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THE GENERAL ASSEMBLY OF PENNSYLVANIA

HOUSE BILL

No. 1973 Session of 2007

INTRODUCED BY SHAPIRO, NICKOL, DeLUCA, MICOZZIE, ADOLPH, ARGALL, BASTIAN, BEAR, BELFANTI, BENNINGTON, BEYER, BIANCUCCI, BISHOP, BOYD, BRENNAN, BUXTON, CAPPELLI, CARROLL, CAUSER, CIVERA, CLYMER, CUTLER, DALEY, DALLY, ELLIS, FABRIZIO, FRANKEL, GALLOWAY, GIBBONS, GILLESPIE, GINGRICH, GODSHALL, GOODMAN, GRELL, HARHAI, HARPER, HORNAMAN, JAMES, JOSEPHS, KAUFFMAN, KILLION, LEACH, LENTZ, MANDERINO, MANN, MANTZ, MARKOSEK, MARSHALL, McILVAINE SMITH, MENSCH, R. MILLER, MILNE, MOYER, MURT, MUSTIO, MYERS, PARKER, PAYNE, PETRARCA, PHILLIPS, PICKETT, PYLE, QUIGLEY, QUINN, RAPP, REICHLEY, ROHRER, RUBLEY, SABATINA, SAINATO, SANTONI, SAYLOR, SCAVELLO, SCHRODER, SIPTROTH, M. SMITH, SOLOBAY, SONNEY, STERN, STURLA, SURRA, SWANGER, R. TAYLOR, THOMAS, WALKO, WANSACZ, WATSON, J. WHITE, YOUNGBLOOD, HENNESSEY, GERGELY, RAMALEY, MELIO, LONGIETTI, HESS, K. SMITH AND DENLINGER, OCTOBER 25, 2007

AS REPORTED FROM COMMITTEE ON INSURANCE, HOUSE OF REPRESENTATIVES, AS AMENDED, NOVEMBER 20, 2007

AN ACT

Amending the act of March 20, 2002 (P.L.154, No.13), entitled "An act reforming the law on medical professional liability; providing for patient safety and reporting; establishing the Patient Safety Authority and the Patient Safety Trust Fund; abrogating regulations; providing for medical professional liability informed consent, damages, expert qualifications, limitations of actions and medical records; establishing the Interbranch Commission on Venue; providing for medical professional liability insurance; establishing the Medical Care Availability and Reduction of Error Fund; providing for medical professional liability claims; establishing the Joint Underwriting Association; regulating medical professional liability insurance; providing for medical licensure regulation; providing for administration; imposing penalties; and making repeals," IN INSURANCE, FURTHER PROVIDING FOR MEDICAL PROFESSIONAL LIABILITY INSURANCE AND FOR THE MEDICAL CARE AVAILABILITY AND REDUCTION OF ERROR FUND; in Health Care Provider Retention Program, ~~defining "independent drug information services"; and further providing for abatement program, for eligibility and for expiration.~~ FURTHER

PROVIDING FOR DEFINITIONS, FOR ABATEMENT PROGRAM, FOR ELIGIBILITY, FOR EXPIRATION AND FOR PROCEDURE.

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

~~Section 1. Section 1101 of the act of March 20, 2002 (P.L.154, No.13), known as the Medical Care Availability and Reduction of Error (Mcare) Act, is amended by adding a definition to read:~~ <—

SECTION 1. SECTIONS 711 AND 712(C) OF THE ACT OF MARCH 20, 2002 (P.L.154, NO.13), KNOWN AS THE MEDICAL CARE AVAILABILITY AND REDUCTION OF ERROR (MCARE) ACT, ARE AMENDED TO READ: <—

SECTION 711. MEDICAL PROFESSIONAL LIABILITY INSURANCE.

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

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

(2) PROVIDE SELF-INSURANCE.

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

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

COMPLY WITH ANY OF THE PROVISIONS OF THIS CHAPTER.

