HOUSE BILL 699

Introduced by Addy, et al.

2/14	Introduced
2/15	Referred to Judiciary
2/16	Fiscal Note Requested
2/17	Hearing
2/27	Fiscal Note Received
3/03	Fiscal Note Printed
3/21	Committee Report--Bill Passed as Amended
3/22	Taken From Printing
3/22	Rereferred to Appropriations
3/28	Hearing
3/29	Committee Report--Bill Passed as Amended
3/29	2nd Reading Passed as Amended
3/30	3rd Reading Passed

Transmitted to Senate

3/31	Referred to Judiciary
4/05	Hearing
4/11	Hearing
	Died in Committee

INTRODUCED BY House BILL NO. 699
Addy Sidney Connelly Beck
Kaltya

A BILL FOR AN ACT ENTITLED: "AN ACT PROVIDING FOR A PATIENT ASSURED COMPENSATION FUND ABOVE LOW PRIMARY LIMITS OF INSURANCE, FOR THE PAYMENT OF MEDICAL LIABILITY CLAIMS AGAINST PHYSICIANS WHO DELIVER BABIES; PROVIDING FOR THE RETURN OF DOLLAR SAVINGS TO ORIGINAL CAPITALIZERS AND TO PATIENTS WHO ARE INJURED IN THE MEDICAL SYSTEM; PROVIDING FOR AN OBSTETRICAL ADVISORY COMMITTEE TO MAKE RECOMMENDATIONS REGARDING OBSTETRICAL CARE; PROVIDING FOR OBJECTIVE GUIDELINES FOR NONECONOMIC DAMAGES PROPORTIONATE TO THE SEVERITY OF INJURY OR THE LIFE EXPECTANCY OF THE INJURED PARTY; PROVIDING FOR VOLUNTARY ENTRY INTO BINDING ARBITRATION FOR OBSTETRICAL CLAIMS WITHOUT REGARD TO NEGLIGENCE OF THE PHYSICIAN; PROVIDING FOR ADMINISTRATION BY THE MONTANA MEDICAL LEGAL PANEL UNDER THE REIMBURSED SUPERVISION OF THE DEPARTMENT OF HEALTH AND ENVIRONMENTAL SCIENCES; PROVIDING FOR CAPITALIZATION BY A PREMIUM TAX ON CASUALTY CARRIERS; AMENDING SECTIONS 27-6-105, 27-6-602, 33-10-102, AND 33-23-311, MCA; AND PROVIDING AN IMMEDIATE EFFECTIVE DATE."

STATEMENT OF INTENT

A statement of intent is required for this bill because it delegates rulemaking authority to the department of health and environmental sciences. This bill is intended to expand the authority of the department and to authorize the writing and adopting of rules in accordance with the Montana Administrative Procedure Act to:

(1) qualify or disqualify physicians for participation in the patient assured compensation fund; and

(2) facilitate the collection of assessments and charges for hospitals and participating physicians under the Patient Assured Compensation Act. This bill is intended to reimburse the department for the cost of writing and adopting the rules.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

NEW SECTION. **Section 1.** Short title. [Sections 1 through 26] may be cited as the "Patient Assured Compensation Act".

NEW SECTION. **Section 2.** Purpose and goals. (1) The purpose of this legislation is to increase the availability of obstetrical care and access to that care, especially in rural areas of Montana, and to maintain the availability and accessibility of obstetrical care in urban areas of Montana.

(2) The goals of this legislation are to:

(a) eliminate from the insurance system any excess insurance money that may be collected because of complex

insurance and legal problems related to excess reserves, excess profits, and the use of shared insurance data from states other than Montana;

(b) require the pass through of savings to those who bear the cost for the Patient Assured Compensation Act, including the class of patients and claimants with injuries received in the medical system;

(c) provide more full and fair compensation to claimants than the current medical-insurance-legal system does in cases involving physicians who deliver babies;

(d) provide in advance a reasonable calculation of the actual amounts to be paid in obstetrics-related claims so that the funds necessary to pay claims can be properly raised from those who pay for the claims to ensure that damages do not increase exponentially;

(e) provide a funding mechanism that is broader than the available base of funds from obstetricians and family practitioners providing obstetric care by using sources that have an interest in the maintenance of core industries in rural areas and that have benefited from previous civil justice reform legislation; and

(f) provide an immediate reduction in the total cost of coverage for medical liability insurance for physicians who deliver babies.

