MEDICAL CARE AVAILABILITY AND REDUCTION OF ERROR (MCARE) ACT

Act of Mar. 20, 2002, P.L. 154, No. 13 Cl. 40

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.

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

CHAPTER 1
PRELIMINARY PROVISIONS

Section 101. Short title.

This act shall be known and may be cited as the Medical Care Availability and Reduction of Error (Mcare) Act.

Section 102. Declaration of policy.

The General Assembly finds and declares as follows:

(1) It is the purpose of this act to ensure that medical care is available in this Commonwealth through a comprehensive and high-quality health care system.

(2) Access to a full spectrum of hospital services and to highly trained physicians in all specialties must be available across this Commonwealth.

(3) To maintain this system, medical professional liability insurance has to be obtainable at an affordable

and reasonable cost in every geographic region of this Commonwealth.

(4) A person who has sustained injury or death as a result of medical negligence by a health care provider must be afforded a prompt determination and fair compensation.

(5) Every effort must be made to reduce and eliminate medical errors by identifying problems and implementing solutions that promote patient safety.

(6) Recognition and furtherance of all of these elements is essential to the public health, safety and welfare of all the citizens of Pennsylvania.

Section 103. Definitions.

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

"Birth center." An entity licensed as a birth center under the act of July 19, 1979 (P.L.130, No.48), known as the Health Care Facilities Act.

"Claimant." A patient, including a patient's immediate family, guardian, personal representative or estate.

"Commissioner." The Insurance Commissioner of the Commonwealth.

"Guardian." A fiduciary who has the care and management of the estate or person of a minor or an incapacitated person.

"Health care provider." A primary health care center or a person, including a corporation, university or other educational institution licensed or approved by the Commonwealth to provide health care or professional medical services as a physician, a certified nurse midwife, a podiatrist, hospital, nursing home, birth center and, except as to section 711(a), an officer, employee or agent of any of them acting in the course and scope of employment.

"Hospital." An entity licensed as a hospital under the act of June 13, 1967 (P.L.31, No.21), known as the Public Welfare Code, or the act of July 19, 1979 (P.L.130, No.48), known as the Health Care Facilities Act.

"Immediate family." A parent, a spouse, a child or an adult sibling residing in the same household.

"Medical professional liability action." Any proceeding in which a medical professional liability claim is asserted, including an action in a court of law or an arbitration proceeding.

"Medical professional liability claim." Any claim seeking the recovery of damages or loss from a health care provider arising out of any tort or breach of contract causing injury or death resulting from the furnishing of health care services which were or should have been provided.

"Nursing home." An entity licensed as a nursing home under the act of July 19, 1979 (P.L.130, No.48), known as the Health Care Facilities Act.

"Patient." A natural person who receives or should have received health care from a health care provider.

"Personal representative." An executor or administrator of a patient's estate.

"Primary health center." 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.

Compiler's Note: The short title of the act of June 13, 1967 (P.L.31, No.21), known as the Public Welfare Code, referred to in this section, was amended by the act of December 28, 2015 (P.L.500, No.92). The amended short title is now the Human Services Code.

Section 104. Liability of nonqualifying health care providers.

Any person rendering services normally rendered by a health care provider who fails to qualify as a health care provider under this act is subject to liability under the law without regard to the provisions of this act.

Section 105. Provider not a warrantor or guarantor.

In the absence of a special contract in writing, a health care provider is neither a warrantor nor a guarantor of a cure.

CHAPTER 3
PATIENT SAFETY

Section 301. Scope.

This chapter relates to the reduction of medical errors for the purpose of ensuring patient safety.

Section 302. Definitions.

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

"Abortion facility." A facility or medical facility as defined in 18 Pa.C.S. § 3203 (relating to definitions) which is subject to this chapter pursuant to section 315(b) or (c) and which is not subject to licensure under the act of July 19, 1979 (P.L.130, No.48), known as the Health Care Facilities Act. (Def. added May 1, 2006, P.L.103, No.30)

"Ambulatory surgical facility." An entity defined as an ambulatory surgical facility under the act of July 19, 1979 (P.L.130, No.48), known as the Health Care Facilities Act.

"Authority." The Patient Safety Authority established in section 303.

"Board." The board of directors of the Patient Safety Authority.

"Department." The Department of Health of the Commonwealth.

"Fund." The Patient Safety Trust Fund established in section 305.

"Health care worker." An employee, independent contractor, licensee or other individual authorized to provide services in a medical facility.

"Incident." An event, occurrence or situation involving the clinical care of a patient in a medical facility which could have injured the patient but did not either cause an unanticipated injury or require the delivery of additional health care services to the patient. The term does not include a serious event.

"Infrastructure." Structures related to the physical plant and service delivery systems necessary for the provision of health care services in a medical facility.

"Infrastructure failure." An undesirable or unintended event, occurrence or situation involving the infrastructure of a medical facility or the discontinuation or significant disruption of a service which could seriously compromise patient safety.

"Licensee." An individual who is all of the following:

(1) Licensed or certified by the department or the Department of State to provide professional services in this Commonwealth.

(2) Employed by or authorized to provide professional services in a medical facility.

"Medical facility." An ambulatory surgical facility, birth center, hospital or abortion facility. (Def. amended May 1, 2006, P.L.103, No.30)

"Patient safety officer." An individual designated by a medical facility under section 309.

"Serious event." An event, occurrence or situation involving the clinical care of a patient in a medical facility that results in death or compromises patient safety and results in an unanticipated injury requiring the delivery of additional health care services to the patient. The term does not include an incident.

Section 303. Establishment of Patient Safety Authority.

(a) Establishment.--There is established a body corporate and politic to be known as the Patient Safety Authority, which shall be an independent agency. The powers and duties of the authority shall be vested in and exercised by a board of directors, which shall have the sole power under section 304(a) to employ staff, including an executive director, legal counsel, consultants or any other staff deemed necessary by the authority. Individuals employed by the authority as staff shall be deemed employees of the Commonwealth for the purpose of participation in the Pennsylvania Employee Benefit Trust Fund. ((a) amended Dec. 22, 2005, P.L.458, No.88)

(b) Composition.--The board of the authority shall consist of 11 members composed and appointed in accordance with the following:

(1) The Physician General or a physician appointed by the Governor if there is no appointed Physician General.

(2) Four residents of this Commonwealth, one of whom shall be appointed by the President pro tempore of the Senate, one of whom shall be appointed by the Minority Leader of the Senate, one of whom shall be appointed by the Speaker of the House of Representatives and one of whom shall be appointed by the Minority Leader of the House of Representatives, who shall serve terms coterminous with their respective appointing authorities.

(3) A health care worker residing in this Commonwealth who is a physician and is appointed by the Governor, who shall serve an initial term of three years.

(4) A health care worker residing in this Commonwealth who is licensed by the Department of State as a nurse and is appointed by the Governor, who shall serve an initial term of three years.

(5) A health care worker residing in this Commonwealth who is licensed by the Department of State as a pharmacist and is appointed by the Governor, who shall serve an initial term of two years.

(6) A health care worker residing in this Commonwealth who is employed by a hospital and is appointed by the Governor, who shall serve an initial term of two years.

(7) Two residents of this Commonwealth, one of whom is a health care worker and one of whom is not a health care worker, appointed by the Governor, who shall each serve a term of four years.

(c) Terms.--With the exception of paragraphs (1) and (2), members of the board shall serve for terms of four years after completion of the initial terms designated in subsection (b) and shall not be eligible to serve more than two full consecutive terms.

(d) Quorum.--A majority of the members of the board shall constitute a quorum. Notwithstanding any other provision of law, action may be taken by the board at a meeting upon a vote of the majority of its members present in person or through the use of amplified telephonic equipment if authorized by the bylaws of the board.

(e) Meetings.--The board shall meet at the call of the chairperson or as may be provided in the bylaws of the board. The board shall hold meetings at least quarterly, which shall be subject to the requirements of 65 Pa.C.S. Ch. 7 (relating to open meetings). Meetings of the board may be held anywhere within this Commonwealth.

(f) Chairperson.--The chairperson shall be the person appointed under subsection (b)(1).

(g) Formation.--The authority shall be formed within 60 days of the effective date of this section.

(h) For purposes of section 924 of the Public Health Service Act (58 Stat. 682, 42 U.S.C. § 299b-24), the authority is the sole public entity eligible to be certified as a patient safety organization as defined in section 921(4) of the Public Health Service Act (42 U.S.C. § 299b-21(4)) when conducting patient safety activities, as defined in section 921(5) of the Public Health Service Act (42 U.S.C. § 299b-21(5)), which fall within the scope of the authority's responsibilities. ((h) added Dec. 22, 2005, P.L.458, No.88)

Section 304. Powers and duties.

(a) General rule.--The authority shall do all of the following:

(1) Adopt bylaws necessary to carry out the provisions of this chapter.

(2) Employ staff as necessary to implement this chapter.

(3) Make, execute and deliver contracts and other instruments.

(4) Apply for, solicit, receive, establish priorities for, allocate, disburse, contract for, administer and spend funds in the fund and other funds that are made available to the authority from any source consistent with the purposes of this chapter.

(5) Contract with a for-profit or registered nonprofit entity or entities, other than a health care provider, to do the following:

(i) Collect, analyze and evaluate data regarding reports of serious events and incidents, including the identification of performance indicators and patterns in frequency or severity at certain medical facilities or in certain regions of this Commonwealth.

(ii) Transmit to the authority recommendations for changes in health care practices and procedures which may be instituted for the purpose of reducing the number and severity of serious events and incidents.

(iii) Directly advise reporting medical facilities of immediate changes that can be instituted to reduce serious events and incidents.

(iv) Conduct reviews in accordance with subsection (b).

(6) Receive and evaluate recommendations made by the entity or entities contracted with in accordance with paragraph (5) and report those recommendations to the department, which shall have no more than 30 days to approve or disapprove the recommendations.

(7) After consultation and approval by the department, issue recommendations to medical facilities on a

facility-specific or on a Statewide basis regarding changes, trends and improvements in health care practices and procedures for the purpose of reducing the number and severity of serious events and incidents. Prior to issuing recommendations, consideration shall be given to the following factors that include expectation of improved quality care, implementation feasibility, other relevant implementation practices and the cost impact to patients, payors and medical facilities. Statewide recommendations shall be issued to medical facilities on a continuing basis and shall be published and posted on the department's and the authority's publicly accessible World Wide Web site.

(8) Meet with the department for purposes of implementing this chapter.

(b) Anonymous reports to the authority.--A health care worker who has complied with section 308(a) may file an anonymous report regarding a serious event with the authority. Upon receipt of the report, the authority shall give notice to the affected medical facility that a report has been filed. The authority shall conduct its own review of the report unless the medical facility has already commenced an investigation of the serious event. The medical facility shall provide the authority with the results of its investigation no later than 30 days after receiving notice pursuant to this subsection. If the authority is dissatisfied with the adequacy of the investigation conducted by the medical facility, the authority shall perform its own review of the serious event and may refer a medical facility and any involved licensee to the department for failure to report pursuant to section 313(e) and (f).

(c) Annual report to General Assembly.--

(1) The authority shall report no later than May 1, 2003, and annually thereafter to the department and the General Assembly on the authority's activities in the preceding year. The report shall include:

(i) A schedule of the year's meetings.

(ii) A list of contracts entered into pursuant to this section, including the amounts awarded to each contractor.

(iii) A summary of the fund receipts and expenditures, including a financial statement and balance sheet.

(iv) The number of serious events and incidents reported by medical facilities on a geographical basis.

(v) The information derived from the data collected, including any recognized trends concerning patient safety.

(vi) The number of anonymous reports filed and reviews conducted by the authority.

(vii) The number of referrals to licensure boards for failure to report under this chapter.

(viii) Recommendations for statutory or regulatory changes which may help improve patient safety in the Commonwealth.

(2) The report shall be distributed to the Secretary of Health, the chair and minority chair of the Public Health and Welfare Committee of the Senate and the chair and minority chair of the Health and Human Services Committee of the House of Representatives.

(3) The annual report shall be made available for public inspection and shall be posted on the authority's publicly accessible World Wide Web site.

Section 305. Patient Safety Trust Fund.

(a) Establishment.--There is hereby established a separate account in the State Treasury to be known as the Patient Safety Trust Fund. The fund shall be administered by the authority. All interest earned from the investment or deposit of moneys accumulated in the fund shall be deposited in the fund for the same use.

(b) Funds.--All moneys deposited into the fund shall be held in trust and shall not be considered general revenue of the Commonwealth but shall be used only to effectuate the purposes of this chapter as determined by the authority.

(c) Payment.--Commencing July 1, 2002, each licensed medical facility shall pay the department a surcharge on its licensing fee, and each abortion facility not subject to State licensure shall pay an assessment as necessary to provide sufficient revenues to operate the authority. When determining the assessment for an abortion facility, the department shall apply the same methodology utilized for an ambulatory surgical facility. The total payment for all medical facilities shall not exceed $5,000,000. The department shall transfer the total payments to the fund within 30 days of receipt.

(d) Base amount.--For each succeeding calendar year, the department shall determine each medical facility's proportionate share of the authority's budget. The total amount shall not exceed $5,000,000 in fiscal year 2002-2003 and shall be increased according to the Consumer Price Index in each succeeding fiscal year.

(e) Expenditures.--Moneys in the fund shall be expended by the authority to implement this chapter.

(f) Dissolution.--In the event that the fund is discontinued or the authority is dissolved by operation of law, any balance remaining in the fund, after deducting administrative costs of liquidation, shall be returned to the medical facilities in proportion to their financial contributions to the fund.

