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THE GENERAL ASSEMBLY OF PENNSYLVANIA

HOUSE BILL

No. 1834 Session of 1987

INTRODUCED BY CHADWICK, MORRIS, BRANDT, LaGROTTA, HECKLER, COY, FLICK, PRESSMANN, NOYE, VAN HORNE, MOWERY, LIVENGOOD, SAURMAN, COLAFELLA, BUSH, WOZNIAK, E. Z. TAYLOR, CAPPABIANCA, HERMAN, MARKOSEK, PITTS, SHOWERS, FARGO, GAMBLE, ROBBINS, RUDY, BLACK, BROUJOS, DeVERTER, MAYERNIK, S. H. SMITH, BATTISTO, BOWSER, LANGTRY, SEVENTY, GODSHALL, STUBAN, GLADECK, BIRMELIN AND CORRIGAN, OCTOBER 13, 1987

REFERRED TO COMMITTEE ON JUDICIARY, OCTOBER 13, 1987

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 disclosure by physicians; further providing for damages, liability and practice and procedure in medical malpractice actions; further providing for professional liability insurance; establishing the Joint Committee on Professional Liability and giving it powers and duties; and making repeals.

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

Section 1. Section 102 of the act of October 15, 1975 (P.L.390, No.111), known as the Health Care Services Malpractice Act, is amended to read:

Section 102. Purpose.--[It is the purpose of this act to make available professional liability insurance at a reasonable

cost, and to establish a system through which a person who has sustained injury or death as a result of tort or breach of contract by a health care provider can obtain a prompt determination and adjudication of his claim and the determination of fair and reasonable compensation.] The General Assembly finds and declares as follows:

(1) There are serious problems with the current system for resolving the claims of individuals who believe themselves to have been injured by the medical negligence of health care providers. Those problems include, but are not limited to, the following:

(i) The cost of resolving those medical negligence claims is rapidly increasing and is becoming an increasingly large and important component of the cost of health care and of the expenses incurred by health care providers.

(ii) The current system further increases costs by inducing health care providers to engage in defensive health care practices, such as the conduct of tests and procedures primarily to produce protection against legal actions.

(iii) The current system unnecessarily increases costs by allowing individuals to receive compensation for expenses for which they have already been, or are entitled to be, compensated.

(iv) These costs are ultimately borne by consumers of health in this Commonwealth, increasing the costs they must pay for health care.

(v) The current system also inefficiently resolves medical negligence claims in that an excessive period of time elapses between the filing of a claim in court and its resolution.

(vi) The imposition of damages for delays in the resolution

of claims, unless imposed as a sanction for dilatory, obdurate or vexatious conduct, is unfair and adversely affects the substantive rights of the individuals against whom they are imposed.

(2) It is necessary to take actions to:

(i) Seek to limit the costs of the present system while increasing its efficiency and equity.

(ii) Make professional liability insurance available to health care providers at a reasonable cost.

Section 2. Section 103 of the act, amended July 15, 1976 (P.L.1028, No.207) and November 6, 1985 (P.L.311, No.78), is amended to read:

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

["Administrator" means the office of Administrator for Arbitration Panels for Health Care.

"Arbitration panel" means Arbitration Panels for Health Care.]

"Claims made" means a policy of professional liability insurance that would limit or restrict the liability of the insurer under the policy to only those claims made or reported during the currency of the policy period and would exclude coverage for claims reported subsequent to the termination even when such claims resulted from occurrences during the currency of the policy period.

"Commissioner" means the Insurance Commissioner of this Commonwealth.

"Committee" means the Joint Committee on Professional Liability established in section 1006.

"Director" means the director of the fund.

"Fund" means the Medical Professional Liability Catastrophe

Loss Fund established in Article VII.

"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.

"Health care provider" means a primary health center or a person, corporation, facility, institution or other entity licensed or approved by the Commonwealth to provide health care or professional medical services as a [physician] medical doctor, an [osteopathic physician or surgeon] osteopath, a certified nurse midwife, a podiatrist, hospital, nursing home[,] or birth center[, and]. The term includes, except as to section 701(a), an officer, employee or agent of [any of them] a health care provider acting in the course and scope of his employment. The term includes a professional corporation, professional association or partnership owned entirely by health care providers.