NEW SECTION. **Section 3.** Legislative findings. The

legislature finds that:

(1) there has been an accelerating and substantial reduction in available obstetrical services in Montana, especially in the rural areas, and this process is likely to continue unless appropriate steps are taken;

(2) the reduction in obstetrical services constitutes a statewide public health problem of a large magnitude and a statewide economic problem of a severe nature;

(3) in addition to the direct loss of obstetrical services in rural areas of Montana, there have been and will likely continue to be:

(a) broader adverse economic impacts to the hospitals in those communities, including the closure of some hospitals with resulting adverse impacts on the communities involved, that flow from a loss of a broad range of basic medical services as physicians who deliver babies retire early or leave the community;

(b) limitations on the availability and access to obstetrical care in urban areas, especially among lower-income women, brought about by increased pressures on limited resources in urban areas from women in rural areas who wish to obtain replacement obstetrical services;

(4) the impacts referred to in subsection (3) are strongly associated with, among other things:

(a) substantial previous increases in the cost of

medical liability insurance, a high level of current costs of medical liability insurance, and anticipated increases in the future cost of medical liability insurance to the point where the income from the delivery of babies does not justify the current or future cost of medical liability coverage;

(b) substantial previous increases in the number of medical liability claims against physicians, with an increased likelihood that each physician will be periodically involved in a number of legal claims;

(c) inducements for early retirement, relocation to another area, or the elimination or limitation of obstetrical services by doctors who deliver babies;

(5) the medical-insurance-legal system, because of its unpredictability and high cost, often deprives the most seriously injured and the least seriously injured of even their out-of-pocket economic damages or provides compensation for intangible damages disproportionate to the severity of the injury or the life expectancy of the injured party.

NEW SECTION. **Section 4.** Definitions. As used in [sections 1 through 26], the following definitions apply:

(1) "Actuarially sound basis" means that the probability of insolvency of the primary pool of funds has been lowered to a level of risk that is prudent to accept,

as determined by an actuary hired by the fund, who is a member of the American academy of actuaries or the casualty actuarial society.

(2) "Administrator" means the administrator of the primary and secondary pool of funds, who is the director of the Montana medical legal panel provided for in 27-6-201.

(3) "Board" means the Montana state board of medical examiners provided for in 2-15-1841.

(4) "Bodily impairment" means temporary or permanent impairment or loss of bodily functions or bodily parts. The term does not include other impairments, including but not limited to mental or emotional processes or behavioral controls.

(5) "Claimant" means a person claiming damages for injury from medical malpractice or required benefits for compensable injuries under [sections 1 through 26].

(6) "Commissioner" means the commissioner of insurance provided for in 2-15-1903.

(7) "Compensable injury" means any physical harm, bodily impairment, disfigurement, or a delay in recovery, under [section 24] that:

(a) is associated with or connected to the birthing process or the rendering of obstetrical care by a physician qualified under the terms of [sections 1 through 26];

(b) is associated in whole or in part with medical

intervention rather than with the condition for which the intervention occurred; and

(c) is not consistent with or reasonably expected as a consequence of medical intervention or is a result of medical intervention to which the patient did not consent.

(8) "Condition" means the general state of health of the patient prior to medical intervention.

(9) "Delay in recovery" means any undue additional time spent under care that is not substantially attributable to the condition for which medical intervention occurred and includes consideration of the general health of the patient.

(10) "Department" means the department of health and environmental sciences provided for in Title 2, chapter 15, part 21.

(11) "Designated premium equivalent" means the dollar amount paid by a patient to a physician or deducted from the charges of a physician under [section 24].

(12) "Disfigurement" means scars or adverse changes in bodily appearance beyond those that are medically required.

(13) "Economic damages" means those compensatory damages payable as a result of a medical malpractice claim against a physician or a physician and other parties, that are objectively determinable and verifiable compensatory damages, including but not limited to medical expenses and care, rehabilitation services, custodial care, loss of

earnings and earning capacity, loss of income, funeral or burial expenses, loss of use of property, costs of repair or replacement of property, costs of obtaining substitute domestic services, loss of employment, loss of business or employment opportunities, and any other objectively determinable and verifiable pecuniary or monetary damages.

