HEALTH CARE SERVICES MALPRACTICE ACT - OMNIBUS AMENDMENTS

Act of Nov. 26, 1996, P.L. 776, No. 135 Cl. 40

Session of 1996

No. 1996-135

HB 2210

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 definitions, for statute of limitations, for professional liability insurance and the Medical Professional Liability Catastrophe Loss Fund, for administration of that fund and for liability of excess carriers; providing for a Medical Professional Liability Insurance Catastrophe Loss Fund Advisory Board and for surcharge limits; further providing for plan operation and rates, for reports to the Insurance Commissioner and for forms of doing business ; providing for medical malpractice; and deleting provisions relating to the Joint Study Committee.

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

Section 1. Section 103 of the act of October 15, 1975 (P.L.390, No.111), known as the Health Care Services Malpractice Act, amended July 15, 1976 (P.L.1028, No.207) and November 6, 1985 (P.L.311, No.78) and repealed in part February 23, 1996 (P.L.27, No.10), is amended to read:

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

"Claimant" means a patient and includes a patient's immediate family, guardian, personal representative or estate.

"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.

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

"Commissioner" means the Insurance Commissioner of this 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.

"Fund coverage limits" means the coverage provided by the Medical Professional Liability Catastrophe Loss Fund under section 701(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 provider" means a primary health center or a person, 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, [an osteopathic physician or surgeon,] a certified nurse midwife, a podiatrist, hospital, nursing home, birth center, and except as to section 701(a), an officer, employee or agent of any of them acting in the course and scope of [his] employment.

"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 [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.] **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 [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.

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

"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.

Section 2. Section 605 of the act, amended July 15, 1976 (P.L.1028, No.207), is amended to read:

Section 605. Statute of Limitations.--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 [Medical Professional Liability Catastrophe Loss Fund established pursuant to section 701.] **fund if the fund 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. 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.

Section 3. Section 701 of the act, amended October 15, 1980 (P.L.971, No.165), is amended 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] **For policies issued or renewed in the calendar years 1997 through 1998, a** health care provider, other than hospitals, who conducts more than 50% of [his] **its** health care business or practice within the Commonwealth of Pennsylvania shall **annually** insure or self-insure [his] **its** professional liability in the amount of [$100,000] **$300,000** per occurrence and [$300,000] **$900,000** per annual aggregate, and hospitals located in the Commonwealth shall insure or self-insure their professional liability in the amount of [$100,000] **$300,000** per occurrence, and [$1,000,000] **$1,500,000** 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.]

(ii) For policies issued or renewed in the calendar years 1999 through 2000, 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 in the amount of $400,000 per occurrence and $1,200,000 per annual aggregate, and hospitals located in this Commonwealth shall insure or self-insure their professional liability in the amount of $400,000 per occurrence and $2,000,000 per annual aggregate.

(iii) For policies issued or renewed in the calendar year 2001, and each year thereafter, 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 in the amount of $500,000 per occurrence and $1,500,000 per annual aggregate, and hospitals located in this Commonwealth shall insure or self-insure their professional liability in the amount of $500,000 per occurrence and $2,500,000 per annual aggregate.

(2) **(i)** A health care provider who conducts 50% or less of [his] **its** health care business or practice within the Commonwealth shall insure or self-insure [his] **its** professional liability in the [amount of $200,000 per occurrence and $600,000 per annual aggregate] **amounts listed in subparagraphs (ii), (iii) and (iv)** and shall not be required to contribute to or be entitled to participate in the fund set forth in Article VII of this act or the plan set forth in Article VIII of this act.

(ii) For 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 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 calendar year 2001, and each year thereafter, basic insurance coverage shall, on an annual basis, be in the amount of $500,000 per occurrence and $1,500,000 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 shall be responsible for the payment of the claim up to the fund 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 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 [his] **its** 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.] **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) [The] **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 [director appointed pursuant to section 702 and subject to the prior approval of the commissioner] **fund, filed with the commissioner and communicated to all basic insurance coverage carriers and self-insured providers**. The surcharge shall be based on the [cost to] **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 [all claims paid] **final claims** and expenses incurred during the preceding [calendar year] **claims period** and to provide an amount necessary to maintain an additional [$15,000,000.] **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.