["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 health care services by a physician or podiatrist: Provided, That prior to the consent having been given, the physician or podiatrist has informed the patient of the nature of the proposed procedure or treatment and of those risks and alternatives to treatment or diagnosis that a reasonable patient would consider material to the decision whether or not to undergo treatment or diagnosis.

No physician or podiatrist shall be liable for a failure to obtain an informed consent in the event of an emergency which prevents consulting the patient. No physician or podiatrist shall be liable for failure to obtain an informed consent if it is established by a preponderance of the evidence that furnishing the information in question to the patient would have resulted in a seriously adverse effect on the patient or on the therapeutic process to the material detriment of the patient's health.]

"Licensure Board" means the State Board of [Medical Education and Licensure] Medicine, the State Board of Osteopathic [Examiners] Medicine, the State Board of Podiatry [Examiners], the Department of Public Welfare and the Department of Health.

"Malpractice insurer" means an insurance company authorized to write professional liability insurance for health care providers in this Commonwealth, health care provider which self-insures professional liability exposure and the Joint Underwriting Association.

"Medical negligence claim" means a 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 caused by a health care provider's provision of, or failure to provide, medical treatment, diagnosis or consultation.

"Medical service" includes, but is not limited to:

(1) the provision of medical treatment, a diagnostic test, medical consultation and any service incident to them; or

(2) a decision, consultation, recommendation or other advice made as part of a formal peer review process regarding the qualifications of a health care provider to provide health care

or the appropriateness of health care by a health care provider, rendered individually or as a member of a group, such as a committee performing peer review as defined in section 2 of the act of July 20, 1974 (P.L.564, No.193), known as the "Peer Review Protection Act."

["Patient" means a natural person who receives or should have received health care from a licensed health care provider.]

"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.

"Professional liability" means liability for damages, attorney fees, expenses and other cost awards in a professional liability action.

"Professional liability action" means an action asserting a professional liability claim.

"Professional liability claim" means a claim arising out of a health care provider's provision of, or failure to provide, a medical service, regardless of the theory of liability or cause of action upon which the claim is premised.

"Professional liability insurance" means insurance against professional 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].

Section 3. Articles II, III, IV, V and VI of the act are repealed.

Section 4. The act is amended by adding articles to read:

ARTICLE II-A

Medical Negligence Claims

Section 201-A. Applicability.--This article applies to medical negligence claims accruing on or after the effective date of this article.

Section 202-A. Informed Consent.--(a) Except in emergencies and in other situations as the court deems appropriate, a physician owes a duty to a patient to obtain the patient's informed consent prior to performing a major invasive procedure on the patient.

(b) Consent is informed if the patient has been apprised of the general nature of the procedure and the risks and alternatives that a reasonable patient would consider material to the decision whether or not to undergo the procedure.

(c) Consent to a procedure may be express or implied and need not be in writing.

(1) The following shall be presumed to be true if contained in a writing signed by the patient:

(i) The patient consented to a specified procedure.

(ii) The patient was apprised of a specified risk or alternative to a specified procedure.

(iii) The patient was apprised of all risks and alternatives to a specified procedure that a reasonable patient would consider material to the decision whether or not to undergo the procedure.

(2) The presumption under paragraph (1) shall only be overcome by clear and convincing evidence.

(d) Nothing in this section shall be construed as imposing a duty on a physician to apprise a patient of information:

(1) the patient knows or should know;

(2) the patient has requested not to be revealed to him; or

(3) which would be detrimental for the patient's health if it were to be known by the patient.

(e) A physician shall not be held to a higher duty to obtain a patient's consent than provided in this section in the absence of a written contract with the patient which expressly imposes the higher duty on the physician.

(f) In the case of a minor, consent to a procedure may be obtained from a parent or guardian; and the information and consent under subsections (b), (c), (d) and (e) apply to the parent or guardian rather than the patient. In the case of an incompetent other than a minor, consent to a procedure may be obtained from the patient's guardian or an immediate family member of the patient, that is, a spouse, parent, adult child or adult sibling; and the information and consent under subsections (b), (c), (d) and (e) apply to the guardian or immediate family member rather than the patient. "Incompetent," as used in this subsection, does not require a judicial determination of incompetency.

Section 203-A. Absence of Warranty.--A health care provider is neither a warrantor nor a guarantor of a cure or an effective treatment to an individual in the absence of a written contract with the individual expressly imposing such a duty on the health care provider.