(14) "Hospital" means a hospital as defined in 50-5-101.

(15) "Malpractice claim" means a malpractice claim as defined in 27-6-103.

(16) "Medical intervention" means the rendering as well as the omission of any care, treatment, or services provided within the course of treatment administered by or under the control of a physician or hospital.

(17) "Montana medical legal panel" means the panel provided for in 27-6-104.

(18) "Noneconomic damages" means those damages payable as a result of a medical malpractice claim against a physician or a physician and other parties that are subjectively determined to be nonmonetary or nonpecuniary damages, including but not limited to pain, suffering, inconvenience, grief, physical impairment, disfigurement, mental suffering or anguish, emotional distress, loss of society and companionship, loss of consortium, fear of loss, fear of illness, fear of injury, injury to reputation,

humiliation, and any other subjectively determined nonmonetary or nonpecuniary damages.

(19) "Obstetrical advisory council" means an advisory council created pursuant to 2-15-122 by the department and provided for in [section 20].

(20) "Patient" means an individual who receives or should have received care from a physician and includes any person having a claim of any kind, whether derivative or otherwise, as a result of alleged medical malpractice on the part of a physician or having a compensable injury. Derivative claims include but are not limited to the claim of a parent or parents, guardian, trustee, child, relative, attorney, or any other representative of a patient, including claims for economic damages, noneconomic damages, attorney fees or expenses, and all similar claims.

(21) "Patient assured compensation fund" or "fund" means the fund created under [section 5] and comprised of a primary pool of funds and a secondary pool of funds.

(22) "Physical harm" means a wound, infection, disease, or death.

(23) "Physician" means a physician as defined in 27-6-103.

(24) "Primary pool of funds" means that separate and segregated portion of the fund established for the payment of claims, expenses, and other allowed and required

expenditures pursuant to [sections 1 through 26], except for money payable from the secondary pool of funds.

(25) "Representative" means the spouse, parent, guardian, trustee, attorney, or other legal agent of the patient.

(26) "Secondary pool of funds" means that separate and segregated portion of the fund established for the payment of compensation, expenses, and other allowed and required expenditures pursuant to [section 24].

(27) "Surplus" means the excess of total assets minus liabilities of the primary pool of funds as defined by standard accounting practices for insurance carriers.

NEW SECTION. **Section 5. Purpose -- attachment to department -- deposit and investment.** (1) There is a patient assured compensation fund. Money for the fund collected and received pursuant to [sections 1 through 26] is to be used exclusively for the purposes stated in [sections 1 through 26].

(2) The fund is attached to the department for administrative purposes only, pursuant to 2-15-121, except as otherwise provided in [sections 1 through 26]. The department may promulgate rules and regulations implementing [sections 1 through 26].

(3) The primary and secondary pool of funds and any income from those funds must be held in trust. The funds

must be deposited in segregated accounts (one for the primary pool of funds and one for the secondary pool of funds), invested, and reinvested by the department pursuant to law. The fund may not become a part of or revert to the general fund of the state.

NEW SECTION. **Section 6.** **Reimbursement to department.** The department must be reimbursed from the primary pool of funds for any expenses incurred in the administration of [sections 1 through 26].

NEW SECTION. **Section 7.** **Capitalization and maintenance of primary pool of funds and secondary pool of funds -- surcharge.** (1) To capitalize the primary pool of funds and the secondary pool of funds, there is levied and collected on all insurance carriers authorized to write and engaged in writing casualty insurance pursuant to 33-1-206 in this state during 1987 and engaged in writing casualty insurance as of December 31, 1988, a one-time refundable surcharge in the form of a 1.17% premium tax surcharge based on 1987 carrier annual reports made pursuant to 33-2-705. A total of $100,000 of the surcharge forms the capitalization of the secondary pool of funds and the balance of the surcharge forms the capitalization of the primary pool of funds. If the surcharges provided for in this section are refunded, the refund must be made in the method and manner provided for in [section 10].