(g) Failure to make payment.--If, after 30 days' notice, a medical facility fails to pay a surcharge or assessment levied by the department under this chapter, the department may impose an administrative penalty of $1,000 per day until the surcharge is paid.

(305 amended May 1, 2006, P.L.103, No.30)

Section 306. Department responsibilities.

(a) General rule.--The department shall do all of the following:

(1) Review and approve patient safety plans in accordance with section 307.

(2) Receive reports of serious events and infrastructure failures under section 313.

(3) Investigate serious events and infrastructure failures.

(4) In conjunction with the authority, analyze and evaluate existing health care procedures and approve recommendations issued by the authority pursuant to section 304(a)(6) and (7).

(5) Meet with the authority for purposes of implementing this chapter.

(b) Department consideration.--The recommendations made to medical facilities pursuant to subsection (a)(4) may be considered by the department for licensure purposes under the act of July 19, 1979 (P.L.130, No.48), known as the Health Care Facilities Act, and, in the case of abortion facilities, for approval or revocation purposes pursuant to 28 Pa. Code § 29.43 (relating to facility approval), but shall not be considered mandatory unless adopted by the department as regulations

pursuant to the act of June 25, 1982 (P.L.633, No.181), known as the Regulatory Review Act. ((b) amended May 1, 2006, P.L.103, No.30)

Section 307. Patient safety plans.

(a) Development and compliance.--A medical facility shall develop, implement and comply with an internal patient safety plan that shall be established for the purpose of improving the health and safety of patients. The plan shall be developed in consultation with the licensees providing health care services in the medical facility.

(b) Requirements.--A patient safety plan shall:

(1) Designate a patient safety officer as set forth in section 309.

(2) Establish a patient safety committee as set forth in section 310.

(3) Establish a system for the health care workers of a medical facility to report serious events and incidents which shall be accessible 24 hours a day, seven days a week.

(4) Prohibit any retaliatory action against a health care worker for reporting a serious event or incident in accordance with the act of December 12, 1986 (P.L.1559, No.169), known as the Whistleblower Law.

(5) Provide for written notification to patients in accordance with section 308(b).

(c) Approval.--Within 60 days from the effective date of this section, a medical facility shall submit its patient safety plan to the department for approval consistent with the requirements of this section. Unless the department approves or rejects the plan within 60 days of receipt, the plan shall be deemed approved.

(d) Employee notification.--Upon approval of the patient safety plan, a medical facility shall notify all health care workers of the medical facility of the patient safety plan. Compliance with the patient safety plan shall be required as a condition of employment or credentialing at the medical facility.

Section 308. Reporting and notification.

(a) Reporting.--A health care worker who reasonably believes that a serious event or incident has occurred shall report the serious event or incident according to the patient safety plan of the medical facility unless the health care worker knows that a report has already been made. The report shall be made immediately or as soon thereafter as reasonably practicable, but in no event later than 24 hours after the occurrence or discovery of a serious event or incident.

(b) Duty to notify patient.--A medical facility through an appropriate designee shall provide written notification to a patient affected by a serious event or, with the consent of the patient, to an available family member or designee within seven days of the occurrence or discovery of a serious event. If the patient is unable to give consent, the notification shall be given to an adult member of the immediate family. If an adult member of the immediate family cannot be identified or located, notification shall be given to the closest adult family member. For unemancipated patients who are under 18 years of age, the parent or guardian shall be notified in accordance with this subsection. The notification requirements of this subsection shall not be subject to the provisions of section 311(a). Notification under this subsection shall not constitute an acknowledgment or admission of liability.

(c) Liability.--A health care worker who reports the occurrence of a serious event or incident in accordance with

subsection (a) or (b) shall not be subject to any retaliatory action for reporting the serious event or incident and shall have the protections and remedies set forth in the act of December 12, 1986 (P.L.1559, No.169), known as the Whistleblower Law.

(d) Limitation.--Nothing in this section shall limit a medical facility's ability to take appropriate disciplinary action against a health care worker for failure to meet defined performance expectations or to take corrective action against a licensee for unprofessional conduct, including making false reports or failure to report serious events under this chapter.

Section 309. Patient safety officer.

A patient safety officer of a medical facility shall do all of the following:

(1) Serve on the patient safety committee.

(2) Ensure the investigation of all reports of serious events and incidents.

(3) Take such action as is immediately necessary to ensure patient safety as a result of any investigation.

(4) Report to the patient safety committee regarding any action taken to promote patient safety as a result of investigations commenced pursuant to this section.

Section 310. Patient safety committee.

(a) Composition.--

(1) A hospital's patient safety committee shall be composed of the medical facility's patient safety officer and at least three health care workers of the medical facility and two residents of the community served by the medical facility who are not agents, employees or contractors of the medical facility. No more than one member of the patient safety committee shall be a member of the medical facility's board of trustees. The committee shall include members of the medical facility's medical and nursing staff. The committee shall meet at least monthly.

(2) An ambulatory surgical facility's, abortion facility's or birth center's patient safety committee shall be composed of the medical facility's patient safety officer and at least one health care worker of the medical facility and one resident of the community served by the ambulatory surgical facility, abortion facility or birth center who is not an agent, employee or contractor of the ambulatory surgical facility, abortion facility or birth center. No more than one member of the patient safety committee shall be a member of the medical facility's board of governance. The committee shall include members of the medical facility's medical and nursing staff. The committee shall meet at least quarterly. ((2) amended May 1, 2006, P.L.103, No.30)

(b) Responsibilities.--A patient safety committee of a medical facility shall do all of the following:

(1) Receive reports from the patient safety officer pursuant to section 309.

(2) Evaluate investigations and actions of the patient safety officer on all reports.

(3) Review and evaluate the quality of patient safety measures utilized by the medical facility. A review shall include the consideration of reports made under sections 304(a)(5) and (b), 307(b)(3) and 308(a).

(4) Make recommendations to eliminate future serious events and incidents.

(5) Report to the administrative officer and governing body of the medical facility on a quarterly basis regarding the number of serious events and incidents and its

recommendations to eliminate future serious events and incidents.

Section 311. Confidentiality and compliance.

(a) Prepared materials.--Any documents, materials or information solely prepared or created for the purpose of compliance with section 310(b) or of reporting under section 304(a)(5) or (b), 306(a)(2) or (3), 307(b)(3), 308(a), 309(4), 310(b)(5) or 313 which arise out of matters reviewed by the patient safety committee pursuant to section 310(b) or the governing board of a medical facility pursuant to section 310(b) are confidential and shall not be discoverable or admissible as evidence in any civil or administrative action or proceeding. Any documents, materials, records or information that would otherwise be available from original sources shall not be construed as immune from discovery or use in any civil or administrative action or proceeding merely because they were presented to the patient safety committee or governing board of a medical facility.

(b) Meetings.--No person who performs responsibilities for or participates in meetings of the patient safety committee or governing board of a medical facility pursuant to section 310(b) shall be allowed to testify as to any matters within the knowledge gained by the person's responsibilities or participation on the patient safety committee or governing board of a medical facility, provided, however, the person shall be allowed to testify as to any matters within the person's knowledge which was gained outside of the persons's responsibilities or participation on the patient safety committee or governing board of a medical facility pursuant to section 310(b).

(c) Applicability.--The confidentiality protections set forth in subsections (a) and (b) shall only apply to the documents, materials or information prepared or created pursuant to the responsibilities of the patient safety committee or governing board of a medical facility set forth in section 310(b).

(d) Received materials.--Except as set forth in subsection (f), any documents, materials or information received by the authority or department from the medical facility, health care worker, patient safety committee or governing board of a medical facility solely prepared or created for the purpose of compliance with section 310(b) or of reporting under section 304(a)(5) or (b), 306(a)(2) or (3), 307(b)(3), 308(a), 309(4), 310(b)(5) or 313 shall not be discoverable or admissible as evidence in any civil or administrative action or proceeding. Any records received by the authority or department from the medical facility, health care worker, patient safety committee or governing board of a medical facility pursuant to the requirements of this act shall not be discoverable from the department or the authority in any civil or administrative action or proceeding. Documents, materials, records or information may be used by the authority or department to comply with the reporting requirements under subsection (f) and section 304(a)(7) or (c) or 306(b).

(e) Document review.--

(1) Except as set forth in paragraph (2), no current or former employee of the authority, the department or the Department of State shall be allowed to testify as to any matters gained by reason of his or her review of documents, materials, records or information submitted to the authority by the medical facility or health care worker pursuant to the requirements of this act.

(2) Paragraph (1) does not apply to findings or actions by the department or the Department of State which are public records.

(f) Access.--

(1) The department shall have access to the information under section 313(a) or (c) and may use such information for the sole purpose of any licensure, approval or corrective action against a medical facility. This exemption to use the information received pursuant to section 313(a) or (c) shall only apply to licensure or corrective actions and shall not be utilized to permit the disclosure of any information obtained under section 313(a) or (c) for any other purpose. ((1) amended May 1, 2006, P.L.103, No.30)

(2) The Department of State shall have access to the information under section 313(a) and may use such information for the sole purpose of any licensure or disciplinary action against a health care worker. This exemption to use the information received pursuant to section 313(a) shall only apply to licensure or disciplinary actions and shall not be utilized to permit the disclosure of any information obtained under section 313(a) for any other purpose.

(g) Original source document.--In the event an original source document as set forth in subsection (a) is determined by a court of competent jurisdiction to be unavailable from the health care worker or medical facility in a civil action or proceeding, then in that circumstance alone the department may be required pursuant to a court order to release that original source document to the party identified in the court order.

(h) Right-to-know requests.--Any documents, materials or information made confidential by subsection (a) shall not be subject to requests under the act of June 21, 1957 (P.L.390, No.212), referred to as the Right-to-Know Law.

(i) Liability.--Notwithstanding any other provision of law, no person providing information or services to the patient safety committee, governing board of a medical facility, authority or department shall be held by reason of having provided such information or services to have violated any criminal law, or to be civilly liable under any law, unless such information is false and the person providing such information knew or had reason to believe that such information was false and was motivated by malice toward any person directly affected by such action.

Compiler's Note: The act of June 21, 1957 (P.L.390, No.212), referred to as the Right-to-Know Law, referred to in subsec. (h), was repealed by the act of Feb. 14, 2008 (P.L.6, No.3), known as the Right-to-Know Law.

Section 312. Patient safety discount.

(312 expired December 31, 2007. See section 5106 of this act.)

Section 313. Medical facility reports and notifications.

(a) Serious event reports.--A medical facility shall report the occurrence of a serious event to the department and the authority within 24 hours of the medical facility's confirmation of the occurrence of the serious event. The report to the department and the authority shall be in the form and manner prescribed by the authority in consultation with the department and shall not include the name of any patient or any other identifiable individual information.

(b) Incident reports.--A medical facility shall report the occurrence of an incident to the authority in a form and manner

prescribed by the authority and shall not include the name of any patient or any other identifiable individual information.

(c) Infrastructure failure reports.--A medical facility shall report the occurrence of an infrastructure failure to the department within 24 hours of the medical facility's confirmation of the occurrence or discovery of the infrastructure failure. The report to the department shall be in the form and manner prescribed by the department.

(d) Effect of report.--Compliance with this section by a medical facility shall satisfy the reporting requirements of the act of July 19, 1979 (P.L.130, No.48), known as the Health Care Facilities Act.

(e) Notification to licensure boards.--If a medical facility discovers that a licensee providing health care services in the medical facility during a serious event failed to report the event in accordance with section 308(a), the medical facility shall notify the licensee's licensing board of the failure to report.

(f) Failure to report or notify.--Failure to report a serious event or an infrastructure failure as required by this section or to develop and comply with the patient safety plan in accordance with section 307 or to notify the patient in accordance with section 308(b) shall be a violation of the Health Care Facilities Act and, in the case of an abortion facility, may be a basis for revocation of approval pursuant to 28 Pa. Code § 29.43 (relating to facility approval). In addition to any penalty which may be imposed under the Health Care Facilities Act or under 18 Pa.C.S. Ch. 32 (relating to abortion), a medical facility which fails to report a serious event or an infrastructure failure or to notify a licensure board in accordance with this chapter may be subject to an administrative penalty of $1,000 per day imposed by the department. ((f) amended May 1, 2006, P.L.103, No.30)

(g) Report submission.--Within 30 days following notice published pursuant to section 5103, a medical facility shall begin reporting serious events, incidents and infrastructure failures consistent with the requirements of this section.

Section 314. Existing regulations.

The provisions of 28 Pa. Code § 51.3(f) and (g) (relating to notification) shall be abrogated with respect to a medical facility upon the reporting of a serious event, incident or infrastructure failure pursuant to section 313.

Section 315. Abortion facilities.

(a) General.--This section shall apply to abortion facilities.

(b) Application during current year.--An abortion facility that performs 100 or more abortions after the effective date of this act during the calendar year in which this section takes effect shall be subject to the provisions of this chapter at the beginning of the immediately following calendar year and during each subsequent calendar year unless the facility gives the department written notice that it will not be performing 100 or more abortions during such following calendar year and does not perform 100 or more abortions during that calendar year.

(c) Application in subsequent calendar years.--In the calendar years following the effective date of this act, this chapter shall apply to an abortion facility not subject to subsection (b) on the day following the performance of its 100th abortion and for the remainder of that calendar year and during each subsequent calendar year unless the facility gives the department written notice that it will not be performing 100

or more abortions during such following calendar year and does not perform 100 or more abortions during that calendar year.