Section 204-A. Collateral Source.--(a) Public benefits which a claimant has received prior to trial, or which a claimant will receive in the future, as a consequence of the injury which gives rise to the claim at issue shall not be recoverable as an item of damage. These benefits shall be admissible into evidence.

(b) Group benefits that a claimant has received prior to trial, or will receive in the future, from a group medical or disability program paid for by an employer as a consequence of the injury which gives rise to the claim at issue shall not be recoverable as an item of damage. These benefits shall be admissible into evidence.

(c) The existence of provisions for subrogation in a contract applicable to amounts recovered by the plaintiff shall be admissible into evidence.

(d) The partial abrogation of the collateral source in subsections (a) and (b) do not apply to the following:

(1) A financial benefit that a claimant has received or may receive by virtue of a health insurance or disability program for which more than 50% of the premium was paid out-of-pocket by the claimant, a member of the claimant's family residing in the same household or a person obligated by law to provide support to the claimant.

(2) Life insurance, pension or profit-sharing plans or other deferred compensation plans.

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

(e) As used in this section:

"Group benefits" means compensation or benefits for which 50% or more of the cost has been paid by the employer of the claimant, of a member of the claimant's household or of an individual legally responsible for the claimant.

"Public benefits" means compensation or benefits paid,

payable or required by the Federal Government, a state government or a local government and any other public programs providing medical benefits, including, but not limited to, Social Security and workers' compensation.

Section 205-A. Punitive Damages.--(a) Punitive damages may be awarded over and above compensatory damages only where there is a showing, by clear and convincing evidence, that the tort-feasor's conduct was outrageous because:

(1) the tort-feasor acted with an evil motive; or

(2) the tort-feasor knew or had reason to know of facts creating a high degree of risk of physical harm to another person and acted or failed to act in conscious disregard of or indifference to the risk.

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

(c) Punitive damages shall not exceed 200% of the compensatory damages awarded.

Section 206-A. Joint and Several Liability.--If recovery is allowed against more than one defendant, all defendants shall be jointly and severally liable for economic and noneconomic damages; however, if a defendant's responsibility is 10% or less of the total responsibility or if a defendant's responsibility is less than the plaintiff's responsibility, that defendant shall be liable only for that proportion of the total dollar amount awarded as noneconomic damages in the ratio of the amount of that defendant's causal negligence to the amount of causal negligence attributed to all parties to the action. The plaintiff may recover the full amount of the allowed recovery from any defendant against whom the plaintiff is not barred from recovery by this section. Any defendant who is compelled to pay

more than that defendant's percentage share may seek contribution.

Section 207-A. Statute of Limitations.--(a) Except as provided in subsection (b) or (c), an action asserting a medical negligence 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 three 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 three-year limitation in subsection (a) shall not apply.

(c) If the injured individual is a minor under six years of age, the action must be commenced within two 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 three years from the minor's sixth 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.

(f) If the basic coverage insurance carrier receives notice of a complaint filed against a health care provider subject to Article VII more than four years after the breach of duty or other event causing the injury occurred which (complaint) is

filed within the time limits set forth in this section, the action shall be defended and paid by the fund. If the complaint is filed after four years because of the willful concealment by the health care provider or the provider's basic coverage insurance carrier, the fund shall have the right of full indemnity, including defense costs, from the health care provider or the insurance carrier.

Section 208-A. Dilatory or Frivolous Motions, Claims and Defenses.--(a) On a pleading, motion or other paper filed in an action, the signature of an attorney or party constitutes a certification of all of the following:

(1) The attorney or party has read the document that is being signed.

(2) To the best of the attorney's or party's knowledge, information and belief formed after reasonable inquiry, the document is well grounded in fact.

(3) Claims or defenses are warranted by existing law or by a good faith argument for the extension, modification or reversal of existing law. This paragraph applies only to a signature by an attorney.

(4) The document is not being filed for purposes of delay or of needless increase in the cost of the litigation.

(b) If a pleading, motion or other paper filed in an action is not signed, it shall be stricken unless it is signed promptly after the omission is called to the attention of the party.

(c) If a certification under subsection (a) is false, the court, upon motion or upon its own initiative, shall impose upon the person who signed the document or a represented party, or both, an appropriate sanction. A sanction under this subsection may include an order to pay to the other party the amount of the

reasonable expenses incurred because of the filing, including a reasonable attorney fee.

ARTICLE III-A

Pretrial Procedure

Section 301-A. Applicability.--This article applies to medical negligence claims filed on or after the effective date of this article.

