHING IN A RELATED FIELD OF MEDICINE SO AS TO EQUIP THE WITNESS TO PROVIDE EXPERT TESTIMONY AS TO THE PREVAILING PROFESSIONAL STANDARD OF CARE IN A GIVEN FIELD OF MEDICINE. SUCH TRAINING, EXPERIENCE OR KNOWLEDGE MUST BE AS A RESULT OF ACTIVE INVOLVEMENT IN THE PRACTICE OR FULL-TIME TEACHING OF MEDICINE WITHIN THE FIVE-YEAR PERIOD BEFORE THE INCIDENT GIVING RISE TO THE CLAIM.

(F) AN EXPERT WITNESS NOT OFFERING AN OPINION AS TO THE STANDARD OF CARE WHO OTHERWISE IS COMPETENT TO TESTIFY ABOUT MEDICAL OR SCIENTIFIC ISSUES BY VIRTUE OF EDUCATION, TRAINING OR EXPERIENCE, IS NOT PRECLUDED FROM TESTIFYING BECAUSE OF AN ABSENCE OF BOARD CERTIFICATION OR THE LACK OF A MEDICAL LICENSE WITHIN THE UNITED STATES.

SECTION 829-A. PRETRIAL DISPOSITION OF FRIVOLOUS MEDICAL PROFESSIONAL LIABILITY CLAIMS.--(A) (1) EXCEPT AS SET FORTH IN PARAGRAPH (2), IF A MEDICAL PROFESSIONAL LIABILITY CLAIM IS SUBJECT TO PRETRIAL DISPOSITION, THE PREVAILING PARTY SHALL HAVE A CAUSE OF ACTION AGAINST THE ADVERSE PARTY.

(2) IF THE PREVAILING PARTY IS AWARDED, IN THE UNDERLYING ACTION, DAMAGES SUBSTANTIALLY SIMILAR TO THE DAMAGES UNDER SUBSECTION (B), THE CAUSE OF ACTION UNDER THIS SECTION IS EXTINGUISHED. A COPY OF THE DAMAGE ORDER IN THE UNDERLYING ACTION IS REQUIRED TO APPLY THIS PARAGRAPH.

(B) (1) THE DAMAGES FOR A CAUSE OF ACTION UNDER SUBSECTION (A) CONSIST OF REASONABLE ATTORNEY FEES AND COSTS OF PRETRIAL DISPOSITION.

(2) IF THE TRIER OF FACT DETERMINES THAT THE ADVERSE PARTY ACTED WITH THE INTENT TO HARASS THE PREVAILING PARTY OR TO DELAY ADJUDICATION OF THE CASE, DAMAGES UNDER PARAGRAPH (1) SHALL BE TRIPLED.

(C) DISCOVERY IN AN ACTION UNDER THIS SECTION SHALL BE LIMITED TO A DETERMINATION OF DAMAGES UNDER SUBSECTION (B).

(D) AN ACTION UNDER THIS SECTION MUST BE FILED WITHIN ONE YEAR OF THE FINAL DETERMINATION OF THE PRETRIAL DISPOSITION.

(E) AS USED IN THIS ACT:

"ADVERSE PARTY" MEANS ANY OF THE FOLLOWING:

(1) A PLAINTIFF WHOSE COMPLAINT IS DISMISSED BECAUSE OF PRELIMINARY OBJECTIONS.

(2) A DEFENDANT WHOSE PRELIMINARY OBJECTIONS ARE OVERRULED.

(3) A PLAINTIFF AGAINST WHOM SUMMARY JUDGMENT IS ENTERED.

(4) A DEFENDANT WHOSE MOTION FOR SUMMARY JUDGMENT IS DENIED. THE TERM INCLUDES AN ATTORNEY WHO ACTS WITHOUT KNOWLEDGE OR CONSENT OF THE ATTORNEY'S CLIENT.

"PRETRIAL DISPOSITION" MEANS ANY OF THE FOLLOWING:

(1) DISMISSAL OF COMPLAINT BECAUSE OF PRELIMINARY OBJECTIONS.

(2) OVERRULING OF PRELIMINARY OBJECTIONS.

(3) ENTRY OF SUMMARY JUDGMENT.

(4) DENIAL OF SUMMARY JUDGMENT.

"PREVAILING PARTY" MEANS ANY OF THE FOLLOWING:

(1) A DEFENDANT WHOSE PRELIMINARY OBJECTIONS ARE SUSTAINED.

(2) A PLAINTIFF WHO WITHSTANDS PRELIMINARY OBJECTIONS.

(3) A DEFENDANT WHOSE MOTION FOR SUMMARY JUDGMENT IS GRANTED.

(4) A PLAINTIFF WHO WITHSTANDS A MOTION FOR SUMMARY JUDGMENT.

"REASONABLE ATTORNEY FEES" MEANS ATTORNEY FEES AT A REASONABLE HOURLY RATE FOR HOURS ACTUALLY AND REASONABLY SPENT WHICH ARE:

(1) ACTUALLY PAID; OR

(2) BILLED FOR BASED UPON TIME SHEETS SUBMITTED TO THE COURT.

"UNDERLYING ACTION" MEANS AN ACTION FOR MEDICAL MALPRACTICE WHICH IS SUBJECT TO PRELIMINARY DISPOSITION.

SECTION 833-A. COLLATERAL SOURCES.--(A) EXCEPT AS SET FORTH IN SUBSECTION (D), A CLAIMANT IN A MEDICAL PROFESSIONAL LIABILITY ACTION IS PRECLUDED FROM RECOVERING DAMAGES FOR PAST MEDICAL EXPENSES OR PAST LOST EARNINGS TO THE EXTENT THAT THE LOSS IS COVERED BY A PRIVATE OR PUBLIC BENEFIT OR GRATUITY THAT CLAIMANT HAS RECEIVED PRIOR TO TRIAL.

(B) THE CLAIMANT HAS THE OPTION TO INTRODUCE INTO EVIDENCE THE AMOUNT OF MEDICAL EXPENSES INCURRED, BUT THE JURY SHALL BE INSTRUCTED NOT TO AWARD DAMAGES FOR SUCH EXPENSES EXCEPT TO THE EXTENT THAT THE CLAIMANT REMAINS LEGALLY RESPONSIBLE FOR SUCH PAYMENT.

(C) EXCEPT AS SET FORTH IN SUBSECTION (D), THERE SHALL BE NO RIGHT OF SUBROGATION OR REIMBURSEMENT FROM A CLAIMANT'S TORT RECOVERY WITH RESPECT TO A PUBLIC OR PRIVATE BENEFIT COVERED IN

SUBSECTION (A).

(D) THE COLLATERAL SOURCE REDUCTION SET FORTH IN SUBSECTION (A) SHALL NOT APPLY TO THE FOLLOWING:

(1) LIFE INSURANCE, PENSION OR PROFIT-SHARING PLANS OR OTHER DEFERRED COMPENSATION PLANS, INCLUDING AGREEMENTS PERTAINING TO THE PURCHASE OF A BUSINESS.

(2) SOCIAL SECURITY BENEFITS.

(3) PUBLIC BENEFITS PAID OR PAYABLE UNDER A PROGRAM WHICH, UNDER FEDERAL STATUTE, PROVIDES FOR RIGHT OF REIMBURSEMENT WHICH SUPERSEDES STATE LAW FOR THE AMOUNT OF BENEFITS PAID FROM A VERDICT OR SETTLEMENT.

SECTION 834-A. PERIODIC PAYMENT OF FUTURE DAMAGES.--(A) (1) AT THE OPTION OF ANY PARTY TO AN ACTION ASSERTING A MEDICAL PROFESSIONAL LIABILITY CLAIM, FUTURE DAMAGES FOR ECONOMIC LOSS SHALL BE AWARDED IN:

(I) PERIODIC PAYMENTS AS PROVIDED IN THIS SUBSECTION, EXCEPT AS PROVIDED IN SUBSECTION (B); OR

(II) A LUMP SUM PAYMENT REDUCED TO PRESENT VALUE BY USING A DISCOUNT RATE OF 3%.

(2) THE TRIER OF FACT SHALL ISSUE SEPARATE FINDINGS FOR EACH CLAIMANT SPECIFYING THE AMOUNT OF:

(I) ANY PAST DAMAGES FOR:

(A) MEDICAL EXPENSES IN A LUMP SUM.

(B) LOSS OF WORK EARNINGS IN A LUMP SUM.

(C) OTHER ECONOMIC LOSSES IN A LUMP SUM.

(D) NONECONOMIC LOSSES IN A LUMP SUM.

(II) ANY FUTURE DAMAGES FOR:

(A) MEDICAL EXPENSES BY YEAR.

(B) LOSS OF WORK EARNINGS BY YEAR.

(C) OTHER ECONOMIC LOSSES BY YEAR.

(D) NONECONOMIC LOSSES IN A LUMP SUM.

(3) THE TRIER OF FACT MAY VARY THE AMOUNT OF PERIODIC PAYMENTS FOR MEDICAL AND OTHER RECOVERABLE EXPENSES FROM YEAR TO YEAR TO ACCOUNT FOR DIFFERENT ANNUAL EXPENDITURE REQUIREMENTS. FOR EXAMPLE, THE TRIER OF FACT MAY PROVIDE FOR INITIAL PURCHASE AND REPLACEMENTS OF MEDICALLY NECESSARY EQUIPMENT IN THE YEARS THAT EXPENDITURES WILL BE REQUIRED.

(4) THE TRIER OF FACT MAY INCORPORATE INTO ANY FUTURE MEDICAL EXPENSE AWARD ADJUSTMENTS TO ACCOUNT FOR REASONABLY ANTICIPATED INFLATION AND MEDICAL CARE INNOVATIONS, SUCH AS NEW TECHNOLOGY, DRUGS, AND TECHNIQUES, THAT WILL DECREASE MEDICAL COSTS, OR MAKE A SEPARATE FINDING ON THE APPLICABLE ANNUAL PERCENTAGE CHANGE.

(I) THE COMMISSIONER SHALL ANNUALLY ESTABLISH, BY JANUARY 1 OF EACH YEAR, A FUTURE MEDICAL EXPENSE ADJUSTMENT FACTOR THAT TAKES INTO ACCOUNT REASONABLY ANTICIPATED MEDICAL EXPENSE INFLATION AS WELL AS MEDICAL CARE INNOVATIONS THAT WILL DECREASE MEDICAL COSTS.

