

THE GENERAL ASSEMBLY OF PENNSYLVANIA

SENATE BILL

No. 1137 Session of 2007

INTRODUCED BY D. WHITE, RAFFERTY, PILEGGI, ORIE, SCARNATI, ROBBINS, ERICKSON, GORDNER, C. WILLIAMS, FONTANA, MADIGAN, ARMSTRONG, PIPPY, FERLO, WONDERLING, WAUGH AND BAKER, OCTOBER 23, 2007

SENATOR ARMSTRONG, APPROPRIATIONS, RE-REPORTED AS AMENDED, OCTOBER 29, 2007

AN ACT

1 Amending the act of March 20, 2002 (P.L.154, No.13), entitled
2 "An act reforming the law on medical professional liability;
3 providing for patient safety and reporting; establishing the
4 Patient Safety Authority and the Patient Safety Trust Fund;
5 abrogating regulations; providing for medical professional
6 liability informed consent, damages, expert qualifications,
7 limitations of actions and medical records; establishing the
8 Interbranch Commission on Venue; providing for medical
9 professional liability insurance; establishing the Medical
10 Care Availability and Reduction of Error Fund; providing for
11 medical professional liability claims; establishing the Joint
12 Underwriting Association; regulating medical professional
13 liability insurance; providing for medical licensure
14 regulation; providing for administration; imposing penalties;
15 and making repeals," further providing for medical
16 professional liability insurance and, for the Medical Care <—
17 Availability and Reduction of Error Fund AND FOR ACTUARIAL <—
18 DATA; providing for the Medical Care Availability and
19 Reduction of Error (Mcare) Reserve Fund; and further
20 providing for abatement program, for the Health Care Provider
21 Retention Account and for expiration.

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

24 Section 1. Sections 711 and 712, 712 AND 745 of the act of <—
25 March 20, 2002 (P.L.154, No.13), known as the Medical Care
26 Availability and Reduction of Error (Mcare) Act, are amended to

1 read:

2 Section 711. Medical professional liability insurance.

3 (a) Requirement.--A health care provider providing health
4 care services in this Commonwealth shall:

5 (1) purchase medical professional liability insurance
6 from an insurer which is licensed or approved by the
7 department; or

8 (2) provide self-insurance.

9 (b) Proof of insurance.--A health care provider required by
10 subsection (a) to purchase medical professional liability
11 insurance or provide self-insurance shall submit proof of
12 insurance or self-insurance to the department within 60 days of
13 the policy being issued.

14 (c) Failure to provide proof of insurance.--If a health care
15 provider fails to submit the proof of insurance or self-
16 insurance required by subsection (b), the department shall,
17 after providing the health care provider with notice, notify the
18 health care provider's licensing authority. A health care
19 provider's license shall be suspended or revoked by its
20 licensure board or agency if the health care provider fails to
21 comply with any of the provisions of this chapter.

22 (d) Basic coverage limits.--A health care provider shall
23 insure or self-insure medical professional liability in
24 accordance with the following:

25 (1) For policies issued or renewed in the calendar year
26 2002, the basic insurance coverage shall be:

27 (i) \$500,000 per occurrence or claim and \$1,500,000
28 per annual aggregate for a health care provider who
29 conducts more than 50% of its health care business or
30 practice within this Commonwealth and that is not a

1 hospital.

2 (ii) \$500,000 per occurrence or claim and \$1,500,000
3 per annual aggregate for a health care provider who
4 conducts 50% or less of its health care business or
5 practice within this Commonwealth.

6 (iii) \$500,000 per occurrence or claim and
7 \$2,500,000 per annual aggregate for a hospital.

8 (2) For policies issued or renewed in the calendar years
9 2003, 2004 and 2005, the basic insurance coverage shall be:

10 (i) \$500,000 per occurrence or claim and \$1,500,000
11 per annual aggregate for a participating health care
12 provider that is not a hospital.

13 (ii) \$1,000,000 per occurrence or claim and
14 \$3,000,000 per annual aggregate for a nonparticipating
15 health care provider.