(2) Except as otherwise provided in this section, the primary pool of funds is fully nonassessable. In order to maintain the primary pool of funds, the following annual surcharges must be levied against physicians qualified under [section 16]:

(a) (i) for coverage from the primary pool of funds from $100,000 per occurrence and $300,000 in the annual aggregate up to $1 million per occurrence and $3 million in the annual aggregate for all claims made during the policy period of the qualifying physician's primary policy of insurance required by [sections 1 through 26] and pursuant to that primary policy, as to physicians insured for purposes of at least some obstetrical privileges with an insurer authorized under [sections 1 through 26]:

(A) as a family practitioner, an annual surcharge of $6,313;

(B) as an obstetrician, an annual surcharge of $13,141;

(ii) an annual surcharge, separately and additionally paid by any professional service corporation, partnership, or other business entity and its employees desiring to qualify as physicians under [sections 1 through 26] in the same manner as charges are levied by the carrier providing primary coverage, at a rate to be determined by the actuary hired by the administrator;

(b) for each physician subject to the terms of [sections 1 through 26] who, after January 1, 1990, has an adverse ruling as to any medical malpractice claim by the Montana medical legal panel or a judgment or settlement as to a claim in excess of $25,000 and less than $50,000, the one-time sum of $500 because of the claim. If the amount of the judgment or settlement as to the claim is $50,000 or more, the one-time sum of $1,000 because of the claim. Any insurer required to report to the board pursuant to 37-3-402 shall also provide the report to the administrator and shall include in the report the amount of each settlement or judgment for each physician for whom a report is made. The certificate of authority of the insurer must be suspended by the commissioner pursuant to 33-2-119 if the reports are not provided to the administrator as required by 37-3-402 or within a reasonable time thereafter.

(c) after January 1, 1990, $5 from each physician subject to the provisions of [sections 1 through 26] for each baby delivered by that physician and $5 from each hospital for each baby delivered at the hospital. As a basis for the surcharge, by January 31, 1991, and on January 31 each year thereafter, each physician and each hospital shall report to the administrator the number of babies delivered by them during the preceding calendar year.

(3) Beginning with the first year of operation of

[sections 1 through 26], the annual surcharges for physicians provided for in subsection (2)(a) are subject to annual adjustment by the administrator, based upon requirements for the actuarial soundness of the primary pool of funds, under the same limitations and with the same requirements as a rate change undertaken by the primary carrier of the physician.

(4) The first annual surcharge for physicians provided for in this section must be collected by the Montana medical legal panel pursuant to 27-6-206 or within 30 days of [the effective date of this act], whichever occurs later. Beginning in 1990 and in each year thereafter, all subsequent annual surcharges for physicians provided for in this section and beginning in 1991, all surcharges provided for physicians in subsection (2)(b) and for physicians and hospitals in subsection (2)(c) must be collected by the Montana medical legal panel pursuant to 27-6-206. All collections must be remitted to the department within 14 days of receipt.

(5) The one-time refundable surcharges for casualty insurance carriers provided for in this section must be collected by the commissioner on March 1, 1989, pursuant to 33-2-705 without deferral or installment or within 30 days of [the effective date of this act], whichever occurs later. The surcharge must be remitted to the department by the

commissioner within 14 days of receipt, and if the surcharge is not timely paid as provided in this section, the certificate of authority of the insurer must be suspended by the commissioner pursuant to 33-2-119 until the surcharge is paid.

(6) The secondary pool of funds must be maintained solely through the surcharges on physicians and hospitals pursuant to subsections (2)(b) and (2)(c), distribution from excess surplus pursuant to [section 10], the collection of designated premium equivalents pursuant to [section 24], and the revenues from any other source dedicated to the purposes of the secondary pool of funds.

NEW SECTION. **Section 8. Actuarial soundness of primary pool of funds.** (1) The fund's primary pool of funds must be maintained on an actuarially sound basis and may not become operational until a statement is prepared by an actuary, hired by the administrator, who is a member of the American academy of actuaries or the casualty actuarial society certifying that the primary pool of funds is expected to be actuarially sound.

(2) If the primary pool of funds would at any time be rendered insolvent by payment of all fixed and known obligations that will become final within 2 years from that time, the amount of future noneconomic damages payable within that calendar year must be prorated among existing

claimants at the time of the determination in a manner sufficient to eliminate or reduce the insolvent circumstance to the extent possible. Any amount due and unpaid at the end of the 2-year period must be paid in the following 1-year period and must be paid before the obligations that become final during that year may be paid.