(II) THE COMMISSIONER MAY RELY ON SUCH EVIDENCE AS THE COMMISSIONER REASONABLY DEEMS APPROPRIATE, PROVIDED THAT:

(A) THE COMMISSIONER SHALL NOT RELY ON ANY PRICE INDEX UNLESS THE COMMISSIONER USES A ROLLING AVERAGE OF THE PRICE INDEX OR ITS SUBSTANTIAL EQUIVALENT OVER AT LEAST THE MOST RECENT TEN-YEAR PERIOD FOR WHICH DATA IS AVAILABLE.

(B) THE COMMISSIONER SHALL NOT RELY EXCLUSIVELY ON ANY INFLATION PRICE INDEX WITHOUT CONSIDERATION OF REASONABLY ANTICIPATED MEDICAL CARE INNOVATIONS THAT WILL DECREASE MEDICAL COSTS.

(III) THE TRIER OF FACT SHALL USE THE FUTURE MEDICAL EXPENSE ADJUSTMENT FACTOR ESTABLISHED BY THE COMMISSIONER AND CURRENTLY

IN EFFECT, UNLESS A PARTY ESTABLISHES BY CLEAR AND CONVINCING EVIDENCE THAT DIFFERENT ADJUSTMENTS ARE MORE APPROPRIATE.

(5) THE TRIER OF FACT MAY INCORPORATE INTO ANY FUTURE EARNINGS LOSS AWARD ADJUSTMENTS TO ACCOUNT FOR WAGE INFLATION AND PRODUCTIVITY GROWTH, OR MAKE A SEPARATE FINDING ON THE APPLICABLE ANNUAL PERCENTAGE CHANGE.

(I) THE SECRETARY OF LABOR AND INDUSTRY SHALL ANNUALLY ESTABLISH, BY JANUARY 1 OF EACH YEAR, FUTURE EARNINGS LOSS ADJUSTMENT FACTORS THAT TAKE INTO ACCOUNT WAGE INFLATION AND PRODUCTIVITY CHANGES. THE SECRETARY SHALL ESTABLISH SEPARATE FACTORS FOR DIFFERENT JOBS, OCCUPATIONS AND PROFESSIONS AS REASONABLY APPROPRIATE.

(II) THE SECRETARY MAY RELY ON SUCH EVIDENCE AS THE SECRETARY REASONABLY DEEMS APPROPRIATE, PROVIDED THAT THE SECRETARY SHALL NOT RELY ON WAGE CHANGE DATA UNLESS THE COMMISSIONER USES A ROLLING AVERAGE OVER AT LEAST THE MOST RECENT TEN-YEAR PERIOD FOR WHICH DATA IS AVAILABLE.

(III) THE TRIER OF FACT SHALL USE THE APPLICABLE FUTURE EARNINGS LOSS ADJUSTMENT FACTOR ESTABLISHED BY THE SECRETARY AND CURRENTLY IN EFFECT, UNLESS A PARTY ESTABLISHES BY CLEAR AND CONVINCING EVIDENCE THAT DIFFERENT ADJUSTMENTS ARE MORE APPROPRIATE.

(6) THE TRIER OF FACT MAY DETERMINE THAT FUTURE DAMAGES FOR MEDICAL LOSSES WILL CONTINUE FOR THE DURATION OF THE CLAIMANT'S LIFE AND MAKE A LIFETIME MEDICAL EXPENSE AWARD IF SUCH A FINDING IS SUPPORTED BY THE EVIDENCE. IN SUCH A CASE, THE TRIER OF FACT SHALL DETERMINE THE AMOUNT OF MEDICAL EXPENSES THAT THE CLAIMANT WILL INCUR ANNUALLY WHILE LIVING, BUT SHALL NOT BE REQUIRED TO DETERMINE THE LIFE EXPECTANCY OF THE CLAIMANT.

(7) THE TRIER OF FACT MAY AWARD DAMAGES FOR LOSS OF WORK

EARNINGS FOR THE DURATION OF THE CLAIMANT'S PRE-INJURY WORK-LIFE EXPECTANCY OR UNTIL THE CLAIMANT REACHES 65 YEARS OF AGE, WHICHEVER OCCURS EARLIER, IF SUCH A FINDING IS SUPPORTED BY THE EVIDENCE. IN SUCH A CASE, THE TRIER OF FACT SHALL SPECIFY THE CLAIMANT'S PRE-INJURY WORK-LIFE EXPECTANCY.

(8) THE TRIER OF FACT SHALL ADJUST WORK-LOSS DAMAGES TO ACCOUNT FOR THE INAPPLICABILITY OF FEDERAL, STATE AND LOCAL TAXES AND SOCIAL SECURITY WITHHOLDING TO PERSONAL INJURY AWARDS.

(9) FUTURE DAMAGES FOR MEDICAL EXPENSES AND OTHER ECONOMIC LOSS MUST BE PAID IN THE YEARS THAT THE TRIER OF FACT FINDS THEY WILL ACCRUE. UNLESS THE COURT ORDERS OR APPROVES A DIFFERENT SCHEDULE FOR PAYMENT, THE ANNUAL AMOUNTS DUE MUST BE PAID IN 12 EQUAL MONTHLY INSTALLMENTS, ROUNDED TO THE NEAREST DOLLAR. EACH INSTALLMENT IS DUE AND PAYABLE ON THE FIRST DAY OF THE MONTH IN WHICH IT ACCRUES.

(10) INTEREST DOES NOT ACCRUE ON A PERIODIC PAYMENT BEFORE PAYMENT IS DUE. IF THE PAYMENT IS NOT MADE ON OR BEFORE THE DUE DATE, INTEREST ACCRUES AS OF THAT DATE.

(11) LIABILITY TO A CLAIMANT FOR PERIODIC PAYMENTS NOT YET DUE FOR MEDICAL EXPENSES TERMINATES UPON THE CLAIMANT'S DEATH.

(12) LIABILITY TO A CLAIMANT FOR LOSS OF EARNINGS SHALL NOT TERMINATE AT THE CLAIMANT'S DEATH; PROVIDED HOWEVER, THAT THIS SECTION SHALL NOT BE CONSTRUED AS EXTENDING A LOSS OF WORK EARNINGS AWARD BEYOND THE TIME FRAME PERMITTED UNDER PARAGRAPH (7).

(13) EACH PARTY LIABLE FOR ALL OR A PORTION OF THE JUDGMENT SHALL PROVIDE FUNDING FOR THE AWARDED PERIODIC PAYMENTS, SEPARATELY OR JOINTLY WITH ONE OR MORE OTHERS, BY MEANS OF AN ANNUITY CONTRACT OR OTHER QUALIFIED FUNDING PLAN WHICH IS APPROVED BY THE COURT. THE COMMISSIONER SHALL PUBLISH A LIST OF

INSURERS DESIGNATED BY THE COMMISSIONER AS QUALIFIED TO PARTICIPATE IN THE FUNDING OF PERIODIC-PAYMENT JUDGMENTS.

(14) IN THE EVENT THAT A CLAIMANT DEFAULTS ON A REQUIRED PERIODIC PAYMENT DUE TO THE INSOLVENCY OF AN INSURER PARTICIPATING IN A QUALIFIED FUNDING PLAN, THE CLAIMANT SHALL BE ENTITLED TO RECEIVE THE PAYMENT FROM:

(I) THE MEDICAL PROFESSIONAL LIABILITY CATASTROPHE LOSS FUND; OR

(II) IF THE FUND HAS CEASED OPERATIONS, THE PROPERTY AND CASUALTY INSURANCE GUARANTY ASSOCIATION.

THE COMMISSIONER SHALL PROMULGATE REGULATIONS FOR THE IMPLEMENTATION OF THIS SECTION.

(15) THE COURT WHICH ENTERS JUDGMENT SHALL RETAIN JURISDICTION TO ENFORCE THE JUDGMENT AND TO RESOLVE RELATED DISPUTES.

(B) FUTURE DAMAGES SHALL NOT BE AWARDED IN PERIODIC PAYMENTS IF THE CLAIMANT OBJECTS AND STIPULATES THAT THE CLAIM FOR FUTURE DAMAGES FOR ECONOMIC LOSS, WITHOUT REDUCTION TO PRESENT VALUE, DOES NOT EXCEED $100,000. IN SUCH A CASE, FUTURE DAMAGES SHALL BE REDUCED TO PRESENT WORTH USING A DISCOUNT RATE OF 4% WITH NO ADJUSTMENTS FOR INFLATION OR PRODUCTIVITY GROWTH.

(C) IN THE EVENT THAT THE CLAIMANT RECEIVES A COLLATERAL SOURCE PAYMENT FOR AN ECONOMIC LOSS FOR WHICH THE CLAIMANT RECEIVES A PERIODIC PAYMENT UNDER SUBSECTION (A) OR A LUMP-SUM PAYMENT UNDER SUBSECTION (B), THE CLAIMANT SHALL REFUND THAT PORTION OF THE PERIODIC PAYMENT OR LUMP-SUM PAYMENT THAT IS OFFSET BY THE COLLATERAL SOURCE PAYMENT. FOR PURPOSES OF THIS SECTION, A COLLATERAL SOURCE PAYMENT IS A PAYMENT OR OTHER COMPENSATION THAT WOULD BE SUBJECT TO A COLLATERAL SOURCE REDUCTION UNDER SECTION 602 IF THE PAYMENT OR OTHER COMPENSATION

WAS MADE FOR A PAST ECONOMIC LOSS.

(D) AT THE REQUEST OF THE DEFENDANT, THE CLAIMANT SHALL MAINTAIN A COLLATERAL SOURCE BENEFIT IN EFFECT OR OBTAIN A COLLATERAL SOURCE BENEFIT. IN SUCH A CASE, THE DEFENDANT SHALL BE REQUIRED TO COMPENSATE THE CLAIMANT FOR THE REASONABLE COSTS INCURRED BY THE CLAIMANT TO THE EXTENT THAT THE COSTS ARE NOT COVERED BY A COLLATERAL SOURCE. SUCH COSTS SHALL BE REIMBURSED IN THE YEARS THAT THE COSTS ACCRUE IN 12 EQUAL MONTHLY PAYMENTS PAYABLE ON THE FIRST DAY OF EACH MONTH, UNLESS THE COURT REQUIRES A DIFFERENT SCHEDULE.

