SENATE AMENDED

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THE GENERAL ASSEMBLY OF PENNSYLVANIA

HOUSE BILL

No. 489 Session of 2007

INTRODUCED BY SCHRODER, RUBLEY, BARRAR, BELFANTI, CALTAGIRONE, FRANKEL, GEORGE, GINGRICH, HENNESSEY, KAUFFMAN, KORTZ, O'NEILL, PETRONE, PICKETT, READSHAW, REICHLEY, ROHRER, ROSS, WATSON, DENLINGER, MURT AND LONGIETTI, FEBRUARY 26, 2007

SENATOR TOMLINSON, APPROPRIATIONS, IN SENATE, RE-REPORTED AS AMENDED, DECEMBER 10, 2007

AN ACT

~~Amending the act of December 4, 1996 (P.L.893, No.141), entitled "An act providing for volunteer health services; limiting liability of a volunteer license holder; and requiring reports,"~~ <—

AMENDING THE ACT OF MARCH 20, 2002 (P.L.154, NO.13), ENTITLED <—
"AN ACT REFORMING THE LAW ON MEDICAL PROFESSIONAL LIABILITY; PROVIDING FOR PATIENT SAFETY AND REPORTING; ESTABLISHING THE PATIENT SAFETY AUTHORITY AND THE PATIENT SAFETY TRUST FUND; ABROGATING REGULATIONS; PROVIDING FOR MEDICAL PROFESSIONAL LIABILITY INFORMED CONSENT, DAMAGES, EXPERT QUALIFICATIONS, LIMITATIONS OF ACTIONS AND MEDICAL RECORDS; ESTABLISHING THE INTERBRANCH COMMISSION ON VENUE; PROVIDING FOR MEDICAL PROFESSIONAL LIABILITY INSURANCE; ESTABLISHING THE MEDICAL CARE AVAILABILITY AND REDUCTION OF ERROR FUND; PROVIDING FOR MEDICAL PROFESSIONAL LIABILITY CLAIMS; ESTABLISHING THE JOINT UNDERWRITING ASSOCIATION; REGULATING MEDICAL PROFESSIONAL LIABILITY INSURANCE; PROVIDING FOR MEDICAL LICENSURE REGULATION; PROVIDING FOR ADMINISTRATION; IMPOSING PENALTIES; AND MAKING REPEALS," IN INSURANCE, FURTHER PROVIDING FOR MEDICAL PROFESSIONAL LIABILITY INSURANCE, FOR THE MEDICAL CARE AVAILABILITY AND REDUCTION OF ERROR FUND AND FOR ACTUARIAL DATA; PROVIDING FOR THE MEDICAL CARE AVAILABILITY AND REDUCTION OF ERROR (MCARE) RESERVE FUND AND THE MEDICAL SAFETY AUTOMATION FUND; TRANSFERRING THE VOLUNTEER HEALTH SERVICES ACT INTO THE ACT; further providing for license renewal, continuing education requirements and disciplinary and corrective measures; IN THE HEALTH CARE PROVIDER <—
RETENTION PROGRAM, FURTHER PROVIDING FOR THE ABATEMENT PROGRAM, FOR THE HEALTH CARE PROVIDER RETENTION ACCOUNT AND FOR EXPIRATION; FURTHER PROVIDING FOR EXPIRATION OF THE

PATIENT SAFETY DISCOUNT; AND MAKING A RELATED REPEAL.

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

~~Section 1. Section 6 of the act of December 4, 1996 (P.L.893, No.141), known as the Volunteer Health Services Act, is amended to read:~~ <—

~~Section 6. License renewal; disciplinary and corrective measures.~~

~~(a) Renewal term.--~~A ~~volunteer license shall be subject to biennial renewal.~~

~~(b) Fee exemption.--~~Holders of ~~volunteer licenses shall be exempt from renewal fees imposed by the appropriate licensing board. [Volunteer]~~

~~(c) Continuing education.--Except as set forth in subsection (d), volunteer~~ licensees ~~shall comply with any continuing education requirements imposed by board rulemaking as a general condition of biennial renewal.~~

~~(d) Nurses.--Volunteer licensees~~

SECTION 1. SECTIONS 711(D), 712(C) AND 745 OF THE ACT OF MARCH 20, 2002 (P.L.154, NO.13), KNOWN AS THE MEDICAL CARE AVAILABILITY AND REDUCTION OF ERROR (MCARE) ACT, ARE AMENDED TO READ: <—

SECTION 711. MEDICAL PROFESSIONAL LIABILITY INSURANCE.