16 (iii) \$500,000 per occurrence or claim and
17 \$2,500,000 per annual aggregate for a hospital.

18 (3) Unless the commissioner finds pursuant to section
19 745(a) that additional basic insurance coverage capacity is
20 not available, for policies issued or renewed in calendar
21 year 2006 and each year thereafter subject to paragraph (4),
22 the basic insurance coverage shall be:

23 (i) Up to \$750,000 per occurrence or claim and
24 \$2,250,000 per annual aggregate for a participating
25 health care provider that is not a hospital.

26 (ii) Up to \$1,000,000 per occurrence or claim and
27 \$3,000,000 per annual aggregate for a nonparticipating
28 health care provider.

29 (iii) Up to \$750,000 per occurrence or claim and
30 \$3,750,000 per annual aggregate for a hospital.

1 If the commissioner finds pursuant to section 745(a) that
2 additional basic insurance coverage capacity is not
3 available, the basic insurance coverage requirements shall
4 remain at the level required by paragraph (2); and the
5 commissioner shall conduct a study every [two years] year
6 until the commissioner finds that additional basic insurance
7 coverage capacity is available, at which time the
8 commissioner shall increase the required basic insurance
9 coverage in accordance with this paragraph.

10 (4) Unless the commissioner finds pursuant to section
11 745(b) that additional basic insurance coverage capacity is
12 not available, for policies issued or renewed [three] two
13 years after the increase in coverage limits required by
14 paragraph (3) and for each year thereafter, the basic
15 insurance coverage shall be:

16 (i) Up to \$1,000,000 per occurrence or claim and
17 \$3,000,000 per annual aggregate for a participating
18 health care provider that is not a hospital.

19 (ii) Up to \$1,000,000 per occurrence or claim and
20 \$3,000,000 per annual aggregate for a nonparticipating
21 health care provider.

22 (iii) Up to \$1,000,000 per occurrence or claim and
23 \$4,500,000 per annual aggregate for a hospital.

24 If the commissioner finds pursuant to section 745(b) that
25 additional basic insurance coverage capacity is not
26 available, the basic insurance coverage requirements shall
27 remain at the level required by paragraph (3); and the
28 commissioner shall conduct a study every [two years] year
29 until the commissioner finds that additional basic insurance
30 coverage capacity is available, at which time the

1 commissioner shall increase the required basic insurance
2 coverage in accordance with this paragraph.

3 (5) The amount of basic insurance coverage per
4 occurrence or claim under paragraphs (3) and (4) shall be no
5 less than \$500,000 and shall be set in \$50,000 increments.

6 (6) IN NO EVENT SHALL THE TOTAL COVERAGE FOR BASIC ←
7 PRIMARY INSURANCE AND THE FUND, PER OCCURRENCE OR CLAIM, BE
8 LESS THAN \$1,000,000 OR LESS THAN \$3,000,000 PER ANNUAL
9 AGGREGATE FOR A PARTICIPATING OR NONPARTICIPATING HEALTH CARE
10 PROVIDER, EXCEPT HOSPITALS WHICH HAVE TOTAL COVERAGE LIMITS
11 OF NOT LESS THAN \$1,000,000 PER OCCURRENCE OR LESS THAN
12 \$4,500,000 PER ANNUAL AGGREGATE.

13 (e) Fund participation.--A participating health care
14 provider shall be required to participate in the fund.

15 (f) Self-insurance.--

16 (1) If a health care provider self-insures its medical
17 professional liability, the health care provider shall submit
18 its self-insurance plan, such additional information as the
19 department may require and the examination fee to the
20 department for approval.

21 (2) The department shall approve the plan if it
22 determines that the plan constitutes protection equivalent to
23 the insurance required of a health care provider under
24 subsection (d).

25 (g) Basic insurance liability.--

26 (1) An insurer providing medical professional liability
27 insurance shall not be liable for payment of a claim against
28 a health care provider for any loss or damages awarded in a
29 medical professional liability action in excess of the basic
30 insurance coverage required by subsection (d) unless the

1 health care provider's medical professional liability
2 insurance policy or self-insurance plan provides for a higher
3 limit.