SECTION 835-A. PERMISSIBLE ARGUMENT AS TO DAMAGES AT TRIAL.--(A) EXCEPT AS PROVIDED IN SUBSECTION (B), IN A MEDICAL PROFESSIONAL LIABILITY ACTION TRIED BEFORE A JUDGE, JURY OR OTHER TRIBUNAL, AN ATTORNEY DURING CLOSING ARGUMENT:

(1) MAY SPECIFICALLY ARGUE IN LUMP SUMS OR BY MATHEMATICAL FORMULAE THE AMOUNT THE ATTORNEY DEEMS TO BE AN APPROPRIATE AWARD FOR ALL PAST AND FUTURE ECONOMIC OR NONECONOMIC DAMAGES OR BOTH ECONOMIC AND NONECONOMIC DAMAGES CLAIMED TO BE RECOVERABLE.

(2) MAY, ON BEHALF OF A DEFENDANT, ARGUE TO THE JUDGE, JURY OR OTHER TRIBUNAL THAT AN AWARD OF ZERO DAMAGES IS APPROPRIATE, EVEN IF THERE IS A FINDING OF LIABILITY AGAINST THE DEFENDANT.

(B) (1) NO PARTY MAY ARGUE A SPECIFIC SUM AS PROVIDED IN SUBSECTION (A) UNLESS THE PARTY FIRST DISCLOSES TO THE COURT AND OPPOSING COUNSEL THAT THE PARTY INTENDS TO ARGUE THE SPECIFIC DAMAGES LISTED IN SUBSECTION (A) PRIOR TO THE PRESENTATION OF CLOSING ARGUMENTS.

(2) NOTHING IN THIS SUBSECTION SHALL BE CONSTRUED TO PREVENT A DEFENDANT FROM ARGUING IN ANY CASE THAT THE FACTS AND EVIDENCE SUPPORT A FINDING OF NO LIABILITY.

(3) NOTWITHSTANDING PARAGRAPH (1), ARGUMENTS AS TO

APPROPRIATE AMOUNT OF ECONOMIC DAMAGES MAY BE MADE WITHOUT NOTICE TO OPPOSING COUNSEL IF EVIDENCE SUPPORTING ECONOMIC DAMAGES HAS BEEN INTRODUCED AT TRIAL.

(C) WHENEVER, IN A MEDICAL PROFESSIONAL LIABILITY ACTION TRIED BEFORE A JURY, SPECIFIC LUMP SUMS OR MATHEMATICAL FORMULAE ARE ARGUED DURING CLOSING ARGUMENTS AS PROVIDED FOR IN SUBSECTION (A), THE TRIAL COURT SHALL INSTRUCT THE JURY THAT THE SUMS OR MATHEMATICAL FORMULAE ARGUED ARE NOT EVIDENCE BUT ONLY ARGUMENTS AND THAT THE DETERMINATION OF THE AMOUNT OF APPROPRIATE DAMAGES TO BE AWARDED, IF ANY, IS SOLELY FOR THE JURY'S DETERMINATION.

SECTION 6. SECTION 841-A(D) OF THE ACT, ADDED NOVEMBER 26, 1996 (P.L.776, NO.135), IS AMENDED TO READ:

SECTION 841-A. MANDATORY REPORTING.--* * *

(D) EACH LICENSURE BOARD SHALL SUBMIT A REPORT NOT LATER THAN MARCH 1 OF EACH YEAR TO THE CHAIRMAN AND THE MINORITY CHAIRMAN OF THE CONSUMER PROTECTION AND PROFESSIONAL LICENSURE COMMITTEE OF THE SENATE AND TO THE CHAIRMAN AND MINORITY CHAIRMAN OF THE PROFESSIONAL LICENSURE COMMITTEE OF THE HOUSE OF REPRESENTATIVES. THE REPORT SHALL INCLUDE, BUT NOT BE LIMITED TO[, THE NUMBER OF REPORTS RECEIVED UNDER SUBSECTION (A), THE STATUS OF THE INVESTIGATIONS OF THOSE REPORTS, ANY DISCIPLINARY ACTION WHICH HAS BEEN TAKEN AND THE LENGTH OF TIME FROM THE RECEIPT OF EACH REPORT TO FINAL LICENSURE BOARD ACTION.]:

(1) THE NUMBER OF COMPLAINT FILES AGAINST BOARD LICENSEES THAT WERE OPENED IN THE PRECEDING FIVE CALENDAR YEARS.

(2) THE NUMBER OF COMPLAINT FILES AGAINST BOARD LICENSEES THAT WERE CLOSED IN THE PRECEDING FIVE CALENDAR YEARS.

(3) THE NUMBER OF DISCIPLINARY SANCTIONS IMPOSED UPON BOARD LICENSEES IN THE PRECEDING FIVE CALENDAR YEARS.

(4) THE NUMBER OF REVOCATIONS, AUTOMATIC SUSPENSIONS, IMMEDIATE TEMPORARY SUSPENSIONS AND 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.

SECTION 7. SECTION 901 OF THE ACT IS AMENDED TO READ:

SECTION 901. INVESTIGATIONS.--(A) THE STATE BOARD OF MEDICAL EDUCATION AND LICENSURE, THE STATE BOARD OF OSTEOPATHIC EXAMINERS AND THE STATE BOARD OF PODIATRY EXAMINERS SHALL EMPLOY SUCH QUALIFIED INVESTIGATORS AND ATTORNEYS AS ARE NECESSARY TO FULLY IMPLEMENT THEIR AUTHORITY TO REVOKE, SUSPEND, LIMIT OR OTHERWISE REGULATE THE LICENSES OF PHYSICIANS; ISSUE REPRIMANDS, FINES, REQUIRE REFRESHER EDUCATIONAL COURSES, OR REQUIRE LICENSEES TO SUBMIT TO MEDICAL TREATMENT.

(B) ANY COMMONWEALTH AGENCY THAT OBTAINS INFORMATION INDICATING THAT A BOARD-REGULATED PRACTITIONER EMPLOYED BY THE COMMONWEALTH AGENCY OR WITH WHOM THE COMMONWEALTH AGENCY CONTRACTS AS AN INDEPENDENT CONTRACTOR WAS INVOLVED IN AN EVENT, OCCURRENCE OR SITUATION THAT COMPROMISED PATIENT SAFETY AND RESULTED IN UNINTENDED INJURY REQUIRING THE DELIVERY OF ADDITIONAL HEALTH CARE SERVICES TO A PATIENT SHALL MAKE OR CAUSE TO BE MADE A REPORT TO THE APPROPRIATE BOARD LISTED IN SUBSECTION (A) WITHIN 60 DAYS OF OBTAINING THE INFORMATION. ANY PERSON OR COMMONWEALTH AGENCY WHO MAKES A REPORT PURSUANT TO THIS SECTION IN GOOD FAITH AND WITHOUT MALICE SHALL BE IMMUNE FROM ANY CIVIL OR CRIMINAL LIABILITY ARISING FROM THE REPORT.

SECTION 8. THE ACT IS AMENDED BY ADDING SECTIONS TO READ:

SECTION 901.1. REPORTING TO STATE LICENSING BOARDS.--A PHYSICIAN, A CERTIFIED NURSE MIDWIFE OR A PODIATRIST SHALL REPORT TO THE STATE BOARD OF MEDICINE, THE STATE BOARD OF OSTEOPATHIC MEDICINE OR THE STATE BOARD OF PODIATRY, AS APPROPRIATE, WITHIN 60 DAYS OF THE OCCURRENCE OF ANY OF THE FOLLOWING:

(1) A COMPLAINT IN A CIVIL ACTION BASED ON MEDICAL MALPRACTICE IS FILED AGAINST THE INDIVIDUAL.

(2) DISCIPLINARY ACTION IS TAKEN AGAINST THE INDIVIDUAL BY A HEALTH CARE LICENSING AUTHORITY OF ANOTHER JURISDICTION.

(3) THE INDIVIDUAL IS SENTENCED FOR AN OFFENSE GRADED ABOVE A SUMMARY OFFENSE. THIS PARAGRAPH INCLUDES SENTENCING IN ANOTHER JURISDICTION FOR AN OFFENSE WHICH, IF COMMITTED IN THIS COMMONWEALTH WOULD BE GRADED ABOVE A SUMMARY OFFENSE.

(4) THE INDIVIDUAL IS ARRESTED FOR, OR CHARGED IN AN INDICTMENT OR INFORMATION WITH:

(I) A FELONY; OR

(II) AN OFFENSE UNDER THE ACT OF APRIL 14, 1972 (P.L.233, NO.64), KNOWN AS "THE CONTROLLED SUBSTANCE, DRUG, DEVICE AND COSMETIC ACT."

(5) A HEALTH CARE FACILITY OR HOSPITAL, AS A RESULT OF A PEER REVIEW PROCEEDING, TERMINATES OR CURTAILS THE INDIVIDUAL'S EMPLOYMENT, ASSOCIATION OR PROFESSIONAL PRIVILEGES.

SECTION 901.2. DUTY TO NOTIFY LICENSING BOARD ABOUT CERTAIN ARRESTS.--A BOARD-REGISTERED PRACTITIONER WHO IS LICENSED BY A LICENSURE BOARD SHALL NOTIFY THE LICENSING BOARD IN WRITING WITHIN 60 DAYS OF AN ARREST FOR A FELONY OR FOR AN OFFENSE UNDER THE ACT OF APRIL 14, 1972 (P.L.233, NO.64), KNOWN AS "THE CONTROLLED SUBSTANCE, DRUG, DEVICE AND COSMETIC ACT."

SECTION 9. SECTION 902 OF THE ACT IS AMENDED TO READ:

SECTION 902. HEARINGS.--(A) THE STATE BOARD OF [MEDICAL EDUCATION AND LICENSURE] MEDICINE, THE STATE BOARD OF OSTEOPATHIC [EXAMINERS] MEDICINE AND THE STATE BOARD OF PODIATRY [EXAMINERS] SHALL APPOINT, WITH THE APPROVAL OF THE GOVERNOR, SUCH HEARING EXAMINERS AS SHALL BE NECESSARY TO CONDUCT HEARINGS IN ACCORDANCE WITH THE DISCIPLINARY AUTHORITY GRANTED BY THE ACT OF JULY 20, 1974 (P.L.551, NO.190), KNOWN AS THE "MEDICAL PRACTICE ACT OF 1974," AND THE ACT OF MARCH 19, 1909 (P.L.46, NO.29), ENTITLED, AS AMENDED, "AN ACT TO REGULATE THE PRACTICE OF OSTEOPATHY AND SURGERY IN THE STATE OF PENNSYLVANIA; TO PROVIDE FOR THE ESTABLISHMENT OF A STATE BOARD OF OSTEOPATHIC EXAMINERS; TO DEFINE THE POWERS AND DUTIES OF SAID BOARD OF OSTEOPATHIC EXAMINERS; TO PROVIDE FOR THE EXAMINING AND LICENSING OF OSTEOPATHIC PHYSICIANS AND SURGEONS IN THIS STATE; AND TO PROVIDE PENALTIES FOR THE VIOLATION OF THIS ACT."