[(2)] **(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, 1981 for all claims which become final between January 1, 1981 and August 31, 1981 and annually thereafter 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. [All claims which become final between January 1, 1980 and the effective date of this amendatory act shall be computed on the effective date of this amendatory act and shall be paid on or before December 31, 1980.

(3)] **(9)** Notwithstanding the above provisions relating to an annual surcharge, the commissioner shall have the authority, during [September 1981 and during] September of each year [thereafter], if the fund would be exhausted by the payment in full of all claims which have become final and the expenses of the [office of the director] **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, 1981 and] August 31 of each year [thereafter] and the expenses of the [office of the director, as of December 31, 1980 and] **fund as of** December 31 of each year [thereafter].

[(4)] **(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. [A fee shall be charged by the director to all self-insurers for examination and approval of their plans.]

(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 4. Section 702 of the act, amended July 15, 1976 (P.L.1028, No.207) and October 15, 1980 (P.L.971, No.165), is amended to read:

Section 702. Director and Administration of Fund.--(a) The fund shall be administered by a director who shall be appointed by the Governor and whose salary shall be fixed by the Executive Board. The director may employ and fix the compensation of such clerical and other assistants as may be deemed necessary and may promulgate rules and regulations relating to procedures for the reporting of claims to the fund.

(b) The director shall be provided with adequate offices in which the records shall be kept and official business shall be transacted, and the director shall also be provided with necessary office furniture and other supplies.

(c) The basic coverage insurance carrier or self-insured provider shall promptly notify the director of any case where it reasonably believes that the value of the claim exceeds the basic insurer's coverage or self-insurance plan or falls under section 605. Such information, **including the fund's claim file**, shall be confidential, notwithstanding the [act of July 19, 1974 (P.L.486, No.175) referred to as the Public Agency Open Meeting Law, and] 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."** Failure to so notify the director shall make the basic coverage insurance carrier or self-insured provider responsible for the payment of the entire award or verdict, provided that the fund has been prejudiced by the failure of notice.

(d) The basic coverage insurance carrier or self-insured provider shall be responsible to provide a defense to the claim, including defense of the fund, except as provided for in section 605. In such instances where the director has been notified in accordance with subsection (c), the director may[, at his option,] join in the defense and be represented by counsel.

(e) In the event that the basic coverage insurance carrier or self-insured provider 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 have no effect upon any excess claim against the fund or its duty to continue the defense of the claim.

(f) The director is authorized to defend, litigate, settle or compromise any claim payable by the fund. A health care provider's basic insurance coverage carrier shall have the right to approve any settlement entered into by the director on behalf of its insured health care provider. If the basic insurance coverage carrier does not disapprove a settlement prior to execution by the director, it shall be deemed approved by the basic insurance coverage carrier. In the event that more than one health care provider defendant is party to a settlement, the health care provider's basic insurance coverage carrier shall have the right to approve only that portion of the settlement which is contributed on behalf of its insured health care provider.

(g) The director is hereby empowered to purchase, on behalf of the fund, as much insurance or re-insurance as is necessary to preserve the fund.

(h) Nothing in this act shall preclude the director from adjusting or paying for the adjustment of claims.

(i) Upon the request of a party to a case within the fund coverage limits, the fund may provide for a mediator in instances where multiple carriers disagree on 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 fund shall promulgate such rules and regulations as are necessary to implement this provision. Proceedings conducted under this section shall be confidential and shall not be considered public information subject to disclosure under the Right-to-Know Law and the "Sunshine Act."

(j) Delay damages and postjudgment interest applicable to the fund's liability in a case shall be paid by the fund and shall not be charged against the insured's annual aggregate limits. The basic insurance carrier or self-insurer shall be responsible for its proportionate share of delay damages and post-judgment interest.

(k) The fund shall have the authority to borrow money for periods of less than two years in order to pay claims and expenses until sufficient revenues are realized by the fund.

Section 5. Section 705 of the act, added July 15, 1976 (P.L.1028, No.207), is 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 [Medical Professional Liability Catastrophe Loss Fund] **fund** 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 coverage** limits [of liability provided by the Medical Professional Liability Catastrophe Loss Fund].