(d) Patient safety plan.--An abortion facility shall submit its patient safety plan under section 307(c) within 60 days following the application of this chapter to the facility.

(e) Reporting.--An abortion facility shall begin reporting serious events, incidents and infrastructure failures consistent with the requirements of section 313 upon the submission of its patient safety plan to the department.

(f) Construction.--Nothing in this chapter shall be construed to limit the provisions of 18 Pa.C.S. Ch. 32 (relating to abortion) or any regulation adopted under 18 Pa.C.S. Ch. 32.

(315 added May 1, 2006, P.L.103, No.30)

CHAPTER 4
HEALTH CARE-ASSOCIATED INFECTIONS
(Ch. added July 20, 2007, P.L.331, No.52)

Section 401. Scope of chapter.

This chapter relates to the reduction and prevention of health care-associated infections.

(401 added July 20, 2007, P.L.331, No.52)

Section 402. 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:

"Ambulatory surgical facility." An entity defined as an ambulatory surgical facility under the act of July 19, 1979 (P.L.130, No.48), known as the Health Care Facilities Act.

"Antimicrobial agent." A general term for drugs, chemicals or other substances that kill or slow the growth of microbes, including, but not limited to, antibacterial drugs, antiviral agents, antifungal agents and antiparasitic drugs.

"Authority." The Patient Safety Authority established under this act.

"Centers for Disease Control and Prevention" or "CDC." The United States Department of Health and Human Services Centers for Disease Control and Prevention.

"Colonization." The first stage of microbial infection or the presence of nonreplicating microorganisms usually present in host tissues that are in contact with the external environment.

"Council." The Pennsylvania Health Care Cost Containment Council established under the act of July 8, 1986 (P.L.408, No.89), known as the Health Care Cost Containment Act.

"Department." The Department of Health of the Commonwealth.

"Fund." The Patient Safety Trust Fund as defined in section 305.

"Health care-associated infection." A localized or systemic condition that results from an adverse reaction to the presence of an infectious agent or its toxins that:

(1) occurs in a patient in a health care setting;

(2) was not present or incubating at the time of admission, unless the infection was related to a previous admission to the same setting; and

(3) if occurring in a hospital setting, meets the criteria for a specific infection site as defined by the Centers for Disease Control and Prevention and its National Healthcare Safety Network.

"Health Care Facilities Act." The act of July 19, 1979 (P.L.130, No.48), known as the Health Care Facilities Act.

"Health care facility." A hospital or nursing home licensed or otherwise regulated to provide health care services under the laws of this Commonwealth.

"Health payor." An individual or entity providing a group health, sickness or accident policy, subscriber contract or program issued or provided by an entity, including any one of the following:

(1) The act of June 2, 1915 (P.L.736, No.338), known as the Workers' Compensation Act.

(2) The act of May 17, 1921 (P.L.682, No.284), known as The Insurance Company Law of 1921.

(3) The act of December 29, 1972 (P.L.1701, No.364), known as the Health Maintenance Organization Act.

(4) The act of May 18, 1976 (P.L.123, No.54), known as the Individual Accident and Sickness Insurance Minimum Standards Act.

(5) 40 Pa.C.S. Ch. 61 (relating to hospital plan corporations).

(6) 40 Pa.C.S. Ch. 63 (relating to professional health services plan corporations).

"Medical assistance." The Commonwealth's medical assistance program established under the act of June 13, 1967 (P.L.31, No.21), known as the Public Welfare Code.

"Methicillin-resistant Staphylococcus aureus" or "MRSA." A strain of bacteria that is resistant to certain antibiotics and is difficult to treat medically.

"Multidrug-resistant organism" or "MDRO." Microorganisms, predominantly bacteria, that are resistant to more than one class of antimicrobial agents.

"National Healthcare Safety Network" or "NHSN." A secure Internet-based data collection system managed by the Division of Healthcare Quality Promotion at the Centers for Disease Control and Prevention.

"Nationally recognized standards." Standards developed by the Department of Health and Human Services Centers for Disease Control and Prevention (CDC) and its National Healthcare Safety Network.

"Nursing home." An entity licensed as a long-term care nursing facility under the act of July 19, 1979 (P.L.130, No.48), known as the Health Care Facilities Act.

"Surveillance system." An ongoing and comprehensive method of measuring health status, outcomes and related processes of care, analyzing data and providing information from data sources within a health care facility to assist in reducing health care-associated infections.

(402 added July 20, 2007, P.L.331, No.52)

Compiler's Note: The short title of the act of June 13, 1967 (P.L.31, No.21), known as the Public Welfare Code, referred to in this section, was amended by the act of December 28, 2015 (P.L.500, No.92). The amended short title is now the Human Services Code.

Section 403. Infection control plan.

(a) Development and compliance.--Within 120 days of the effective date of this section, a health care facility and an ambulatory surgical facility shall develop and implement an internal infection control plan that shall be established for the purpose of improving the health and safety of patients and health care workers and shall include:

(1) A multidisciplinary committee including representatives from each of the following if applicable to that specific health care facility:

(i) Medical staff that could include the chief medical officer or the nursing home medical director.

(ii) Administration representatives that could include the chief executive officer, the chief financial officer or the nursing home administrator.

(iii) Laboratory personnel.

(iv) Nursing staff that could include a director of nursing or a nursing supervisor.

(v) Pharmacy staff that could include the chief of pharmacy.

(vi) Physical plant personnel.

(vii) A patient safety officer.

(viii) Members from the infection control team, which could include an epidemiologist.

(ix) The community, except that these representatives may not be an agent, employee or contractor of the health care facility or ambulatory surgical facility.

(2) Effective measures for the detection, control and prevention of health care-associated infections.

(3) Culture surveillance processes and policies.

(4) A system to identify and designate patients known to be colonized or infected with MRSA or other MDRO that includes:

(i) The procedures necessary for requiring cultures and screenings for nursing home residents admitted to a hospital.

(ii) The procedures for identifying other high-risk patients admitted to the hospital who necessitate routine cultures and screening.

(5) The procedures and protocols for staff who may have had potential exposure to a patient or resident known to be colonized or infected with MRSA or MDRO, including cultures and screenings, prophylaxis and follow-up care.

(6) An outreach process for notifying a receiving health care facility or an ambulatory surgical facility of any patient known to be colonized prior to transfer within or between facilities.

(7) A required infection-control intervention protocol which includes:

(i) Infection control precautions, based on nationally recognized standards, for general surveillance of infected or colonized patients.

(ii) Intervention protocols based on evidence-based standards.

(iii) Isolation procedures.

(iv) Physical plant operations related to infection control.

(v) Appropriate use of antimicrobial agents.

(vi) Mandatory educational programs for personnel.

(vii) Fiscal and human resource requirements.

(8) The procedure for distribution of advisories issued under section 405(b)(4) so as to ensure easy access in each health care facility for all administrative staff, medical personnel and health care workers.

(b) Department review.--No later than 14 days after implementation of its infection control plan, a health care facility and an ambulatory surgical facility shall submit the plan to the department. The department shall review each health care facility's and ambulatory surgical facility's infection control plan to ensure compliance under the Health Care Facilities Act and section 408(3). If, at any time, the

department finds that an infection control plan does not meet the requirements of this chapter or any applicable laws, the health care facility or ambulatory surgical facility shall modify its plan to come into compliance.

(c) Notification.--Upon submission to the department of its infection control plan, a health care facility and an ambulatory surgical facility shall notify all health care workers, physical plant personnel and medical staff of the facility of the infection control plan. Compliance with the infection control plan shall be enforced by the facility.

(403 added July 20, 2007, P.L.331, No.52)

Section 404. Health care facility reporting.

(a) Nursing home reporting.--In addition to reporting pursuant to the Health Care Facilities Act, a nursing home shall also electronically report health care-associated infection data to the department and the authority using nationally recognized standards based on CDC definitions, provided that the data is reported on a patient-specific basis in the form, with the time for reporting and format as determined by the department and the authority.

(b) Hospital reporting.--A hospital shall report health care-associated infection data to the CDC and its National Healthcare Safety Network no later than 180 days following the effective date of this section. A hospital shall:

(1) Report all components as defined in the NHSN Manual, Patient Safety Component Protocol and any successor edition, for all patients throughout the facility on a continuous basis.

(2) Report patient-specific data to include, at a minimum, patient identification number, gender and date of birth. The patient identification number must be compatible with the patient identifier on the uniform billing forms submitted to the council.

(3) Report data on a monthly basis in accordance with protocols defined in the NHSN Manual as updated by the CDC.

(4) Authorize the department, the authority and the council to have access to the NHSN for facility-specific reports of health care-associated infection data contained in the NHSN database for purposes of viewing and analyzing that data.

(c) Strategic assessments.--Each hospital, other than those currently using a qualified electronic surveillance system, shall by December 31, 2007, conduct a strategic assessment of the utility and efficacy of implementing a qualified electronic surveillance system pursuant to subsections (d) and (e) for the purpose of improving infection control and prevention. The assessment shall also include an examination of financial and technological barriers to implementation of a qualified electronic surveillance system pursuant to subsections (d) and (e). The assessment shall be submitted to the department within 14 days of completion.

(d) Qualified electronic surveillance system.--A qualified electronic surveillance system shall include the following minimum elements:

(1) Extractions of existing electronic clinical data from health care facility systems on an ongoing, constant and consistent basis.

(2) Translation of nonstandardized laboratory, pharmacy and/or radiology data into uniform information that can be analyzed on a population-wide basis.

(3) Clinical support, educational tools and training to ensure that information provided under this subsection

will assist the hospital in reducing the incidence of health care-associated infections in a manner that meets or exceeds benchmarks.

(4) Clinical improvement measurements designed to provide positive and negative feedback to health care facility infection control staff.

(5) Collection of data that is patient-specific for the entire facility.

(e) Electronic surveillance system implementation.--Except as otherwise provided in this subsection, a hospital shall have a qualified electronic surveillance system in place by December 31, 2008. The following apply:

(1) If a determination has been made under subsection (c) that a qualified electronic surveillance system can be implemented, the hospital shall comply with subsection (f) until implementation.

(2) If a determination has been made under subsection (c) that a qualified electronic surveillance system cannot be implemented, by December 31, 2008, the hospital shall comply with subsection (f) until such time as a qualified electronic surveillance system is implemented.

(f) Surveillance system.--Until a hospital implements a qualified electronic surveillance system, the facility shall use a surveillance system that includes:

(1) A written plan of the elements of the surveillance process to include, but not be limited to, definitions, collection of surveillance data and reporting of information.

(2) Identification of personnel resources that will be used in the surveillance process.

(3) Identification of information or technological support needed to implement the surveillance system.

(4) A process for periodic evaluation and validation to ensure accuracy of surveillance.

(g) Continued reporting.--Until hospitals begin reporting to NHSN and have authorized access to the department, the authority and the council, hospitals shall continue to meet reporting requirements pursuant to Chapter 3 of this act and section 6 of the act of July 8, 1986 (P.L.408, No.89), known as the Health Care Cost Containment Act.

(404 added July 20, 2007, P.L.331, No.52)

Section 405. Patient Safety Authority jurisdiction.

(a) Health care facility reports to authority.--The occurrence of a health care-associated infection in a health care facility shall be deemed a serious event as defined in section 302. The report to the authority shall also be subject to all of the confidentiality protections set forth in section 311. The occurrence of a health care-associated infection shall only constitute a serious event for hospitals if it meets the criteria for reporting as defined by the current CDC and NHSN Manual, Patient Safety Component Protocol and any successor edition.

(b) Duties.--In addition to its existing responsibilities, the authority is responsible for all of the following:

(1) Establishing, based on CDC definitions, uniform definitions using nationally recognized standards for the identification and reporting of health care-associated infections by nursing homes.

(2) Publishing a notice in the Pennsylvania Bulletin stating the uniform reporting requirements established pursuant to this subsection and the effective date for the commencement of required reporting by hospitals consistent

with this chapter, which, at a minimum, shall begin 120 days after publication of the notice.

(3) Publishing a notice in the Pennsylvania Bulletin stating the uniform reporting requirements established pursuant to this subsection and section 404(a) and the effective date for the commencement of required reporting by nursing homes consistent with this chapter, which, at a minimum, shall begin 120 days after publication of the notice.

(4) Issuing advisories to health care facilities in a manner similar to section 304(a)(7).

(5) Including a separate category for providing information about health care-associated infections in the annual report under section 304(c).

(6) Creating and conducting training programs for infection control teams, health care workers and physical plant personnel about the prevention and control of health care-associated infections. Nothing in this act shall preclude the authority from working with the department or any organization in conducting these programs.

(7) Appointing an advisory panel of health care-associated infection control experts, including at least one representative of a not-for-profit nursing home, at least one representative of a for-profit nursing home, at least one representative of a county nursing home and at least two representatives of a hospital, one of which must be from a rural hospital, to assist in carrying out the requirements of this chapter.

(c) Public comment.--Prior to publishing a notice under subsection (b)(2) and (3), the authority shall solicit public comments for at least 30 days. The authority shall respond to the comments it receives during the 30-day public comment period.

(405 added July 20, 2007, P.L.331, No.52)

Section 406. Payment for performing routine cultures and screenings.

The cost of routine cultures and screenings performed on patients in compliance with a health care facility's and ambulatory surgical facility's infection control plan shall be considered a reimbursable cost to be paid by health payors and medical assistance upon Federal approval. These costs shall be subject to any copayment, coinsurance or deductible in amounts imposed in any applicable policy issued by a health payor and to any agreements between a health care facility, ambulatory surgical facility and payor.