(B) THE STATE BOARD OF [MEDICAL EDUCATION AND LICENSURE] MEDICINE OR THE STATE BOARD OF OSTEOPATHIC [EXAMINERS] MEDICINE SHALL HAVE THE POWER TO ADOPT AND PROMULGATE RULES AND REGULATIONS SETTING FORTH THE FUNCTIONS, POWERS, STANDARDS AND DUTIES TO BE FOLLOWED BY ANY HEARING EXAMINERS APPOINTED UNDER THE PROVISIONS OF THIS SECTION.

(C) SUCH HEARING EXAMINERS SHALL HAVE THE POWER TO CONDUCT HEARINGS IN ACCORDANCE WITH THE REGULATIONS OF THE STATE BOARD OF [MEDICAL EDUCATION AND LICENSURE] MEDICINE OR THE STATE BOARD OF OSTEOPATHIC [EXAMINERS] MEDICINE, AND TO ISSUE SUBPOENAS REQUIRING THE ATTENDANCE AND TESTIMONY OF INDIVIDUALS OR THE PRODUCTION OF, PERTINENT BOOKS, RECORDS, DOCUMENTS AND PAPERS BY PERSONS WHOM THEY BELIEVE TO HAVE INFORMATION RELEVANT TO ANY MATTER PENDING BEFORE THE EXAMINER. SCH EXAMINER SHALL ALSO HAVE THE POWER TO ADMINISTER OATHS.

(D) A COMPLAINT AGAINST A LICENSED PRACTITIONER MUST BE FILED WITH THE APPROPRIATE BOARD WITHIN TEN YEARS OF THE BOARD'S RECEIPT OF NOTICE OF THE EVENTS UNDERLYING THE COMPLAINT.

(E) LATCHES SHALL NOT BAR A HEARING UNDER THIS SECTION.

SECTION 10. THE ACT IS AMENDED BY ADDING A SECTION TO READ:

SECTION 902.1. CONFIDENTIALITY OF RECORDS OF STATE BOARD OF MEDICINE OR STATE BOARD OF OSTEOPATHIC MEDICINE.--(A) THIS SECTION SHALL APPLY ONLY TO REPORTS, COMMUNICATIONS, RECORDS, PAPERS AND OTHER OBJECTS IN THE CUSTODY OF THE STATE BOARD OF MEDICINE OR STATE BOARD OF OSTEOPATHIC MEDICINE AND TO PERSONS EMPLOYED BY OR ACTING IN THEIR OFFICIAL CAPACITY ON BEHALF OF OR FOR THE STATE BOARD OF MEDICINE OR STATE BOARD OF OSTEOPATHIC MEDICINE.

(B) ALL REPORTS, COMMUNICATIONS, RECORDS, PAPERS AND OTHER OBJECTS DISCLOSING THE INSTITUTION, PROGRESS OR RESULT OF AN INVESTIGATION UNDERTAKEN BY THE STATE BOARD OF MEDICINE OR STATE BOARD OF OSTEOPATHIC MEDICINE OR CONCERNING A COMPLAINT FILED WITH THE STATE BOARD OF MEDICINE OR STATE BOARD OF OSTEOPATHIC MEDICINE SHALL BE CONFIDENTIAL AND PRIVILEGED, SHALL NOT BE SUBJECT TO SUBPOENA OR DISCOVERY AND SHALL NOT BE INTRODUCED INTO EVIDENCE IN ANY JUDICIAL OR ADMINISTRATIVE PROCEEDING. NO PERSON WHO HAS INVESTIGATED OR HAS ACCESS TO OR CUSTODY OF A REPORT, COMMUNICATION, RECORD, PAPER OR OTHER OBJECT WHICH IS CONFIDENTIAL AND PRIVILEGED UNDER THIS SUBSECTION SHALL BE REQUIRED TO TESTIFY IN ANY JUDICIAL OR ADMINISTRATIVE PROCEEDING WITHOUT THE WRITTEN CONSENT OF THE STATE BOARD OF MEDICINE OR STATE BOARD OF OSTEOPATHIC MEDICINE. THIS SECTION SHALL NOT PRECLUDE OR LIMIT INTRODUCTION OF THE CONTENTS OF AN INVESTIGATIVE FILE OR RELATED WITNESS TESTIMONY IN A HEARING OR PROCEEDING HELD BEFORE THE STATE BOARD OF MEDICINE OR STATE

BOARD OF OSTEOPATHIC MEDICINE.

(C) ALL REPORTS, COMMUNICATIONS, RECORDS, PAPERS AND OTHER OBJECTS DISCLOSING A PERSON'S ADMISSION, PARTICIPATION, PROGRESS OR COMPLETION OF ANY IMPAIRED PROFESSIONAL PROGRAM APPROVED BY THE STATE BOARD OF MEDICINE OR STATE BOARD OF OSTEOPATHIC MEDICINE SHALL BE CONFIDENTIAL AND PRIVILEGED, SHALL NOT BE SUBJECT TO SUBPOENA OR DISCOVERY AND SHALL NOT BE INTRODUCED INTO EVIDENCE IN ANY JUDICIAL OR ADMINISTRATIVE PROCEEDING. NO PERSON WHO HAS PREPARED OR WHO HAS ACCESS TO OR CUSTODY OF A REPORT, COMMUNICATION, RECORD, PAPER OR OTHER OBJECT WHICH IS CONFIDENTIAL AND PRIVILEGED UNDER THIS SUBSECTION SHALL BE PERMITTED OR REQUIRED TO TESTIFY IN ANY JUDICIAL OR ADMINISTRATIVE PROCEEDING. THIS SECTION SHALL NOT PRECLUDE OR LIMIT THE AVAILABILITY OR INTRODUCTION OF IMPAIRED PROFESSIONAL PROGRAM RECORDS OR RELATED WITNESS TESTIMONY IN A PROCEEDING BEFORE THE STATE BOARD OF MEDICINE OR STATE BOARD OF OSTEOPATHIC MEDICINE FOR ALLEGED VIOLATIONS OF AN IMPAIRED PROFESSIONAL PROGRAM AGREEMENT.

(D) EXCEPT AS PROVIDED IN SUBSECTIONS (B) AND (C), THIS SECTION SHALL NOT PREVENT DISCLOSURE OF ANY REPORT, COMMUNICATION, RECORD, PAPER OR OTHER OBJECT PERTAINING TO THE STATUS OF A LICENSE, PERMIT OR CERTIFICATE ISSUED OR PREPARED BY THE STATE BOARD OF MEDICINE OR STATE BOARD OF OSTEOPATHIC MEDICINE OR RELATING TO A PUBLIC DISCIPLINARY PROCEEDING OR HEARING.

SECTION 11. SECTION 905 OF THE ACT IS AMENDED TO READ:

SECTION 905. REVIEW BY STATE LICENSING BOARDS.--(A) IF APPLICATION FOR REVIEW IS MADE TO THE STATE BOARD OF [MEDICAL EDUCATION AND LICENSURE] MEDICINE, THE STATE BOARD OF OSTEOPATHIC [EXAMINERS] MEDICINE OR THE STATE BOARD OF PODIATRY

[EXAMINERS] WITHIN 20 DAYS FROM THE DATE OF ANY DECISION MADE AS A RESULT OF A HEARING HELD BY A HEARING EXAMINER, THE STATE BOARD OF [MEDICAL EDUCATION AND LICENSURE] MEDICINE, THE STATE BOARD OF OSTEOPATHIC [EXAMINERS] MEDICINE OR THE STATE BOARD OF PODIATRY [EXAMINERS] SHALL REVIEW THE EVIDENCE, AND IF DEEMED ADVISABLE BY THE BOARD, HEAR ARGUMENT AND ADDITIONAL EVIDENCE. IF THE APPROPRIATE BOARD DETERMINES THAT A LICENSEE HAS PRACTICED NEGLIGENTLY, THE BOARD MAY IMPOSE DISCIPLINARY OR CORRECTIVE MEASURES.

(B) AS SOON AS PRACTICABLE, THE STATE BOARD OF [MEDICAL EDUCATION AND LICENSURE] MEDICINE, THE STATE BOARD OF OSTEOPATHIC [EXAMINERS] MEDICINE OR THE STATE BOARD OF PODIATRY [EXAMINERS] SHALL MAKE A DECISION AND SHALL FILE THE SAME WITH ITS FINDING OF THE FACTS ON WHICH IT IS BASED AND SEND A COPY THEREOF TO EACH OF THE PARTIES IN DISPUTE.

SECTION 12. THE ACT IS AMENDED BY ADDING SECTIONS TO READ:

SECTION 908. CONTINUING MEDICAL EDUCATION.--(A) IN ACCORDANCE WITH SECTION 901, THE STATE BOARD OF MEDICINE SHALL ADOPT, PROMULGATE AND ENFORCE RULES AND REGULATIONS ESTABLISHING A PROGRAM OF CONTINUING MEDICAL EDUCATION AND SHALL ESTABLISH THE NUMBER OF REQUIRED HOURS. IN SO DOING, THE BOARD MAY, AMONG OTHER THINGS, DO THE FOLLOWING:

(1) REVIEW AND USE GUIDELINES AND PRONOUNCEMENTS REGARDING PROFESSIONAL CONTINUING EDUCATION OF RECOGNIZED EDUCATIONAL AND PROFESSIONAL ORGANIZATIONS.

(2) PRESCRIBE EDUCATIONAL COURSE CONTENT, ORGANIZATION AND DURATION.

(3) TAKE INTO ACCOUNT THE ACCESSIBILITY OF CONTINUING EDUCATION COURSE SITES.