(b) No carrier providing excess professional liability insurance for a health care provider covered by the [Medical Professional Catastrophe Loss Fund] **fund** shall be liable for any loss resulting from the insolvency or dissolution of the [catastrophe loss] fund.

Section 6. The act is amended by adding a section to read:

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 Advisory Board.

(b) The 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 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 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 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.

Section 7. Section 803 of the act, amended October 15, 1980 (P.L.971, No.165), is amended to read:

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 director of the [Catastrophe Loss Fund and the Insurance Commissioner] **fund and the commissioner.** Such certification shall be subject to the review and approval of the [Insurance Commissioner] **commissioner.** Within 60 days following such certification and approval the director of the fund 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 [Insurance Commissioner and the Insurance Commissioner] **commissioner. The commissioner** shall approve a premium increase sufficient to generate the requisite income to:

(1) reimburse the fund for any payment made by the fund 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 with interest at a rate equal to that earned by the fund on its invested assets within one year of any payment made by the fund as compensation for any deficit incurred by the Joint Underwriting Association.

Section 8. Section 809 of the act is amended to read:

Section 809. [Annual Reports to Insurance Commissioner.--The plan shall report to the commissioner annually on a date and, on a form prescribed by the commissioner the total amount of premium dollars collected, the total amount of claims paid and expenses incurred therewith, the total amount of reserve set aside for future claims, the nature and substance of each claim, the date and place in which each claim arose, the amounts paid, if any, and the disposition of each claim (judgment of arbitration panel, judgment of court, settlement or otherwise), and such additional information as the commissioner shall require.] **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 the claims information specified in subsection (b).**

(b) Sixty days after the end of any calendar year, the fund 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 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 9. Section 811 of the act, added November 26, 1978 (P.L.1324, No.320), is amended to read:

Section 811. Professional Corporations, Professional Associations and Partnerships.--(a) The Joint Underwriting Association shall offer basic coverage insurance 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 and upon payment of the annual surcharge as required by section 701(e), the professional corporation, professional association or partnership shall be entitled to such excess coverage from the [Medical Professional Liability Catastrophe Loss Fund] **fund** as is provided in this act.

(c) Any professional corporation, professional association, or partnership which acquires basic coverage insurance 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 [Medical Professional Liability Catastrophe Loss Fund] **fund** as provided in this act.

(d) Any professional corporation, professional association or partnership which participates in or contributes to the [Medical Professional Liability Catastrophe Loss Fund] **fund** shall be subject to all other provisions of this act.

Section 10. The act is amended by adding an article to read:

ARTICLE VIII-A
Medical Malpractice
SUBARTICLE A
Preliminary Provisions

Section 801-A. Declaration of Policy.--The General Assembly finds and declares that it is the purpose of this article to streamline the legal process relating to medical negligence lawsuits in this Commonwealth so that there may be prompt and efficient adjudication of such claims.

SUBARTICLE B
Professional Liability Claims

Section 811-A. Informed Consent.--(a) Except in emergencies, a physician owes a duty to a patient to obtain the informed consent of the patient or the patient's authorized representative prior to conducting the following procedures:

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

(2) Administering radiation or chemotherapy.

(3) Administering a blood transfusion.

(4) Inserting a surgical device or appliance.

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

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

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

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

Section 812-A. Punitive Damages.--(a) Punitive damages may be awarded for conduct that is the result of the health care provider's

willful or wanton conduct or reckless indifference to the rights of others. In assessing punitive damages, the trier of fact can properly consider the character of the health care provider's act, the nature and extent of the harm to the patient that the health care provider caused or intended to cause and the wealth of the health care provider.

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

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

(d) (1) When punitive damages are claimed, a praecipe to strike punitive damages may be filed. Upon the filing of a praecipe to strike punitive damages, an order shall issue striking without prejudice the claim for punitive damages. This shall have the effect of tolling the statute of limitations as to the health care provider filing the praecipe.

