No. 111

AN ACT

HB 1367

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.

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

ARTICLE I
Preliminary Provisions

Section 101. Short Title.—This act shall be known and may be cited as the "Health Care Services Malpractice Act."

Section 102. Purpose.—It is the purpose of this act to make available professional liability insurance at a reasonable cost, and to establish a system through which a person who has sustained injury or death as a result of tort or breach of contract by a health care provider can obtain a prompt determination and adjudication of his claim and the determination of fair and reasonable compensation.

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.

"Health care provider" means a person, corporation, facility institution or other entity licensed or approved by the Commonwealth to provide health care or professional services as a physician, including a medical doctor and a doctor of osteopathy and a doctor of podiatry; hospital; nursing home; health maintenance organization; or 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.

"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.

ARTICLE II
Services Rendered by Non-health Care Providers

Section 201. Liability of Non-qualifying Health Care Providers.—Any person rendering services normally rendered by a health care provider who fails to qualify as a health care provider under this act is subject to liability under the law without regard to the provisions of this act.

ARTICLE III
Administrator for Arbitration Panels for Health Care

Section 301. Appointment and Compensation of Administrator.—There is established within the Department of Justice the office of Administrator for Arbitration Panels for Health Care to be appointed by the Governor. The salary of the administrator shall be set by the Executive Board.

Section 302. Removal of Administrator for Cause.—The administrator may be removed by the Governor for incompetence, neglect of duty, misconduct in office, or other good cause to be stated in writing in the order of removal.

Section 303. Appointment of Employees.—The administrator shall appoint a secretary and such other employees as are required to administer this act.

Section 304. Fees Paid by Health Care Providers.—(a) The administration of this act shall be funded in part from fees charged to each health care provider practicing in the Commonwealth and payable to the administrator.

(b) Physicians and podiatrists practicing in the Commonwealth shall be charged $50 annually.

(c) An annual fee of $500 shall be charged to each hospital with 250 or more beds. An annual fee of $350 shall be charged to all other hospitals. An annual fee of $100 shall be charged to all other health care organizations.

Section 305. Preparation and Furnishing of Documents.—The administrator shall prepare, print and furnish upon request and free of charge, such blank forms and literature as he considers necessary to facilitate and promote the efficient administration of this act.

Section 306. Submission of Annual Report.—The administrator shall submit to the Governor and the General Assembly annually, on or before December 1, a report of the work of the administrator's office during the preceding fiscal year.

Section 307. Rules and Regulations.—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.

Section 308. Arbitration Panels for Health Care.—(a) The administrator shall establish a separate arbitration panel for each claim; and after each panel renders its decision on the claim it shall be disbanded.

(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 as one of the health care provider panel members where the claim involves a member of one of those classes of health care providers.

(c) Arbitration panel candidates shall be selected from a pool of candidates generated by the administrator. The rules and regulations promulgated by the administrator pertaining to the selection of arbitrators shall provide that the administrator shall send simultaneously to each party an identical list of five arbitration panel candidates in each of the three categories together with a brief biographical statement on each candidate. A party may strike from the list any two names which are unacceptable in each category. Any mutually agreeable candidate may be invited by the administrator to serve. Where insufficient mutually agreeable candidates are selected for

any category a second list of that category shall be sent by the administrator. If a complete arbitration panel is not selected by mutual agreement of the parties the administrator shall appoint the remainder of the arbitration panel. Any appointment by the administrator shall be subject to challenge by any party for cause. A request to strike an arbitrator for cause shall be determined by the administrator. The parties shall not be restricted to the arbitration panel candidates submitted for consideration; but, if all parties mutually agree upon an arbitration panelist within a designated category, the panelist shall be invited to serve.

(d) The attorney and health care provider members of each arbitration panel shall be or have been practicing members of their respective professions.

(e) Arbitration panel members shall be paid on a per diem or salary basis as fixed by the Executive Board plus actual and necessary expenses incurred in the performance of their official duties. The administrator shall provide for all other necessary expenses of the arbitration panels.

(f) No member shall participate in a case in which he may have an interest.

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.

ARTICLE IV
Procedure For Filing a Claim

Section 401. Filing of Complaint.—A patient or his representative, having a claim for loss or damages 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 administrator shall refer the complaint to the appropriate arbitration panel. The filing of the complaint with the administrator shall toll the statute of limitations.

