No. 207

AN ACT

HB 2063

Amending the act of October 15, 1975 (No.111), entitled "An act relating to medical and health related malpractice insurance, prescribing the powers and duties of the Insurance Department; providing for a joint underwriting plan; the Arbitration Panels for Health Care, compulsory screening of claims; collateral sources requirement; limitation on contingent fee compensation; establishing a Catastrophe Loss Fund; and prescribing penalties," further providing for the powers and duties of the administrator, changing definitions, and further providing for liability and exemptions.

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

Section 1. Section 103, act of October 15, 1975 (No.111), known as the "Health Care Services Malpractice Act," is amended to read:

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

"Administrator" means the office of Administrator for Arbitration Panels for Health Care.

"Arbitration panel" means Arbitration Panels for Health Care.

"Claims made" means a policy of professional liability insurance that would limit or restrict the liability of the insurer under the policy to only those claims made or reported during the currency of the policy period and would exclude coverage for claims reported subsequent to the termination even when such claims resulted from occurrences during the currency of the policy period.

"Commissioner" means the Insurance Commissioner of this Commonwealth.

"Government" means the Government of the United States, any state, any political subdivision of a state, any instrumentality of one or more states, or any agency, subdivision, or department of any such government, including any corporation or other association organized by a government for the execution of a government program and subject to control by a government, or any corporation or agency established under an interstate compact or international treaty.

"Health care provider" means a ***primary health center or a*** person, corporation, facility institution or other entity licensed or approved by the Commonwealth to provide health care or professional ***medical*** services as a physician, **[including a medical doctor and a doctor of osteopathy and a doctor of podiatry;]** ***an osteopathic physician or surgeon, a podiatrist,*** hospital, nursing home, **[; health maintenance organization; or]** ***and except***

as to section 701(a), an officer, employee or agent of any of them acting in the course and scope of his employment.

"Informed consent" means for the purposes of this act and of any proceedings arising under the provisions of this act, the consent of a patient to the performance of health care services by a physician or podiatrist: Provided, That prior to the consent having been given, the physician or podiatrist has informed the patient of the nature of the proposed procedure or treatment and of those risks and alternatives to treatment or diagnosis that a reasonable patient would consider material to the decision whether or not to undergo treatment or diagnosis. No physician or podiatrist shall be liable for a failure to obtain an informed consent in the event of an emergency which prevents consulting the patient. No physician or podiatrist shall be liable for failure to obtain an informed consent if it is established by a preponderance of the evidence that furnishing the information in question to the patient would have resulted in a seriously adverse effect on the patient or on the therapeutic process to the material detriment of the patient's health.

"Licensure Board" means the State Board of Medical Education and Licensure, the State Board of Osteopathic Examiners, the State Board of Podiatry Examiners, the Department of Public Welfare and the Department of Health.

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

"Primary health center" means a community-based nonprofit corporation meeting standards prescribed by the Department of Health, which provides preventive, diagnostic, therapeutic, and basic emergency health care by licensed practitioners who are employees of the corporation or under contract to the corporation.

"Professional liability insurance" means insurance against liability on the part of a health care provider arising out of any tort or breach of contract causing injury or death **[occurring in or]** resulting from the furnishing of medical services which were or should have been provided.

Section 2. Section 307, subsection (b) of section 308, sections 309, 401 and 502 of the act are amended to read:

Section 307. Rules and Regulations.—***(a)*** The administrator shall adopt and publish such uniform rules and regulations as may be necessary to carry out the provisions of this act, and shall prescribe the means, methods and practices necessary to effectuate such provisions. Such rules and regulations shall be consistent with the common and statutory law of the Commonwealth, the Pennsylvania Rules of Civil Procedure, and the Pennsylvania rules of evidence. Such rules and regulations, after consultation with the Secretary of Health, may include provisions for the use of forms which provide for the disclosure of the nature of the proposed treatment or diagnosis, risks of the proposed treatment or diagnosis, and alternate methods of treatment or diagnosis.

(b) The administrator shall have the power to consider and approve offers of settlement for fiduciaries, minors and incompetent parties at any time prior to the first meeting of the arbitration panel. The fund may be represented at any negotiation of settlement exceeding the basic coverage insurance carrier limit of liability.

(c) Prior to appointment of an arbitration panel chairman, the administrator is authorized and empowered to rule on all preliminary motions.

Section 308. Arbitration Panels for Health Care.—* * *

(b) Each arbitration panel shall be composed of seven members including two health care providers, two attorneys, one of whom shall be designated as chairman by the administrator, who shall determine questions of law and three lay persons who are not health care providers nor licensed to practice law. Wherever possible, the administrator shall select a hospital administrator, podiatrist, or **[osteopath]** ***osteopathic physician or surgeon*** as one of the health care provider panel members where the claim involves a member of one of those classes of health care providers.