(2) At the close of discovery, the claimant shall have the right to move to reinstate a claim for punitive damages against a health care provider who has filed a praecipe to strike punitive damages. Upon hearing the motion for reinstatement of the claim for punitive damages, the judge shall determine whether the evidence adduced during discovery supports a prima facie case for the imposition of punitive damages against the health care provider. Upon the judicial finding of a prima facie case, the claim for punitive damages shall be reinstated.

(3) The claimant shall have no right to discover the financial assets or wealth of the health care provider who filed a praecipe to strike punitive damages until the claim has been reinstated by the court pursuant to paragraph (2) or by agreement of the parties.

(e) A claim for punitive damages shall be bifurcated at the time of trial. After a verdict has been rendered on the issue of liability and compensatory damages by the trier of fact, the question of punitive damages shall be adjudicated by the trier of fact.

(f) The trier of fact shall separately determine whether and to what amount punitive damages shall be awarded, subject to the standard set forth in subsection (a). Evidence of the health care provider's wealth or financial condition shall then be admissible into evidence for the purpose of adjudicating punitive damages.

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

Section 813-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 presented for an improper purpose, 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, which may include a civil penalty not to exceed $5,000. 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.

SUBARTICLE C
Pretrial Procedure

Section 821-A. Complaint Procedure.--(a) A complaint of a claimant 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 certification 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 health care provider deviated from a standard of care, the signature of an attorney further constitutes certification 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 a basis to conclude that the health care provider deviated from that standard; and the information upon which the expert bases the opinion.

(c) (1) Certification by an attorney pursuant to subsections (a) and (b) is unnecessary in the following instances:

(i) A client first contacts an attorney less than 120 days before expiration of the statute of limitations.

(ii) A health care provider has failed to produce copies of medical records requested by the patient or his attorney, for a period of more than 60 days following a request for such records.

(iii) A qualified expert has advised the attorney that, based upon the records available, it cannot be determined whether any health care provider deviated from accepted practice without first conducting discovery.

(iv) Expert testimony is unnecessary for prosecution of the claim.

(v) The trial court determines that the interest of justice would be served by waiving the requirement of certification under the facts of the case.

(2) If an attorney proceeds without expert certification, the health care provider may move to require such certification as follows:

(i) If an attorney has proceeded because the statute of limitations may expire in less than 120 days, certification must follow within 90 days of filing suit.

(ii) If an attorney has proceeded because of the failure of a health care provider to furnish records, certification must follow within 90 days of the claimant being supplied with complete copies of the records requested.

(iii) If an attorney has proceeded because of the need to conduct discovery before a determination of malpractice has occurred, certification must follow within 90 days of the claimant being supplied with the requested discovery. In the case of discovery by deposition, the time within which to comply shall begin to run upon receipt by the claimant of signed transcripts.

(d) If an attorney is found to have violated the certification requirement, the court or opposing counsel may report such attorney to the Disciplinary Board of the Supreme Court of Pennsylvania; and the court may impose an appropriate sanction, including an order to pay the amount of the reasonable expenses incurred because of the filing, including a reasonable attorney fee.

(e) Nothing set forth in this section shall entitle the health care provider to discovery of the identity of claimant's consulting experts. If the health care provider seeks a determination as to whether the claimant has violated the certification requirement, the matter may be referred to the Disciplinary Board; or a motion may be filed with the court. The trial court, upon motion, shall conduct an in-camera review of claimant counsel's evaluation of the claim before filing suit, for purposes of determining whether referral to the Disciplinary Board or a sanction is appropriate. In any proceeding before the court or the Disciplinary Board, the identity of consulting experts shall remain privileged.

Section 822-A. Limitation on Discovery.--Discovery shall proceed in an expeditious manner and shall be completed within one year after the health care provider files an answer to the complaint or in a manner consistent with the rules of the county in which an action is pending or the applicable rules of court, but all discovery shall be completed no later than two years after a claim is commenced. Discovery may be extended for an additional period of up to 180 days upon filing of a petition with the court showing good cause for extension within two years after a claim is commenced.

Section 823-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. A claimant shall distribute trial expert reports within 60 days after completion of discovery. A health care provider shall distribute trial expert reports within 60 days after receipt of claimant's trial expert reports. 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. The parties shall be permitted to submit additional or supplemental trial expert reports, provided there is no delay in the trial of the case.