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(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)] 745(B) THAT ADDITIONAL BASIC INSURANCE COVERAGE CAPACITY IS NOT AVAILABLE, FOR POLICIES ISSUED OR RENEWED IN CALENDAR YEAR [2006] 2009 AND EACH YEAR THEREAFTER SUBJECT TO PARAGRAPH (4), THE BASIC INSURANCE COVERAGE AS DETERMINED BY THE COMMISSIONER SHALL BE:

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

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

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

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

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

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

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

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

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

IF THE COMMISSIONER FINDS PURSUANT TO SECTION 745(B) THAT ADDITIONAL BASIC INSURANCE COVERAGE CAPACITY IS NOT

AVAILABLE, THE BASIC INSURANCE COVERAGE REQUIREMENTS SHALL REMAIN AT THE LEVEL REQUIRED BY PARAGRAPH (3); AND THE COMMISSIONER SHALL CONDUCT A STUDY EVERY [TWO YEARS] YEAR UNTIL THE COMMISSIONER FINDS THAT ADDITIONAL BASIC INSURANCE COVERAGE CAPACITY IS AVAILABLE, AT WHICH TIME THE COMMISSIONER SHALL INCREASE THE REQUIRED BASIC INSURANCE COVERAGE IN ACCORDANCE WITH THIS PARAGRAPH.

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

(6) IN NO EVENT SHALL THE TOTAL COVERAGE FOR BASIC PRIMARY INSURANCE AND THE FUND, PER OCCURRENCE OR CLAIM, BE LESS THAN $1,000,000 OR LESS THAN $3,000,000 PER ANNUAL AGGREGATE FOR A PARTICIPATING OR NONPARTICIPATING HEALTH CARE PROVIDER, EXCEPT HOSPITALS WHICH HAVE TOTAL COVERAGE LIMITS OF NOT LESS THAN $1,000,000 PER OCCURRENCE OR LESS THAN $4,500,000 PER ANNUAL AGGREGATE.

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

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(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) OR (4) AND, NOTWITHSTANDING SUBPARAGRAPH (I), FOR EACH CALENDAR YEAR FOLLOWING THE INCREASE IN THE BASIC INSURANCE COVERAGE REQUIREMENT, THE LIMIT OF LIABILITY OF THE FUND SHALL BE [$250,000 FOR EACH OCCURRENCE AND $750,000 PER ANNUAL AGGREGATE.

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

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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] <u>PURSUANT TO SECTION 711(D)(3) OR (4), THE COMMISSIONER SHALL CONDUCT A STUDY REGARDING THE AVAILABILITY OF ADDITIONAL BASIC INSURANCE COVERAGE CAPACITY AS SET FORTH IN THIS SUBSECTION. IN ORDER FOR THE COMMISSIONER TO MAKE A FINAL DETERMINATION REGARDING</u> THE INCREASE OF THE BASIC INSURANCE COVERAGE REQUIREMENT IN ACCORDANCE WITH SECTION 711(D)(3) <u>OR (4)</u>, 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 INCLUDING ECONOMIC CONSIDERATIONS WITHIN OR OUTSIDE THIS COMMONWEALTH IN ACCORDANCE WITH SOUND ACTUARIAL PRINCIPLES.

(3) UPON REVIEW OF THE STUDY BY THE COMMISSIONER, A FINAL DETERMINATION SHALL BE ISSUED BY THE COMMISSIONER BY JULY 1, 2008, AND BY JULY 1 OF EACH YEAR THEREAFTER IF A STUDY IS REQUIRED PURSUANT TO SECTION 711(D)(3) OR (4).

SECTION 2. CHAPTER 7 OF THE ACT IS AMENDED BY ADDING SUBCHAPTERS TO READ:

SUBCHAPTER E

MEDICAL CARE AVAILABILITY AND REDUCTION OF ERROR (MCARE) RESERVE FUND

SECTION 751. ESTABLISHMENT.

THERE IS ESTABLISHED WITHIN THE STATE TREASURY A SPECIAL FUND TO BE KNOWN AS THE MEDICAL CARE AVAILABILITY AND REDUCTION OF ERROR (MCARE) RESERVE FUND.

SECTION 752. ALLOCATION.