Section 402. Hearing and Determination of Claim.—Upon assignment of a claim to an arbitration panel, said arbitration panel shall expeditiously hear and determine the claim in accordance with the rules and regulations adopted by the administrator.

ARTICLE V
Procedure Before the Arbitration Panel for Health Care

Section 501. Location of Hearings.—Arbitration panel hearings shall be conducted in the county where the cause of action arose, but may, within the discretion of the administrator, be held in any other place.

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.

Section 503. Service of Complaints and Hearing Notices.—Service of complaints and notice of all hearings and proceedings before the arbitration panel, unless otherwise directed, shall be made personally or given by certified mail, and proof of the mailing of notice shall be prima facie evidence of service.

Section 504. Service of Briefs and Pleadings.—All briefs or pleadings shall contain a certification that on or before the day of filing, a copy of the document was served on opposing counsel, or on the adverse party or parties if there is no counsel of record.

Section 505. Vote Required for Deciding Matters.—A majority vote of the full arbitration panel shall be required to decide all matters except questions of law before it.

Section 506. Applicability of Laws, Rules and Evidence.—Except as provided in this act, the arbitration panel is bound by the common and statutory law of the Commonwealth, the Pennsylvania Rules of Civil Procedure, and the Pennsylvania rules of evidence.

Section 507. Appointment of Expert Witnesses.—The arbitration panel may, upon the application of either party or upon its own motion, appoint a disinterested and qualified expert to make any necessary professional or expert examination of the claimant or relevant evidentiary matter and to testify as a witness in respect thereto. Such an expert witness shall be allowed necessary expenses and a reasonable fee to be fixed and paid by the arbitration panel.

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

(1) examine the relevant facts to determine if a case exists for recovery;

(2) make findings of fact;

(3) take depositions and testimony;

(4) assure both parties full access to the facts;

(5) make available to the parties the norms, standards and criteria employed by health care providers in the Professional Standards Review Organization region;

(6) subpoena witnesses, and administer oaths;

(7) apply to the court of common pleas to enforce the attendance and testimony of witnesses and the production and examination of books, papers and records;

(8) consider and approve offers of settlement and proposals of adjustment between plaintiffs and defendants;

(9) make determinations as to liability and award of damages; and

(10) exercise all other powers and duties conferred upon it by law.

(b) A copy of the arbitration panel's decision shall be sent to each party at the same time it is submitted to the administrator.

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 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 510. Admissibility of Record on Appeal.—Where an appeal is taken the decision, and findings of fact, if any, of the arbitration panel shall be admissible as evidence before the court; provided, however, that any award of damages shall not be admissible as evidence.

Section 511. Transfer and Enforcement of Judgment.—(a) If an appeal is not entered within the prescribed time, the party in whose favor the award shall have been made may request the administrator to transfer the record and judgment to the court of common pleas in the district where the plaintiff or defendant resides, for execution. It shall be the duty of the prothonotary, at the request of the party in whose favor the award shall have been made, and upon receipt and filing of the arbitration award from the administrator, to issue execution, or such other process as may be necessary and proper, to carry into effect the judgment entered upon such award, subject to the provisions of law concerning the stay of execution upon judgments.

(b) After judgment, the plaintiff may proceed upon said transferred record and judgment for the collection thereof, with costs, by execution, bill of discovery or attachment, in like manner as if the same were a judgment of the court to which it has been transferred.

Section 512. Liability not Admitted by Advance Payment.—In an action brought to recover damages under this act, no advance payment made by the defendant health care provider or his professional liability insurer to or for the plaintiff shall be construed as an admission of liability for injuries or damages suffered by the plaintiff.

Section 513. Reduction of Award by Advance Payment.—Any final award in favor of the plaintiff, shall be reduced to the extent of any advance payment. The advance payment shall inure to the exclusive benefit of the defendant or the insurer making the payment.

Section 514. Submission of Findings to Licensing Boards.—In the event that the arbitration panel finds that the injury or death of the patient was the result in whole or in part of tort or breach of contract by a health care provider, and such decision is not overturned on appeal, the arbitration panel shall report such findings to the licensure board and the Professional Standards Review Organization. The appropriate board of licensure shall promptly investigate the report and take such disciplinary action as may be appropriate.