(4) WAIVE THE REQUIREMENT IN THE FOLLOWING INSTANCES:

(I) WHEN THE REQUIREMENT CREATES INDIVIDUAL HARDSHIP, IF THE BOARD FINDS THAT GOOD CAUSE IS SHOWN AND THAT PUBLIC SAFETY AND WELFARE ARE NOT JEOPARDIZED BY THE WAIVER.

(II) WHEN THE LICENSEE IS RETIRED FROM ACTIVE PRACTICE.

(B) EXCEPT AS PROVIDED IN SUBSECTION (A)(4), EACH PERSON LICENSED TO PRACTICE MEDICINE AND SURGERY WITHOUT RESTRICTION MUST FULFILL CONTINUING MEDICAL EDUCATION REQUIREMENTS DURING THE TWO-YEAR PERIOD IMMEDIATELY PRECEDING A BIENNIAL DATE FOR REREGISTERING WITH THE BOARD.

SECTION 909. MANDATORY REFERRAL FOR CLAIMS HISTORY.--(A) IF A HEALTH CARE PROVIDER SHALL HAVE THREE OR MORE JUDGMENTS ENTERED AGAINST IT OR BE PARTY TO A SETTLEMENT INVOLVING CONTRIBUTION BY THE FUND WITHIN ANY TWO-YEAR PERIOD, THE PROVIDER SHALL BE REFERRED TO THE PROFESSIONAL LICENSURE BOARD FOR INVESTIGATION.

SECTION 13. THE ACT IS AMENDED BY ADDING AN ARTICLE TO READ:

ARTICLE IX-A

PATIENT SAFETY

SECTION 901-A. SCOPE.

THIS ARTICLE RELATES TO PATIENT SAFETY.

SECTION 902-A. DEFINITIONS.

THE FOLLOWING WORDS AND PHRASES WHEN USED IN THIS ARTICLE SHALL HAVE THE MEANINGS GIVEN TO THEM IN THIS SECTION UNLESS THE CONTEXT CLEARLY INDICATES OTHERWISE:

"AMBULATORY SURGICAL FACILITY." AN ENTITY DEFINED AS AN AMBULATORY SURGICAL FACILITY UNDER THE ACT OF JULY 19, 1979 (P.L.130, NO.48), KNOWN AS THE HEALTH CARE FACILITIES ACT.

"AUTHORITY." THE PATIENT SAFETY AUTHORITY ESTABLISHED IN SECTION 903-A.

"BIRTH CENTER." AN ENTITY DEFINED AS A BIRTH CENTER UNDER

THE ACT OF JULY 19, 1979 (P.L.130, NO.48), KNOWN AS THE HEALTH CARE FACILITIES ACT.

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

"FUND." THE PATIENT SAFETY TRUST FUND ESTABLISHED IN SECTION 905-A.

"HEALTH CARE WORKER." AN EMPLOYEE, INDEPENDENT CONTRACTOR, LICENSEE OR OTHER INDIVIDUAL AUTHORIZED TO PROVIDE SERVICES IN A MEDICAL FACILITY.

"HOSPITAL." AN ENTITY DEFINED AS A HOSPITAL UNDER THE ACT OF JULY 19, 1979 (P.L.130, NO.48), KNOWN AS THE HEALTH CARE FACILITIES ACT.

"INCIDENT." AN UNDESIRABLE OR UNINTENDED EVENT, OCCURRENCE OR SITUATION INVOLVING THE CLINICAL CARE OF A PATIENT IN A MEDICAL FACILITY WHICH COULD HAVE INJURED THE PATIENT BUT DID NOT EITHER CAUSE AN INJURY OR REQUIRE THE DELIVERY OF ADDITIONAL HEALTH CARE SERVICES TO THE PATIENT. THE TERM DOES NOT INCLUDE A SERIOUS EVENT.

"LICENSEE." AN INDIVIDUAL WHO IS ALL OF THE FOLLOWING:

(1) LICENSED OR CERTIFIED BY THE DEPARTMENT OF STATE TO PROVIDE PROFESSIONAL SERVICES IN THIS COMMONWEALTH.

(2) EMPLOYED BY OR AUTHORIZED TO PROVIDE PROFESSIONAL SERVICES IN A MEDICAL FACILITY.

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

"PATIENT SAFETY OFFICER." AN INDIVIDUAL DESIGNATED BY A MEDICAL FACILITY UNDER SECTION 909-A.

"SERIOUS EVENT." AN EVENT, OCCURRENCE OR SITUATION IN A MEDICAL FACILITY THAT COMPROMISES PATIENT SAFETY AND RESULTS IN AN UNDESIRABLE INJURY REQUIRING THE DELIVERY OF ADDITIONAL HEALTH CARE SERVICES TO A PATIENT. THE TERM DOES NOT INCLUDE AN

INCIDENT.

SECTION 903-A. ESTABLISHMENT OF AUTHORITY.

(A) ESTABLISHMENT.--THERE IS HEREBY ESTABLISHED A BODY CORPORATE AND POLITIC TO BE KNOWN AS THE PATIENT SAFETY AUTHORITY. THE POWERS AND DUTIES OF THE AUTHORITY SHALL BE VESTED IN AND EXERCISED BY A BOARD OF DIRECTORS.

(B) COMPOSITION.--THE BOARD OF THE AUTHORITY SHALL CONSIST OF 11 MEMBERS, COMPOSED AND APPOINTED IN ACCORDANCE WITH THE FOLLOWING:

(1) THE PHYSICIAN GENERAL.

(2) FOUR RESIDENTS OF THIS COMMONWEALTH, ONE OF WHOM SHALL BE APPOINTED BY THE PRESIDENT PRO TEMPORE OF THE SENATE, ONE OF WHOM SHALL BE APPOINTED BY THE MINORITY LEADER OF THE SENATE, ONE OF WHOM SHALL BE APPOINTED BY THE SPEAKER OF THE HOUSE OF REPRESENTATIVES AND ONE OF WHOM SHALL BE APPOINTED BY THE MINORITY LEADER OF THE HOUSE OF REPRESENTATIVES, WHO SHALL SERVE TERMS COTERMINOUS WITH THEIR RESPECTIVE APPOINTING AUTHORITIES.

(3) A HEALTH CARE WORKER RESIDING IN THIS COMMONWEALTH WHO IS A PHYSICIAN AND IS APPOINTED BY THE GOVERNOR, WHO SHALL SERVE AN INITIAL TERM OF THREE YEARS.

(4) A HEALTH CARE WORKER RESIDING IN THIS COMMONWEALTH WHO IS LICENSED BY THE DEPARTMENT OF STATE AS A NURSE AND IS APPOINTED BY THE GOVERNOR, WHO SHALL SERVE AN INITIAL TERM OF THREE YEARS.

(5) A HEALTH CARE WORKER RESIDING IN THIS COMMONWEALTH WHO IS LICENSED BY THE DEPARTMENT OF STATE AS A PHARMACIST AND IS APPOINTED BY THE GOVERNOR, WHO SHALL SERVE AN INITIAL TERM OF TWO YEARS.

(6) A HEALTH CARE WORKER RESIDING IN THIS COMMONWEALTH

WHO IS EMPLOYED BY A HOSPITAL AND IS APPOINTED BY THE GOVERNOR, WHO SHALL SERVE AN INITIAL TERM OF TWO YEARS.

(7) TWO RESIDENTS OF THIS COMMONWEALTH WHO ARE NOT HEALTH CARE WORKERS AND ARE APPOINTED BY THE GOVERNOR, WHO SHALL SERVE A TERM OF FOUR YEARS.

(C) TERMS.--WITH THE EXCEPTION OF PARAGRAPHS (1) AND (2), MEMBERS OF THE BOARD SHALL SERVE FOR TERMS OF FOUR YEARS AFTER THE INITIAL TERMS DESIGNATED IN SUBSECTION (B). NO APPOINTED MEMBER SHALL BE ELIGIBLE TO SERVE MORE THAN TWO FULL CONSECUTIVE TERMS.

(D) QUORUM.--A MAJORITY OF THE MEMBERS OF THE BOARD SHALL CONSTITUTE A QUORUM. NOTWITHSTANDING ANY OTHER PROVISION OF LAW, ACTION MAY BE TAKEN BY THE BOARD AT A MEETING UPON A VOTE OF THE MAJORITY OF ITS MEMBERS PRESENT IN PERSON OR THROUGH THE USE OF AMPLIFIED TELEPHONIC EQUIPMENT IF AUTHORIZED BY THE BYLAWS OF THE BOARD. THE BOARD SHALL MEET AT THE CALL OF THE CHAIRPERSON OR AS MAY BE PROVIDED IN THE BYLAWS OF THE BOARD. THE BOARD SHALL MEET AT LEAST QUARTERLY. MEETINGS OF THE BOARD MAY BE HELD ANYWHERE WITHIN THIS COMMONWEALTH. THE PHYSICIAN GENERAL SHALL BE THE CHAIRPERSON.

SECTION 904-A. POWERS AND DUTIES.

(A) GENERAL RULE.--THE AUTHORITY SHALL DO ALL OF THE FOLLOWING:

(1) ADOPT BYLAWS NECESSARY TO CARRY OUT THE PROVISIONS OF THIS ACT.

(2) EMPLOY STAFF AS NECESSARY TO IMPLEMENT THIS ACT.

(3) MAKE, EXECUTE AND DELIVER CONTRACTS AND OTHER INSTRUMENTS.

(4) APPLY FOR, SOLICIT, RECEIVE, ESTABLISH PRIORITIES FOR, ALLOCATE, DISBURSE, CONTRACT FOR, ADMINISTER AND SPEND

FUNDS IN THE FUND AND OTHER FUNDS THAT ARE MADE AVAILABLE TO THE AUTHORITY FROM ANY SOURCE CONSISTENT WITH THE PURPOSES OF THIS ACT.

(5) CONTRACT WITH AN EXPERIENCED FOR-PROFIT OR NONPROFIT ENTITY OR ENTITIES, OTHER THAN A HEALTH CARE PROVIDER, TO DO ALL OF THE FOLLOWING:

(I) COLLECT, ANALYZE AND EVALUATE DATA REGARDING REPORTS OF SERIOUS EVENTS AND INCIDENTS, INCLUDING THE IDENTIFICATION OF A PATTERN IN FREQUENCY OR SEVERITY AT CERTAIN MEDICAL FACILITIES OR IN CERTAIN REGIONS OF THIS COMMONWEALTH.