4 (2) If a claim exceeds the limits of a participating
5 health care provider's basic insurance coverage or self-
6 insurance plan, the fund shall be responsible for payment of
7 the claim against the participating health care provider up
8 to the fund liability limits.

9 (h) Excess insurance.--

10 (1) No insurer providing medical professional liability
11 insurance with liability limits in excess of the fund's
12 liability limits to a participating health care provider
13 shall be liable for payment of a claim against the
14 participating health care provider for a loss or damages in a
15 medical professional liability action except the losses and
16 damages in excess of the fund coverage limits.

17 (2) No insurer providing medical professional liability
18 insurance with liability limits in excess of the fund's
19 liability limits to a participating health care provider
20 shall be liable for any loss resulting from the insolvency or
21 dissolution of the fund.

22 (i) Governmental entities.--A governmental entity may
23 satisfy its obligations under this chapter, as well as the
24 obligations of its employees to the extent of their employment,
25 by either purchasing medical professional liability insurance or
26 assuming an obligation as a self-insurer, and paying the
27 assessments under this chapter.

28 (j) Exemptions.--The following participating health care
29 providers shall be exempt from this chapter:

30 (1) A physician who exclusively practices the specialty

1 of forensic pathology.

2 (2) A participating health care provider who is a member
3 of the Pennsylvania military forces while in the performance
4 of the member's assigned duty in the Pennsylvania military
5 forces under orders.

6 (3) A retired licensed participating health care
7 provider who provides care only to the provider or the
8 provider's immediate family members.

9 Section 712. Medical Care Availability and Reduction of Error
10 Fund.

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

20 (b) Transfer of assets and liabilities.--

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

26 (ii) The rights of the Medical Professional
27 Liability Catastrophe Loss Fund established under section
28 701(d) of the former Health Care Services Malpractice Act
29 are transferred to and assumed by the fund.

30 (2) The liabilities and obligations of the Medical

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

4 (c) Fund liability limits.--

5 (1) For calendar year 2002, the limit of liability of
6 the fund created in section 701(d) of the former Health Care
7 Services Malpractice Act for each health care provider that
8 conducts more than 50% of its health care business or
9 practice within this Commonwealth and for each hospital shall
10 be \$700,000 for each occurrence and \$2,100,000 per annual
11 aggregate.

12 (2) The limit of liability of the fund for each
13 participating health care provider shall be as follows:

14 (i) For calendar year 2003 and each year thereafter,
15 the limit of liability of the fund shall be \$500,000 for
16 each occurrence and \$1,500,000 per annual aggregate.

17 (ii) If the basic insurance coverage requirement is
18 increased in accordance with section 711(d)(3) or (4)
19 and, notwithstanding subparagraph (i), for each calendar
20 year following the increase in the basic insurance
21 coverage requirement, the limit of liability of the fund
22 shall be [\$250,000 for each occurrence and \$750,000 per
23 annual aggregate.

24 (iii) If the basic insurance coverage requirement is
25 increased in accordance with section 711(d)(4) and,
26 notwithstanding subparagraphs (i) and (ii), for each
27 calendar year following the increase in the basic
28 insurance coverage requirement, the limit of liability of
29 the fund shall be zero] \$1,000,000 per occurrence and
30 \$3,000,000 per annual aggregate, except hospitals which

1 shall be \$1,000,000 per occurrence and \$4,500,000 per
2 annual aggregate, minus the amount the commissioner
3 determines for basic insurance coverage under section
4 711(d)(3) and (4).

5 (d) Assessments.--

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

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

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

19 (iii) Pay principal and interest on moneys
20 transferred into the fund in accordance with section
21 713(c).

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

24 (2) The department shall notify all basic insurance
25 coverage insurers and self-insured participating health care
26 providers of the assessment by November 1 for the succeeding
27 calendar year. The BEGINNING JANUARY 1, 2008, THE department <—
28 shall bill and collect the assessment from all participating
29 health care providers.

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

1 department.