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

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

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

(II) $500,000 PER OCCURRENCE OR CLAIM AND $1,500,000 PER ANNUAL AGGREGATE FOR A HEALTH CARE PROVIDER WHO CONDUCTS 50% OR LESS OF ITS HEALTH CARE BUSINESS OR PRACTICE WITHIN THIS COMMONWEALTH.

(III) $500,000 PER OCCURRENCE OR CLAIM AND $2,500,000 PER ANNUAL AGGREGATE FOR A HOSPITAL.

(2) FOR POLICIES ISSUED OR RENEWED IN THE CALENDAR YEARS 2003, 2004 AND 2005, THE BASIC INSURANCE COVERAGE SHALL BE:

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

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

(III) $500,000 PER OCCURRENCE OR CLAIM AND $2,500,000 PER ANNUAL AGGREGATE FOR A HOSPITAL.

(3) UNLESS THE COMMISSIONER FINDS PURSUANT TO SECTION 745(A) THAT ADDITIONAL BASIC INSURANCE COVERAGE CAPACITY IS NOT AVAILABLE, FOR POLICIES ISSUED OR RENEWED IN CALENDAR

YEAR 2006 AND EACH YEAR THEREAFTER SUBJECT TO PARAGRAPH (4), THE BASIC INSURANCE COVERAGE SHALL BE:

(I) UP TO $750,000 PER OCCURRENCE OR CLAIM AND $2,250,000 PER ANNUAL AGGREGATE FOR A PARTICIPATING HEALTH CARE PROVIDER THAT IS NOT A HOSPITAL.

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

(III) UP TO $750,000 PER OCCURRENCE OR CLAIM AND $3,750,000 PER ANNUAL AGGREGATE FOR A HOSPITAL.

IF THE COMMISSIONER FINDS PURSUANT TO SECTION 745(A) THAT ADDITIONAL BASIC INSURANCE COVERAGE CAPACITY IS NOT AVAILABLE, THE BASIC INSURANCE COVERAGE REQUIREMENTS SHALL REMAIN AT THE LEVEL REQUIRED BY PARAGRAPH (2); AND THE COMMISSIONER SHALL CONDUCT A STUDY EVERY [TWO YEARS] YEAR UNTIL THE COMMISSIONER FINDS THAT ADDITIONAL BASIC INSURANCE COVERAGE CAPACITY IS AVAILABLE, AT WHICH TIME THE COMMISSIONER SHALL INCREASE THE REQUIRED BASIC INSURANCE COVERAGE IN ACCORDANCE WITH THIS PARAGRAPH.

(4) UNLESS THE COMMISSIONER FINDS PURSUANT TO SECTION 745(B) THAT ADDITIONAL BASIC INSURANCE COVERAGE CAPACITY IS NOT AVAILABLE, FOR POLICIES ISSUED OR RENEWED [THREE] TWO YEARS AFTER THE INCREASE IN COVERAGE LIMITS REQUIRED BY PARAGRAPH (3) AND FOR EACH YEAR THEREAFTER, THE BASIC INSURANCE COVERAGE SHALL BE:

(I) UP TO $1,000,000 PER OCCURRENCE OR CLAIM AND $3,000,000 PER ANNUAL AGGREGATE FOR A PARTICIPATING HEALTH CARE PROVIDER THAT IS NOT A HOSPITAL.

(II) UP TO $1,000,000 PER OCCURRENCE OR CLAIM AND $3,000,000 PER ANNUAL AGGREGATE FOR A NONPARTICIPATING

HEALTH CARE PROVIDER.

(III) UP TO $1,000,000 PER OCCURRENCE OR CLAIM AND $4,500,000 PER ANNUAL AGGREGATE FOR A HOSPITAL.