(II) TRANSMIT TO THE AUTHORITY RECOMMENDATIONS FOR CHANGES IN HEALTH CARE PRACTICES AND PROCEDURES, WHICH MAY BE INSTITUTED FOR THE PURPOSE OF REDUCING THE NUMBER AND SEVERITY OF SERIOUS EVENTS AND INCIDENTS.

(III) DIRECTLY ADVISE REPORTING MEDICAL FACILITIES OF IMMEDIATE CHANGES THAT CAN BE INSTITUTED TO REDUCE SERIOUS EVENTS AND INCIDENTS.

(6) RECEIVE AND EVALUATE RECOMMENDATIONS MADE BY THE ENTITY OR ENTITIES CONTRACTED WITH IN ACCORDANCE WITH PARAGRAPH (5) AND REPORT THOSE RECOMMENDATIONS TO THE DEPARTMENT, WHICH SHALL HAVE NO MORE THAN 30 DAYS TO REVIEW THE RECOMMENDATIONS.

(7) AFTER CONSULTATION AND APPROVAL BY THE DEPARTMENT, ISSUE RECOMMENDATIONS TO MEDICAL FACILITIES ON A FACILITY-SPECIFIC AND STATEWIDE BASIS REGARDING CHANGES, TRENDS AND IMPROVEMENTS IN HEALTH CARE PRACTICES AND PROCEDURES FOR THE PURPOSE OF REDUCING THE NUMBER AND SEVERITY OF SERIOUS EVENTS AND INCIDENTS. SUCH RECOMMENDATIONS SHALL BE ISSUED TO MEDICAL FACILITIES AND THE DEPARTMENT ON A CONTINUING BASIS

AND SHALL BE PUBLISHED AND POSTED ON THE DEPARTMENT'S AND THE AUTHORITY'S PUBLICLY ACCESSIBLE WORLD WIDE WEB SITES.

(8) MEET AT LEAST QUARTERLY WITH THE DEPARTMENT FOR PURPOSES OF IMPLEMENTING THIS ARTICLE.

(B) ANONYMOUS REPORTS TO THE AUTHORITY.--A HEALTH CARE WORKER WHO HAS COMPLIED WITH SECTION 908-A(A) MAY FILE AN ANONYMOUS REPORT REGARDING A SERIOUS EVENT WITH THE AUTHORITY. THE AUTHORITY SHALL RECEIVE AND INVESTIGATE THE REPORT AFTER NOTICE TO THE AFFECTED MEDICAL FACILITY. THE AUTHORITY SHALL CONDUCT ITS OWN REVIEW, 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 CITE A MEDICAL FACILITY AND ANY INVOLVED LICENSEE FOR FAILURE TO REPORT PURSUANT TO SECTION 913-A(C) AND (D).

(C) ANNUAL REPORT TO GENERAL ASSEMBLY.--

(1) THE AUTHORITY SHALL REPORT NO LATER THAN MAY 1, 2003, AND ANNUALLY THEREAFTER TO THE DEPARTMENT AND THE GENERAL ASSEMBLY ON THE AUTHORITY'S ACTIVITIES IN THE PRECEDING YEAR. THE REPORT SHALL INCLUDE, BUT NOT BE LIMITED TO:

(I) A SCHEDULE OF THE YEAR'S MEETINGS.

(II) A LIST OF CONTRACTS ENTERED INTO PURSUANT TO THIS SECTION, INCLUDING THE AMOUNTS AWARDED TO EACH CONTRACTOR.

(III) A SUMMARY OF THE FUND RECEIPTS AND

EXPENDITURES, INCLUDING A FINANCIAL STATEMENT AND BALANCE SHEET.

(IV) THE NUMBER OF SERIOUS EVENTS AND INCIDENTS REPORTED BY MEDICAL FACILITIES ON A GEOGRAPHICAL BASIS.

(V) THE INFORMATION DERIVED FROM THE DATA COLLECTED INCLUDING ANY RECOGNIZED TRENDS CONCERNING PATIENT SAFETY.

(VI) RECOMMENDATIONS FOR STATUTORY OR REGULATORY CHANGES WHICH MAY HELP IMPROVE PATIENT SAFETY IN THE COMMONWEALTH.

(2) THE ANNUAL REPORT SHALL ALSO BE DISTRIBUTED TO THE SECRETARY OF HEALTH, THE CHAIR AND MINORITY CHAIR OF THE PUBLIC HEALTH AND WELFARE COMMITTEE OF THE SENATE AND THE CHAIR AND MINORITY CHAIR OF THE HEALTH AND HUMAN SERVICES COMMITTEE OF THE HOUSE OF REPRESENTATIVES.

(3) THE ANNUAL REPORT SHALL BE MADE AVAILABLE FOR PUBLIC INSPECTION AND SHALL BE POSTED ON THE DEPARTMENT'S PUBLICLY ACCESSIBLE WORLD WIDE WEB SITE.

SECTION 905-A. PATIENT SAFETY TRUST FUND.

(A) ESTABLISHMENT.--THERE IS HEREBY ESTABLISHED A SEPARATE ACCOUNT IN THE STATE TREASURY TO BE KNOWN AS THE PATIENT SAFETY TRUST FUND. THE FUND SHALL BE ADMINISTERED BY THE AUTHORITY. ALL INTEREST EARNED FROM THE INVESTMENT OR DEPOSIT OF MONEYS ACCUMULATED IN THE FUND SHALL BE DEPOSITED IN THE FUND FOR THE SAME USE.

(B) FUNDS.--ALL MONEYS DEPOSITED INTO THE FUND SHALL BE HELD IN TRUST AND SHALL NOT BE CONSIDERED GENERAL REVENUE OF THE COMMONWEALTH BUT SHALL BE USED ONLY TO EFFECTUATE THE PURPOSES OF THIS ARTICLE AS DETERMINED BY THE AUTHORITY.

(C) 2002 ASSESSMENT.--PRIOR TO THE FIRST DAY OF JUNE 2002,

EACH MEDICAL FACILITY SHALL PAY THE DEPARTMENT A SURCHARGE ON ITS LICENSING FEE AS NECESSARY TO PROVIDE SUFFICIENT REVENUES TO OPERATE THE AUTHORITY. THE ASSESSMENT SHALL NOT EXCEED A TOTAL OF $5,000,000. THE DEPARTMENT SHALL TRANSFER THE TOTAL SURCHARGE AMOUNT TO THE FUND.

(D) BASE AMOUNT.--FOR EACH SUCCEEDING CALENDAR YEAR, THE DEPARTMENT SHALL DETERMINE AND ASSESS EACH MEDICAL FACILITY ITS PROPORTIONATE SHARE OF THE AUTHORITY'S BUDGET. THE AMOUNT SHALL BE CAPPED AT $5,000,000 IN 2002 AND INCREASED ACCORDING TO THE CONSUMER PRICE INDEX IN EACH SUCCEEDING YEAR.

(E) EXPENDITURES.--MONEYS IN THE FUND MAY BE EXPENDED BY THE AUTHORITY TO IMPLEMENT THIS ARTICLE.

(F) DISSOLUTION.--IN THE EVENT THAT THE FUND IS DISCONTINUED OR THE AUTHORITY IS DISSOLVED BY OPERATION OF LAW, ANY BALANCE REMAINING IN THE FUND, AFTER DEDUCTING ADMINISTRATIVE COSTS OF LIQUIDATION, SHALL BE RETURNED TO THE MEDICAL FACILITIES IN PROPORTION TO THEIR FINANCIAL CONTRIBUTIONS TO THE FUND IN THE PRECEDING CALENDAR YEAR.

(G) FAILURE TO PAY ASSESSMENT.--IF AFTER 30 DAYS' NOTICE A MEDICAL FACILITY FAILS TO PAY AN ASSESSMENT LEVIED BY THE DEPARTMENT UNDER THIS ARTICLE, THE DEPARTMENT MAY ASSESS AN ADMINISTRATIVE PENALTY OF $1,000 PER DAY UNTIL THE ASSESSMENT IS PAID.

SECTION 906-A. DEPARTMENT RESPONSIBILITIES.

(A) GENERAL RULE.--THE DEPARTMENT SHALL DO ALL OF THE FOLLOWING:

(1) REVIEW AND APPROVE PATIENT SAFETY PLANS IN ACCORDANCE WITH SECTION 907-A.

(2) RECEIVE REPORTS OF SERIOUS EVENTS UNDER SECTIONS 904-A AND 913-A.

(3) INVESTIGATE SERIOUS EVENTS.

(4) IN CONJUNCTION WITH THE AUTHORITY, ANALYZE AND EVALUATE EXISTING HEALTH CARE PROCEDURES AND APPROVE RECOMMENDATIONS ISSUED BY THE AUTHORITY PURSUANT TO SECTION 904-A(A)(6) AND (7).

(5) MEET AT LEAST QUARTERLY WITH THE AUTHORITY TO RECEIVE ITS RECOMMENDATIONS TO IMPROVE PATIENT SAFETY.

(B) DEPARTMENT CONSIDERATION.--THE RECOMMENDATIONS MADE TO MEDICAL FACILITIES PURSUANT TO SUBSECTION (A)(4) MAY BE CONSIDERED BY THE DEPARTMENT FOR LICENSURE PURPOSES UNDER THE ACT OF JULY 19, 1979 (P.L.130, NO.48), KNOWN AS THE HEALTH CARE FACILITIES ACT, BUT SHALL NOT BE CONSIDERED MANDATORY UNLESS ADOPTED BY THE DEPARTMENT AS REGULATIONS PURSUANT TO THE ACT OF JUNE 25, 1982 (P.L.633, NO.181), KNOWN AS THE REGULATORY REVIEW ACT.

SECTION 907-A. PATIENT SAFETY PLANS.

(A) DEVELOPMENT.--A MEDICAL FACILITY SHALL DEVELOP AND IMPLEMENT AN INTERNAL PATIENT SAFETY PLAN FOR THE PURPOSE OF IMPROVING THE HEALTH AND SAFETY OF PATIENTS. THE PLAN SHALL BE DEVELOPED IN CONSULTATION WITH THE LICENSEES PROVIDING HEALTH CARE SERVICES IN THE MEDICAL FACILITY.

(B) REQUIREMENTS.--A PATIENT SAFETY PLAN SHALL:

(1) DESIGNATE A PATIENT SAFETY OFFICER AS SET FORTH IN SECTION 909-A.