ARTICLE VI
Awards

Section 601. Right of Recovery of Damages.—Upon a finding by the arbitration panel that the defendant's conduct was tortious or constituted a breach of contract, the plaintiff shall have the same rights of recovery for damages as are now provided by law.

Section 602. Reduction of Award by Other Benefits.—The loss and damages awarded under this act shall be reduced by any public collateral source of compensation or benefits. A right of subrogation is not enforceable against any benefit or compensation awarded under this act or against any health care provider or its liability insurer.

Section 603. Award of Punitive Damages.—In the event the arbitration panel finds that the injury or damage to the patient was caused in whole or in part by the wilful or wanton misconduct of any of the defendants, the panel may award such punitive damages against the defendant as may be awarded at law.

Section 604. Attorney's Fees.—(a) When a plaintiff is represented by an attorney in the prosecution of his claim the plaintiff's attorney fees from any award made from the first $100,000 may not exceed 30%, from the second $100,000 attorney fees may not exceed 25%, and attorney fees may not exceed 20% on the balance of any award.

(b) A plaintiff has the right to elect to pay for the attorney's services on a mutually satisfactory per diem basis. The election, however, must be exercised in written form at the time of employment.

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 against a health care provider subject to the provisions of Article VII more than four years after the breach of contract or tort occurred, such claim shall be 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 concealment of the health care provider, the fund shall have the right of indemnity from such health care provider. A filing pursuant to section 401 shall toll the running of the limitations contained herein.

Section 606. Provider not a Warrantor or Guarantor.—In the absence of a special contract in writing, a health care provider is neither a warrantor nor a guarantor of a cure.

ARTICLE VII
Medical Professional Liability Catastrophe Loss Fund

Section 701. Professional Liability Insurance and Fund.—(a) Every health care provider subject to the provisions of this act 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.

(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.

(c) 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 action which are in excess of $100,000. 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 and $3,000,000 per annual aggregate.

(d) The fund shall be funded by the levying of an annual surcharge on all health care providers. 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. 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 of the fund and the levying, payment and collection of the surcharges.

(e) 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.

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.

(b) The director shall be provided with adequate offices in which the records shall be kept and official business shall be transacted, and the director shall also be provided with necessary office furniture and other supplies.

(c) The basic coverage insurance carrier 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 falls under section 605. Failure to so notify the director shall make the basic coverage insurance carrier 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 shall at all times be responsible to provide a defense for the insured health care provider. 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 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.

(f) The director is authorized to defend, litigate, settle and/or compromise any claim in excess of the basic coverage hereinbefore provided.

(g) The director is hereby empowered to purchase, on behalf of the fund, as much insurance or re-insurance as is necessary to preserve the fund.

(h) Nothing in this act shall preclude the director from adjusting or paying for the adjustment of claims.

Section 703. Discontinuance of Fund.—If after collection of the second annual surcharge, and following the collection of any subsequent annual surcharge, the fund is reduced below $7,500,000, the director shall certify such facts to the Governor and the General Assembly. If upon the expiration of 25 legislative days, following such certification, no remedial action is taken by the General Assembly, and enacted into law, the liability of the fund for claims arising from occurrences after such period shall cease and the Joint Underwriting Association created under Article VIII shall terminate and the provisions of Article VII, section 701(a) and Article VIII shall no longer apply. In such case, the fund will continue to function until all of its

liability for claims has been satisfied. The director is authorized to continue to collect a surcharge annually without limit, to the extent necessary to satisfy the obligations of the fund. Such surcharge must be filed with and approved by the commissioner prior to use. Any moneys remaining in the fund following the satisfaction of all its liabilities shall be returned to the health care providers under such terms and conditions as determined by a plan prepared by the director and approved by the commissioner.

Section 704. Amount and Liability for Continued Surcharge.—Determination of the adequacy of the surcharge is to be based on the reasonably anticipated payment of claims and other expenses of the fund during the period for which the surcharge is made. The surcharge shall be assessed against each health care provider qualifying as such at the time the surcharge is made.