MONEY IN THE MEDICAL CARE AVAILABILITY AND REDUCTION OF ERROR (MCARE) RESERVE FUND SHALL BE ALLOCATED ANNUALLY AS FOLLOWS:

(1) TWENTY-FIVE PERCENT OF THE TOTAL AMOUNT IN THE

MEDICAL CARE AVAILABILITY AND REDUCTION OF ERROR (MCARE) RESERVE FUND, UP TO A MAXIMUM AMOUNT OF $25,000,000, SHALL BE TRANSFERRED TO THE PATIENT SAFETY TRUST FUND FOR USE BY THE DEPARTMENT OF PUBLIC WELFARE FOR IMPLEMENTING SECTION 407.

(2) TWENTY-FIVE PERCENT OF THE TOTAL AMOUNT IN THE MEDICAL CARE AVAILABILITY AND REDUCTION OF ERROR (MCARE) RESERVE FUND, UP TO A MAXIMUM AMOUNT OF $25,000,000, SHALL BE TRANSFERRED TO THE MEDICAL SAFETY AUTOMATION FUND.

(3) ALL OTHER FUNDS IN THE MEDICAL CARE AVAILABILITY AND REDUCTION OF ERROR (MCARE) RESERVE FUND SHALL REMAIN IN THE MEDICAL CARE AVAILABILITY AND REDUCTION OF ERROR (MCARE) RESERVE FUND FOR THE SOLE PURPOSE OF REDUCING THE UNFUNDED LIABILITY OF THE FUND.

SUBCHAPTER F

MEDICAL SAFETY AUTOMATION FUND

SECTION 762. MEDICAL SAFETY AUTOMATION FUND ESTABLISHED.

THERE IS ESTABLISHED WITHIN THE STATE TREASURY A SPECIAL FUND TO BE KNOWN AS THE MEDICAL SAFETY AUTOMATION FUND. NO MONEY IN THE MEDICAL SAFETY AUTOMATION FUND SHALL BE USED UNTIL LEGISLATION IS ENACTED FOR THE PURPOSE OF PROVIDING MEDICAL SAFETY AUTOMATION SYSTEM GRANTS TO HEALTH CARE PROVIDERS UNDER THE ACT OF JULY 19, 1979 (P.L.130, NO.48), KNOWN AS THE HEALTH CARE FACILITIES ACT, A GROUP PRACTICE OR A COMMUNITY-BASED HEALTH CARE PROVIDER.

SECTION 2.1. THE ACT IS AMENDED BY ADDING A CHAPTER TO READ:

CHAPTER 10

VOLUNTEER HEALTH SERVICES

SECTION 1001. SCOPE.

THIS CHAPTER RELATES TO VOLUNTEER HEALTH SERVICES.

SECTION 1002. PURPOSE.

IT IS THE PURPOSE OF THIS CHAPTER TO INCREASE THE AVAILABILITY OF PRIMARY HEALTH CARE SERVICES BY ESTABLISHING A PROCEDURE THROUGH WHICH PHYSICIANS AND OTHER HEALTH CARE PRACTITIONERS WHO ARE RETIRED FROM ACTIVE PRACTICE MAY PROVIDE PROFESSIONAL SERVICES AS A VOLUNTEER IN APPROVED CLINICS SERVING FINANCIALLY QUALIFIED PERSONS AND IN APPROVED CLINICS LOCATED IN MEDICALLY UNDERSERVED AREAS OR HEALTH PROFESSIONALS SHORTAGE AREAS.

SECTION 1003. 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:

"APPROVED CLINIC." AN ORGANIZED COMMUNITY-BASED CLINIC OFFERING PRIMARY HEALTH CARE SERVICES TO INDIVIDUALS AND FAMILIES WHO CANNOT PAY FOR THEIR CARE, TO MEDICAL ASSISTANCE CLIENTS OR TO RESIDENTS OF MEDICALLY UNDERSERVED AREAS OR HEALTH PROFESSIONALS SHORTAGE AREAS. THE TERM MAY INCLUDE, BUT SHALL NOT BE LIMITED TO, A STATE HEALTH CENTER, NONPROFIT COMMUNITY-BASED CLINIC AND FEDERALLY QUALIFIED HEALTH CENTER, AS DESIGNATED BY FEDERAL RULEMAKING OR AS APPROVED BY THE DEPARTMENT OF HEALTH OR THE DEPARTMENT OF PUBLIC WELFARE.

"BOARD." THE STATE BOARD OF MEDICINE, THE STATE BOARD OF OSTEOPATHIC MEDICINE, THE STATE BOARD OF DENTISTRY, THE STATE BOARD OF PODIATRY, THE STATE BOARD OF NURSING, THE STATE BOARD OF OPTOMETRY AND THE STATE BOARD OF CHIROPRACTIC.