IF THE COMMISSIONER FINDS PURSUANT TO SECTION 745(B) THAT ADDITIONAL BASIC INSURANCE COVERAGE CAPACITY IS NOT AVAILABLE, THE BASIC INSURANCE COVERAGE REQUIREMENTS SHALL REMAIN AT THE LEVEL REQUIRED BY PARAGRAPH (3); AND THE COMMISSIONER SHALL CONDUCT A STUDY EVERY [TWO YEARS] YEAR UNTIL THE COMMISSIONER FINDS THAT ADDITIONAL BASIC INSURANCE COVERAGE CAPACITY IS AVAILABLE, AT WHICH TIME THE COMMISSIONER SHALL INCREASE THE REQUIRED BASIC INSURANCE COVERAGE IN ACCORDANCE WITH THIS PARAGRAPH.

(5) THE AMOUNT OF BASIC INSURANCE COVERAGE PER OCCURRENCE OR CLAIM UNDER PARAGRAPHS (3) AND (4) SHALL BE NO LESS THAN $500,000 AND SHALL BE SET IN $50,000 INCREMENTS.

(E) FUND PARTICIPATION.--A PARTICIPATING HEALTH CARE PROVIDER SHALL BE REQUIRED TO PARTICIPATE IN THE FUND.

(F) SELF-INSURANCE.--

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

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

(G) BASIC INSURANCE LIABILITY.--

(1) AN INSURER PROVIDING MEDICAL PROFESSIONAL LIABILITY INSURANCE SHALL NOT BE LIABLE FOR PAYMENT OF A CLAIM AGAINST

A HEALTH CARE PROVIDER FOR ANY LOSS OR DAMAGES AWARDED IN A MEDICAL PROFESSIONAL LIABILITY ACTION IN EXCESS OF THE BASIC INSURANCE COVERAGE REQUIRED BY SUBSECTION (D) UNLESS THE HEALTH CARE PROVIDER'S MEDICAL PROFESSIONAL LIABILITY INSURANCE POLICY OR SELF-INSURANCE PLAN PROVIDES FOR A HIGHER LIMIT.

(2) IF A CLAIM EXCEEDS THE LIMITS OF A PARTICIPATING HEALTH CARE PROVIDER'S BASIC INSURANCE COVERAGE OR SELF-INSURANCE PLAN, THE FUND SHALL BE RESPONSIBLE FOR PAYMENT OF THE CLAIM AGAINST THE PARTICIPATING HEALTH CARE PROVIDER UP TO THE FUND LIABILITY LIMITS.

(H) EXCESS INSURANCE.--

(1) NO INSURER PROVIDING MEDICAL PROFESSIONAL LIABILITY INSURANCE WITH LIABILITY LIMITS IN EXCESS OF THE FUND'S LIABILITY LIMITS TO A PARTICIPATING HEALTH CARE PROVIDER SHALL BE LIABLE FOR PAYMENT OF A CLAIM AGAINST THE PARTICIPATING HEALTH CARE PROVIDER FOR A LOSS OR DAMAGES IN A MEDICAL PROFESSIONAL LIABILITY ACTION EXCEPT THE LOSSES AND DAMAGES IN EXCESS OF THE FUND COVERAGE LIMITS.

(2) NO INSURER PROVIDING MEDICAL PROFESSIONAL LIABILITY INSURANCE WITH LIABILITY LIMITS IN EXCESS OF THE FUND'S LIABILITY LIMITS TO A PARTICIPATING HEALTH CARE PROVIDER SHALL BE LIABLE FOR ANY LOSS RESULTING FROM THE INSOLVENCY OR DISSOLUTION OF THE FUND.

(I) GOVERNMENTAL ENTITIES.--A GOVERNMENTAL ENTITY MAY SATISFY ITS OBLIGATIONS UNDER THIS CHAPTER, AS WELL AS THE OBLIGATIONS OF ITS EMPLOYEES TO THE EXTENT OF THEIR EMPLOYMENT, BY EITHER PURCHASING MEDICAL PROFESSIONAL LIABILITY INSURANCE OR ASSUMING AN OBLIGATION AS A SELF-INSURER, AND PAYING THE ASSESSMENTS UNDER THIS CHAPTER.