NEW SECTION. **Section 9. Staff.** The administrator, using money from the fund as considered necessary, appropriate, or desirable by the department, may purchase the services of persons, firms, and corporations to aid in protecting the fund against claims, fully administering [sections 1 through 26], determining the actuarial soundness of the primary pool of funds, and determining the return of savings to persons and entities paying any portion of the original capitalization of the primary pool of funds, as well as for making recommendations to subsequent legislative sessions.

NEW SECTION. **Section 10. Return of savings.** (1) On July 1, 1993, and on July 1 of each year thereafter, if the primary pool of funds is actuarially sound, all surplus in the primary pool of funds in excess of $1 million over the sum of the amount necessary to make that fund actuarially sound and the amount of the original annual surcharge set by [sections 1 through 26] times the number of qualified physicians must be distributed equally among:

(a) the casualty insurance carriers who have paid surcharges into the primary pool of funds, pro rata and proportionate to their original contributions until such contributions have been repaid; and

(b) the secondary pool of funds.

(2) The administrator, upon receipt of capital contributions pursuant to [sections 1 through 26], shall issue the person or entity paying the capital contribution a certificate representing the contribution and containing the terms of repayment, if any. The collection of capital contributions or the prospects of a return of savings may not be considered to be an unregistered investment contract or otherwise require registration as a security under the securities laws of Montana.

NEW SECTION. **Section 11. Reinsurance authority.** The fund has the power to negotiate for, contract for, and purchase reinsurance, subject to the control of the department.

NEW SECTION. **Section 12. Claims for payment.** Except as otherwise provided in [sections 8(2) and 24]:

(1) claims for payment from the primary or secondary pool of funds that become final during the first 6 months of the calendar year must be computed on June 30 and must be paid no later than the following July 15; and

(2) claims for payment from the primary or secondary

pool of funds that become final during the last 6 months of the calendar year must be computed on December 31 and must be paid no later than the following January 15.

NEW SECTION. **Section 13. Claims against fund -- procedure.** (1) The department shall issue a warrant in the amount of each claim, in the manner required for payment under [sections 1 through 26], submitted to it against the primary pool of funds on June 30 and December 31 of each year.

(2) The only claim against the primary pool of funds must be a voucher or other appropriate request by the administrator, submitted along with:

(a) a certified copy of a final judgment against the fund; or

(b) a duplicate original of a settlement entered into by the administrator on behalf of the primary pool of funds involving a physician qualified under the terms of [sections 1 through 26].

(3) The only claim against the secondary pool of funds must be a voucher or other appropriate request by the administrator, submitted along with:

(a) a certified copy of a final judgment of entitlement to the benefits of [section 24]; or

(b) a certified copy of a settlement for the benefits of [section 24] approved by the Montana medical legal panel.

NEW SECTION. **Section 14. Payment from primary pool of funds after exhaustion of insurance coverage -- excess claims -- procedure.** (1) If a physician qualified under [sections 1 through 26] or his insurer as required by [section 16] has agreed to settle liability on a claim by payment of its policy limits and the claimant is demanding an amount in excess of the policy limits or if the annual aggregate under the insurance for the physician has been paid by or on behalf of the physician, the claimant shall notify the administrator in the manner provided in subsection (2) and receive a reply from the administrator as a condition precedent to recovery from the primary pool of funds.

(2) The claimant shall provide the administrator in writing, postage prepaid by certified mail, a short and plain statement of the nature of the claim and the additional amount for which the claimant will settle. The statement must include, separately stated, the amounts previously paid and the additional amounts demanded with respect to the damages as a whole without regard to any previous payment. The statement must also include:

(a) the amount of any past damages, itemized as to economic and noneconomic damages; and

(b) any future damages and the periods over which they will accrue, on an annual basis, for each of the following

types:

(i) medical and other costs of health care;

(ii) other economic loss; and

(iii) noneconomic loss.

(3) The calculation of future damages under subsection (2) must be based on the costs and losses during the period of time the claimant will sustain those costs and losses unless a claim of wrongful death is involved. In wrongful death claims, future damages must be based on the losses during the period of time the injured party would have lived but for the injury upon which the claim is based, and the claimed future damages must be expressed in current values without regard to future changes in the earning power or purchasing power of the dollar.

(4) If a claim of wrongful death is not involved, the statement under subsection (2) must state the claimed severity of the injury and whether the injury is limited to mental or emotional harm or involves physical harm. If the injury involves physical harm, the claimant shall state whether the physical harm includes bodily impairment or disfigurement.