ARTICLE VIII
Availability of Insurance

Section 801. Plan to Assure Availability of Insurance.—The commissioner shall establish and implement or approve and supervise a plan assuring that professional liability insurance will be conveniently and expeditiously available, subject only to payment or provisions for payment of the premium, to those providers who cannot conveniently obtain insurance through ordinary methods at rates not in excess of those applicable to similarly situated health care providers under the plan. The plan may provide reasonable means for the transfer of health care providers insured thereunder into the ordinary insurance market, at the same or lower rates pursuant to regulations established by the Insurance Commissioner. The plan may be implemented by a joint underwriting association that results in all applicants being conveniently afforded access to the insurance coverages on reasonable and not unfairly discriminatory terms.

Section 802. Participation in Plan.—The plan shall consist of all insurers authorized to write insurance pursuant to section 202(c)(4) and (11) of the act of May 17, 1921 (P.L.682, No.284), known as "The Insurance Company Law of 1921." The plan shall provide for equitable apportionment of the financial burdens of insurance provided to applicants under the plan and the costs of operation of the plan among all participating insurers writing such insurance coverage.

Section 803. Plan Operation, Rates and Deficits.—(a) Subject to the supervision and approval of the commissioner, insurers may consult and agree with each other and with other appropriate persons as to the organization, administration and operation of the plan and as to rates and rate modifications for insurance coverages provided under the plan. Rates and rate modifications adopted or changed for insurance coverages provided under the plan shall be approved by the commissioner in accordance with the act of June 11, 1947 (P.L.538,

No.246), known as "The Casualty and Surety Rate Regulatory Act."

(b) In the event that the Joint Underwriting Association suffers a deficit in any calendar year, the board of directors of the Joint Underwriting Association shall so certify to the director of the Catastrophe Loss Fund and the Insurance Commissioner. Such certification shall be subject to the review and approval of the Insurance Commissioner. Within 60 days following such certification and approval the director of the fund shall make sufficient payment to the Joint Underwriting Association to compensate for said deficit. A deficit shall exist whenever the sum of the earned premiums collected by the Joint Underwriting Association and the investment income therefrom is exhausted by virtue of payment of or allocation for the Joint Underwriting Association's necessary administrative expenses, taxes, losses, loss adjustment expenses and reserves, including reserves for: (1) losses incurred, (2) losses incurred but not reported, (3) loss adjustment expenses, (4) unearned premiums.

Section 804. Authority of Insurance Commissioner.—To carry out the objectives of this article, the commissioner may adopt rules, make orders, enter into agreements with other governmental or private entities and individuals and form and operate or authorize the formation and operation of bureaus and other legal entities.

Section 805. Financing and Payment of Premiums.—The plan shall assure that there is available through the private sector or otherwise, to all applicants, adequate premium financing or provision for the installment payment of premiums subject to customary terms and conditions.

Section 806. Selection of Insurer to Administer Plan.—The commissioner may select an insurer to administer any plan established pursuant to this article. Such insurer shall be admitted to transact the business of insurance in this Commonwealth.

Section 807. Approval of Policies on "Claims Made" Basis.—The Insurance Commissioner shall not approve a policy written on a "claims made" basis by any insurer doing business in this Commonwealth unless such insurer shall guarantee to the commissioner the continued availability of suitable liability protection for health care providers subsequent to the discontinuance of professional practice by the health care provider or the sooner termination of the insurance policy by the insurer or the health care provider for so long as there is a reasonable probability of a claim for injury for which the health care provider may be held liable.

Section 808. When Plan Exclusive Source of Insurance.—If the private insurance market unfairly discriminates against higher risk physicians by denying professional liability insurance coverage to 50% or more of all physicians in insurance rating classes 3, 4 or 5, or their equivalents the commissioner, after notice in the Pennsylvania Bulletin and public hearings, may declare that the plan established under this

article shall be the sole and exclusive source of professional liability insurance for health care providers within this Commonwealth. The commissioner may dissolve the plan if he determines that it is no longer necessary and that an adequate market will be maintained for professional liability insurance for health care providers by the private insurance market. The commissioner may reestablish the plan if he shall find that the private industry has failed to provide an adequate market for professional liability insurance by denying professional liability insurance coverage to 50% or more of all rating classes 3, 4 or 5, or their equivalents, and may declare it the sole and exclusive source of such insurance under the procedure set forth in this section.