"HEALTH CARE PRACTITIONER." AN INDIVIDUAL LICENSED TO PRACTICE A COMPONENT OF THE HEALING ARTS BY A LICENSING BOARD WITHIN THE DEPARTMENT OF STATE.

"LICENSEE." AN INDIVIDUAL WHO HOLDS A CURRENT, ACTIVE, UNRESTRICTED LICENSE AS A HEALTH CARE PRACTITIONER ISSUED BY THE

APPROPRIATE BOARD.

"PRIMARY HEALTH CARE SERVICES." THE TERM INCLUDES, BUT IS NOT LIMITED TO, REGULAR CHECKUPS, IMMUNIZATIONS, SCHOOL PHYSICALS, HEALTH EDUCATION, PRENATAL AND OBSTETRICAL CARE, EARLY PERIODIC SCREENING AND DIAGNOSTIC TESTING AND HEALTH EDUCATION.

"VOLUNTEER LICENSE." A LICENSE ISSUED BY THE APPROPRIATE BOARD TO A HEALTH CARE PRACTITIONER WHO DOCUMENTS, TO THE BOARD'S SATISFACTION, THAT THE INDIVIDUAL WILL PRACTICE ONLY IN APPROVED CLINICS WITHOUT REMUNERATION, WHO IS:

(1) A RETIRED HEALTH CARE PRACTITIONER; OR

(2) A NONRETIRED HEALTH CARE PRACTITIONER WHO IS NOT REQUIRED TO MAINTAIN PROFESSIONAL LIABILITY INSURANCE UNDER CHAPTER 7, BECAUSE THE HEALTH CARE PRACTITIONER IS NOT OTHERWISE PRACTICING MEDICINE OR PROVIDING HEALTH CARE SERVICES IN THIS COMMONWEALTH.

SECTION 1004. VOLUNTEER STATUS.

A LICENSEE IN GOOD STANDING WHO RETIRES FROM ACTIVE PRACTICE OR A NONRETIRED LICENSEE WHO DOES NOT OTHERWISE CURRENTLY PRACTICE OR PROVIDE HEALTH CARE SERVICES IN THIS COMMONWEALTH AND IS NOT REQUIRED TO MAINTAIN PROFESSIONAL LIABILITY INSURANCE UNDER CHAPTER 7 MAY APPLY, ON FORMS PROVIDED BY THE APPROPRIATE BOARD, FOR A VOLUNTEER LICENSE.

SECTION 1005. REGULATIONS.

EACH BOARD SHALL PROMULGATE REGULATIONS GOVERNING THE VOLUNTEER LICENSE CATEGORY. THE REGULATIONS SHALL INCLUDE QUALIFICATIONS FOR OBTAINING A VOLUNTEER LICENSE.

SECTION 1006. LICENSE RENEWAL; DISCIPLINARY AND CORRECTIVE MEASURES.

(A) RENEWAL TERM.--A VOLUNTEER LICENSE SHALL BE SUBJECT TO

BIENNIAL RENEWAL.

(B) FEE EXEMPTION.--HOLDERS OF VOLUNTEER LICENSES SHALL BE EXEMPT FROM RENEWAL FEES IMPOSED BY THE APPROPRIATE LICENSING BOARD.

(C) CONTINUING EDUCATION.--EXCEPT AS SET FORTH IN SUBSECTION (D), HOLDERS OF VOLUNTEER LICENSES SHALL COMPLY WITH ANY CONTINUING EDUCATION REQUIREMENTS IMPOSED BY BOARD RULEMAKING AS A GENERAL CONDITION OF BIENNIAL RENEWAL.

(D) PHYSICIANS.--

(1) HOLDERS OF VOLUNTEER LICENSES WHO ARE PHYSICIANS SHALL COMPLETE A MINIMUM OF 20 CREDIT HOURS OF AMERICAN MEDICAL ASSOCIATION PHYSICIAN'S RECOGNITION AWARD CATEGORY 2 ACTIVITIES DURING THE PRECEDING BIENNIAL PERIOD AS A CONDITION OF BIENNIAL RENEWAL AND ARE OTHERWISE EXEMPT FROM ANY CONTINUING EDUCATION REQUIREMENT IMPOSED BY SECTION 910, OR BY BOARD RULEMAKING.

(2) PHYSICIANS WHO ARE COVERED BY SECTION 1010.2 AND HOLD AN UNRESTRICTED LICENSE TO PRACTICE MEDICINE SHALL COMPLETE THE CONTINUING MEDICAL EDUCATION REQUIREMENTS ESTABLISHED BY THE BOARDS UNDER SECTION 910 TO BE ELIGIBLE FOR RENEWAL OF THE UNRESTRICTED LICENSE.