2 (e) Discount on surcharges and assessments.--

3 (1) For calendar year 2002, the department shall
4 discount the aggregate surcharge imposed under section
5 701(e)(1) of the Health Care Services Malpractice Act by 5%
6 of the aggregate surcharge imposed under that section for
7 calendar year 2001 in accordance with the following:

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

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

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

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

28 (i) Fifty percent of the aggregate discount shall be
29 granted equally to hospitals and to participating health
30 care providers that were assessed as members of one of

1 the four highest rate classes of the prevailing primary
2 premium.

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

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

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

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

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

30 (i) If three claims have been paid during the past

1 five most recent claims periods by the fund, a 10%
2 increase shall be charged.

3 (ii) If four or more claims have been paid during
4 the past five most recent claims periods by the fund, a
5 20% increase shall be charged.

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

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

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

30 (h) Self-insured health care providers.--A participating

1 health care provider that has an approved self-insurance plan
2 shall be assessed an amount equal to the assessment imposed on a
3 participating health care provider of like class, size, risk and
4 kind as determined by the department.

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

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

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

20 (l) Sole and exclusive source of funding.--Except as
21 provided in subsection (m), the surcharges imposed under section
22 701(e)(1) of the Health Care Services Malpractice Act and
23 assessments on participating health care providers and any
24 income realized by investment or reinvestment shall constitute
25 the sole and exclusive sources of funding for the fund. Nothing
26 in this subsection shall prohibit the fund from accepting
27 contributions from nongovernmental sources. A claim against or a
28 liability of the fund shall not be deemed to constitute a debt
29 or liability of the Commonwealth or a charge against the General
30 Fund.

1 (m) Supplemental funding.--Notwithstanding the provisions of
2 75 Pa.C.S. § 6506(b) (relating to surcharge) to the contrary,
3 beginning January 1, 2004, and for a period of nine calendar
4 years thereafter, all surcharges levied and collected under 75
5 Pa.C.S. § 6506(a) by any division of the unified judicial system
6 shall be remitted to the Commonwealth for deposit in the Medical
7 Care Availability and Restriction of Error Fund. These funds
8 shall be used to reduce surcharges and assessments in accordance
9 with subsection (e). Beginning January 1, 2014, and each year
10 thereafter, the surcharges levied and collected under 75 Pa.C.S.
11 § 6506(a) shall be deposited into the General Fund.

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

17 SECTION 745. ACTUARIAL DATA. ←

18 (A) INITIAL STUDY.--THE FOLLOWING SHALL APPLY:

19 (1) NO LATER THAN APRIL 1, 2005, EACH INSURER PROVIDING
20 MEDICAL PROFESSIONAL LIABILITY INSURANCE IN THIS COMMONWEALTH
21 SHALL FILE LOSS DATA AS REQUIRED BY THE COMMISSIONER. FOR
22 FAILURE TO COMPLY, THE COMMISSIONER SHALL IMPOSE AN
23 ADMINISTRATIVE PENALTY OF \$1,000 FOR EVERY DAY THAT THIS DATA
24 IS NOT PROVIDED IN ACCORDANCE WITH THIS PARAGRAPH.

25 (2) BY JULY 1, 2005, THE COMMISSIONER SHALL CONDUCT A
26 STUDY REGARDING THE AVAILABILITY OF ADDITIONAL BASIC
27 INSURANCE COVERAGE CAPACITY. THE STUDY SHALL INCLUDE AN
28 ESTIMATE OF THE TOTAL CHANGE IN MEDICAL PROFESSIONAL
29 LIABILITY INSURANCE LOSS-COST RESULTING FROM IMPLEMENTATION
30 OF THIS ACT PREPARED BY AN INDEPENDENT ACTUARY. THE FEE FOR

1 THE INDEPENDENT ACTUARY SHALL BE BORNE BY THE FUND. IN
2 DEVELOPING THE ESTIMATE, THE INDEPENDENT ACTUARY SHALL
3 CONSIDER ALL OF THE FOLLOWING:

4 (I) THE MOST RECENT ACCIDENT YEAR AND RATEMAKING
5 DATA AVAILABLE.