Section 824-A. Discovery Conference and Mediation.--(a) At any time after commencement of the action, but within 60 days after the answer was filed, the court may direct the attorneys for the parties to appear for a conference on the subjects of discovery and mediation. In addition, the court shall convene a discovery conference 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 to additions of matters set forth in the motion shall be served no 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 826-A.

(e) The court shall also inquire of the parties whether they are willing to participate in an early mediation session to be held within 60 days of the discovery conference. The court shall order mediation if either party requests mediation or upon its own motion. The court may exercise its discretion and not order mediation if it appears likely that mediation would not be productive. The court shall assign as mediators those attorneys that are agreeable to the court and the bar generally who have experience in such litigation.

Section 825-A. Conciliation Schedule.--(a) Within 90 days after the conclusion of the discovery period set forth in section 822-A, the court shall hold at least one mandatory conciliation conference.

(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.

(c) Conciliation may take the form of a settlement conference or mediation as requested by the parties or the court.

Section 826-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) 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 827-A. Affidavit of Noninvolvement.--(a) Any health care provider named as a defendant in a medical malpractice action may cause the action against that provider to be dismissed upon the filing of an affidavit of noninvolvement with the court. The affidavit of noninvolvement shall set forth, with particularity, the facts which demonstrate that the provider was misidentified or otherwise not involved, individually or through its servants or employees, in the care and treatment of the claimant, and was not obligated, either individually or through its servants or employees, to provide for the care and treatment of the claimant.

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

(c) A codefendant or claimant shall have the right to challenge an affidavit of noninvolvement by filing a motion and submitting

an affidavit which contradicts the assertions of noninvolvement made by the health care provider in the affidavit of noninvolvement.

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

SUBARTICLE D
Trial Procedure

Section 831-A. Advance Payments.--No advance payment made by the health care provider or the provider's basic coverage insurance carrier to or for the claimant shall be construed as an admission of liability for injuries or damages suffered by the claimant. Evidence of an advance payment shall not be admissible in a proceeding.

Section 832-A. Periodic Payment of Damages.--(a) In any medical malpractice action in which a final verdict has been reached that includes an award of future damages, the court, upon motion of any party, may consider that the damages be paid by periodic or installment payments, provided that the terms of such payments be agreed to by all parties.

(b) If a judgment ordering the payment of damages by periodic payments is agreed to as set forth in subsection (a), consideration shall be given to the following terms, which shall include, but not be limited to:

(1) An appropriate time frame.

(2) The amount of damages per installment.

(3) The posting of security or purchase of an annuity that will assure full payment of the awarded damages.

(4) Any other conditions deemed necessary to secure the payment of awarded damages to the claimant.

(c) Included within its judgment, the court shall make inquiry to determine that the claimant, or the claimant's guardian, has made a reasonable and informed decision as to the person designated as the beneficiary and residual beneficiary of the periodic payments.

SUBARTICLE E
Mandatory Reporting and Preservation of Medical Records

Section 841-A. Mandatory Reporting.--(a) Each malpractice insurer, including the Medical Professional Liability Catastrophe Loss Fund 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. § 11101 et seq.). 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) Upon receipt of a report received pursuant to subsection (a), the appropriate 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 and take appropriate disciplinary action. 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," 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.

SUBARTICLE F

Mandatory Risk Management Programs

Section 851-A. Mandatory Risk Management Programs.--(a) Hospitals, nursing homes and public health centers qualifying as a health care provider as defined in this chapter shall submit to the commissioner for review and approval an institutional plan of risk management.

(b) Every insurance company or exchange or self-insurance plan providing professional liability coverage to individuals defined as health care providers in this chapter shall submit to the Insurance Department for review and approval a program of risk management to be offered to all such individuals.

Section 11. Section 1006 of the act is repealed.

Section 12. 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 13. All acts and parts of acts are repealed insofar as they are inconsistent with this act.

Section 14. This act shall take effect as follows:

(1) The addition of Article VIII-A of the act shall take effect in 60 days.

(2) The remainder of this act shall take effect immediately.

APPROVED--The 26th day of November, A. D. 1996.

THOMAS J. RIDGE