(2) ESTABLISH A PATIENT SAFETY COMMITTEE AS SET FORTH IN SECTION 910-A.

(3) ESTABLISH A SYSTEM FOR HEALTH CARE WORKERS OF A MEDICAL FACILITY TO REPORT SERIOUS EVENTS AND INCIDENTS WHICH SHALL BE ACCESSIBLE 24 HOURS A DAY, SEVEN DAYS A WEEK.

(4) PROHIBIT ANY RETALIATORY ACTION AGAINST A HEALTH

CARE WORKER FOR REPORTING A SERIOUS EVENT OR INCIDENT IN ACCORDANCE WITH THE ACT OF DECEMBER 12, 1986 (P.L.1559, NO.169), KNOWN AS THE WHISTLEBLOWER LAW.

(C) APPROVAL.--WITHIN 90 DAYS OF THE EFFECTIVE DATE OF THIS SECTION, AND COMMENSURATE WITH ITS LICENSING APPLICATION OR RENEWAL THEREAFTER, A MEDICAL FACILITY SHALL SUBMIT ITS PATIENT SAFETY PLAN TO THE DEPARTMENT FOR APPROVAL CONSISTENT WITH THE REQUIREMENTS OF THIS SECTION. UNLESS THE DEPARTMENT APPROVES OR REJECTS THE PLAN WITHIN 60 DAYS OF RECEIPT, THE PLAN SHALL BE DEEMED APPROVED.

(D) EMPLOYEE NOTIFICATION.--UPON APPROVAL OF THE PATIENT SAFETY PLAN, A MEDICAL FACILITY SHALL NOTIFY ALL HEALTH CARE WORKERS OF THE MEDICAL FACILITY OF THE PATIENT SAFETY PLAN. COMPLIANCE WITH THE PATIENT SAFETY PLAN SHALL BE REQUIRED AS A CONDITION OF EMPLOYMENT OR CREDENTIALING AT THE MEDICAL FACILITY.

SECTION 908-A. HEALTH CARE WORKERS.

(A) REPORTING.--A HEALTH CARE WORKER WHO REASONABLY BELIEVES THAT A SERIOUS EVENT OR INCIDENT HAS OCCURRED SHALL REPORT THE INCIDENT OR SERIOUS EVENT ACCORDING TO THE PATIENT SAFETY PLAN OF THE MEDICAL FACILITY, UNLESS THE HEALTH CARE WORKER KNOWS THAT A REPORT HAS ALREADY BEEN MADE. THE REPORT SHALL BE MADE IMMEDIATELY OR AS SOON THEREAFTER AS REASONABLY PRACTICABLE, BUT IN NO EVENT LATER THAN 24 HOURS AFTER THE OCCURRENCE OF A SERIOUS EVENT OR INCIDENT.

(B) DUTY TO NOTIFY PATIENT.--A LICENSEE RESPONSIBLE FOR THE PATIENT DURING THE OCCURRENCE OF A SERIOUS EVENT IN A MEDICAL FACILITY SHALL PROVIDE WRITTEN NOTIFICATION TO THE AFFECTED PATIENT AND, WITH THE CONSENT OF THE PATIENT, TO AN AVAILABLE FAMILY MEMBER, OF THE SERIOUS EVENT WITHIN SEVEN DAYS OF

OCCURRENCE. FOR UNEMANCIPATED PATIENTS WHO ARE UNDER 18 YEARS OF AGE, THE PARENT OR GUARDIAN SHALL BE NOTIFIED IN ACCORDANCE WITH THIS SUBSECTION.

(C) LIABILITY.--A HEALTH CARE WORKER WHO REPORTS THE OCCURRENCE OF A SERIOUS EVENT OR INCIDENT IN ACCORDANCE WITH SUBSECTION (A) OR (B) SHALL NOT BE SUBJECT TO ANY RETALIATORY ACTION FOR REPORTING THE SERIOUS EVENT OR INCIDENT, AS SET FORTH IN THE ACT OF DECEMBER 12, 1986 (P.L.1559, NO.169), KNOWN AS THE WHISTLEBLOWER LAW.

(D) LIMITATION.--NOTHING IN THIS SECTION SHALL LIMIT A MEDICAL FACILITY'S ABILITY TO TAKE APPROPRIATE DISCIPLINARY ACTION AGAINST A HEALTH CARE WORKER FOR FAILURE TO MEET DEFINED PERFORMANCE EXPECTATIONS OR TO TAKE CORRECTIVE ACTION AGAINST A LICENSEE FOR UNPROFESSIONAL CONDUCT, INCLUDING MAKING FALSE REPORTS OR FAILING TO REPORT SERIOUS EVENTS UNDER THIS ARTICLE.

SECTION 909-A. PATIENT SAFETY OFFICER.

A PATIENT SAFETY OFFICER OF A MEDICAL FACILITY SHALL DO ALL OF THE FOLLOWING:

(1) SERVE ON THE PATIENT SAFETY COMMITTEE.

(2) ENSURE THE INVESTIGATION OF ALL REPORTS OF SERIOUS EVENTS AND INCIDENTS.

(3) TAKE SUCH ACTION AS IS IMMEDIATELY NECESSARY TO ENSURE PATIENT SAFETY AS A RESULT OF THE INVESTIGATION.

(4) REPORT TO THE PATIENT SAFETY COMMITTEE REGARDING ANY ACTION TAKEN TO PROMOTE PATIENT SAFETY AS A RESULT OF INVESTIGATIONS COMMENCED PURSUANT TO THIS SECTION.

SECTION 910-A. PATIENT SAFETY COMMITTEE.

(A) COMPOSITION.--

(1) A HOSPITAL'S PATIENT SAFETY COMMITTEE SHALL BE COMPOSED OF THE MEDICAL FACILITY'S PATIENT SAFETY OFFICER,

AND AT LEAST THREE HEALTH CARE WORKERS OF THE MEDICAL FACILITY AND TWO RESIDENTS OF THE COMMUNITY SERVED BY THE MEDICAL FACILITY WHO ARE NOT AGENTS, EMPLOYEES OR CONTRACTORS OF THE MEDICAL FACILITY. NO MORE THAN ONE MEMBER OF THE PATIENT SAFETY COMMITTEE SHALL BE A MEMBER OF THE MEDICAL FACILITY'S BOARD OF TRUSTEES. THE COMMITTEE SHALL INCLUDE MEMBERS OF THE MEDICAL FACILITY'S MEDICAL AND NURSING STAFF.

(2) AN AMBULATORY SURGICAL FACILITY'S OR BIRTH CENTER'S PATIENT SAFETY COMMITTEE SHALL BE COMPOSED OF THE MEDICAL FACILITY'S PATIENT SAFETY OFFICER, AND AT LEAST TWO HEALTH CARE WORKERS OF THE MEDICAL FACILITY AND ONE RESIDENT OF THE COMMUNITY SERVED BY THE AMBULATORY SURGICAL FACILITY OR BIRTH CENTER WHO IS NOT AN AGENT, EMPLOYEE OR CONTRACTOR OF THE AMBULATORY SURGICAL FACILITY OR BIRTH CENTER. NO MORE THAN ONE MEMBER OF THE PATIENT SAFETY COMMITTEE SHALL BE A MEMBER OF THE MEDICAL FACILITY'S BOARD OF GOVERNANCE. THE COMMITTEE SHALL INCLUDE MEMBERS OF THE MEDICAL FACILITY'S MEDICAL AND NURSING STAFF.

(C) RESPONSIBILITIES.--A PATIENT SAFETY COMMITTEE OF A MEDICAL FACILITY SHALL DO ALL OF THE FOLLOWING:

(1) MEET AT LEAST MONTHLY.

(2) RECEIVE REPORTS FROM THE PATIENT SAFETY OFFICER.

(3) EVALUATE INVESTIGATIONS AND ACTIONS OF THE PATIENT SAFETY OFFICER ON ALL REPORTS.

(4) REVIEW AND EVALUATE THE QUALITY OF SERVICES PROVIDED BY THE MEDICAL FACILITY. A REVIEW SHALL INCLUDE DISCUSSIONS OF REPORTS MADE UNDER SECTION 908-A AND ANALYSES OF HEALTH CARE PROCEDURES AND PRACTICES.

(5) MAKE RECOMMENDATIONS TO IMPROVE THE QUALITY OF SERVICES PROVIDED BY THE MEDICAL FACILITY, INCLUDING

RECOMMENDATIONS TO ELIMINATE FUTURE SERIOUS EVENTS AND INCIDENTS.

(6) REPORT TO THE ADMINISTRATIVE OFFICER AND GOVERNING BODY OF THE MEDICAL FACILITY ON A QUARTERLY BASIS THE NUMBER OF SERIOUS EVENTS AND INCIDENTS AND THE ACTIONS TAKEN BY THE MEDICAL FACILITY TO ADDRESS THE PATIENT SAFETY ISSUES INVOLVED AND ITS RECOMMENDATIONS TO IMPROVE THE QUALITY OF SERVICES PROVIDED BY THE MEDICAL FACILITY.

SECTION 911-A. PEER REVIEW.

(A) ALL REPORTS, DATA, LOGS, INFORMATION, DOCUMENTS, FINDINGS, COMPILATIONS, SUMMARIES, TESTIMONY AND OTHER RECORDS GENERATED, ACQUIRED OR OBTAINED BY A PATIENT, SAFETY OFFICER, ADMINISTRATIVE OFFICER, GOVERNING BODY OF A MEDICAL FACILITY, PATIENT SAFETY AUTHORITY, PATIENT SAFETY COMMITTEE OR THE DEPARTMENT IN ACCORDANCE WITH THIS ARTICLE SHALL BE RECORDS WITHIN THE MEANING OF SECTION 4 OF THE ACT OF JULY 20, 1974 (P.L.564, NO.193), KNOWN AS THE PEER REVIEW PROTECTION ACT, AND SHALL BE AFFORDED THE STATUTORY PROTECTIONS GRANTED RECORDS OF A REVIEW ORGANIZATION UNDER THE PEER REVIEW PROTECTION ACT.

(B) ALL INFORMATION COLLECTED UNDER SUBSECTION (A) SHALL NOT BE CONSIDERED ORIGINAL SOURCE DOCUMENTS AS DEFINED IN THE PEER REVIEW PROTECTION ACT.