Section 809. Annual Reports to Insurance Commissioner.—The plan shall report to the commissioner annually on a date and, on a form prescribed by the commissioner the total amount of premium dollars collected, the total amount of claims paid and expenses incurred therewith, the total amount of reserve set aside for future claims, the nature and substance of each claim, the date and place in which each claim arose, the amounts paid, if any, and the disposition of each claim (judgment of arbitration panel, judgment of court, settlement or otherwise), and such additional information as the commissioner shall require.

Section 810. Studies and Recommendations for Changes.—The plan shall conduct studies and review member records for the purpose of determining the causes of patient compensation claims and make recommendations for legislative, regulatory and other changes necessary to reduce the frequency and severity of such claims.

ARTICLE IX
Disciplinary Proceedings

Section 901. Investigations.—The State Board of Medical Education and Licensure, the State Board of Osteopathic Examiners and the State Board of Podiatry Examiners shall employ such qualified investigators and attorneys as are necessary to fully implement their authority to revoke, suspend, limit or otherwise regulate the licenses of physicians; issue reprimands, fines, require refresher educational courses, or require licensees to submit to medical treatment.

Section 902. Hearings.—(a) The State Board of Medical Education and Licensure, the State Board of Osteopathic Examiners and the State Board of Podiatry Examiners shall appoint, with the approval of the Governor, such hearing examiners as shall be necessary to conduct hearings in accordance with the disciplinary authority granted by the act of July 20, 1974 (P.L.551, No.190), known as the "Medical Practice Act of 1974," and the act of March 19, 1909 (P.L.46, No.29), entitled, as amended, "An act to regulate the practice of osteopathy and surgery in the State of Pennsylvania; to provide for the establishment of a State Board of Osteopathic Examiners; to define the powers and duties of said

Board of Osteopathic Examiners; to provide for the examining and licensing of osteopathic physicians and surgeons in this State; and to provide penalties for the violation of this act."

(b) The State Board of Medical Education and Licensure or the State Board of Osteopathic Examiners shall have the power to adopt and promulgate rules and regulations setting forth the functions, powers, standards and duties to be followed by any hearing examiners appointed under the provisions of this section.

(c) Such hearing examiners shall have the power to conduct hearings in accordance with the regulations of the State Board of Medical Education and Licensure or the State Board of Osteopathic Examiners, and to issue subpoenas requiring the attendance and testimony of individuals or the production of, pertinent books, records, documents and papers by persons whom they believe to have information relevant to any matter pending before the examiner. Such examiner shall also have the power to administer oaths.

Section 903. Hearing Examiners' Decisions.—The hearing examiner shall hear evidence submitted and arguments of counsel, if any, with reasonable dispatch, and shall promptly record his decision, supported by findings of fact, and a copy thereof shall immediately be sent to the State Board of Medical Education and Licensure or the State Board of Osteopathic Examiners and to counsel of record, or the parties, if not represented.

Section 904. Evidence.—In all hearings proof may be made by oral testimony or by deposition or interrogatories. Such depositions shall be taken in the manner and upon the notice required by the rules for taking depositions in civil cases and may be introduced into evidence without regard to the availability of the witness to testify at the time of trial. Any witness, however, may be subpoenaed by any party to the controversy to testify pursuant to the rules appropriate to civil actions and shall be considered to be the witness of the party who offered the deposition.

Section 905. Review by State Licensing Boards.—(a) If application for review is made to the State Board of Medical Education and Licensure, the State Board of Osteopathic Examiners or the State Board of Podiatry Examiners within 20 days from the date of any decision made as a result of a hearing held by a hearing examiner, the State Board of Medical Education and Licensure, the State Board of Osteopathic Examiners or the State Board of Podiatry Examiners shall review the evidence, and if deemed advisable by the board, hear argument and additional evidence.

(b) As soon as practicable, the State Board of Medical Education and Licensure, the State Board of Osteopathic Examiners or the State Board of Podiatry Examiners shall make a decision and shall file the same with its finding of the facts on which it is based and send a copy thereof to each of the parties in dispute.

Section 906. Judicial Review.—Decision by the State Board of Medical Education and Licensure, the State Board of Osteopathic Examiners or the State Board of Podiatry Examiners shall be conclusive and binding as to all questions of fact, but any medical practitioner may, within 30 days from the date of such decision appeal to the Commonwealth Court of Pennsylvania alleging certain errors of law under the same terms and conditions as cover appeals in actions involving State agencies.

