

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, BAKER, REGOLA,  
BROWNE AND BOSCOLA, OCTOBER 23, 2007

AS REPORTED FROM COMMITTEE ON INSURANCE, HOUSE OF  
REPRESENTATIVES, AS AMENDED, DECEMBER 5, 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, 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 (Meare)~~ FOR PENNSYLVANIANS (MCAP) Reserve <—  
20 Fund; ~~and~~ further providing for abatement program, for the <—  
21 Health Care Provider Retention Account and for expiration; <—  
22 AND PROVIDING FOR EXPIRATION OF CERTAIN SECTIONS.

23 The General Assembly of the Commonwealth of Pennsylvania

24 hereby enacts as follows:

25 Section 1. Sections 711, 712 and 745 of the act of March 20,  
26 2002 (P.L.154, No.13), known as the Medical Care Availability

1 and Reduction of Error (Mcare) Act, are amended to 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. 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 (4) FOR CALENDAR YEAR BEGINNING JANUARY 1, 2008, THE ←  
3 DEPARTMENT MAY DELAY OR SUSPEND THE COLLECTION OF ASSESSMENTS  
4 UNTIL THE REQUIREMENTS UNDER SECTION 752(B) ARE MET.

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

6 (1) For calendar year 2002, the department shall  
7 discount the aggregate surcharge imposed under section  
8 701(e)(1) of the Health Care Services Malpractice Act by 5%  
9 of the aggregate surcharge imposed under that section for  
10 calendar year 2001 in accordance with the following:

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

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

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

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

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

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

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

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

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

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

1 five most recent claims periods and shall be in accordance  
2 with the following:

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

6 (ii) If four or more claims have been paid during  
7 the past five most recent claims periods by the fund, a  
8 20% increase shall be charged.

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

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

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

1 same defined region during the past five most recent claims  
2 periods.

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

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

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

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

23 (l) Sole and exclusive source of funding.--Except as  
24 provided in subsection (m), the surcharges imposed under section  
25 701(e)(1) of the Health Care Services Malpractice Act and  
26 assessments on participating health care providers and any  
27 income realized by investment or reinvestment shall constitute  
28 the sole and exclusive sources of funding for the fund. Nothing  
29 in this subsection shall prohibit the fund from accepting  
30 contributions from nongovernmental sources. A claim against or a

1 liability of the fund shall not be deemed to constitute a debt  
2 or liability of the Commonwealth or a charge against the General  
3 Fund.

4 (m) Supplemental funding.--Notwithstanding the provisions of  
5 75 Pa.C.S. § 6506(b) (relating to surcharge) to the contrary,  
6 beginning January 1, 2004, and for a period of nine calendar  
7 years thereafter, all surcharges levied and collected under 75  
8 Pa.C.S. § 6506(a) by any division of the unified judicial system  
9 shall be remitted to the Commonwealth for deposit in the Medical  
10 Care Availability and Restriction of Error Fund. These funds  
11 shall be used to reduce surcharges and assessments in accordance  
12 with subsection (e). Beginning January 1, 2014, and each year  
13 thereafter, the surcharges levied and collected under 75 Pa.C.S.  
14 § 6506(a) shall be deposited into the General Fund.

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

20 Section 745. Actuarial data.

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

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

28 (2) By July 1, 2005, the commissioner shall conduct a  
29 study regarding the availability of additional basic  
30 insurance coverage capacity. The study shall include an

1 estimate of the total change in medical professional  
2 liability insurance loss-cost resulting from implementation  
3 of this act prepared by an independent actuary. The fee for  
4 the independent actuary shall be borne by the fund. In  
5 developing the estimate, the independent actuary shall  
6 consider all of the following:

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

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

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

13 (1) Three years following the increase of the basic  
14 insurance coverage requirement in accordance with section  
15 711(d)(3), each insurer providing medical professional  
16 liability insurance in this Commonwealth shall file loss data  
17 with the commissioner upon request. For failure to comply,  
18 the commissioner shall impose an administrative penalty of  
19 \$1,000 for every day that this data is not provided in  
20 accordance with this paragraph.

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

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

3 (ii) Any other relevant factors including economic  
4 considerations within or outside this Commonwealth in  
5 accordance with sound actuarial principles.

6 Section 2. Chapter 7 of the act is amended by adding  
7 ~~subchapters~~ A SUBCHAPTER to read: <—

8 SUBCHAPTER E <—

9 MEDICAL CARE AVAILABILITY AND REDUCTION OF ERROR

10 (MCARE) RESERVE FUND

11 Section 751. Establishment.

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

15 Section 752. Allocation.

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

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

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

28 (3) Twenty five percent of the total amount in the  
29 Medical Care Availability and Reduction of Error (Mcare)  
30 Reserve Fund shall be transferred to the Medical Safety

1 ~~Automation Fund.~~

2 ~~SUBCHAPTER F~~

3 ~~MEDICAL SAFETY AUTOMATION FUND~~

4 ~~Section 762. Medical Safety Automation Fund established.~~

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

13 ~~SUBCHAPTER E~~ ←

14 ~~MEDICAL CARE AVAILABILITY FOR PENNSYLVANIANS~~

15 ~~(MCAP) RESERVE FUND~~

16 ~~SECTION 751. ESTABLISHMENT.~~

17 ~~THERE IS ESTABLISHED WITHIN THE STATE TREASURY A SPECIAL FUND~~  
18 ~~TO BE KNOWN AS THE MEDICAL CARE AVAILABILITY FOR PENNSYLVANIANS~~  
19 ~~(MCAP) RESERVE FUND.~~