Section 302-A. Complaint.--(a) A complaint of a plaintiff represented by an attorney shall be signed by at least one attorney of record in the attorney's individual name. The attorney's address shall be stated. The signature of an attorney constitutes a certificate that the attorney has read the pleading; that the attorney has performed a reasonable investigation of the facts and applicable law; and that, based upon that investigation, there is good ground to support the alleged facts and each cause of action asserted against a defendant.

(b) If a complaint alleges that a defendant deviated from a standard of care, the signature of an attorney further constitutes a certificate that the attorney has a report from a qualified expert which states the standard of care; the expert's opinion that, based upon the information available after reasonable investigation, there is reason to believe the defendant deviated from that standard; and the information upon which the expert bases the opinion. An expert is not qualified unless the expert meets the criteria specified in section 402-A.

Section 303-A. Limitation on Discovery.--Discovery shall be completed within one year after a claim is commenced. Discovery may be extended for an additional period of up to 180 days upon filing of a petition, showing good cause for extension, with the

court within one year after a claim is commenced.

Section 304-A. Expert Reports.--No party shall be permitted to have a witness testify as an expert unless the other parties have been provided with a trial expert report as required by section 302-A(b). A plaintiff shall distribute trial expert reports within three months after commencement of the action. A defendant shall distribute trial expert reports within six months after commencement of the action. The trial expert report shall state the substance of the facts and opinions to which the expert will testify and summarize the grounds for each opinion. A party may be exempted from the requirements of this section upon the filing of a petition showing good cause for the exemption.

Section 305-A. Discovery Conference.--(a) At any time after commencement of the action, the court may direct the attorneys for the parties to appear for a conference on the subject of discovery. The court shall do so upon motion by the attorney for any party if the motion includes all of the following:

(1) A statement of the issues as they then appear.

(2) A proposed plan and schedule of discovery.

(3) Any limitations proposed to be placed on discovery.

(4) Any other proposed orders with respect to discovery.

(5) A statement showing that the attorney making the motion has made a reasonable effort to reach agreement with opposing attorneys on the matters set forth in the motion.

(b) Each party and each attorney are under a duty to participate in good faith in the framing of a discovery plan. Notice of the motion shall be served on all parties. Objections of additions to matters set forth in the motion shall be served not later than ten days after service of the motion.

(c) Following the discovery conference, the court shall enter an order tentatively identifying the issues for discovery purposes, establishing a plan and schedule for discovery; setting limitations on discovery, if any; and determining such other matters, including the allocation of expenses, as are necessary for the proper management of discovery in the action. An order may be altered or amended whenever justice so requires.

(d) Subject to the right of a party who properly moves for a discovery conference to prompt convening of the conference, the court may combine the discovery conference with a pretrial conference required by section 308-A.

Section 306-A. Conciliation Schedule.--(a) Within 90 days after the conclusion of the discovery period set forth in section 303-A, the court shall hold at least one mandatory conciliation conference. The procedure for the conciliation conference shall be set forth in the Pennsylvania Rules of Civil Procedure.

(b) Any party may file a petition requesting that a conciliation conference be held prior to or after the conclusion of the discovery period. The petition shall certify that the parties agree the claim is ready for a conciliation conference and that meaningful settlement discussions would be helpful. The court may schedule a conference in this event.

Section 307-A. Priority.--After the time for discovery under section 303-A and for the mandatory conciliation conference under section 306-A(a) has passed, medical negligence claims shall be given civil calendar priority and handled expeditiously.

Section 308-A. Pretrial Conference.--(a) At least 30 days prior to trial, the court shall direct the attorneys for the

parties to appear before it for a conference to consider:

(1) The simplification of the issues.

(2) The necessity or desirability of amendments to the pleadings.

(3) The possibility of obtaining admissions of fact and of documents which will avoid unnecessary proof.

(4) The limitation of the number of expert witnesses.

(5) Such other matters as may aid in the disposition of the action.

(b) The court shall make an order which recites the action taken at the conference, the amendments allowed to the pleadings and the agreements made by the parties as to any of the matters considered and which limits the issues for trial to those not disposed of by admissions or agreements of counsel. The order controls the subsequent course of the action unless it is modified to prevent manifest injustice. The court, in its discretion, may establish, by rule, a pretrial calendar on which actions may be placed for consideration.