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Section 309. Jurisdiction of Arbitration Panel.—The arbitration panel shall have original exclusive jurisdiction to hear and decide any claim **[for loss or damages]** brought by a patient or his representative ***for loss or damages resulting from the furnishing of medical services which were or which should have been provided. The arbitration panel shall also have original exclusive jurisdiction to hear and decide any claim asserted against a nonhealth care provider who is made a party defendant with a health care provider.***

Section 401. Filing of Complaint.—A patient or his representative, having a claim for loss or damages ***resulting from the furnishing of medical services which were or which should have been provided,*** shall file with the administrator a complaint or such other form, with such fees, as prescribed by the rules and regulations adopted by the administrator. The dministrator shall refer the complaint to the appropriate arbitration panel. The filing of the complaint with the administrator shall toll the statute of limitations.

Section 502. Joinder of Additional Parties.—At any time up to the selection of the panel members, a party may join any additional party who may be necessary and proper to a just determination of the claim. ***The arbitration panel shall have jurisdiction over such additional parties whether they be health care providers or nonhealth care providers.***

Section 3. Paragraph (8) of subsection (a) of section 508 of the act is amended to read:

Section 508. Powers and Duties of Arbitration Panel.—(a) The arbitration panel is authorized and empowered to:

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(8) consider and approve offers of settlement **[and proposals of adjustment between plaintiffs and defendants;]** ***involving fiduciaries, minors and incompetent parties;***

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Section 4. Section 509 of the act is amended to read:

Section 509. Judicial Review.—Appeals from determinations made by the arbitration panel shall be a trial de novo in the court of common pleas in accordance with the rules regarding appeals in compulsory civil arbitration and the Pennsylvania Rules of Civil Procedure except that the party seeking to file an appeal must first pay all record costs ***of arbitration*** to the prothonotary of the court in which he seeks to file his appeal. If the court of common pleas finds at the completion of the trial that the basis for the appeal was capricious, frivolous and unreasonable, then the appellant shall be liable for all costs of arbitration and trial, including record costs, arbitrator's compensation discovery costs, and fees and expenses of the arbitration panel's expert witnesses.

Section 5. Section 605 of the act is amended to read:

Section 605. Statute of Limitations.—All claims for recovery pursuant to this act must be commenced within the existing applicable statutes of limitation. In the event that any claim is **[filed]** ***made*** against a health care provider subject to the provisions of Article VII more than four years after the breach of contract or tort occurred ***which is filed within the statute of limitations***, such claim shall be ***defended and*** paid by the Medical Professional Liability Catastrophe Loss Fund established pursuant to section 701. If such claim is made after four years because of the **[wilfull]** ***willful*** concealment **[of]** ***by*** the health care provider ***or his insurer***, the fund shall have the right of ***full*** indemnity ***including defense costs*** from such health care provider ***or his insurer.*** A filing pursuant to section 401 shall toll the running of the limitations contained herein.

Section 6. Section 701 of the act is amended to read:

Section 701. Professional Liability Insurance and Fund.—(a) Every health care provider **[subject to the provisions of this act]** ***as defined in this act, practicing medicine or podiatry or otherwise providing health care services in the Commonwealth*** shall insure his **[liability by purchasing]** professional liability **[insurance in the amount of $100,000 per occurrence and $300,000 per annual aggregate, hereinafter known as "basic coverage insurance." General and special hospitals may maintain professional liability insurance in the amount of $1,000,000. Upon certification by the administrator, of the aforementioned amount of insurance maintained by all general and special hospitals, all such hospitals shall be exempt from the provisions of this article.]** ***or provide proof of self-insurance in accordance with this section.***

(1) A health care provider, other than hospitals, who conducts more than 50% of his health care business or practice within the Commonwealth of Pennsylvania shall insure or self-insure his professional liability in the amount of $100,000 per occurrence and $300,000 per annual aggregate,

and hospitals located in the Commonwealth shall insure or self-insure their professional liability in the amount of $100,000 per occurrence, and $1,000,000 per annual aggregate, hereinafter known as "basic coverage insurance" and they shall be entitled to participate in the fund.

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

(3) For the purposes of this section, "health care business or practice" shall mean the number of patients to whom health care services are rendered by a health care provider within an annual period.

(4) All self-insurance plans shall be submitted with such information as the commissioner shall require for approval and shall be approved by the commissioner upon his finding that the plan constitutes protection equivalent to the insurance requirements of a health care provider.

(5) A fee shall be charged by the Insurance Department to all self-insurers for examination and approval of their plans.

(6) Self-insured health care providers and hospitals if exempt from this act shall submit the information required under section 809 to the commissioner.

(b) No insurer providing professional liability insurance **[to a health care provider pursuant to the provisions of section 701(a)]** shall be liable for payment of any claim against a health care provider for any loss or damages awarded in a professional liability action in excess of $100,000 per occurrence and $300,000 per annual aggregate ***for each health care provider against whom an award is made unless the health care provider's professional liability policy or self-insurance plan provides for a higher annual aggregate limit.***

(c) A government may satisfy its obligations pursuant to this act, as well as the obligations of its employees to the extent of their employment, by either purchasing insurance or assuming such obligation as a self-insurer.