20 ~~SECTION 752. ALLOCATION.~~

21 ~~(A) ANNUAL ALLOCATION.--MONEY IN THE MEDICAL CARE~~  
22 ~~AVAILABILITY FOR PENNSYLVANIANS (MCAP) RESERVE FUND SHALL BE~~  
23 ~~ALLOCATED ANNUALLY AS FOLLOWS:~~

24 ~~(1) FIFTY PERCENT OF THE TOTAL AMOUNT IN THE MEDICAL~~  
25 ~~CARE AVAILABILITY FOR PENNSYLVANIANS (MCAP) RESERVE FUND~~  
26 ~~SHALL REMAIN IN THE MEDICAL CARE AVAILABILITY FOR~~  
27 ~~PENNSYLVANIANS (MCAP) RESERVE FUND FOR THE SOLE PURPOSE OF~~  
28 ~~REDUCING THE UNFUNDED LIABILITY OF THE FUND.~~

29 ~~(2) FIFTY PERCENT OF THE TOTAL AMOUNT IN THE MEDICAL~~  
30 ~~CARE AVAILABILITY FOR PENNSYLVANIANS (MCAP) RESERVE FUND~~

1       SHALL BE DEDICATED TO FUNDING THE PROGRAM ESTABLISHED UNDER  
2       SUBSECTION (B).

3       (B) ENACTMENT OF LEGISLATION.--NO MONEY IN THE MEDICAL CARE  
4       AVAILABILITY FOR PENNSYLVANIANS (MCAP) RESERVE FUND SHALL BE  
5       USED UNTIL LEGISLATION IS ENACTED THAT PROVIDES BOTH ASSISTANCE  
6       TO CERTAIN SMALL BUSINESS EMPLOYERS IN COVERING THEIR LOW WAGE  
7       UNINSURED AND ACCESS TO AFFORDABLE HEALTH INSURANCE COVERAGE FOR  
8       UNINSURED LOW-INCOME ADULT PENNSYLVANIANS.

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

11      Section 1102. Abatement program.

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

22      (b) Other [abatement.--] abatements.--

23          (1) Emergency physicians not employed full time by a  
24          trauma center or working under an exclusive contract with a  
25          trauma center shall retain eligibility for an abatement  
26          pursuant to section 1104(b)(2) for calendar years 2003, 2004,  
27          2005 and 2006. Commencing in calendar year 2007, these  
28          emergency physicians shall be eligible for an abatement  
29          pursuant to section 1104(b)(1).

30          (2) Birth centers shall retain eligibility for abatement

1 pursuant to section 1104(b)(2) for calendar years 2003, 2004,  
2 2005, 2006 and 2007. Commencing in calendar year 2008, birth  
3 centers shall be eligible for an abatement pursuant to  
4 section 1104(b)(1).

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

7 Section 1112. Health Care Provider Retention Account.

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

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

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

28 ~~(c.1) Transfers to the Medical Care Availability and~~ <—  
29 ~~Reduction of Error (Mcare) Reserve Fund. If the Secretary of~~  
30 ~~the Budget makes a transfer from the account under subsection~~

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

7 (C.1) TRANSFERS TO THE MEDICAL CARE AVAILABILITY FOR ←  
8 PENNSYLVANIANS (MCAP) RESERVE FUND.--IF THE SECRETARY OF THE  
9 BUDGET MAKES A TRANSFER FROM THE ACCOUNT UNDER SUBSECTION (C),  
10 THE REMAINING FUNDS IN THE ACCOUNT SHALL BE TRANSFERRED TO THE  
11 MEDICAL CARE AVAILABILITY FOR PENNSYLVANIANS (MCAP) RESERVE  
12 FUND. IF THE SECRETARY OF THE BUDGET DOES NOT MAKE A TRANSFER  
13 FROM THE ACCOUNT UNDER SUBSECTION (C), ALL OF THE FUNDS IN THE  
14 ACCOUNT SHALL BE TRANSFERRED TO THE MEDICAL CARE AVAILABILITY  
15 FOR PENNSYLVANIANS (MCAP) RESERVE FUND.

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

19 (e) Administration assistance.--The Insurance Department  
20 shall provide assistance to the Department of Public Welfare in  
21 administering the account.

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

24 Section 1115. Expiration.

25 The Health Care Provider Retention Program established under  
26 this chapter shall expire December 31, [2008] ~~2009~~ 2011. ←

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

28 Section 5106. Expiration.

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

30 SECTION 7. IF THE REQUIREMENTS OF SECTION 752(B) OF THE ACT ←

1 ARE NOT SATISFIED WITHIN 90 DAYS AFTER ENACTMENT, SECTIONS 711,  
2 712(D), (E), (G), (H) AND (I) OF THE ACT SHALL EXPIRE JUNE 30,  
3 2008. IF THESE SECTIONS EXPIRE ON JUNE 30, 2008, THE FUND SHALL  
4 CONTINUE TO BE RESPONSIBLE FOR PAYMENT OF CLAIMS AGAINST  
5 PARTICIPATING HEALTH CARE PROVIDERS AS OF JUNE 30, 2008, UP TO  
6 THE FUND LIABILITY LIMITS AS OF JUNE 30, 2008, TO THE EXTENT THE  
7 FUND WOULD HAVE BEEN RESPONSIBLE FOR PAYMENT OF SUCH CLAIMS IF  
8 SECTIONS 711, 712(D), (E), (G), (H) AND (I) OF THE ACT DID NOT  
9 EXPIRE JUNE 30, 2008.

10 Section 7 8. This act shall take effect immediately.

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