(406 added July 20, 2007, P.L.331, No.52)

Section 407. Quality improvement payment.

(a) General rule.--Commencing on January 1, 2009, the Department of Public Welfare in consultation with the department shall make a quality improvement payment to a health care facility that achieves at least a 10% reduction for that facility in the total number of reported health care-associated infections over the preceding year pursuant to section 408(7)(i). For calendar year 2010 and thereafter, the Department of Public Welfare shall consult with the department to establish appropriate percentage benchmarks for the reduction of health care-associated infections in each health care facility in order to be eligible for a payment pursuant to this section.

(b) Additional quality improvement payments.--Nothing in this section shall prevent the Department of Public Welfare in consultation with the department from providing additional quality improvement payments to a health care facility that has

implemented a qualified electronic surveillance system and has achieved or exceeded reductions in the total number of reported health care-associated infections for that facility over the preceding year as provided in subsection (a).

(c) Eligibility.--In addition to meeting the requirements contained in this section, to be eligible for a quality improvement payment, a health care facility must be in compliance with health care-associated reporting requirements contained in this act and the Health Care Facilities Act.

(d) Distribution of funds.--Funds for the purpose of implementing this section shall be appropriated to the Department of Public Welfare and distributed to eligible health care facilities as set forth in this section. Quality improvement payments to health care facilities shall be limited to funds available for this purpose.

(407 added July 20, 2007, P.L.331, No.52)

Compiler's Note: The Department of Public Welfare, referred to in this section, was redesignated as the Department of Human Services by Act 132 of 2014.

Section 408. Duties of Department of Health.

The department is responsible for the following:

(1) The development of a public health awareness campaign on health care-associated infections to be known as the Community Awareness Program. The program shall provide information to the public on causes and symptoms of health care-associated infections, diagnosis and treatment prevention methods and the proper use of antimicrobial agents.

(2) The consideration and determination of the feasibility of establishing an active surveillance program involving other entities, such as athletic teams or correctional facilities for the purpose of identifying those persons in the community that are colonized and at risk of susceptibility to and transmission of MRSA bacteria.

(3) The review of each health care facility's and ambulatory surgical facility's infection control plan. This review shall be performed pursuant to the department's authority under the Health Care Facilities Act and the regulations promulgated thereunder.

(4) The development of recommendations and best practices that implement and effectuate improved screenings and cultures and other means for the reduction and elimination of health care-associated infections.

(5) The development of recommendations regarding evidence-based screening protocols for an individual with MRSA and MDRO prior to admission to a hospital.

(6) The review of strategic assessments under section 404(c) and the provision of assistance to hospitals in implementing a qualified electronic surveillance system pursuant to the requirements of section 404(d) and (e).

(7) The development of a methodology, in consultation with the authority and the council, for determining and assessing the rate of health care-associated infections that occur in health care facilities in this Commonwealth. This methodology shall be used:

(i) to determine the rate of reduction in health care-associated infection rates within a health care facility during a reporting period;

(ii) to compare health care-associated infection rates among similar health care facilities within this Commonwealth; and

(iii) to compare health care-associated infection rates among similar health care facilities nationwide.

(8) The development, in consultation with the authority and the council, of reasonable benchmarks to measure the progress health care facilities make toward reducing health care-associated infections. Beginning in 2010, all health care facilities shall be measured against these benchmarks. A health care facility with a rate of health care-associated infections that does not meet the benchmark appropriate to that type of facility shall be required to submit a plan of correction to the department within 60 days of receiving notification that the rate does not meet the benchmark. After 180 days, a facility that has not shown progress in reducing its rate of infection shall consult with and obtain department approval for a new plan of correction that includes resources available to assist the health care facility. After an additional 180 days, a facility that fails to show progress in reducing its rate of infection may be subject to action under the Health Care Facilities Act.

(9) Publishing a notice in the Pennsylvania Bulletin of the specific benchmarks the department shall use to measure the progress of health care facilities in reducing health care-associated infections. Prior to publishing the notice, the department shall seek public comments for at least 30 days. The department shall respond to the comments it receives during the 30-day public comment period.

(408 added July 20, 2007, P.L.331, No.52)

Section 409. Nursing home assessment to Patient Safety Authority.

(a) Assessment.--Commencing July 1, 2008, each nursing home shall pay the department a surcharge on its licensing fee as necessary to provide sufficient revenues for the authority to perform its responsibilities under this chapter. The total annual assessment for all nursing homes shall not be more than an aggregate amount of $1,000,000. The department shall transfer the total assessment amount to the fund within 30 days of receipt.

(b) Base amount.--For each succeeding calendar year, the authority shall determine the appropriate assessment amount and the department shall assess each nursing home its proportionate share of the authority's budget for its responsibilities under this chapter. The total assessment amount shall not be more than $1,000,000 in fiscal year 2008-2009 and shall be increased according to the Consumer Price Index in each succeeding fiscal year.

(c) Expenditures.--Money appropriated to the fund under this chapter shall be expended by the authority to implement this chapter.

(d) Dissolution.--In the event that the fund is discontinued or the authority is dissolved by operation of law, any balance paid by nursing homes remaining in the fund, after deducting administrative costs of liquidation, shall be returned to the nursing homes in proportion to their financial contributions to the fund in the preceding licensing period.

(e) Failure to pay surcharge.--If, after 30 days' notice, a nursing home fails to pay a surcharge levied by the department under this chapter, the department may assess an administrative penalty of $1,000 per day until the surcharge is paid.

(f) Reimbursable cost.--Subject to Federal approval, the annual assessment amount paid by a nursing home shall be a reimbursable cost under the medical assistance program. The Department of Public Welfare shall pay each nursing home, as a

separate, pass-through payment, an amount equal to the assessment paid by a nursing home multiplied by the facility's medical assistance occupancy rate as reported in its annual cost report.

(409 added July 20, 2007, P.L.331, No.52)

Compiler's Note: The Department of Public Welfare, referred to in this section, was redesignated as the Department of Human Services by Act 132 of 2014.

Section 410. Scope of reporting.

For purposes of reporting health care-associated infections to the Commonwealth, its agencies and independent agencies, this chapter sets forth the applicable criteria to be utilized by health care facilities in making such reports. Nothing in this act shall supersede the requirements set forth in the act of April 23, 1956 (1955 P.L.1510, No.500), known as the Disease Prevention and Control Law of 1955, and the regulations promulgated thereunder.

(410 added July 20, 2007, P.L.331, No.52)

Section 411. Penalties.

(a) Violation of Health Care Facilities Act.--The failure of a health care facility to report health care-associated infections as required by sections 404 and 405 or the failure of a health care facility or ambulatory surgical facility to develop, implement and comply with its infection control plan in accordance with the requirements of section 403 shall be a violation of the Health Care Facilities Act.

(b) Administrative penalty.--In addition to any penalty that may be imposed under the Health Care Facilities Act, a health care facility which negligently fails to report a health care-associated infection as required under this chapter may be subject to an administrative penalty of $1,000 per day imposed by the department.

(411 added July 20, 2007, P.L.331, No.52)

CHAPTER 5
MEDICAL PROFESSIONAL LIABILITY

Section 501. Scope.

This chapter relates to medical professional liability.

Section 502. Declaration of policy.

The General Assembly finds and declares that it is the purpose of this chapter to ensure a fair legal process and reasonable compensation for persons injured due to medical negligence in this Commonwealth. Ensuring the future availability of and access to quality health care is a fundamental responsibility that the General Assembly must fulfill as a promise to our children, our parents and our grandparents.

Section 503. 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:

"Commission." The Interbranch Commission on Venue established in section 514.

"Department." The Insurance Department of the Commonwealth.

"Health care provider." A primary health care center, a personal care home licensed by the Department of Public Welfare pursuant to the act of June 13, 1967 (P.L.31, No.21), known as the Public Welfare Code, or a person, including a corporation, university or other educational institution licensed or approved by the Commonwealth to provide health care or professional

medical services as a physician, a certified nurse midwife, a podiatrist, hospital, nursing home, birth center, and an officer, employee or agent of any of them acting in the course and scope of employment.

"Informed consent." The consent of a patient to the performance of a procedure in accordance with section 504.

Compiler's Note: The short title of the act of June 13, 1967 (P.L.31, No.21), known as the Public Welfare Code, referred to in this section, was amended by the act of December 28, 2015 (P.L.500, No.92). The amended short title is now the Human Services Code.

Compiler's Note: The Department of Public Welfare, referred to in this section, was redesignated as the Department of Human Services by Act 132 of 2014.

Section 504. Informed consent.

(a) Duty of physicians.--Except in emergencies, a physician owes a duty, which may be fulfilled by a physician or by a qualified practitioner under subsection (b), 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) Requirements to obtain informed consent.--Consent is informed if the patient or the patient's authorized representative 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. A physician may delegate the task of obtaining the informed consent of the patient or the patient's authorized representative to a qualified practitioner for a procedure under subsection (a) performed by a physician or performed by a qualified practitioner. If claims for failure to obtain informed consent are alleged, the physician or qualified practitioner shall be entitled to present evidence of the description of that procedure and those risks and alternatives that a physician or qualified practitioner, acting in accordance with accepted medical standards of medical practice, would provide.

(b.1) Consent from another qualified practitioner.--A physician or qualified practitioner performing a procedure under subsection (a) may rely on information provided by another qualified practitioner to obtain the informed consent of the patient or the patient's authorized representative.

(b.2) Evidence.--Information provided by another qualified practitioner under subsection (b.1) shall be competent evidence in a proceeding in which it is alleged that a physician or qualified practitioner performing a procedure under subsection (a) failed to obtain informed consent.

(b.3) Construction.--Nothing under this section shall be construed to require a physician to delegate the authority to obtain informed consent to a qualified practitioner or prohibit a patient or the patient's authorized representative from requesting the physician, rather than the delegated qualified practitioner under subsection (b.1), answer a question

concerning the procedure, risks or alternatives to the procedure or obtain informed consent. If the patient or patient's authorized representative makes a request that the physician act under this subsection, the physician shall obtain informed consent.

(c) Expert testimony.--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) Liability.--

(1) Liability under this section for failure to obtain the informed consent only may be established 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).

(2) Liability may be established under this section for failure to seek a patient's informed consent if the physician or qualified practitioner knowingly misrepresents to the patient the professional credentials, training or experience of the physician or qualified practitioner who performs the procedure.

(e) Human research exception.--The requirements under this section shall be deemed satisfied if informed consent is obtained for human research conducted pursuant to approval by an institutional review board or similar entity in accordance with 21 CFR Pt. 50 (relating to protection of human subjects), 45 CFR Pt. 46 (relating to protection of human subjects) and any other applicable Federal laws and regulations.

(f) Applicability.--A physician or qualified practitioner performing a procedure under subsection (a) shall not be required to obtain a separate or new informed consent from the patient or the patient's authorized representative, provided that informed consent was already obtained by a physician or another qualified practitioner with respect to the procedure.

(g) Definition.--As used in this section, the term "qualified practitioner" means a:

(1) "Physician assistant" as defined in section 2 of the act of December 20, 1985 (P.L.457, No.112), known as the Medical Practice Act of 1985, or section 2 of the act of October 5, 1978 (P.L.1109, No.261), known as the Osteopathic Medical Practice Act;

(2) "Certified registered nurse practitioner" as defined in section 2(12) of the act of May 22, 1951 (P.L.317, No.69), known as The Professional Nursing Law;

(3) "Midwife or nurse-midwife" as defined in section 2 of the Medical Practice Act of 1985; and

(4) Registered nurse under section 3 of The Professional Nursing Law who is authorized under the registered nurse's scope of practice to perform the procedure as delegated by the physician or a registered nurse authorized to administer anesthesia under 49 Pa. Code § 21.17 (relating to anesthesia) or a successor statute or regulation.

The term shall include another physician and a physician participating in a medical residency or fellowship training program. A qualified practitioner shall have knowledge of the patient's condition and the procedure enumerated under subsection (a) to be conducted on the patient and shall be acting under the supervision of, at the direction of, or in collaboration or cooperation with, the physician.

(504 amended June 30, 2021, P.L.330, No.61)

Compiler's Note: Section 2 of Act 61 of 2021 provided that the amendment of section 504 shall apply to all pending litigation. The term "pending litigation" means any action in which a final order has not yet been entered prior to the effective date of this section.

Section 504.1. Informed consent in pelvic, rectal and prostate examinations.

(a) General rule.--A health care provider, in the course of participating in or overseeing a professional instruction or clinical training program, owes a duty to a patient to obtain specific informed consent, in verbal and written form, before knowingly performing any of the following examinations on a patient who is anesthetized or unconscious in a facility that provides health care services:

(1) Pelvic examination.

(2) Rectal examination.

(3) Prostate examination.

(b) Exceptions.--Subsection (a) does not apply if:

(1) the examination is within the scope of care ordered for the patient; or

(2) the examination is necessary in the case of a medical emergency for the purpose of diagnosis or treatment and the patient is incapable of providing specific informed consent.

(c) Liability.--

(1) A health care provider shall be liable under section 504 for a violation of this section. In the event that a student participating in and being overseen by a health care provider as part of the professional instruction or clinical training program violates this section, the health care provider overseeing the student's professional instruction or clinical training program shall be liable under section 504.

(2) Notwithstanding paragraph (1), the university, educational institution or other corporate entity that hosts the professional instruction or clinical training program shall be liable to an individual damaged by a violation of this section for a $1,000 penalty. Nothing in this paragraph shall preclude or limit an individual from recovering any other damages from a university, educational institution or other corporate entity.