(D.1) NURSES.--HOLDERS OF VOLUNTEER LICENSES who are nurses shall complete a minimum of 20 credit hours of continuing education during the preceding biennial period as a condition of biennial renewal and are otherwise exempt from any continuing education requirements imposed by section 12.1 of the act of May 22, 1951 (P.L.317, No.69), known as The Professional Nursing Law, as a condition of biennial renewal.

~~(e) Disciplinary matters.--In the enforcement of disciplinary matters, holders of volunteer licenses shall be~~ <

~~subject to those standards of conduct applicable to all licensees licensed by the appropriate board.~~

~~Section 2. This act shall take effect in 60 days.~~

(E) DISCIPLINARY MATTERS.--IN THE ENFORCEMENT OF DISCIPLINARY MATTERS, HOLDERS OF VOLUNTEER LICENSES SHALL BE SUBJECT TO THOSE STANDARDS OF CONDUCT APPLICABLE TO ALL LICENSEES LICENSED BY THE APPROPRIATE BOARD. <——

SECTION 1007. LIABILITY.

(A) GENERAL RULE.--A HOLDER OF A VOLUNTEER LICENSE WHO, IN GOOD FAITH, RENDERS PROFESSIONAL HEALTH CARE SERVICES UNDER THIS CHAPTER SHALL NOT BE LIABLE FOR CIVIL DAMAGES ARISING AS A RESULT OF ANY ACT OR OMISSION IN THE RENDERING OF CARE UNLESS THE CONDUCT OF THE VOLUNTEER LICENSEE FALLS SUBSTANTIALLY BELOW PROFESSIONAL STANDARDS WHICH ARE GENERALLY PRACTICED AND ACCEPTED IN THE COMMUNITY AND UNLESS IT IS SHOWN THAT THE VOLUNTEER LICENSEE DID AN ACT OR OMITTED THE DOING OF AN ACT WHICH THE PERSON WAS UNDER A RECOGNIZED DUTY TO A PATIENT TO DO, KNOWING OR HAVING REASON TO KNOW THAT THE ACT OR OMISSION CREATED A SUBSTANTIAL RISK OF ACTUAL HARM TO THE PATIENT.

(B) APPLICATION.--THIS SECTION SHALL NOT APPLY UNLESS THE APPROVED CLINIC POSTS IN A CONSPICUOUS PLACE ON ITS PREMISES AN EXPLANATION OF THE EXEMPTIONS FROM CIVIL LIABILITY PROVIDED UNDER SUBSECTION (A). THE PROTECTIONS PROVIDED BY THIS SECTION SHALL NOT APPLY TO INSTITUTIONAL HEALTH CARE PROVIDERS, SUCH AS HOSPITALS OR APPROVED CLINICS, SUBJECT TO VICARIOUS LIABILITY FOR THE CONDUCT OF A VOLUNTEER LICENSE HOLDER. THE LIABILITY OF SUCH INSTITUTIONAL DEFENDANTS SHALL BE GOVERNED BY THE STANDARD OF CARE ESTABLISHED BY COMMON LAW.

SECTION 1008. REPORT.

BEGINNING MARCH 5, 1997, AND EVERY 30 DAYS THEREAFTER UNTIL

SUCH REGULATIONS ARE IN EFFECT, THE CHAIRMEN OF THE APPROPRIATE BOARDS SHALL REPORT IN WRITING TO THE COMMISSIONER OF PROFESSIONAL AND OCCUPATIONAL AFFAIRS ON THE STATUS OF THE VOLUNTEER LICENSE REGULATIONS, WHO SHALL CONVEY THE REQUIRED REPORTS TO THE CONSUMER PROTECTION AND PROFESSIONAL LICENSURE COMMITTEE AND THE PUBLIC HEALTH AND WELFARE COMMITTEE OF THE SENATE AND THE PROFESSIONAL LICENSURE COMMITTEE AND THE HEALTH AND HUMAN SERVICES COMMITTEE OF THE HOUSE OF REPRESENTATIVES.

SECTION 1009. EXEMPTIONS.

FOR THE PURPOSES OF THIS CHAPTER, VOLUNTEER LICENSEES WHO ARE OTHERWISE SUBJECT TO THE PROVISIONS OF CHAPTER 7 SHALL BE EXEMPT FROM THE REQUIREMENTS OF THAT ACT WITH REGARD TO THE MAINTENANCE OF LIABILITY INSURANCE COVERAGE. VOLUNTEER LICENSEES HOLDING A LICENSE ISSUED BY THE STATE BOARD OF CHIROPRACTIC SHALL BE EXEMPT FROM THE PROVISIONS OF SECTION 508 OF THE ACT OF DECEMBER 16, 1986 (P.L.1646, NO.188), KNOWN AS THE CHIROPRACTIC PRACTICE ACT.