Section 309-A. Affidavit of Noninvolvement.--The court shall dismiss without prejudice a defendant physician who files with the court an affidavit verifying that the physician did not treat the patient, does not employ a person who treated the patient, and did not supervise a person while that person was engaged in the treatment of the patient.

ARTICLE IV-A

Trial Procedure

Section 401-A. Applicability.--This article applies to medical negligence claims filed on or after the effective date of this article.

Section 402-A. Qualifications of Expert Witnesses.--No

person shall be permitted to testify as an expert witness regarding the standard of care unless the person has educational and professional knowledge as a general foundation for testimony, is duly licensed in any state of the United States, has current personal experience and practical familiarity with the medical subject that is being considered and is actively engaged in direct patient care in the practice of the medical subject of the testimony. No person shall be permitted to testify as a medical expert against a defendant board-certified specialist unless that person is board certified.

Section 403-A. Advance Payments.--(a) No advance payment made by the defendant health care provider or his professional liability insurer to or for the plaintiff shall be construed as an admission of liability for injuries or damages suffered by the plaintiff. Evidence of an advance payment shall not be admissible in a proceeding.

(b) A final award in favor of the plaintiff shall be reduced to the extent of an advance payment. The advance payment shall inure to the exclusive benefit of the defendant or the insurer making the payment.

Section 404-A. Delay Damages.--Except as a sanction imposed by the court on a finding of dilatory, obdurate or vexatious conduct, no damages for delay shall be awarded; and no interest shall accrue prior to judgment.

Section 405-A. Reduction of Award to Present Worth.--(a) In an action alleging damages for bodily injury or death, the trier of fact shall reduce all items of damage awarded for future loss of earning capacity to their present worth by application of a simple interest discount factor equal to the average yearly index of five-year United States Government note interest rates.

(b) By January 31, based on available statistics, the Secretary of Banking shall compute the average yearly index of five-year United States Government note interest rates in the following manner:

(1) Make a determination for each calendar year of the five-year base period of the average yearly interest rate payable by the Federal Government in each year on United States Government treasury notes issued in that year with maturities of five years. If, for any year of the five-year base period, no United States Government treasury notes with maturities of five years have been issued, the secretary shall make a determination for each calendar year of the five-year base period of the average yearly interest rate payable by the Federal Government in each year on United States Government treasury notes issued in that year with maturity closest to five years.

(2) Determine the sum of the average yearly interest rates for each year in the five-year base period and divide this sum by five, the number of years in the five-year base period.

(3) Cause the quotient under paragraph (2) to be filed with the Legislative Reference Bureau for publication in the Pennsylvania Bulletin as the average yearly index of five-year United States Government note interest rates. The average yearly index of five-year United States Government note interest rates shall be effective upon publication to the Pennsylvania Bulletin and shall apply to damage awards for future loss of earning capacity entered after publication.

(c) As used in this section, the term "five-year base period" means that period of five calendar years immediately preceding the January in which the secretary is making the calculations of the average yearly index of five-year United

States Government note interest rates.

ARTICLE VI-A

Mandatory Reporting

Section 601-A. Reporting by Malpractice Insurers and the Director of the Fund.--Malpractice insurers shall report to the appropriate State board each health care provider of that board on behalf of whom a settlement, award or judgment has been made or entered on or after the effective date of this article if the malpractice insurer of the fund is liable in an amount in excess of $200,000. Each report shall include the name, address and license, certificate or registration number of the health care provider who is the subject of the report and a summary of the case. Each report shall be submitted within 30 days of the settlement, award or judgment. The Insurance Department shall monitor and enforce compliance with this section. The Bureau of Professional and Occupational Affairs and the professional licensure boards shall have access to information pertaining to compliance.

Section 602-A. Immunity for Reporting.--A malpractice insurer or person who reports under section 601-A in good faith and without malice shall be immune from a civil or criminal liability arising from the report.

Section 603-A. Action by Professional Licensure Boards.--Upon receipt of a report under section 601-A, the appropriate professional licensure board and the Bureau of Professional and Occupational Affairs shall review the report and conduct an investigation. If the information obtained through the investigation warrants, the board shall promptly initiate a disciplinary proceeding against the health care provider. Information received under this article 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," and the act of July 3, 1986 (P.L.388, No.84), known as the "Sunshine Act," until used in a formal disciplinary proceeding.