(d) Delegation.--A health care provider may delegate the task of obtaining the specific informed consent of a patient to a qualified practitioner for an examination under subsection (a). For the purpose of this subsection, a qualified practitioner may not be a student participating in or being overseen by a health care provider as part of the professional instruction or clinical training program.

(e) Definitions.--As used in this section, the following words and phrases shall have the meanings given to them in this subsection:

"Health care provider." A primary health care center or a person, including a corporation, university or other educational institution licensed or approved by the Commonwealth to provide health care or professional medical services as a physician, a physician assistant, a certified registered nurse practitioner, a registered nurse under section 3 of the act of May 22, 1951 (P.L.317, No.69), known as The Professional Nursing Law, who is authorized under the registered nurse's scope of practice to perform the procedure as delegated by the physician or a registered nurse authorized to administer anesthesia under 49 Pa. Code § 21.17 (relating to anesthesia), a certified nurse

midwife, a podiatrist, hospital, nursing home, birth center, ambulatory surgical facility and an officer, employee or agent of any of them acting in the course and scope of employment.

"Hospital." An entity licensed as a hospital under the act of June 13, 1967 (P.L.31, No.21), known as the Human Services Code, or the act of July 19, 1979 (P.L.130, No.48), known as the Health Care Facilities Act.

"Patient." A natural person who receives or should have received health care from a health care provider.

"Specific informed consent." The consent of a patient to the performance of an examination in accordance with this section after the patient has received a description of the examination, the purpose for providing the examination and any risks or alternatives to the examination so that a reasonably prudent patient may make an informed decision as to the examination.

(504.1 added Nov. 21, 2023, P.L.181, No.31)

Section 505. Punitive damages.

(a) Award.--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) Gross negligence.--A showing of gross negligence is insufficient to support an award of punitive damages.

(c) Vicarious liability.--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) Total amount of damages.--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.

(e) Allocation.--Upon the entry of a verdict including an award of punitive damages, the punitive damages portion of the award shall be allocated as follows:

(1) 75% shall be paid to the prevailing party; and

(2) 25% shall be paid to the Medical Care Availability and Reduction of Error Fund.

Section 506. Affidavit of noninvolvement.

(a) General provisions.--Any health care provider named as a defendant in a medical professional liability 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) Statute of limitations.--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) Challenge.--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) False or inaccurate filing or statement.--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.

Section 507. 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. Notwithstanding section 508, evidence of an advance payment shall not be admissible by a claimant in a medical professional liability action.

Section 508. Collateral sources.

(a) General rule.--Except as set forth in subsection (d), a claimant in a medical professional liability action is precluded from recovering damages for past medical expenses or past lost earnings incurred to the time of trial to the extent that the loss is covered by a private or public benefit or gratuity that the claimant has received prior to trial.

(b) Option.--The claimant has the option to introduce into evidence at trial the amount of medical expenses actually incurred, but the claimant shall not be permitted to recover for such expenses as part of any verdict except to the extent that the claimant remains legally responsible for such payment.

(c) No subrogation.--Except as set forth in subsection (d), there shall be no right of subrogation or reimbursement from a claimant's tort recovery with respect to a public or private benefit covered in subsection (a).

(d) Exceptions.--The collateral source provisions set forth in subsection (a) shall not apply to the following:

(1) Life insurance, pension or profit-sharing plans or other deferred compensation plans, including agreements pertaining to the purchase or sale of a business.

(2) Social Security benefits.

(3) Cash or medical assistance benefits which are subject to repayment to the Department of Public Welfare.

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

Compiler's Note: The Department of Public Welfare, referred to in this section, was redesignated as the Department of Human Services by Act 132 of 2014.

Section 509. Payment of damages.

(a) General rule.--In a medical professional liability action, the trier of fact shall make a determination with separate findings for each claimant specifying the amount of all of the following:

(1) Except as provided for under section 508, past damages for:

(i) medical and other related expenses in a lump sum;

(ii) loss of earnings in a lump sum; and

(iii) noneconomic loss in a lump sum.

(2) Future damages for:

(i) medical and other related expenses by year;

(ii) loss of earnings or earning capacity in a lump sum; and

(iii) noneconomic loss in a lump sum.

(b) Future damages.--

(1) Except as set forth in paragraph (8), future damages for medical and other related expenses shall be paid as periodic payments after payment of the proportionate share of counsel fees and costs based upon the present value of the future damages awarded pursuant to this subsection. The trier of fact may vary the amount of periodic payments for future damages as set forth in subsection (a)(2)(i) from year to year for the expected life of the claimant to account for different annual expenditure requirements, including the immediate needs of the claimant. The trier of fact shall also provide for purchase and replacement of medically necessary equipment in the years that expenditures will be required as may be necessary.

(2) The trier of fact may incorporate into any future medical expense award adjustments to account for reasonably anticipated inflation and medical care improvements as presented by competent evidence.

(3) Future damages as set forth in subsection (a)(2)(i) shall be paid in the years that the trier of fact finds they will accrue. Unless the court orders or approves a different schedule for payment, the annual amounts due must be paid in equal quarterly installments rounded to the nearest dollar. Each installment is due and payable on the first day of the month in which it accrues.

(4) Interest does not accrue on a periodic payment before payment is due. If the payment is not made on or before the due date, the legal rate of interest accrues as of that date.

(5) Liability to a claimant for periodic payments not yet due for medical expenses terminates upon the claimant's death.

(6) Each party liable for all or a portion of the judgment shall provide funding for the awarded periodic payments, separately or jointly with one or more others, by means of an annuity contract, trust or other qualified funding plan which is approved by the court. The commissioner shall annually publish a list of insurers designated by the commissioner as qualified to participate in the funding of periodic payment judgments. No annuity contractor may be placed on the commissioner's list of insurers unless the insurer has received the highest rating for claims paying ability by two independent financial services within the last 12 months.

(7) If an insurer defaults on a required periodic payment due to insolvency, the claimant shall be entitled to receive the payment from the Medical Care Availability

and Reduction of Error Fund or, if the fund has ceased operations, from the Pennsylvania Life and Health Insurance Guaranty Association or the Property and Casualty Insurance Guaranty Association, whichever is applicable.

(8) Future damages for medical and other related expenses shall not be awarded in periodic payments if the claimant objects and stipulates that the total amount of the future damages for medical and other related expenses, without reduction to present value, does not exceed $100,000.

(c) Effect of full funding.--If full funding of an award pursuant to this section has been provided, the judgment is discharged, and any outstanding liens as a result of the judgment are released.

(d) Retained jurisdiction.--The court which enters judgment shall retain jurisdiction to enforce the judgment and to resolve related disputes.

Section 510. Reduction to present value.

Future damages for loss of earnings or earning capacity in a medical professional liability action shall be reduced to present value based upon the return that the claimant can earn on a reasonably secure fixed income investment. These damages shall be presented with competent evidence of the effect of productivity and inflation over time. The trier of fact shall determine the applicable discount rate based upon competent evidence.

Section 511. Preservation and accuracy of medical records.

(a) Timing.--Entries in patient charts concerning care rendered shall be made contemporaneously or as soon as practicable. Except as otherwise provided for in this section, it shall be considered unprofessional conduct and a violation of the applicable licensing statute to make alterations to a patient's chart.

(b) Corrections and disposal of records.--It shall not be considered unprofessional conduct or a violation of the applicable licensing statute for a health care provider to:

(1) Correct information on a patient's chart where information has been entered erroneously or where it is necessary to clarify entries made on the chart, provided that such corrections or additions shall be clearly identified as subsequent entries by a date and time.

(2) Add information to a patient's chart where it was not available at the time the record was first created, provided that:

(i) Such additions shall be clearly dated as subsequent entries.

(ii) A health care provider may add supplemental information within a reasonable time.

(3) Routinely dispose of medical records as permitted by law.

(c) Alteration of records.--In any medical professional liability action in which the claimant proves by a preponderance of the evidence that there has been an intentional alteration or destruction of medical records, the court in its discretion may instruct the jury to consider whether such intentional alteration or destruction constitutes an adverse inference.

(d) Licensure sanction.--Alteration or destruction of medical records for the purpose of eliminating information that would give rise to a medical professional liability action on the part of a health care provider shall constitute a ground for suspension. A health care provider who is aware of alteration or destruction in violation of this section shall

report any party suspected of such conduct to the appropriate licensure board.

Section 512. Expert qualifications.

(a) General rule.--No person shall be competent to offer an expert medical opinion in a medical professional liability action against a physician unless that person possesses sufficient education, training, knowledge and experience to provide credible, competent testimony and fulfills the additional qualifications set forth in this section as applicable.

(b) Medical testimony.--An expert testifying on a medical matter, including the standard of care, risks and alternatives, causation and the nature and extent of the injury, must meet the following qualifications:

(1) Possess an unrestricted physician's license to practice medicine in any state or the District of Columbia.

(2) Be engaged in or retired within the previous five years from active clinical practice or teaching. Provided, however, the court may waive the requirements of this subsection for an expert on a matter other than the standard of care if the court determines that the expert is otherwise competent to testify about medical or scientific issues by virtue of education, training or experience.

(c) Standard of care.--In addition to the requirements set forth in subsections (a) and (b), an expert testifying as to a physician's standard of care also must meet the following qualifications:

(1) Be substantially familiar with the applicable standard of care for the specific care at issue as of the time of the alleged breach of the standard of care.

(2) Practice in the same subspecialty as the defendant physician or in a subspecialty which has a substantially similar standard of care for the specific care at issue, except as provided in subsection (d) or (e).

(3) In the event the defendant physician is certified by an approved board, be board certified by the same or a similar approved board, except as provided in subsection (e).

(d) Care outside specialty.--A court may waive the same subspecialty requirement for an expert testifying on the standard of care for the diagnosis or treatment of a condition if the court determines that:

(1) the expert is trained in the diagnosis or treatment of the condition, as applicable; and

(2) the defendant physician provided care for that condition and such care was not within the physician's specialty or competence.

(e) Otherwise adequate training, experience and knowledge.--A court may waive the same specialty and board certification requirements for an expert testifying as to a standard of care if the court determines that the expert possesses sufficient training, experience and knowledge to provide the testimony as a result of active involvement in or full-time teaching of medicine in the applicable subspecialty or a related field of medicine within the previous five-year time period.

Section 513. Statute of repose.

(a) General rule.--Except as provided in subsection (b) or (c), no cause of action asserting a medical professional liability claim may be commenced after seven years from the date of the alleged tort or breach of contract.

(b) Injuries caused by foreign object.--If the injury is or was caused by a foreign object unintentionally left in the individual's body, the limitation in subsection (a) shall not apply.

(c) Injuries of minors.--No cause of action asserting a medical professional liability claim may be commenced by or on behalf of a minor after seven years from the date of the alleged tort or breach of contract or after the minor attains the age of 20 years, whichever is later.

(d) Death or survival actions.--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 two years after the death in the absence of affirmative misrepresentation or fraudulent concealment of the cause of death.

(e) Applicability.--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) Definition.--For purposes of this section, a "minor" is an individual who has not yet attained the age of 18 years.

Section 514. Interbranch Commission on Venue.

(a) Declaration of policy.--The General Assembly further recognizes that recent changes in the health care delivery system have necessitated a revamping of the corporate structure for various medical facilities and hospitals across this Commonwealth. This has unduly expanded the reach and scope of existing venue rules. Training of new physicians in many geographic regions has also been severely restricted by the resultant expansion of venue applicability rules. These physicians and health care institutions are essential to maintaining the high quality of health care that our citizens have come to expect.

(b) Establishment of Interbranch Commission on Venue.--The Interbranch Commission on Venue for actions relating to medical professional liability is established as follows:

(1) The commission shall consist of the following members:

(i) The Chief Justice of the Supreme Court or a designee of the Chief Justice.

(ii) The chairperson of the Civil Procedural Rules Committee, who shall serve as the chairperson of the commission.

(iii) A judge of a court of common pleas appointed by the Chief Justice.

(iv) The Attorney General or a designee of the Attorney General.

(v) The General Counsel.

(vi) Two attorneys at law appointed by the Governor.

(vii) Four individuals, one each appointed by the:

(A) President pro tempore of the Senate;

(B) Minority Leader of the Senate;

(C) Speaker of the House of Representatives; and

(D) Minority Leader of the House of Representatives.

(2) The commission has the following functions:

(i) To review and analyze the issue of venue as it relates to medical professional liability actions filed in this Commonwealth.

(ii) To report, by September 1, 2002, to the General Assembly and the Supreme Court on the results of the review and analysis. The report shall include

recommendations for such legislative action or the promulgation of rules of court on the issue of venue as the commission shall determine to be appropriate.

(3) The commission shall expire September 1, 2002.

Section 515. Remittitur.

(a) General rule.--In any case in which a defendant health care provider challenges a verdict on grounds of excessiveness, the trial court shall, in deciding a motion for remittitur, consider evidence of the impact, if any, upon availability or access to health care in the community if the defendant health care provider is required to satisfy the verdict rendered by the jury.

(b) Factors and evidence.--A trial court denying a motion for remittitur shall specifically set forth the factors and evidence it considered with respect to the impact of the verdict upon availability or access to health care in the community.

(c) Abuse of discretion.--An appellate court reviewing a lower court's denial of remittitur may find an abuse of discretion if evidence of the impact of paying the verdict upon availability and access to health care in the community has not been adequately considered by the lower court.

(d) Limit of security.--A trial court or appellate court may limit or reduce the amount of security that a defendant health care provider must post to prevent execution if the court finds that requiring a bond in excess of the limits of available insurance coverage would effectively deny the right to appeal.