(J) EXEMPTIONS.--THE FOLLOWING PARTICIPATING HEALTH CARE PROVIDERS SHALL BE EXEMPT FROM THIS CHAPTER:

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

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

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

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

* * *

(C) FUND LIABILITY LIMITS.--

(1) FOR CALENDAR YEAR 2002, THE LIMIT OF LIABILITY OF THE FUND CREATED IN SECTION 701(D) OF THE FORMER HEALTH CARE SERVICES MALPRACTICE ACT FOR EACH HEALTH CARE PROVIDER THAT CONDUCTS MORE THAN 50% OF ITS HEALTH CARE BUSINESS OR PRACTICE WITHIN THIS COMMONWEALTH AND FOR EACH HOSPITAL SHALL BE $700,000 FOR EACH OCCURRENCE AND $2,100,000 PER ANNUAL AGGREGATE.

(2) THE LIMIT OF LIABILITY OF THE FUND FOR EACH PARTICIPATING HEALTH CARE PROVIDER SHALL BE AS FOLLOWS:

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

(II) IF THE BASIC INSURANCE COVERAGE REQUIREMENT IS INCREASED IN ACCORDANCE WITH SECTION 711(D)(3) <u>OR (4)</u> AND, NOTWITHSTANDING SUBPARAGRAPH (I), FOR EACH CALENDAR

YEAR FOLLOWING THE INCREASE IN THE BASIC INSURANCE COVERAGE REQUIREMENT, THE LIMIT OF LIABILITY OF THE FUND SHALL BE [$250,000 FOR EACH OCCURRENCE AND $750,000 PER ANNUAL AGGREGATE.

(III) IF THE BASIC INSURANCE COVERAGE REQUIREMENT IS INCREASED IN ACCORDANCE WITH SECTION 711(D)(4) AND, NOTWITHSTANDING SUBPARAGRAPHS (I) AND (II), FOR EACH CALENDAR YEAR FOLLOWING THE INCREASE IN THE BASIC INSURANCE COVERAGE REQUIREMENT, THE LIMIT OF LIABILITY OF THE FUND SHALL BE ZERO.] $1,000,000 PER OCCURRENCE AND $3,000,000 PER ANNUAL AGGREGATE, EXCEPT HOSPITALS WHICH SHALL BE $1,000,000 PER OCCURRENCE AND $4,500,000 PER ANNUAL AGGREGATE, MINUS THE AMOUNT THE COMMISSIONER DETERMINES FOR BASIC INSURANCE COVERAGE UNDER SECTION 711(D)(3) AND (4).

* * *

SECTION 2. THE DEFINITION OF "HEALTH CARE PROVIDER" IN SECTION 1101 OF THE ACT IS AMENDED AND THE SECTION IS AMENDED BY ADDING A DEFINITION TO READ:

Section 1101. Definitions.

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

* * *

"HEALTH CARE PROVIDER." [AN INDIVIDUAL WHO IS ALL OF] ANY OF <—— THE FOLLOWING:

(1) A NURSING HOME THAT IS A PARTICIPATING HEALTH CARE PROVIDER AS DEFINED IN SECTION 702.

(2) AN INDIVIDUAL WHO IS ALL OF THE FOLLOWING:

(I) A PHYSICIAN, LICENSED PODIATRIST[,] OR CERTIFIED

NURSE MIDWIFE [OR NURSING HOME].

(II) A PARTICIPATING HEALTH CARE PROVIDER AS DEFINED IN SECTION 702.

"Independent drug information service." A university-based outreach program intended to promote unbiased, high quality evidence-based, patient-centered, cost-effective pharmaceutical decisions.

* * *

Section ~~2~~ 3. Section 1102(a) of the act, amended October 27, 2006 (P.L.1198, No.128), is amended to read: <——

Section 1102. Abatement program.

(a) Establishment.--There is hereby established within the Insurance Department a program to be known as the Health Care Provider Retention Program. The Insurance Department, in conjunction with the Department of Public Welfare, shall administer the program. The program shall provide assistance in the form of assessment abatements to health care providers for calendar years 2003, 2004, 2005, 2006 [and 2007], 2007 and 2008, except that licensed podiatrists shall not be eligible for calendar years 2003 and 2004, and nursing homes shall not be eligible for calendar years 2003, 2004 and 2005.