6 (II) ANY OTHER RELEVANT FACTORS WITHIN OR OUTSIDE
7 THIS COMMONWEALTH IN ACCORDANCE WITH SOUND ACTUARIAL
8 PRINCIPLES.

9 (B) ADDITIONAL STUDY.--THE FOLLOWING SHALL APPLY:

10 (1) THREE YEARS FOLLOWING THE INCREASE OF THE BASIC
11 INSURANCE COVERAGE REQUIREMENT IN ACCORDANCE WITH SECTION
12 711(D)(3), EACH INSURER PROVIDING MEDICAL PROFESSIONAL
13 LIABILITY INSURANCE IN THIS COMMONWEALTH SHALL FILE LOSS DATA
14 WITH THE COMMISSIONER UPON REQUEST. FOR FAILURE TO COMPLY,
15 THE COMMISSIONER SHALL IMPOSE AN ADMINISTRATIVE PENALTY OF
16 \$1,000 FOR EVERY DAY THAT THIS DATA IS NOT PROVIDED IN
17 ACCORDANCE WITH THIS PARAGRAPH.

18 (2) THREE MONTHS FOLLOWING THE REQUEST MADE UNDER
19 PARAGRAPH (1), THE COMMISSIONER SHALL CONDUCT A STUDY
20 REGARDING THE AVAILABILITY OF ADDITIONAL BASIC INSURANCE
21 COVERAGE CAPACITY. THE STUDY SHALL INCLUDE AN ESTIMATE OF THE
22 TOTAL CHANGE IN MEDICAL PROFESSIONAL LIABILITY INSURANCE
23 LOSS-COST RESULTING FROM IMPLEMENTATION OF THIS ACT PREPARED
24 BY AN INDEPENDENT ACTUARY. THE FEE FOR THE INDEPENDENT
25 ACTUARY SHALL BE BORNE BY THE FUND. IN DEVELOPING THE
26 ESTIMATE, THE INDEPENDENT ACTUARY SHALL CONSIDER ALL OF THE
27 FOLLOWING:

28 (I) THE MOST RECENT ACCIDENT YEAR AND RATEMAKING
29 DATA AVAILABLE.

30 (II) ANY OTHER RELEVANT FACTORS INCLUDING ECONOMIC

1 CONSIDERATIONS WITHIN OR OUTSIDE THIS COMMONWEALTH IN
2 ACCORDANCE WITH SOUND ACTUARIAL PRINCIPLES.

3 Section 2. Chapter 7 of the act is amended by adding
4 subchapters to read:

5 SUBCHAPTER E

6 MEDICAL CARE AVAILABILITY AND REDUCTION OF ERROR

7 (MCARE) RESERVE FUND

8 Section 751. Establishment.

9 There is established within the State Treasury a special fund
10 to be known as the Medical Care Availability and Reduction of
11 Error (Mcare) Reserve Fund.

12 Section 752. Allocation.

13 Money in the Medical Care Availability and Reduction of Error
14 (Mcare) Reserve Fund shall be allocated annually as follows:

15 (1) Fifty percent of the total amount in the Medical
16 Care Availability and Reduction of Error (Mcare) Reserve Fund
17 shall remain in the Medical Care Availability and Reduction
18 of Error (Mcare) Reserve Fund for the sole purpose of
19 reducing the unfunded liability of the fund.

20 (2) Twenty-five percent of the total amount in the
21 Medical Care Availability and Reduction of Error (Mcare)
22 Reserve Fund shall be transferred to the Patient Safety Trust
23 Fund for use by the Department of Public Welfare for
24 implementing section 407.

25 (3) Twenty-five percent of the total amount in the
26 Medical Care Availability and Reduction of Error (Mcare)
27 Reserve Fund shall be transferred to the Medical Safety
28 Automation Fund.

29 SUBCHAPTER F

30 MEDICAL SAFETY AUTOMATION FUND

1 Section 762. Medical Safety Automation Fund established.

2 There is established within the State Treasury a special fund
3 to be known as the Medical Safety Automation Fund. No money in
4 the Medical Safety Automation Fund shall be used until
5 legislation is enacted for the purpose of providing medical
6 safety automation system grants to health care providers under
7 the act of July 19, 1979 (P.L.130, No.48), known as the Health
8 Care Facilities Act, a group practice or a community-based
9 health care provider.