Section 516. Ostensible agency.

(a) Vicarious liability.--A hospital may be held vicariously liable for the acts of another health care provider through principles of ostensible agency only if the evidence shows that:

(1) a reasonably prudent person in the patient's position would be justified in the belief that the care in question was being rendered by the hospital or its agents; or

(2) the care in question was advertised or otherwise represented to the patient as care being rendered by the hospital or its agents.

(b) Staff privileges.--Evidence that a physician holds staff privileges at a hospital shall be insufficient to establish vicarious liability through principles of ostensible agency unless the claimant meets the requirements of subsection (a)(1) or (2).

CHAPTER 6
LONG-TERM CARE NURSING FACILITIES
(Reserved)

(Ch. (Reserved) added July 20, 2007, P.L.331, No.52)

CHAPTER 7
INSURANCE

SUBCHAPTER A
PRELIMINARY PROVISIONS

Compiler's Note: Section 4(a) of Act 44 of 2003 provided that Subchapter A is repealed insofar as it relates to health care providers that conduct less than 50% of their health care business or practice within this Commonwealth.

Section 701. Scope.

This chapter relates to medical professional liability insurance.

Section 702. Definitions.

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

"Basic insurance coverage." The limits of medical professional liability insurance required under section 711(d).

"Claims made." Medical professional liability insurance that insures those claims made or reported during a period which is insured and excludes coverage for a claim reported subsequent to the period even if the claim resulted from an occurrence during the period which was insured.

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

"Deficit." A joint underwriting association loss which exceeds the sum of earned premiums collected by the joint underwriting association and investment income.

"Department." The Insurance Department of the Commonwealth.

"Fund." The Medical Care Availability and Reduction of Error (Mcare) Fund established in section 712.

"Fund coverage limits." The coverage provided by the Medical Care Availability and Reduction of Error Fund under section 712.

"Government." 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 business or practice." The number of patients to whom health care services are rendered by a health care provider within an annual period.

"Health care provider." A participating health care provider or nonparticipating health care provider.

"Joint underwriting association." The Pennsylvania Professional Liability Joint Underwriting Association established in section 731.

"Joint underwriting association loss." The sum of the administrative expenses, taxes, losses, loss adjustment expenses, unearned premiums and reserves, including reserves for losses incurred and losses incurred but not reported, of the joint underwriting association.

"Licensure authority." The State Board of Medicine, the State Board of Osteopathic Medicine, the State Board of Podiatry, the Department of Public Welfare and the Department of Health.

"Medical professional liability insurance." 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.

"Nonparticipating health care provider." A health care provider as defined in section 103 that conducts 20% or less of its health care business or practice within this Commonwealth.

"Participating health care provider." A health care provider as defined in section 103 that conducts more than 20% of its health care business or practice within this Commonwealth or a

nonparticipating health care provider who chooses to participate in the fund.

"Prevailing primary premium." The schedule of occurrence rates approved by the commissioner for the joint underwriting association.

Compiler's Note: The Department of Public Welfare, referred to in this section, was redesignated as the Department of Human Services by Act 132 of 2014.

SUBCHAPTER B
FUND

Compiler's Note: Section 4(a) of Act 44 of 2003 provided that Subchapter B is repealed insofar as it relates to health care providers that conduct less than 50% of their health care business or practice within this Commonwealth.

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) $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) $1,000,000 per occurrence or claim and $3,000,000 per annual aggregate for a nonparticipating health care provider.

(iii) $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 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 years after the increase in coverage limits required by paragraph (3) and for each year thereafter, the basic insurance coverage shall be:

(i) $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) $1,000,000 per occurrence or claim and $3,000,000 per annual aggregate for a nonparticipating health care provider.

(iii) $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 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.

(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.

(a) Establishment.--There is hereby established within the State Treasury a special fund to be known as the Medical Care Availability and Reduction of Error Fund. Money in the fund shall be used to pay claims against participating health care providers for losses or damages awarded in medical professional liability actions against them in excess of the basic insurance coverage required by section 711(d), liabilities transferred in accordance with subsection (b) and for the administration of the fund.

(b) Transfer of assets and liabilities.--

(1) (i) The money in the Medical Professional Liability Catastrophe Loss Fund established under section 701(d) of the former act of October 15, 1975 (P.L.390, No.111), known as the Health Care Services Malpractice Act, is transferred to the fund.

(ii) The rights of the Medical Professional Liability Catastrophe Loss Fund established under section 701(d) of the former Health Care Services Malpractice Act are transferred to and assumed by the fund.

(2) The liabilities and obligations of the Medical Professional Liability Catastrophe Loss Fund established under section 701(d) of the former Health Care Services Malpractice Act are transferred to and assumed by the 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) 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.

(d) Assessments.--

(1) For calendar year 2003 and for each year thereafter, the fund shall be funded by an assessment on each participating health care provider. Assessments shall be levied by the department on or after January 1 of each year. The assessment shall be based on the prevailing primary premium for each participating health care provider and shall, in the aggregate, produce an amount sufficient to do all of the following:

(i) Reimburse the fund for the payment of reported claims which became final during the preceding claims period.

(ii) Pay expenses of the fund incurred during the preceding claims period.

(iii) Pay principal and interest on moneys transferred into the fund in accordance with section 713(c).

(iv) Provide a reserve that shall be 10% of the sum of subparagraphs (i), (ii) and (iii).

(2) The department shall notify all basic insurance coverage insurers and self-insured participating health care providers of the assessment by November 1 for the succeeding calendar year.

(3) Any appeal of the assessment shall be filed with the department.

(e) Discount on surcharges and assessments.--

(1) For calendar year 2002, the department shall discount the aggregate surcharge imposed under section

701(e)(1) of the Health Care Services Malpractice Act by 5% of the aggregate surcharge imposed under that section for calendar year 2001 in accordance with the following:

(i) Fifty percent of the aggregate discount shall be granted equally to hospitals and to participating health care providers that were surcharged as members of one of the four highest rate classes of the prevailing primary premium.

(ii) Notwithstanding subparagraph (i), 50% of the aggregate discount shall be granted equally to all participating health care providers.

(iii) The department shall issue a credit to a participating health care provider who, prior to the effective date of this section, has paid the surcharge imposed under section 701(e)(1) of the former Health Care Services Malpractice Act for calendar year 2002 prior to the effective date of this section.

(2) For calendar years 2003 and 2004, the department shall discount the aggregate assessment imposed under subsection (d) for each calendar year by 10% of the aggregate surcharge imposed under section 701(e)(1) of the former Health Care Services Malpractice Act for calendar year 2001 in accordance with the following:

(i) Fifty percent of the aggregate discount shall be granted equally to hospitals and to participating health care providers that were assessed as members of one of the four highest rate classes of the prevailing primary premium.

(ii) Notwithstanding subparagraph (i), 50% of the aggregate discount shall be granted equally to all participating health care providers.

(3) For calendar years 2005 and thereafter, if the basic insurance coverage requirement is increased in accordance with section 711(d)(3) or (4), the department may discount the aggregate assessment imposed under subsection (d) by an amount not to exceed the aggregate sum to be deposited in the fund in accordance with subsection (m).

(f) Updated rates.--The joint underwriting association shall file updated rates for all health care providers with the commissioner by May 1 of each year. The department shall review and may adjust the prevailing primary premium in line with any applicable changes which have been approved by the commissioner.

(g) Additional adjustments of the prevailing primary premium.--The department shall adjust the applicable prevailing primary premium of each participating health care provider in accordance with the following:

(1) The applicable prevailing primary premium of a participating health care provider which is not a hospital may be adjusted through an increase in the individual participating health care provider's prevailing primary premium not to exceed 20%. Any adjustment shall be based upon the frequency of claims paid by the fund on behalf of the individual participating health care provider during the past five most recent claims periods and shall be in accordance with the following:

(i) If three claims have been paid during the past five most recent claims periods by the fund, a 10% increase shall be charged.

(ii) If four or more claims have been paid during the past five most recent claims periods by the fund, a 20% increase shall be charged.

(2) The applicable prevailing primary premium of a participating health care provider which is not a hospital and which has not had an adjustment under paragraph (1) may be adjusted through an increase in the individual participating health care provider's prevailing primary premium not to exceed 20%. Any adjustment shall be based upon the severity of at least two claims paid by the fund on behalf of the individual participating health care provider during the past five most recent claims periods.

(3) The applicable prevailing primary premium of a participating health care provider not engaged in direct clinical practice on a full-time basis may be adjusted through a decrease in the individual participating health care provider's prevailing primary premium not to exceed 10%. Any adjustment shall be based upon the lower risk associated with the less-than-full-time direct clinical practice.

(4) The applicable prevailing primary premium of a hospital may be adjusted through an increase or decrease in the individual hospital's prevailing primary premium not to exceed 20%. Any adjustment shall be based upon the frequency and severity of claims paid by the fund on behalf of other hospitals of similar class, size, risk and kind within the same defined region during the past five most recent claims periods.

(h) Self-insured health care providers.--A participating health care provider that has an approved self-insurance plan shall be assessed an amount equal to the assessment imposed on a participating health care provider of like class, size, risk and kind as determined by the department.

(i) Change in basic insurance coverage.--If a participating health care provider changes the term of its medical professional liability insurance coverage, the assessment shall be calculated on an annual basis and shall reflect the assessment percentages in effect for the period over which the policies are in effect.

(j) Payment of claims.--Claims which became final during the preceding claims period shall be paid on or before December 31 following the August 31 on which they became final.

(k) Termination.--Upon satisfaction of all liabilities of the fund, the fund shall terminate. Any balance remaining in the fund upon such termination shall be returned by the department to the participating health care providers who participated in the fund in proportion to their assessments in the preceding calendar year.

(l) Sole and exclusive source of funding.--Except as provided in subsection (m), the surcharges imposed under section 701(e)(1) of the Health Care Services Malpractice Act and assessments on participating health care providers and any income realized by investment or reinvestment shall constitute the sole and exclusive sources of funding for the fund. Nothing in this subsection shall prohibit the fund from accepting contributions from nongovernmental sources. A claim against or a liability of the fund shall not be deemed to constitute a debt or liability of the Commonwealth or a charge against the General Fund.

(m) ((m) repealed June 30, 2011, P.L.159, No.26)

(n) Waiver of right to consent to settlement.--A participating health care provider may maintain the right to consent to a settlement in a basic insurance coverage policy for medical professional liability insurance upon the payment of an additional premium amount.

Compiler's Note: Section 4(a) of Act 44 of 2003 provided that subsection (e)(2) and (3) are repealed insofar as it relates to physicians and certified nurse midwives.

Section 713. Administration of fund.

(a) General rule.--The fund shall be administered by the department. The department shall contract with an entity or entities for the administration of claims against the fund in accordance with 62 Pa.C.S. (relating to procurement), and, to the fullest extent practicable, the department shall contract with entities that:

(1) Are not writing, underwriting or brokering medical professional liability insurance for participating health care providers; however, the department may contract with a subsidiary or affiliate of any writer, underwriter or broker of medical professional liability insurance.

(2) Are not trade organizations or associations representing the interests of participating health care providers in this Commonwealth.

(3) Have demonstrable knowledge of and experience in the handling and adjusting of professional liability or other catastrophic claims.

(4) Have developed, instituted and utilized best practice standards and systems for the handling and adjusting of professional liability or other catastrophic claims.

(5) Have demonstrable knowledge of and experience with the professional liability marketplace and the judicial systems of this Commonwealth.

(b) Reinsurance.--The department may purchase, on behalf of and in the name of the fund, as much insurance or reinsurance as is necessary to preserve the fund or retire the liabilities of the fund.

(c) Transfers.--The Governor may transfer to the fund from the Catastrophic Loss Benefits Continuation Fund, or such other funds as may be appropriate, such money as is necessary in order to pay the liabilities of the fund until sufficient revenues are realized by the fund. Any transfer made under this subsection shall be repaid with interest pursuant to section 2 of the act of August 22, 1961 (P.L.1049, No.479), entitled "An act authorizing the State Treasurer under certain conditions to transfer sums of money between the General Fund and certain funds and subsequent transfers of equal sums between such funds, and making appropriations necessary to effect such transfers."

(d) Confidentiality.--Information provided to the department or maintained by the department regarding a claim or adjustments to an individual participating health care provider's assessment shall be confidential, notwithstanding the act of June 21, 1957 (P.L.390, No.212), referred to as the Right-to-Know Law, or 65 Pa.C.S. Ch. 7 (relating to open meetings).

Compiler's Note: The act of June 21, 1957 (P.L.390, No.212), referred to as the Right-to-Know Law, referred to in subsec. (d), was repealed by the act of Feb. 14, 2008 (P.L.6, No.3), known as the Right-to-Know Law.

Section 714. Medical professional liability claims.

(a) Notification.--A basic coverage insurer or self-insured participating health care provider shall promptly notify the department in writing of any medical professional liability claim.

(b) Failure to notify.--If a basic coverage insurer or self-insured participating health care provider fails to notify the department as required under subsection (a) and the

department has been prejudiced by the failure of notice, the insurer or provider shall be solely responsible for the payment of the entire award or verdict that results from the medical professional liability claim.

(c) Defense.--A basic coverage insurer or self-insured participating health care provider shall provide a defense to a medical professional liability claim, including a defense of any potential liability of the fund, except as provided for in section 715. The department may join in the defense and be represented by counsel.

(d) Responsibilities.--In accordance with section 713, the department may defend, litigate, settle or compromise any medical professional liability claim payable by the fund.