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Section ~~3. Section 1103~~ 4. SECTIONS 1103 AND 1104(A) AND (B) of the act, added December 22, 2005 (P.L.458, No.88), ~~is~~ ARE amended to read: <—— <——

Section 1103. Eligibility.

~~A health care provider shall not be eligible for assessment~~ <——

(A) PAYMENT OF TAXES.-- <——

(1) A HEALTH CARE PROVIDER SHALL BE ELIGIBLE FOR ASSESSMENT ABATEMENT UNDER THE PROGRAM IF THE DEPARTMENT OF

REVENUE HAS DETERMINED THAT THE HEALTH CARE PROVIDER HAS FILED ALL REQUIRED STATE TAX REPORTS AND RETURNS FOR ALL APPLICABLE TAXABLE YEARS AND HAS PAID THE BALANCE OF ANY STATE TAX DUE AS DETERMINED AT ASSESSMENT OR DETERMINATION BY THE DEPARTMENT OF REVENUE THAT ARE NOT SUBJECT TO A TIMELY PERFECTED ADMINISTRATIVE OR JUDICIAL APPEAL OR NOT SUBJECT TO A DULY AUTHORIZED DEFERRED PAYMENT PLAN AS OF THE DATE OF APPLICATION.

(2) NOTWITHSTANDING ANY STATUTE PROVIDING FOR THE CONFIDENTIALITY OF TAX RECORDS, THE DEPARTMENT OF REVENUE MAY SUPPLY THE INSURANCE DEPARTMENT WITH INFORMATION CONCERNING THE STATUS OF DELINQUENT TAXES OWED BY A HEALTH CARE PROVIDER FOR THE PURPOSES OF THIS SUBSECTION.

(B) LIMITATION ON ELIGIBILITY.--A HEALTH CARE PROVIDER SHALL NOT BE ELIGIBLE FOR ASSESSMENT abatement under the program if any of the following apply:

(1) The health care provider's license has been revoked in any state within the ten most recent years or a health care provider has a license revoked during a year in which an abatement was received.

(2) The health care provider's ability, if any, to dispense or prescribe drugs or medication has been revoked in this Commonwealth or any other state within the ten most recent years.

(3) The health care provider has had three or more medical liability claims in the past five most recent years in which a judgment was entered against the health care provider or a settlement was paid on behalf of the health care provider, in an amount equal to or exceeding $500,000 per claim.

(4) The health care provider has been convicted of or has entered a plea of guilty or no contest to an offense which is required to be reported under section 903(3) or (4) within the ten most recent years.

(5) The health care provider has an unpaid surcharge or assessment under this act.

~~(6) The Department of Revenue has determined that the health care provider has not filed all required State tax reports and returns for all applicable taxable years or has not paid any balance of State tax due as determined at settlement, assessment or determination by the Department of Revenue that are not subject to a timely perfected administrative or judicial appeal or subject to a duly authorized deferred payment plan as of the date of application. Notwithstanding the provisions of section 353(f) of the act of March 4, 1971 (P.L.6, No.2), known as the Tax Reform Code of 1971, the Department of revenue shall be authorized to supply the Insurance Department with information concerning the status of delinquent taxes owed by a health care provider for purposes of this paragraph.~~ <—

~~(7) The health care provider has not attended at least~~

(6) (I) THE HEALTH CARE PROVIDER HAS NOT ATTENDED AT LEAST one Commonwealth-sponsored independent drug information service session, either in person or by videoconference. ~~This~~ <— <—

(II) WHEN THE HEALTH CARE PROVIDER IS A NURSING HOME, ITS MEDICAL DIRECTOR SHALL ATTEND THE SESSION ON ITS BEHALF. <—

(III) THIS paragraph does not apply if the Commonwealth has not made such a session available to the

health care provider prior to the date that the health care provider's application is submitted under section 1104.