SECTION 1010. STATE HEALTH CENTERS.

SERVICES OF VOLUNTEERS SHALL NOT BE SUBSTITUTED FOR THOSE OF COMMONWEALTH EMPLOYEES.

SECTION 1010.1. PRESCRIPTION OF MEDICATION FOR FAMILY MEMBERS.

(A) GENERAL RULE.--A HOLDER OF A VOLUNTEER LICENSE WHO WAS ABLE TO PRESCRIBE MEDICATION PURSUANT TO THE LAWS OF THIS COMMONWEALTH WHILE A LICENSEE MAY PRESCRIBE MEDICATION TO ANY MEMBER OF HIS FAMILY NOTWITHSTANDING THE FAMILY MEMBER'S ABILITY TO PAY FOR THAT MEMBER'S OWN CARE OR WHETHER THAT MEMBER IS BEING TREATED AT AN APPROVED CLINIC.

(B) LIABILITY.--THE LIABILITY PROVISIONS OF SECTION 1007(A) SHALL APPLY TO A HOLDER OF A VOLUNTEER LICENSE WHO PRESCRIBES MEDICATION TO A FAMILY MEMBER PURSUANT TO THIS SECTION, WHETHER

OR NOT THE PROVISIONS OF SECTION 1007(B) HAVE BEEN FOLLOWED.

(C) CONSTRUCTION.--NOTHING IN THIS SECTION SHALL BE CONSTRUED TO ALLOW A VOLUNTEER LICENSE HOLDER TO PRESCRIBE MEDICATION OF A TYPE OR IN A MANNER PROHIBITED BY THE LAWS OF THIS COMMONWEALTH.

(D) DEFINITION.--AS USED IN THIS SECTION, THE TERM "FAMILY MEMBER" MEANS A VOLUNTEER LICENSE HOLDER'S SPOUSE, CHILD, DAUGHTER-IN-LAW, SON-IN-LAW, MOTHER, FATHER, SIBLING, MOTHER-IN-LAW, FATHER-IN-LAW, SISTER-IN-LAW, BROTHER-IN-LAW, GRANDPARENT, GRANDCHILD, NIECE, NEPHEW OR COUSIN.

SECTION 1010.2. INDEMNITY AND DEFENSE FOR ACTIVE PRACTITIONERS.

A HEALTH CARE PRACTITIONER WHO PROVIDES HEALTH CARE SERVICES AT AN APPROVED CLINIC WITHOUT REMUNERATION UNDER AN ACTIVE NONVOLUNTEER LICENSE SHALL BE ENTITLED TO INDEMNITY AND DEFENSE UNDER THE TERMS OF WHATEVER LIABILITY INSURANCE COVERAGE IS MAINTAINED BY OR PROVIDED TO THE PRACTITIONER TO COMPLY WITH CHAPTER 7 IN THE SCOPE OF THEIR REGULAR PRACTICE. NO HEALTH CARE PRACTITIONER MAY BE SURCHARGED OR DENIED COVERAGE FOR RENDERING SERVICES AT AN APPROVED CLINIC. NOTHING SET FORTH IN THIS SECTION SHALL LIMIT A CARRIER'S RIGHT TO REFUSE COVERAGE OR TO ADJUST PREMIUMS ON THE BASIS OF MERITORIOUS CLAIMS AGAINST THE PRACTITIONER.

SECTION 1010.3. OPTIONAL LIABILITY COVERAGE.

A HOLDER OF A VOLUNTEER LICENSE OR AN APPROVED CLINIC ACTING ON BEHALF OF A VOLUNTEER LICENSEE WHO ELECTS TO PURCHASE PRIMARY INSURANCE TO COVER SERVICES RENDERED AT AN APPROVED CLINIC SHALL NOT BE OBLIGATED TO PURCHASE EXCESS COVERAGE THROUGH THE MEDICAL CARE AVAILABILITY AND REDUCTION OF ERROR (MCARE) FUND.

SECTION 3. SECTION 1102 OF THE ACT, AMENDED OCTOBER 27, 2006 (P.L.1198, NO.128), IS AMENDED TO READ:

SECTION 1102. ABATEMENT PROGRAM.