10 Section 3. Section 1102 of the act, amended October 27, 2006
11 (P.L.1198, No.128), is amended to read:

12 Section 1102. Abatement program.

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

23 ~~(b) Other abatement. Emergency physicians not employed full~~ <—
24 ~~time by a trauma center or working under an exclusive contract~~

25 (B) OTHER [ABATEMENT.--] ABATEMENTS.-- <—

26 (1) EMERGENCY PHYSICIANS NOT EMPLOYED FULL TIME BY A
27 TRAUMA CENTER OR WORKING UNDER AN EXCLUSIVE CONTRACT with a
28 trauma center shall retain eligibility for an abatement
29 pursuant to section 1104(b)(2) for calendar years 2003, 2004,
30 2005 and 2006. Commencing in calendar year 2007, these

1 emergency physicians shall be eligible for an abatement
2 pursuant to section 1104(b)(1).

3 (2) BIRTH CENTERS SHALL RETAIN ELIGIBILITY FOR ABATEMENT ←
4 PURSUANT TO SECTION 1104(B)(2) FOR CALENDAR YEARS 2003, 2004,
5 2005, 2006 AND 2007. COMMENCING IN CALENDAR YEAR 2008, BIRTH
6 CENTERS SHALL BE ELIGIBLE FOR AN ABATEMENT PURSUANT TO
7 SECTION 1104(B)(1).

8 Section 4. Section 1112 of the act, added December 22, 2005
9 (P.L.458, No.88), is amended to read:

10 Section 1112. Health Care Provider Retention Account.

11 (a) Fund established.--There is established within the
12 General Fund a special account to be known as the Health Care
13 Provider Retention Account. Funds in the account shall be
14 subject to an annual appropriation by the General Assembly to
15 the Department of Public Welfare. The Department of Public
16 Welfare shall administer funds appropriated under this section
17 consistent with its duties under section 201(1) of the act of
18 June 13, 1967 (P.L.31, No.21), known as the Public Welfare Code.

19 (b) Transfers from Mcare Fund.--By December 31 of each year,
20 the Secretary of the Budget may transfer from the Medical Care
21 Availability and Reduction of Error (Mcare) Fund established in
22 section 712(a) to the account an amount equal to the difference
23 between the amount deposited under section 712(m) and the amount
24 granted as discounts under section 712(e)(2) for that calendar
25 year.

26 (c) Transfers from account.--The Secretary of the Budget may
27 annually transfer from the account to the Medical Care
28 Availability and Reduction of Error (MCARE) Fund an amount up to
29 the aggregate amount of abatements granted by the Insurance
30 Department under section 1104(b).

1 (c.1) Transfers to the Medical Care Availability and
2 Reduction of Error (Mcare) Reserve Fund.--If the Secretary of
3 the Budget makes a transfer from the account under subsection
4 (c), the remaining funds in the account shall be transferred to
5 the Medical Care Availability and Reduction of Error (Mcare)
6 Reserve Fund. If the Secretary of the Budget does not make a
7 transfer from the account under subsection (c), all of the funds
8 in the account shall be transferred to the Medical Care
9 Availability and Reduction of Error (Mcare) Reserve Fund.

10 (d) Other deposits.--The Department of Public Welfare may
11 deposit any other funds received by the department which it
12 deems appropriate in the account.

13 (e) Administration assistance.--The Insurance Department
14 shall provide assistance to the Department of Public Welfare in
15 administering the account.

16 Section 5. Section 1115 of the act, amended October 27, 2006
17 (P.L.1198, No.128), is amended to read:

18 Section 1115. Expiration.

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

21 Section 6. Section 5106 of the act is amended to read:

22 Section 5106. Expiration.

23 Section 312 shall expire on December 31, [2007] 2008.

24 Section 7. This act shall take effect ~~in 60 days~~

25 IMMEDIATELY.

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