Section 604-A. Annual Reports to General Assembly.--Each professional licensure board shall submit annually a report to the Professional Licensure Committee of the House of Representatives and the Consumer Protection and Professional Licensure Committee of the Senate. The report shall contain the number of reports received under section 601-A, the status of the investigations of those reports, a disciplinary action which has been taken and the length of time from receipt of each report to final board action.

Section 5. The heading of Article VII of the act is amended to read:

ARTICLE VII

[Medical Professional Liability Catastrophe Loss Fund]

Professional Liability Insurance

Section 6. Section 701(a)(1) and (3) and (d) of the act, amended October 15, 1980 (P.L.971, No.165), are amended and the section is amended by adding a subsection to read:

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)] A health care provider, other than hospitals, who conducts more than 50% of his health care business or practice

within the Commonwealth of Pennsylvania shall insure or self-insure his professional liability in the amount of [$100,000] $200,000 per occurrence and [$300,000] $600,000 per annual aggregate, and hospitals located in the Commonwealth shall insure or self-insure their professional liability in the amount of [$100,000] $200,000 per occurrence, and $1,000,000 per annual aggregate, hereinafter known as "basic coverage insurance" and they shall be entitled to participate in the fund. [In the event that amounts which shall become payable by the fund shall exceed the amount of $20,000,000 in any year following calendar year 1980, basic coverage insurance commencing in the ensuing year shall become $150,000 per occurrence and $450,000 per annual aggregate for health care providers other than hospitals for which basic coverage insurance shall become $150,000 per occurrence and $1,000,000 per annual aggregate.

(ii) In the event that amounts which shall become payable by the fund shall exceed the amount of $30,000,000 in any year following calendar year 1982, basic coverage insurance commencing in the ensuing year shall become $200,000 per occurrence and $600,000 per annual aggregate for health care providers other than hospitals for which basic coverage insurance shall become $200,000 per occurrence and $1,000,000 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] medical services are rendered by a health care provider within an annual period.

* * *

(d) There is hereby created a contingency fund for the

purpose of paying all costs of operation of the fund and 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 his basic coverage insurance [in effect at the time of occurrence] as provided in subsection (a)(1). Such fund shall be known as the "Medical Professional Liability Catastrophe Loss Fund," in this Article VII called the "fund." The limit of liability of the fund shall be $1,000,000 for each occurrence for each health care provider and $3,000,000 per annual aggregate for each health care provider.

* * *

(i) The basic coverage carrier is solely responsible for total investigation, defense and settlement of the claim. The fund is obligated to make payment as directed by the basic coverage carrier up to the fund's limits of liability of $1,000,000 per health care provider. If a health care liability claim is made against a health care provider more than four years after the occurrence on which the claim is based, the claim shall be defended and paid in its entirety by the fund.

Section 7. Section 702(c), (d), (e) and (f) of the act are repealed.

Section 8. Sections 702(h) and 1001 of the act are amended to read:

Section 702. Director and Administration of Fund.--* * *

(h) Nothing in this act shall preclude the director from adjusting or paying for the adjustment of claims under section 207-A(f).

Section 1001. Immunity from Liability for Official Actions.--There shall be no liability on the part of and no cause of action for libel or slander shall arise against any member insurer, the State Board of [Medical Education and Licensure] Medicine, the State Board of Osteopathic [Examiners] Medicine, the State Board of Podiatry [Examiners, the Arbitration Panels, the administrator], the director or the commissioner or his representatives for any action taken by any of them in the performance of their respective powers and duties under this act.

Section 9. Section 1005 of the act is repealed.

Section 10. Section 1006 of the act, amended November 26, 1978 (P.L.1324, No.320), is amended to read:

Section 1006. [Joint] Committee.--[There is hereby created a committee to consist of the commissioner as chairman, the Secretary of Health and two members of the Senate, one member of each party, to be appointed by the President pro tempore and two members of the House of Representatives, one member of each party, to be appointed by the Speaker of the House of Representatives. The committee shall study the distribution of professional liability insurance costs as among the various classes of physicians and health care providers and shall report its findings and recommendations to the General Assembly within one year of the effective date of this act. The committee shall also study all phases and the financial impact of the operations of the Medical Professional Liability Catastrophe Loss Fund and shall report its findings and recommendations to the General Assembly on or before July 1, 1977. This committee shall also study actual or potential problems of conflicts of interest which exist or may exist among members of the arbitration panel