(A) ESTABLISHMENT.--THERE IS HEREBY ESTABLISHED WITHIN THE INSURANCE DEPARTMENT A PROGRAM TO BE KNOWN AS THE HEALTH CARE PROVIDER RETENTION PROGRAM. THE INSURANCE DEPARTMENT, IN CONJUNCTION WITH THE DEPARTMENT OF PUBLIC WELFARE, SHALL ADMINISTER THE PROGRAM. THE PROGRAM SHALL PROVIDE ASSISTANCE IN THE FORM OF ASSESSMENT ABATEMENTS TO HEALTH CARE PROVIDERS FOR CALENDAR YEARS 2003, 2004, 2005, 2006 [AND], 2007 AND 2008, EXCEPT THAT LICENSED PODIATRISTS SHALL NOT BE ELIGIBLE FOR CALENDAR YEARS 2003 AND 2004, AND NURSING HOMES SHALL NOT BE ELIGIBLE FOR CALENDAR YEARS 2003, 2004 AND 2005.

(B) OTHER [ABATEMENT.--] ABATEMENTS.--

(1) EMERGENCY PHYSICIANS NOT EMPLOYED FULL TIME BY A TRAUMA CENTER OR WORKING UNDER AN EXCLUSIVE CONTRACT WITH A TRAUMA CENTER SHALL RETAIN ELIGIBILITY FOR AN ABATEMENT PURSUANT TO SECTION 1104(B)(2) FOR CALENDAR YEARS 2003, 2004, 2005 AND 2006. COMMENCING IN CALENDAR YEAR 2007, THESE EMERGENCY PHYSICIANS SHALL BE ELIGIBLE FOR AN ABATEMENT PURSUANT TO SECTION 1104(B)(1).

(2) BIRTH CENTERS SHALL RETAIN ELIGIBILITY FOR ABATEMENT PURSUANT TO SECTION 1104(B)(2) FOR CALENDAR YEARS 2003, 2004, 2005, 2006 AND 2007. COMMENCING IN CALENDAR YEAR 2008, BIRTH CENTERS SHALL BE ELIGIBLE FOR AN ABATEMENT PURSUANT TO SECTION 1104(B)(1).

SECTION 4. SECTION 1112 OF THE ACT, ADDED DECEMBER 22, 2005 (P.L.458, NO.88), IS AMENDED TO READ:

SECTION 1112. HEALTH CARE PROVIDER RETENTION ACCOUNT.

(A) FUND ESTABLISHED.--THERE IS ESTABLISHED WITHIN THE GENERAL FUND A SPECIAL ACCOUNT TO BE KNOWN AS THE HEALTH CARE PROVIDER RETENTION ACCOUNT. FUNDS IN THE ACCOUNT SHALL BE

SUBJECT TO AN ANNUAL APPROPRIATION BY THE GENERAL ASSEMBLY TO THE DEPARTMENT OF PUBLIC WELFARE. THE DEPARTMENT OF PUBLIC WELFARE SHALL ADMINISTER FUNDS APPROPRIATED UNDER THIS SECTION CONSISTENT WITH ITS DUTIES UNDER SECTION 201(1) OF THE ACT OF JUNE 13, 1967 (P.L.31, NO.21), KNOWN AS THE PUBLIC WELFARE CODE.

(B) TRANSFERS FROM MCARE FUND.--BY DECEMBER 31 OF EACH YEAR, THE SECRETARY OF THE BUDGET MAY TRANSFER FROM THE MEDICAL CARE AVAILABILITY AND REDUCTION OF ERROR (MCARE) FUND ESTABLISHED IN SECTION 712(A) TO THE ACCOUNT AN AMOUNT EQUAL TO THE DIFFERENCE BETWEEN THE AMOUNT DEPOSITED UNDER SECTION 712(M) AND THE AMOUNT GRANTED AS DISCOUNTS UNDER SECTION 712(E)(2) FOR THAT CALENDAR YEAR.

(C) TRANSFERS FROM ACCOUNT.--THE SECRETARY OF THE BUDGET MAY ANNUALLY TRANSFER FROM THE ACCOUNT TO THE MEDICAL CARE AVAILABILITY AND REDUCTION OF ERROR (MCARE) FUND AN AMOUNT UP TO THE AGGREGATE AMOUNT OF ABATEMENTS GRANTED BY THE INSURANCE DEPARTMENT UNDER SECTION 1104(B).