(e) Releases.--In the event that a basic coverage insurer or self-insured participating health care provider enters into a settlement with a claimant to the full extent of its liability as provided in this chapter, it may obtain a release from the claimant to the extent of its payment, which payment shall have no effect upon any claim against the fund or its duty to continue the defense of the claim.

(f) Adjustment.--The department may adjust claims.

(g) Mediation.--Upon the request of a party to a medical professional liability claim within the fund coverage limits, the department may provide for a mediator in instances where multiple carriers disagree on the disposition or settlement of a case. Upon the consent of all parties, the mediation shall be binding. Proceedings conducted and information provided in accordance with this section shall be confidential and shall not be considered public information subject to disclosure under the act of June 21, 1957 (P.L.390, No.212), referred to as the Right-to-Know Law, or 65 Pa.C.S. Ch. 7 (relating to open meetings).

(h) Delay damages and postjudgment interest.--Delay damages and postjudgment interest applicable to the fund's liability on a medical professional liability claim shall be paid by the fund and shall not be charged against the participating health care provider's annual aggregate limits. The basic coverage insurer or self-insured participating health care provider shall be responsible for its proportionate share of delay damages and postjudgment interest.

Compiler's Note: The act of June 21, 1957 (P.L.390, No.212), referred to as the Right-to-Know Law, referred to in subsec. (g), was repealed by the act of Feb. 14, 2008 (P.L.6, No.3), known as the Right-to-Know Law.

Section 715. Extended claims.

(a) General rule.--If a medical professional liability claim against a health care provider who was required to participate in the Medical Professional Liability Catastrophe Loss Fund under section 701(d) of the act of October 15, 1975 (P.L.390, No.111), known as the Health Care Services Malpractice Act, is made more than four years after the breach of contract or tort occurred and if the claim is filed within the applicable statute of limitations, the claim shall be defended by the department if the department received a written request for indemnity and defense within 180 days of the date on which notice of the claim is first given to the participating health care provider or its insurer. Where multiple treatments or consultations took place less than four years before the date on which the health care provider or its 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 in accordance with this chapter.

(b) Payment.--If a health care provider is found liable for a claim defended by the department in accordance with subsection (a), the claim shall be paid by the fund. The limit of liability of the fund for a claim defended by the department under subsection (a) shall be $1,000,000 per occurrence.

(c) Concealment.--If a claim is defended by the department under subsection (a) or paid under subsection (b) and the claim is made after four years because of the willful concealment by the health care provider or its insurer, the fund shall have the right to full indemnity, including the department's defense costs, from the health care provider or its insurer.

(d) Extended coverage required.--Notwithstanding subsections (a), (b) and (c), all medical professional liability insurance policies issued on or after January 1, 2006, shall provide indemnity and defense for claims asserted against a health care provider for a breach of contract or tort which occurs four or more years after the breach of contract or tort occurred and after December 31, 2005.

Section 716. Podiatrist liability.

Within two years of the effective date of this chapter, the department shall calculate the amount necessary to arrange for the separate retirement of the fund's liabilities associated with podiatrists. Any arrangement shall be on terms and conditions proportionate to the individual liability of the class of health care provider. The arrangement may result in assessments for podiatrists different from the assessments for other health care providers. Upon satisfaction of the arrangement, podiatrists shall not be required to contribute to or be entitled to participate in the fund. In cases where the class rejects an arrangement, the department shall present to the provider class new term arrangements at least once in every two-year period. All costs and expenses associated with the completion and implementation of the arrangement shall be paid by podiatrists and may be charged in the form of an addition to the assessment.

SUBCHAPTER C
JOINT UNDERWRITING ASSOCIATION

Section 731. Joint underwriting association.

(a) Establishment.--There is established a nonprofit joint underwriting association to be known as the Pennsylvania Professional Liability Joint Underwriting Association. The joint underwriting association shall consist of all insurers authorized to write insurance in accordance with section 202(c)(4) and (11) of the act of May 17, 1921 (P.L.682, No.284), known as The Insurance Company Law of 1921, and shall be supervised by the department. The powers and duties of the joint underwriting association shall be vested in and exercised by a board of directors.

(b) Duties.--The joint underwriting association shall do all of the following:

(1) Submit a plan of operation to the commissioner for approval.

(2) Submit rates and any rate modification to the department for approval in accordance with the act of June 11, 1947 (P.L.538, No.246), known as The Casualty and Surety Rate Regulatory Act.

(3) Offer medical professional liability insurance to health care providers in accordance with section 732.

(4) File with the department the information required in section 712.

(c) Liabilities.--((c) repealed June 22, 2018, P.L.273, No.41).

Section 732. Medical professional liability insurance.

(a) Insurance.--The joint underwriting association shall offer medical professional liability insurance to health care providers and professional corporations, professional associations and partnerships which are entirely owned by health care providers who cannot conveniently obtain medical professional liability insurance through ordinary methods at rates not in excess of those applicable to similarly situated health care providers, professional corporations, professional associations or partnerships.

(b) Requirements.--The joint underwriting association shall ensure that the medical professional liability insurance it offers does all of the following:

(1) Is conveniently and expeditiously available to all health care providers required to be insured under section 711.

(2) Is subject only to the payment or provisions for payment of the premium.

(3) Provides reasonable means for the health care providers it insures to transfer to the ordinary insurance market.

(4) Provides sufficient coverage for a health care provider to satisfy its insurance requirements under section 711 on reasonable and not unfairly discriminatory terms.

(5) Permits a health care provider to finance its premium or allows installment payment of premiums subject to customary terms and conditions.

Section 733. Deficit.

(a) Filing.--In the event the joint underwriting association experiences a deficit in any calendar year, the board of directors shall file with the commissioner the deficit.

(b) Approval.--Within 30 days of receipt of the filing, the commissioner shall approve or deny the filing. If approved, the joint underwriting association is authorized to borrow funds sufficient to satisfy the deficit.

(c) Rate filing.--Within 30 days of receiving approval of its filing in accordance with subsection (b), the joint underwriting association shall file a rate filing with the department. The commissioner shall approve the filing if the premiums generate sufficient income for the joint underwriting association to avoid a deficit during the following 12 months and to repay principal and interest on the money borrowed in accordance with subsection (b).

SUBCHAPTER D
REGULATION OF MEDICAL PROFESSIONAL LIABILITY INSURANCE

Section 741. Approval.

In order for an insurer to issue a policy of medical professional liability insurance to a health care provider or to a professional corporation, professional association or partnership which is entirely owned by health care providers, the insurer must be authorized to write medical professional liability insurance in accordance with the act of May 17, 1921 (P.L.682, No.284), known as The Insurance Company Law of 1921.

Section 742. Approval of policies on "claims made" basis.

The commissioner shall not approve a medical professional liability insurance policy written on a "claims made" basis by any insurer doing business in this Commonwealth unless the insurer shall guarantee to the commissioner the continued availability of suitable liability protection for a health care provider subsequent to the discontinuance of professional practice by the health care provider or the termination of the insurance policy by the insurer or the health care provider for so long as there is a reasonable probability of a claim for injury for which the health care provider may be held liable.

Section 743. Reports to commissioner and claims information.

(743 repealed June 24, 2013, P.L.66, No.22)

Section 744. Professional corporations, professional associations and partnerships.

A professional corporation, professional association or partnership which is entirely owned by health care providers and which elects to purchase basic insurance coverage in accordance with section 711 from the joint underwriting association or from an insurer licensed or approved by the department shall be required to participate in the fund and, upon payment of the assessment required by section 712, be entitled to coverage from the fund.

Section 745. Actuarial data.

(a) Initial study.--The following shall apply:

(1) No later than April 1, 2005, each insurer providing medical professional liability insurance in this Commonwealth shall file loss data as required by the commissioner. For failure to comply, the commissioner shall impose an administrative penalty of $1,000 for every day that this data is not provided in accordance with this paragraph.

(2) By July 1, 2005, the commissioner shall conduct a study regarding the availability of additional basic insurance coverage capacity. The study shall include an estimate of the total change in medical professional liability insurance loss-cost resulting from implementation of this act prepared by an independent actuary. The fee for the independent actuary shall be borne by the fund. In developing the estimate, the independent actuary shall consider all of the following:

(i) The most recent accident year and ratemaking data available.

(ii) Any other relevant factors within or outside this Commonwealth in accordance with sound actuarial principles.

(b) Additional study.--The following shall apply:

(1) Three years following the increase of the basic insurance coverage requirement in accordance with section 711(d)(3), each insurer providing medical professional liability insurance in this Commonwealth shall file loss data with the commissioner upon request. For failure to comply, the commissioner shall impose an administrative penalty of $1,000 for every day that this data is not provided in accordance with this paragraph.

(2) Three months following the request made under paragraph (1), the commissioner shall conduct a study regarding the availability of additional basic insurance coverage capacity. The study shall include an estimate of the total change in medical professional liability insurance loss-cost resulting from implementation of this act prepared by an independent actuary. The fee for the independent actuary shall be borne by the fund. In developing the

estimate, the independent actuary shall consider all of the following:

(i) The most recent accident year and ratemaking data available.

(ii) Any other relevant factors within or outside this Commonwealth in accordance with sound actuarial principles.

Section 746. Mandatory reporting.

(a) General provisions.--Each medical professional liability insurer and each self-insured health care provider, including the fund established by this chapter, which makes payment in settlement or in partial settlement of or in satisfaction of a judgment in a medical professional liability action or claim shall provide to the appropriate licensure board a true and correct copy of the report required to be filed with the Federal Government by section 421 of the Health Care Quality Improvement Act of 1986 (Public Law 99-660, 42 U.S.C. § 11131). The copy of the report required by this section shall be filed simultaneously with the report required by section 421 of the Health Care Quality Improvement Act of 1986. The 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) Immunity.--A medical professional liability 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) Public information.--Information received under this section 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 65 Pa.C.S. Ch. 7 (relating to open meetings) until used in a formal disciplinary proceeding.

Compiler's Note: The act of June 21, 1957 (P.L.390, No.212), referred to as the Right-to-Know Law, referred to in subsec. (c), was repealed by the act of Feb. 14, 2008 (P.L.6, No.3), known as the Right-to-Know Law.

Section 747. Cancellation of insurance policy.

A termination of a medical professional liability insurance policy by cancellation, except for suspension or revocation of the insured's license or for reason of nonpayment of premium, is not effective against the insured unless notice of cancellation was given within 60 days after the issuance of the policy to the insured, and no cancellation shall take effect unless a written notice stating the reasons for the cancellation and the date and time upon which the termination becomes effective has been received by the commissioner. Mailing of the notice to the commissioner at the commissioner's principal office address shall constitute notice to the commissioner.

Section 748. Regulations.

The commissioner may promulgate regulations to implement and administer this chapter.

CHAPTER 9
ADMINISTRATIVE PROVISIONS

Section 901. Scope.

(a) General rule.--

(1) Except as set forth in subsection (b), this chapter is in pari materia with:

(i) the act of October 5, 1978 (P.L.1109, No.261), known as the Osteopathic Medical Practice Act; and

(ii) the act of December 20, 1985 (P.L.457, No.112), known as the Medical Practice Act of 1985.

(2) No duplication of procedure is required between this chapter and either:

(i) the Osteopathic Medical Practice Act; or

(ii) the Medical Practice Act of 1985.

(b) Conflict.--This chapter shall prevail if there is a conflict between this chapter and either:

(1) the Osteopathic Medical Practice Act; or

(2) the Medical Practice Act of 1985.

Section 902. Definitions.

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

"Licensure board." Either or both of the following, depending on the licensure of the affected individual:

(1) The State Board of Medicine.

(2) The State Board of Osteopathic Medicine.

"Physician." An individual licensed under the laws of this Commonwealth to engage in the practice of:

(1) medicine and surgery in all its branches within the scope of the act of December 20, 1985 (P.L.457, No.112), known as the Medical Practice Act of 1985; or

(2) osteopathic medicine and surgery within the scope of the act of October 5, 1978 (P.L.1109, No.261), known as the Osteopathic Medical Practice Act.

Section 903. Reporting.

A physician shall report to the State Board of Medicine or the State Board of Osteopathic Medicine, as appropriate, within 60 days of the occurrence of any of the following:

(1) Notice of a complaint in a medical professional liability action that is filed against the physician. The physician shall provide the docket number of the case, where the case is filed and a description of the allegations in the complaint.

(2) Information regarding disciplinary action taken against the physician by a health care licensing authority of another state.

(3) Information regarding sentencing of the physician for an offense as provided in section 15 of the act of October 5, 1978 (P.L.1109, No.261), known as the Osteopathic Medical Practice Act, or section 41 of the act of December 20, 1985 (P.L.457, No.112), known as the Medical Practice Act of 1985.

(4) Information regarding an arrest of the physician for any of the following offenses in this Commonwealth or another state:

(i) 18 Pa.C.S. Ch. 25 (relating to criminal homicide);

(ii) 18 Pa.C.S. § 2702 (relating to aggravated assault); or

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

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

Section 904. Commencement of investigation and action.

(a) Investigations by licensure board.--With regard to notices of complaints received pursuant to section 903(1) or a complaint filed with the licensure board, the licensure board

shall develop criteria and standards for review based on the frequency and severity of complaints filed against a physician. Any investigation of a physician based upon a complaint must be commenced no more than four years from the date notice of the complaint is received under section 903(1).

(b) Action by licensure board.--Unless an investigation has already been initiated pursuant to subsection (a), an action against a physician must be commenced by the licensure board no more than four years from the time the licensure board receives the earliest of any of the following:

(1) Notice that a payment against the physician has been reported to the National Practitioner Data Bank.