Section 907. Disposition of Certain Moneys.—(a) All fees, charges and fines collected under the provisions of the act of July 20, 1974 (P.L.551, No.190), known as the "Medical Practice Act of 1974" are hereby specifically appropriated for the exclusive use by the State Board of Medical Education and Licensure in carrying out the provisions of this act.

(b) All fees, charges and fines collected under the provisions of the act of March 19, 1909 (P.L.46, No.29), entitled, as amended, "An act to regulate the practice of osteopathy and surgery in the State of Pennsylvania; to provide for the establishment of a State Board of Osteopathic Examiners; to define the powers and duties of said Board of Osteopathic Examiners; to provide for the examining and licensing of osteopathic physicians and surgeons in this State; and to provide penalties for the violation of this act," are hereby specifically appropriated for the exclusive use by the State Board of Osteopathic Examiners in carrying out the provisions of this act.

(c) All fees, charges and fines collected under the provisions of the act of March 2, 1956 (P.L.1206, No.375), entitled, as amended, "An act relating to and defining the practice of podiatry; conferring powers and imposing duties on the State Board of Podiatry Examiners and the Department of State; requiring licensure; providing for the granting, cancellation, suspension and revocation of licenses; preserving the rights of existing licenses; providing for the promulgation of rules and regulations; transfer of jurisdiction and records to the board; regulation of schools of chiropody and podiatry; reciprocity; and providing penalties, and remedies," are hereby specifically appropriated for the exclusive use by the State Board of Podiatry Examiners in carrying out the provisions of this act.

ARTICLE X
General Provisions

Section 1001. Immunity from Liability for Official Actions.—There shall be no liability on the part of and no cause of action for libel or slander shall arise against any member insurer, the State Board of Medical Education and Licensure, the State Board of Osteopathic Examiners, the State Board of Podiatry Examiners, the arbitration panels, the administrator or the commissioner or his representatives for

any action taken by any of them in the performance of their respective powers and duties under this act.

Section 1002. Cancellation of Insurance Policy.—Any termination of a professional liability insurance policy by cancellation 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 at his office. Mailing of such notice to the administrator at his principal office address shall constitute notice to the administrator.

Section 1003. Inapplicability to Prior Services.—The provisions of this act do not apply to injuries or death from services rendered or which should have been rendered by a health care provider which occurred before the effective date of this act.

Section 1004. Existing Contract Provisions Unaffected.—Every express contract between a patient and health care provider in existence on the effective date of this act, containing provisions inconsistent with the terms and provisions of this act, remains unimpaired, binding and effective as to all parties until the contract expires or is rescinded by law or the mutual agreement of the parties.

Section 1005. Fines and Penalties.—(a) No health care provider shall provide any health care or professional services until such assessments as are levied by the administrator are paid.

(b) Any health care provider licensed by the Commonwealth or operating under a certificate of authority issued by the Commonwealth who violates the provisions of subsection (a) shall upon conviction in a summary proceeding be sentenced to pay a fine of not less than $100 nor more than $1,000 per day for each day of practice while in violation, and may be subject to a suspension of his license or certificate of authority, or both.

Section 1006. Joint Committee.—There is hereby created a committee to consist of the commissioner as chairman, the Secretary of Health and two members of the Senate, one member of each party, to be appointed by the President pro tempore and two members of the House of Representatives, one member of each party, to be appointed by the Speaker of the House of Representatives. The committee shall study the distribution of professional liability insurance costs as among the various classes of physicians and health care providers and shall report its findings and recommendations to the General Assembly within one year of the effective date of this act. The committee shall also study all phases and the financial impact of the operations of the Medical Professional Liability Catastrophe Loss Fund and shall report its findings and recommendations to the General Assembly on or before July 1, 1977. This committee shall also study actual or potential

problems of conflicts of interest which exist or may exist among members of the arbitration panel with each other and with other persons appearing before the arbitration panel or having their interests represented before the arbitration panel. The committee shall promulgate a proposed Code of Ethics with suggested legal sanctions to deal with any violators of the Code of Ethics on or before July 1, 1976.

Section 1007. Repealer.—All acts and parts of acts are repealed in so far as they are inconsistent with this act.

Section 1008. Effective Date.—This act shall take effect in 90 days.

APPROVED—The 15th day of October, A. D. 1975.

MILTON J. SHAPP