(C) ALL INFORMATION COLLECTED UNDER SUBSECTION (A) SHALL NOT BE SUBJECT TO REQUESTS UNDER THE ACT OF JUNE 21, 1957 (P.L.390, NO.212), REFERRED TO AS THE RIGHT-TO-KNOW LAW.

SECTION 912-A. PATIENT SAFETY DISCOUNT.

A MEDICAL FACILITY MAY MAKE APPLICATION TO THE INSURANCE DEPARTMENT FOR CERTIFICATION OF ANY PROGRAM THAT IS RECOMMENDED BY THE AUTHORITY THAT RESULTS IN THE REDUCTION OF SERIOUS EVENTS. THE INSURANCE DEPARTMENT, IN CONSULTATION WITH THE

DEPARTMENT OF HEALTH, SHALL DEVELOP THE CRITERIA FOR SUCH CERTIFICATION. UPON RECEIPT OF THE CERTIFICATION BY THE INSURANCE DEPARTMENT, A MEDICAL FACILITY SHALL RECEIVE A DISCOUNT IN THE RATE OR RATES APPLICABLE FOR MANDATED BASIC INSURANCE COVERAGE REQUIRED BY LAW, WITH THE LEVEL OF SUCH DISCOUNT DETERMINED BY THE INSURANCE DEPARTMENT.

SECTION 913-A. MEDICAL FACILITY REPORTS AND NOTIFICATIONS.

(A) SERIOUS EVENT REPORTS.--A MEDICAL FACILITY SHALL REPORT THE OCCURRENCE OF A SERIOUS EVENT TO THE DEPARTMENT IN ACCORDANCE WITH THE ACT OF JULY 19, 1979 (P.L.130, NO.48), KNOWN AS THE HEALTH CARE FACILITIES ACT. A MEDICAL FACILITY SHALL REPORT THE OCCURRENCE OF A SERIOUS EVENT TO THE AUTHORITY WITHIN 24 HOURS OF THE MEDICAL FACILITY'S CONFIRMATION OF THE OCCURRENCE OF THE SERIOUS EVENT. THE REPORT TO 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) NOTIFICATIONS 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 908-A(A) OR (B), THE MEDICAL FACILITY SHALL NOTIFY THE LICENSEE'S LICENSING BOARD OF THE FAILURE TO REPORT.

(D) FAILURE TO REPORT OR NOTIFY.--A MEDICAL FACILITY WHICH FAILS TO REPORT A SERIOUS EVENT OR TO NOTIFY A LICENSURE BOARD IN ACCORDANCE WITH THIS ACT MAY BE SUBJECT TO A CIVIL PENALTY BY

THE DEPARTMENT OF $1,000 PER DAY.

SECTION 914-A. PRESERVATION AND ACCURACY OF MEDICAL RECORDS.

(A) ENTRIES IN PATIENT CHARTS CONCERNING CARE RENDERED SHALL BE MADE CONTEMPORANEOUSLY. EXCEPT AS OTHERWISE PROVIDED FOR IN THIS SECTION, IT SHALL BE UNLAWFUL TO MAKE ADDITIONS OR DELETIONS TO A PATIENT'S CHART.

(B) IT SHALL NOT BE UNLAWFUL FOR A HEALTH CARE PROVIDER TO:

(1) CORRECT INFORMATION ON A PATIENT'S CHART, WHERE INFORMATION HAS BEEN ENTERED ERRONEOUSLY, OR WHERE IT IS NECESSARY TO CLARIFY ENTRIES MADE THEREON, PROVIDED THAT SUCH CORRECTIONS OR ADDITIONS SHALL BE CLEARLY IDENTIFIED AS SUBSEQUENT ENTRIES BY A DATE AND TIME.

(2) TO ADD INFORMATION TO A PATIENT'S CHART WHERE IT WAS NOT AVAILABLE AT THE TIME THE RECORD WAS FIRST CREATED, PROVIDED THAT:

(I) SUCH ADDITIONS SHALL BE CLEARLY DATED AND TIMED AS SUBSEQUENT ENTRIES.

(II) A HEALTH CARE PROVIDER MAY ADD SUPPLEMENTAL INFORMATION WITHIN A REASONABLE TIME.

(C) IT SHALL BE UNLAWFUL FOR A HEALTH CARE PROVIDER TO DESTROY OR DISCARD DIAGNOSTIC SLIDES, SPECIMENS, SURGICAL HARDWARE OR X-RAYS WITHOUT THE WRITTEN CONSENT OF THE PATIENT, PROVIDED THAT RECORDS MAY BE DESTROYED BY ORDER OF COURT OR AFTER SEVEN YEARS HAS PASSED FROM THEIR CREATION.

(D) IN ANY CIVIL ACTION IN WHICH THE PLAINTIFF PROVES BY A PREPONDERANCE OF THE EVIDENCE THAT THERE HAS BEEN ALTERATION OR DESTRUCTION OF MEDICAL RECORDS, THE TRIAL COURT, IN ITS DISCRETION, MAY INSTRUCT THE JURY TO CONSIDER WHETHER SUCH ALTERATION OR DESTRUCTION OCCURRED IN AN ATTEMPT TO ELIMINATE EVIDENCE THAT A HEALTH CARE PROVIDER BREACHED THE STANDARD OF

CARE WITH RESPECT TO THAT PATIENT.

(E) ALTERATION OR DESTRUCTION OF MEDICAL RECORDS, FOR THE PURPOSE OF ELIMINATING INFORMATION THAT WOULD GIVE RISE TO CIVIL LIABILITY ON THE PART OF A HEALTH CARE PROVIDER, SHALL CONSTITUTE A GROUND FOR SUSPENSION BY THE STATE BOARD OF MEDICINE. A HEALTH CARE PROVIDER WHO IS AWARE OF ALTERATION OR DESTRUCTION IN VIOLATION OF THIS SECTION SHALL REPORT ANY PARTY SUSPECTED OF SUCH CONDUCT TO THE STATE BOARD OF MEDICINE.

SECTION 14. THE ACT IS AMENDED BY ADDING A SECTION TO READ:

SECTION 1005.1. BOARD-IMPOSED CIVIL PENALTY.--IN ADDITION TO ANY OTHER CIVIL REMEDY OR CRIMINAL PENALTY PROVIDED FOR IN THIS ACT, THE ACT OF DECEMBER 20, 1985 (P.L.457, NO.112), KNOWN AS THE "MEDICAL PRACTICE ACT OF 1985," OR THE ACT OF OCTOBER 5, 1978 (P.L.1109, NO.261), KNOWN AS THE "OSTEOPATHIC MEDICAL PRACTICE ACT," THE STATE BOARD OF MEDICINE AND THE STATE BOARD OF OSTEOPATHIC MEDICINE, BY A VOTE OF THE MAJORITY OF THE MAXIMUM NUMBER OF THE AUTHORIZED MEMBERSHIP OF EACH BOARD AS PROVIDED BY LAW, OR BY A VOTE OF THE MAJORITY OF THE DULY QUALIFIED AND CONFIRMED MEMBERSHIP OR A MINIMUM OF FIVE MEMBERS, WHICHEVER IS GREATER, MAY LEVY A CIVIL PENALTY OF UP TO $10,000 ON ANY CURRENT LICENSEE WHO VIOLATES ANY PROVISION OF THE "MEDICAL PRACTICE ACT OF 1985" OR THE "OSTEOPATHIC MEDICAL PRACTICE ACT" OR ON ANY PERSON WHO PRACTICES MEDICINE OR OSTEOPATHIC MEDICINE WITHOUT BEING PROPERLY LICENSED TO DO SO UNDER THE "MEDICAL PRACTICE ACT OF 1985" OR THE "OSTEOPATHIC MEDICAL PRACTICE ACT." THE BOARDS SHALL LEVY THIS PENALTY ONLY AFTER AFFORDING THE ACCUSED PARTY THE OPPORTUNITY FOR A HEARING, AS PROVIDED IN 2 PA.C.S. (RELATING TO ADMINISTRATIVE LAW AND PROCEDURE).

SECTION 15. A PERSON WHO IS AN EMPLOYEE OF THE MEDICAL

PROFESSIONAL LIABILITY CATASTROPHE LOSS FUND ON THE EFFECTIVE DATE OF THIS SECTION SHALL BE GIVEN PRIORITY CONSIDERATION FOR EMPLOYMENT TO FILL VACANCIES WITH EXECUTIVE AGENCIES UNDER THE GOVERNOR'S JURISDICTION.

SECTION 16. THE AMENDMENT OF SECTIONS 103 AND 605 AND THE ADDITION OF ARTICLE VII-A OF THE ACT SHALL APPLY TO ANY CLAIM THAT MEETS ALL OF THE FOLLOWING:

(1) THE CLAIM IS ASSERTED AGAINST A HEALTH CARE PROVIDER FOR A BREACH OF CONTRACT OR TORT.

(2) THE BREACH OF CONTRACT OR TORT UPON WHICH THE CLAIM IS ASSERTED OCCURRED BEFORE OR AFTER THE EFFECTIVE DATE OF THIS SECTION.

(3) THE CLAIM IS FILED AFTER THE EFFECTIVE DATE OF THIS SECTION.

SECTION 17. THE PROVISIONS OF THIS ACT ARE SEVERABLE. IF ANY PROVISION OF THIS ACT OR ITS APPLICATION TO ANY PERSON OR CIRCUMSTANCE IS HELD INVALID, THE INVALIDITY SHALL NOT AFFECT OTHER PROVISIONS OR APPLICATIONS OF THIS ACT WHICH CAN BE GIVEN EFFECT WITHOUT THE INVALID PROVISION OR APPLICATION.

SECTION 18. (A) EXCEPT AS PROVIDED IN SUBSECTION (B), THIS ACT SHALL APPLY TO ALL PENDING ACTIONS INITIATED ON OR AFTER THE EFFECTIVE DATE OF THIS SECTION AND IN WHICH A VERDICT HAS NOT BEEN RENDERED ON THE EFFECTIVE DATE OF THIS SECTION.

(B) THE AMENDMENT OF SECTION 902 OF THE ACT SHALL APPLY TO CAUSES OF ACTION AGAINST LICENSED PRACTITIONERS WHICH ARISE ON OR AFTER THE EFFECTIVE DATE OF THIS ACT.

SECTION 19. THIS ACT SHALL TAKE EFFECT IN 60 DAYS.