(2) Notice that a payment in a medical professional liability action against the physician has been reported to the licensure board by an insurer.

(3) Notice of a report made pursuant to section 903(2), (3) or (4).

(c) Laches.--The defense of laches is unavailable if the licensure board complies with this section.

(d) Applicability.--This section shall apply to actions against a physician initiated on or after the effective date of this chapter.

Section 905. Action on negligence.

If the licensure board determines, based on actions taken pursuant to section 904, that a physician has practiced negligently, the licensure board may impose disciplinary sanctions or corrective measures.

Section 906. Confidentiality agreements.

(a) Confidentiality agreements.--Upon settlement of a medical professional liability action containing a confidentiality agreement or upon a court order sealing the settlement and related records for purposes of confidentiality, the agreement or order shall not be operable against the licensure board to obtain copies of medical records of the patient on whose behalf the action is commenced. Prior to obtaining medical records under this subsection, the licensure board must obtain the consent of the patient or the patient's legal representative.

(b) Applicability.--The addition of subsection (a) shall apply to settlements entered into and court orders issued on or after the effective date of this chapter.

Section 907. Confidentiality of records of licensure boards.

(a) General rule.--All documents, materials or information utilized solely for an investigation undertaken by the State Board of Medicine or State Board of Osteopathic Medicine or concerning a complaint filed with the State Board of Medicine or State Board of Osteopathic Medicine shall be confidential and privileged. No person who has investigated or has access to or custody of documents, materials or information which are confidential and privileged under this subsection shall be required to testify in any judicial or administrative proceeding without the written consent of the State Board of Medicine or State Board of Osteopathic Medicine. This subsection shall not preclude or limit introduction of the contents of an investigative file or related witness testimony in a hearing or proceeding held before the State Board of Medicine or State Board of Osteopathic Medicine. This subsection shall not apply to letters to a licensee that disclose the final outcome of an investigation or to final adjudications or orders issued by the licensure board.

(b) Certain disclosure permitted.--Except as provided in subsection (a), this section shall not prevent disclosure of

any documents, materials or information pertaining to the status of a license, permit or certificate issued or prepared by the State Board of Medicine or State Board of Osteopathic Medicine or relating to a public disciplinary proceeding or hearing.

Section 908. Licensure board-imposed civil penalty.

In addition to any other civil remedy or criminal penalty provided for in this act, the act of December 20, 1985 (P.L.457, No.112), known as the Medical Practice Act of 1985, or the act of October 5, 1978 (P.L.1109, No.261), known as the Osteopathic Medical Practice Act, the State Board of Medicine and the State Board of Osteopathic Medicine, by a vote of the majority of the maximum number of the authorized membership of each board as provided by law or by a vote of the majority of the duly qualified and confirmed membership or a minimum of five members, whichever is greater, may levy a civil penalty of up to $10,000 on any current licensee who violates any provision of this act, the Medical Practice Act of 1985 or the Osteopathic Medical Practice Act or on any person who practices medicine or osteopathic medicine without being properly licensed to do so under the Medical Practice Act of 1985 or the Osteopathic Medical Practice Act. The boards shall levy this penalty only after affording the accused party the opportunity for a hearing as provided in 2 Pa.C.S. (relating to administrative law and procedure).

Compiler's Note: Section 3 of Act 25 of 2009, which amended section 5 of the act of July 2, 1993 (P.L.345, No.49), provided that section 908 is repealed insofar as it is inconsistent with the amendment of section 5.

Section 909. Licensure board report.

(a) Annual report.--Each licensure board shall submit a report not later than March 1 of each year to the chair and the minority chair of the Consumer Protection and Professional Licensure Committee of the Senate and to the chair and minority chair of the Professional Licensure Committee of the House of Representatives. The report shall include:

(1) The number of complaint files against board licensees that were opened in the preceding five calendar years.

(2) The number of complaint files against board licensees that were closed in the preceding five calendar years.

(3) The number of disciplinary sanctions imposed upon board licensees in the preceding five calendar years.

(4) The number of revocations, automatic suspensions, immediate temporary suspensions and stayed and active suspensions imposed, voluntary surrenders accepted, license applications denied and license reinstatements denied in the preceding five calendar years.

(5) The range of lengths of suspensions, other than automatic suspensions and immediate temporary suspensions, imposed during the preceding five calendar years.

(b) Posting.--The report shall be posted on each licensure board's publicly accessible World Wide Web site.

Section 910. Continuing medical education.

(a) Rules and regulations.--Each licensure board shall promulgate and enforce regulations consistent with the act of October 5, 1978 (P.L.1109, No.261), known as the Osteopathic Medical Practice Act, or the act of December 20, 1985 (P.L.457, No.112), known as the Medical Practice Act of 1985, as appropriate, in establishing requirements of continuing medical education for individuals licensed to practice medicine and

surgery without restriction as a condition for renewal of their licenses. Such regulations shall include any fees necessary for the licensure board to carry out its responsibilities under this section.

(b) Required completion.--Beginning with the licensure period commencing January 1, 2003, and following written notice to licensees by the licensure board, individuals licensed to practice medicine and surgery without restriction shall be required to enroll and complete 100 hours of mandatory continuing education during each two-year licensure period. As part of the 100-hour requirement, the licensure board shall establish a minimum number of hours that must be completed in improving patient safety and risk management subject areas.

(c) Review.--The licensure board shall review and approve continuing medical education providers or accrediting bodies who shall be certified to offer continuing medical education credit hours.

(d) Exemption.--Licensees shall be exempt from the provisions of this section as follows:

(1) An individual applying for licensure in this Commonwealth for the first time shall be exempt from the continuing medical education requirement for the biennial renewal period following initial licensure.

(2) An individual holding a current temporary training license shall be exempt from the continuing medical education requirement.

(3) A retired physician who provides care only to immediate family members shall be exempt from the continuing medical education requirement.

(e) Waiver.--The licensure board may waive all or a portion of the continuing education requirement for biennial renewal to a licensee who shows to the satisfaction of the licensure board that he or she was unable to complete the requirements due to serious illness, military service or other demonstrated hardship. A waiver request shall be made in writing, with appropriate documentation, and shall include a description of circumstances sufficient to show why compliance is impossible. A waiver request shall be evaluated by the licensure board on a case-by-case basis. The licensure board shall send written notification of its approval or denial of a waiver request.

(f) Reinstatement.--A licensee seeking to reinstate an inactive or lapsed license shall show proof of compliance with the continuing education requirement for the preceding biennium.

(g) Board approval.--An individual shall retain official documentation of attendance for two years after renewal and shall certify completed courses on a form provided by the licensure board for that purpose to be filed with the biennial renewal form. Official documentation proving attendance shall be produced upon licensure board demand pursuant to random audits of reported credit hours. Electronic submission of documentation is permissible to prove compliance with this subsection. Noncompliance with the requirements of this section may result in disciplinary proceedings.

(h) Regulations.--The licensure board shall promulgate regulations necessary to carry out the provisions of this section within six months of the effective date of this section.

CHAPTER 11
HEALTH CARE PROVIDER RETENTION PROGRAM
(Ch. repealed Oct. 9, 2009, P.L.537, No.50)

CHAPTER 51
MISCELLANEOUS PROVISIONS

(5101 expired October 1, 2002. See Act 13 of 2002.)

(a) Administration.--((a) expired October 1, 2002. See Act 13 of 2002.)
(b) Employees.--If an employee of that fund on the effective date of this section is subsequently furloughed and the employee held a position not covered by a collective bargaining agreement, the employee shall be given priority consideration for employment to fill vacancies with executive agencies under the Governor's jurisdiction.

When the authority has established a Statewide reporting system, the notice shall be transmitted to the Legislative Reference Bureau for publication in the Pennsylvania Bulletin.

(a) Declaration of policy.--The General Assembly recognizes that changes in the medical professional liability insurance market have necessitated the need for a plan to address the unfunded liabilities of the Medical Care Availability and Reduction of Error (Mcare) Fund.
(b) Establishment of Commission on the Mcare Fund.--There is established a Commission on the Mcare Fund for the purpose of reviewing and making recommendations regarding appropriate and effective methods to address any future unfunded liabilities of the Mcare Fund.
(1) The commission shall consist of the following members:

(i) The Insurance Commissioner or designee of the Insurance Commissioner, who shall serve as the chairperson of the commission.

(ii) The Secretary of the Budget or designee of the Office of the Budget.

(iii) The Secretary of Revenue or a designee of the Secretary of Revenue.

(iv) Two members appointed by the President pro tempore of the Senate and two members appointed by the Minority Leader of the Senate.

(v) Two members appointed by the Speaker of the House of Representatives and two members appointed by the Minority Leader of the House of Representatives.

(2) The commission shall establish an advisory committee composed of no more than 15 individuals with expertise in areas including: health care, medical professional liability insurance, the law, finance and actuarial analysis. The members of the advisory committee shall serve without compensation but shall be reimbursed for their actual and necessary expenses for attendance at meetings.

(3) The commission shall undertake a study of the future scope and obligations of the fund and shall submit its report to the Governor and General Assembly by November 15, 2006. The commission shall make recommendations concerning continuation of the Mcare abatement, the elimination or phaseout of the fund and other provisions for providing adequate medical professional liability insurance, including, at a minimum, an evaluation and actuarial analysis of the projected scope of the fund's future unfunded liability and any reasonable and available financing options for retiring those unfunded liabilities.

(4) The commission is authorized to incur expenses deemed necessary to implement this section. Expenses incurred for this purpose shall be paid by the fund.

(5) The commission shall expire November 30, 2006.

(5103.1 added Dec. 22, 2005, P.L.458, No.88)

Section 5104. Repeals.

(a) Specific.--

(1) Section 6506(c) of Title 75 of the Pennsylvania Consolidated Statutes is repealed.

(2) Except as set forth in paragraphs (3), (4) and (5), the act of October 15, 1975 (P.L.390, No.111), known as the Health Care Services Malpractice Act, is repealed.

(3) Section 103 of the Health Care Services Malpractice Act is repealed.

(4) Except as provided in paragraph (5), Article VII of the Health Care Services Malpractice Act is repealed.

(5) Section 701(e)(1) of the Health Care Services Malpractice Act is repealed.

(b) Inconsistent.--

(1) Section 6506(b) of Title 75 of the Pennsylvania Consolidated Statutes is repealed insofar as it is inconsistent with section 712(m).

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

Section 5105. Applicability.

(a) Patient safety discount.--Section 312 shall apply to policies issued or renewed after December 31, 2002.

(b) Actions.--Sections 504(d)(2), 505(e), 508, 509, 510, 513 and 516 shall apply to causes of action which arise on or after the effective date of this section.

Section 5106. Expiration.

Section 312 shall expire on December 31, 2007.

Section 5107. Continuation.

(a) Orders and regulations.--Orders and regulations which were issued or promulgated under the former act of October 15, 1975 (P.L.390, No.111), known as the Health Care Services Malpractice Act, and which are in effect on the effective date of this section shall remain applicable and in full force and effect until modified under this act.

(b) Administration and construction.--To the extent possible under Subchapter C of Chapter 7, the joint underwriting association is authorized to administer Subchapter C of Chapter 7 as a continuation of the former Article VIII of the Health Care Services Malpractice Act.

Section 5108. Effective date.

This act shall take effect as follows:

(1) The following provisions shall take effect immediately:

(i) Chapter 1.
(ii) Section 501.
(iii) Section 502.
(iv) Section 503.
(v) Section 504.
(vi) Section 505.
(vii) Section 506.
(viii) Section 507.
(ix) Section 508.
(x) Section 509.
(xi) Section 510.
(xii) Section 513.
(xiii) Section 514.
(xiii.1) Section 515.
(xiii.2) Section 516.
(xiv) Except as provided in paragraph (3)(i), Chapter 7.
(xv) Section 5101.
(xvi) Section 5102.
(xvii) Section 5103.
(xviii) Section 5104(a)(1) and (2) and (b)(2).
(xix) Section 5105.
(xx) Section 5106.
(xxi) Section 5107.
(xxii) This section.

(2) The following provisions shall take effect 30 days after publication of the notice under section 5103:

(i) Section 313.
(ii) Section 314.

(3) The following provisions shall take effect October 1, 2002:

(i) Section 712(b) and (c)(1).
(ii) Section 5104(a)(4).

(4) Section 5104(a)(3) and (5) and (b)(1) shall take effect January 1, 2004.

(5) The remainder of this act shall take effect in 60 days.

APPENDIX

Supplementary Provisions of Amendatory Statutes

Section 3. The addition of Chapter 11 of the act is a continuation of section 443.7 and Article XIII-A of the act of June 13, 1967 (P.L.31, No.21), known as the Public Welfare Code. All activities initiated under section 443.7 or Article XIII-A of the Public Welfare Code shall continue and remain in full force and effect and may be completed under Chapter 11 of the act. Regulations, rules and decisions which were made under section 443.7 or Article XIII-A of the Public Welfare Code and which are in effect on the effective date of the addition of Chapter 11 of the act shall remain in full force and effect until revoked, vacated or modified under Chapter 11 of the act. Contracts and obligations entered into under section 443.7 or Article XIII-A of the Public Welfare Code are not affected nor impaired by the repeal of section 443.7 and Article XIII-A of the Public Welfare Code.

Compiler's Note: The short title of the act of June 13, 1967 (P.L.31, No.21), known as the Public Welfare Code, referred to in this section, was amended by the act of December 28, 2015 (P.L.500, No.92). The amended short title is now the Human Services Code.

Explanatory Note. Act 88 amended or added section 303 and Chapter 11 of Act 13.