with each other and with other persons appearing before the arbitration panel or having their interests represented before the arbitration panel. The committee shall promulgate a proposed Code of Ethics with suggested legal sanctions to deal with any violators of the Code of Ethics on or before July 1, 1976. This committee shall study the act, its application and operation to determine if any changes in the present act are necessary or advisable. This study shall include consideration of the advisability and potential effect of the application of the act to mental health/mental retardation facilities. The committee shall report on this study on or before July 1, 1979 and each year thereafter.] (a) There is established the Joint Committee on Professional Liability. The committee shall consist of two members of the Senate appointed by the President pro tempore, one from the majority party and one from the minority party; two members of the House of Representatives, appointed by the Speaker of the House, one from the majority party and one from the minority party; the commissioner; the Secretary of Health; the director; and nine nonvoting advisory members. The legislative members shall select a chairman from among their number. Legislative members shall be appointed or reappointed during each regular session of the General Assembly and shall continue as members until the first Tuesday in January of the next odd-numbered year and until their respective successors shall be appointed, provided they continue to be members of the Senate or the House of Representatives. The term of office of those committee members who do not continue to be members of the Senate or the House of Representatives shall cease upon the convening of the next regular session of the General Assembly after their appointment. The nonlegislative members shall serve

a term on the committee coterminous with the office which they hold. Nonlegislative members shall not have a vote on the committee. The committee shall have a continuing existence and may meet and conduct its business at any place within this Commonwealth during the sessions of the General Assembly or any recess and in the interim between sessions.

(b) The chairman shall appoint nine nonvoting advisory members: three attorneys-at-law who, for a period of at least five years immediately prior to their appointment have been principally engaged in the representation of plaintiffs generally and patients in professional liability claims; one member from a list submitted by the Pennsylvania Medical Society, one member from a list submitted by the Hospital Association of Pennsylvania and one member who has national recognition in the field of professional liability; and three health care providers who, for a period of five years immediately prior to their appointment have been principally engaged in providing health care. The terms of advisory members shall continue until the first Tuesday in January in odd-numbered years and until their respective successors are appointed.

(c) The members of the committee shall serve without compensation.

Section 11. The act is amended by adding sections to read:

Section 1006.1. Duties of the Committee.--The committee shall study the distribution of professional liability insurance costs among the various classes of physicians and health care providers in this Commonwealth along with all phases and the financial impact of the operation of the fund. The committee shall also study the provisions of this act, its application and

operation to determine if changes in the act are necessary or advisable. This study shall include consideration of the advisability and potential effect of the application of the act to mental health/mental retardation facilities. The committee shall make a report of its studies and findings to the General Assembly each year.

Section 1006.2. Technical Assistance.--(a) The committee may call upon the director, the Banking and Insurance Committee and the Public Health and Welfare Committee of the Senate and the Insurance Committee and Health and Welfare Committee of the House of Representatives for assistance. The members of the committee shall serve without compensation.

Section 1006.3. Subcommittee.--The committee shall appoint a subcommittee to specifically study the distribution of professional liability insurance costs among the various classes of physicians and health care providers in this Commonwealth along with all phases and the financial impact of the operation of the fund. The subcommittee shall be appointed to include representatives of the legal profession representing both plaintiffs and defendants, the medical profession, the insurance industry and the actuarial profession. The subcommittee shall be charged with performing an in-depth study of current Pennsylvania professional liability insurance practices in order to determine their fairness and equity and the subcommittee shall report these recommendations to the committee, which shall in turn report the findings to the General Assembly.

(b) The subcommittee shall consist of one member representing the medical community, one member representing hospital administration, one member representing the trial bar, one member representing the defense bar, one member representing

The Insurance Federation of Pennsylvania, actuarial experts as needed and those members of the committee who elect to participate ex officio.

(c) The members of this subcommittee shall serve without compensation; but, at their option, they shall receive a per diem allowance established by the committee and payable from general tax revenue, or they shall be reimbursed by the committee from the same sources for actual and necessary expenses not exceeding the per diem allowance incurred while attending sessions of the subcommittee or while engaged on other committee business authorized by the committee.

Section 12. Section 1007.1 of the act is repealed.

Section 13. (a) The act of December 18, 1984 (P.L.1068, No.213), entitled, as amended "An act requiring physicians to obtain informed consent from patients for treatment of breast disease," is repealed.

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

Section 14. This act shall take effect in 60 days.