(C.1) TRANSFERS TO THE MEDICAL CARE AVAILABILITY AND REDUCTION OF ERROR (MCARE) RESERVE FUND.--ANY FUNDS REMAINING IN THE ACCOUNT AFTER THE SECRETARY OF THE BUDGET MAKES THE TRANSFER UNDER SUBSECTION (C) SHALL BE TRANSFERRED TO THE MEDICAL CARE AVAILABILITY AND REDUCTION OF ERROR (MCARE) RESERVE FUND.

(D) OTHER DEPOSITS.--THE DEPARTMENT OF PUBLIC WELFARE MAY DEPOSIT ANY OTHER FUNDS RECEIVED BY THE DEPARTMENT WHICH IT DEEMS APPROPRIATE IN THE ACCOUNT.

(E) ADMINISTRATION ASSISTANCE.--THE INSURANCE DEPARTMENT SHALL PROVIDE ASSISTANCE TO THE DEPARTMENT OF PUBLIC WELFARE IN ADMINISTERING THE ACCOUNT.

SECTION 5. SECTION 1115 OF THE ACT, AMENDED OCTOBER 27, 2006 (P.L.1198, NO.128), IS AMENDED TO READ:

SECTION 1115. EXPIRATION.

THE HEALTH CARE PROVIDER RETENTION PROGRAM ESTABLISHED UNDER THIS CHAPTER SHALL EXPIRE DECEMBER 31, [2008] 2009.

SECTION 6. SECTION 5106 OF THE ACT IS AMENDED TO READ:

SECTION 5106. EXPIRATION.

SECTION 312 SHALL EXPIRE ON DECEMBER 31, [2007] 2008.

SECTION 6.1. REPEALS ARE AS FOLLOWS:

(1) THE GENERAL ASSEMBLY DECLARES THAT THE REPEAL UNDER PARAGRAPH (2) IS NECESSARY TO EFFECTUATE THE ADDITION OF CHAPTER 10 OF THE ACT.

(2) THE ACT OF DECEMBER 4, 1996 (P.L.893, NO.141), KNOWN AS THE VOLUNTEER HEALTH SERVICES ACT, IS REPEALED.

SECTION 6.2. THE ADDITION OF CHAPTER 10 OF THE ACT IS A CONTINUATION OF THE ACT OF DECEMBER 4, 1996 (P.L.893, NO.141), KNOWN AS THE VOLUNTEER HEALTH SERVICES ACT. THE FOLLOWING APPLY:

(1) EXCEPT AS OTHERWISE PROVIDED IN CHAPTER 10 OF THE ACT, ALL ACTIVITIES INITIATED UNDER THE VOLUNTEER HEALTH SERVICES ACT SHALL CONTINUE AND REMAIN IN FULL FORCE AND EFFECT AND MAY BE COMPLETED UNDER CHAPTER 10 OF THE ACT. ORDERS, REGULATIONS, RULES AND DECISIONS WHICH WERE MADE UNDER THE VOLUNTEER HEALTH SERVICES ACT AND WHICH ARE IN EFFECT ON THE EFFECTIVE DATE OF SECTION 6.1 OF THIS ACT SHALL REMAIN IN FULL FORCE AND EFFECT UNTIL REVOKED, VACATED OR MODIFIED UNDER CHAPTER 10 OF THE ACT. CONTRACTS, OBLIGATIONS AND COLLECTIVE BARGAINING AGREEMENTS ENTERED INTO UNDER THE VOLUNTEER HEALTH SERVICES ACT ARE NOT AFFECTED NOR IMPAIRED BY THE REPEAL OF THE VOLUNTEER HEALTH SERVICES ACT.

(2) EXCEPT AS SET FORTH IN PARAGRAPH (3), ANY DIFFERENCE IN LANGUAGE BETWEEN CHAPTER 10 OF THE ACT AND THE VOLUNTEER HEALTH SERVICES ACT IS INTENDED ONLY TO CONFORM TO THE STYLE

OF THE ACT AND IS NOT INTENDED TO CHANGE OR AFFECT THE LEGISLATIVE INTENT, JUDICIAL CONSTRUCTION OR ADMINISTRATION AND IMPLEMENTATION OF THE VOLUNTEER HEALTH SERVICES ACT.

(3) PARAGRAPH (2) DOES NOT APPLY TO THE ADDITION OF SECTION 1006(D.1) OF THE ACT.

SECTION 7. THIS ACT SHALL TAKE EFFECT AS FOLLOWS:

(1) THE ADDITION OF SECTION 1006(D.1) OF THE ACT SHALL TAKE EFFECT IN 60 DAYS.

(2) THE REMAINDER OF THIS ACT SHALL TAKE EFFECT IMMEDIATELY.