SECTION 1104. PROCEDURE. <—

(A) APPLICATION.--A HEALTH CARE PROVIDER MAY APPLY TO THE INSURANCE DEPARTMENT FOR AN ABATEMENT OF THE ASSESSMENT IMPOSED FOR THE PREVIOUS CALENDAR YEAR SPECIFIED ON THE APPLICATION. THE APPLICATION MUST BE SUBMITTED BY THE SECOND MONDAY OF FEBRUARY OF THE CALENDAR YEAR SPECIFIED ON THE APPLICATION AND SHALL BE ON THE FORM REQUIRED BY THE INSURANCE DEPARTMENT. THE DEPARTMENT SHALL REQUIRE THAT THE APPLICATION CONTAIN ALL OF THE FOLLOWING SUPPORTING INFORMATION:

(1) A STATEMENT OF THE APPLICANT'S FIELD OF PRACTICE, INCLUDING ANY SPECIALTY.

(2) EXCEPT FOR PHYSICIANS ENROLLED IN AN APPROVED RESIDENCY OR FELLOWSHIP PROGRAM, A SIGNED CERTIFICATE OF RETENTION.

(3) A SIGNED CERTIFICATION THAT THE HEALTH CARE PROVIDER IS AN ELIGIBLE APPLICANT UNDER SECTION [1103] 1103(B) FOR THE PROGRAM.

(4) SUCH OTHER INFORMATION AS THE INSURANCE DEPARTMENT MAY REQUIRE.

* * *

(B) REVIEW.--UPON RECEIPT OF A COMPLETED APPLICATION AND INFORMATION FROM THE DEPARTMENT OF REVENUE THAT THE HEALTH CARE PROVIDER IS IN COMPLIANCE WITH SECTION 1103(A), THE INSURANCE DEPARTMENT SHALL REVIEW THE APPLICANT'S INFORMATION AND GRANT THE APPLICABLE ABATEMENT OF THE ASSESSMENT FOR THE PREVIOUS CALENDAR YEAR SPECIFIED ON THE APPLICATION IN ACCORDANCE WITH ALL OF THE FOLLOWING:

(1) THE INSURANCE DEPARTMENT SHALL NOTIFY THE DEPARTMENT OF PUBLIC WELFARE THAT THE APPLICANT HAS SELF-CERTIFIED AS ELIGIBLE FOR A 100% ABATEMENT OF THE IMPOSED ASSESSMENT IF THE HEALTH CARE PROVIDER WAS ASSESSED UNDER SECTION 712(D) AS:

(I) A PHYSICIAN WHO IS ASSESSED AS A MEMBER OF ONE OF THE FOUR HIGHEST RATE CLASSES OF THE PREVAILING PRIMARY PREMIUM;

(II) AN EMERGENCY PHYSICIAN;

(III) A PHYSICIAN WHO ROUTINELY PROVIDES OBSTETRICAL SERVICES IN RURAL AREAS AS DESIGNATED BY THE INSURANCE DEPARTMENT; OR

(IV) A CERTIFIED NURSE MIDWIFE.

(2) THE INSURANCE DEPARTMENT SHALL NOTIFY THE DEPARTMENT OF PUBLIC WELFARE THAT THE APPLICANT HAS SELF-CERTIFIED AS ELIGIBLE FOR A 50% ABATEMENT OF THE IMPOSED ASSESSMENT IF THE HEALTH CARE PROVIDER WAS ASSESSED UNDER SECTION 712(D) AS:

(I) A PHYSICIAN BUT IS A PHYSICIAN WHO DOES NOT QUALIFY FOR ABATEMENT UNDER PARAGRAPH (1);

(II) A LICENSED PODIATRIST; OR

(III) A NURSING HOME.

Section ~~4~~ 5. Section 1115 of the act, amended October 27, 2006 (P.L.1198, No.128), is amended to read: <—

Section 1115. Expiration.

The Health Care Provider Retention Program established under this chapter shall expire December 31, [2008] 2009.

Section ~~5~~ 6. This act shall take effect immediately. <—