[(c)] ***(d)*** There is hereby created a contingency fund for the purpose of paying all awards for loss or damages against a health care provider as a consequence of any **[medical malpractice]** ***professional liability*** action **[which are in excess of $100,000]** ***brought under this act to the extent any health care provider's share exceeds his basic insurance coverage.*** Such fund shall be known as the "Medical Professional Liability Catastrophe Loss Fund," in this Article VII called the "fund." The limit of liability of the fund shall be $1,000,000 for each occurrence ***for each health care provider*** and $3,000,000 per annual aggregate ***for each health care provider.***

[(d)] ***(e)*** The fund shall be funded by the levying of an annual surcharge on all health care providers ***except as provided for in subsection (a)(2).*** The surcharge shall be determined by the director appointed pursuant to

section 702 based upon actuarial principles and subject to the prior approval of the commissioner. The surcharge shall not exceed 10% of the cost to each health care provider for maintenance of professional liability insurance or $100, whichever is greater. ***Health care providers having approved self-insurance plans shall be surcharged an amount equal to the surcharge imposed on a health care provider of like class, size, risk and kind as determined by the director.*** The fund and all income from the fund shall be held in trust, deposited in a segregated account, invested and reinvested by the director, and shall not become a part of the General Fund of the Commonwealth. If the total fund exceeds the sum of $15,000,000 at the end of any calendar year after the payment of all claims and expenses, including the expenses of operation of the office of the director, the director shall reduce the surcharge provided in this section in order to maintain the fund at an approximate level of $15,000,000. All claims shall be computed on December 31 of the year in which the claim becomes final. All such claims shall be paid within two weeks thereafter. If the fund would be exhausted by the payment in full of all claims allowed during any calendar year, then the amount paid to each claimant shall be prorated. Any amounts due and unpaid shall be paid in the following calendar year. The annual surcharge on health care providers and any income realized by investment or reinvestment shall constitute the sole and exclusive sources of funding for the fund. No claims or expenses against the fund shall be deemed to constitute a debt of the Commonwealth or a charge against the General Fund of the Commonwealth. The director shall issue rules and regulations consistent with this section regarding the establishment ***and operation*** of the fund ***including all procedures*** and the levying, payment and collection of the surcharges. ***A fee shall be charged by the catastrophe loss fund director to all self-insurers for examination and approval of their plans.***

[(e)] ***(f)*** The failure of any health care provider to comply with any of the provisions of this section or any of the rules and regulations issued by the director shall result in the suspension or revocation of the health care provider's license by the licensure board.

(g) Any physician who exclusively practices the specialty of forensic pathology shall be exempt from the provisions of this act.

(h) All health care providers who are members of the Pennsylvania military forces are exempt from the provisions of this act while in the performance of their assigned duty in the Pennsylvania military forces under orders.

Section 7. Subsections (a), (c), (d), (e) and (f) of section 702 of the act are amended to read:

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

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(c) The basic coverage insurance carrier ***or self-insured provider*** shall promptly notify the director of any case where it reasonably believes that the value of the claim exceeds the basic insurer's coverage ***or self-insurance plan*** or falls under section 605. ***Such information shall be confidential, notwithstanding the act of July 19, 1974 (P.L.486, No.175) referred to as the Public Agency Open Meeting Law, and act of June 21, 1957 (P.L.390, No.212) referred to as the Right To Know Law.*** Failure to so notify the director shall make the basic coverage insurance carrier ***or self-insured provider*** responsible for the payment of the entire award or verdict, provided that the fund has been prejudiced by the failure of notice.

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

(e) In the event that the basic coverage insurance carrier ***or self-insured provider*** enters into a settlement with the claimant to the full extent of its liability as provided above, it may obtain a release from the claimant to the extent of its payment, which payment shall have no effect upon any excess claim against the fund ***or its duty to continue the defense of the claim.***

(f) The director is authorized to defend, litigate, settle **[and]** or compromise any claim **[in excess of the basic coverage hereinbefore provided.]** ***payable by the fund.***

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Section 8. The act is amended by adding a section to read:

Section 705. Liability of Excess Carriers.—(a) No insurer providing excess professional liability insurance to any health care provider eligible for coverage under the Medical Professional Liability Catastrophe Loss Fund shall be liable for payment of any claim against a health care provider for any loss or damages except those in excess of the limits of liability provided by the Medical Professional Liability Catastrophe Loss Fund.

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

Section 9. Section 1002 of the act is amended to read:

Section 1002. Cancellation of Insurance Policy.—Any termination of a professional liability insurance policy by cancellation, ***except for suspension or revocation of the insured's license or approval by the Commonwealth to provide health care services or for reason of nonpayment of premium,*** is not effective against the insured covered thereby, unless notice of cancellation shall have been given within 60 days after the issuance of such contract of insurance against the insured covered thereunder and no cancellation shall take effect unless a written notice stating the reasons for the cancellation and the date and time upon which

termination becomes effective has been received by the **[administrator]** ***commissioner*** at his office. Mailing of such notice to the **[administrator]** ***commissioner*** at his principal office address shall constitute notice to the **[administrator]** ***commissioner.***

Section 10. This act shall take effect immediately and be retroactive to January 13, 1976.

APPROVED—The 15th day of July, A. D. 1976.

MILTON J. SHAPP