(5) The statement under subsection (2) must also specify what percentage of the claimed damages are alleged to be the responsibility of each physician against whom a claim is made.

(6) If, within 30 days after receipt of the statement, the administrator has not accepted the offer of settlement in writing, the claimant may proceed with any claim against the physician. The patient assured compensation fund must be named as a necessary and proper party in any state or federal court proceeding for all causes of action arising after [the effective date of this act].

(7) (a) The statute of limitations with respect to any medical malpractice claim against a qualified physician under [sections 1 through 26] is tolled by the deposit in the United States mail of the writing required by this section and does not begin to run again until the greater of:

(i) 30 days after mailing; or

(ii) the running of the applicable limitation period under 27-6-702.

(b) The time period of tolling is not computed as part of the period within which the action may be brought.

NEW SECTION. **Section 15.** **Discharge of obligation to pay amount from funds.** The obligation to pay an amount from the primary or secondary pool of funds may be discharged, unless otherwise required or permitted by law, through:

(1) payment in one lump sum for accrued damages;

(2) an agreement requiring periodic payments from the primary or secondary pool of funds over a period of years;

(3) the purchase of an annuity payable to the claimant, with the administrator having the power to contract with those insurers permitted under 25-9-403(4); or

(4) any combination of the payment plans in subsections (1) through (3).

NEW SECTION. **Section 16.** **Qualifications for physician.** (1) In order to become and remain qualified under the provisions of [sections 1 through 26], in addition to the procedures established by the department for regulation of application for qualification, a physician must:

(a) pay all surcharges required by [sections 1 through 26] in a timely manner;

(b) at the time of qualification, irrevocably agree in writing to be bound by the results of any arbitration provided for in [section 24];

(c) (i) if acting as an individual physician, be insured and continue to be insured by an authorized insurer under a valid and collectible policy of medical liability insurance in at least the amounts required by subsection (2), for purposes of at least some obstetrical privileges as an obstetrician or as a family practitioner; or

(ii) if a member of a professional service corporation, partnership, or other business entity desiring to qualify as a physician, have one or more members of the business entity insured as an obstetrician or as a family practitioner with

some obstetrical privileges;

(d) establish proof of qualifying coverage for lower limits and proof of specialty.

(2) Proof under subsection (1) may be established by the physician's insurance carrier annually filing with the administrator proof that the physician is insured by a policy of malpractice liability insurance in the amount of at least $100,000 per occurrence and $300,000 in the annual aggregate for all claims made during the policy period, along with the specialty under which such policy was issued. Any insurer offering such a policy may offer a policy with deductible options of up to one-half of the limits. The administrator may require a professional corporation seeking to qualify to provide information necessary to determine if the corporation is eligible as a physician.

NEW SECTION. **Section 17. Failure of physician to qualify for change of coverage -- limits of liability of fund -- rights and duties of physician.** (1) A physician who fails to qualify under [sections 1 through 26] or who becomes disqualified is not covered by the provisions of [sections 1 through 26] after the date of disqualification and is subject to liability under the law without regard to the provisions of [sections 1 through 26]. If a physician does not qualify, the claimant's remedy will not be affected by the terms and provisions of [sections 1 through 26]. The

primary pool of funds is not liable for any amounts up to the limits of qualifying coverage of a physician established in [section 16]. The secondary pool of funds is liable only up to the amounts contained in that fund in the manner provided in [section 24].

(2) Within 14 business days of receipt of the information required for qualification of a physician, the administrator shall notify the physician whether the physician is qualified, and if so, the date he became qualified.

(3) The primary pool of funds is not liable for any amounts until the limits of the qualifying coverage for lower limits of the physician have been paid or are payable and then only above those limits of coverage. The maximum liability of the primary pool of funds is $1 million per occurrence and $3 million in the annual aggregate for all claims made during the policy period of the coverage for lower limits. The claimant's remedy for amounts over the limits of the primary pool of funds are not affected by the terms and provisions of [sections 1 through 26], except as otherwise provided.

(4) Except as otherwise provided in [sections 1 through 26], the rights and duties of a physician qualifying under [sections 1 through 26], including but not limited to the nature, extent, and limits of coverage of the primary

pool of funds, are the same as the rights and duties of that physician under his qualifying coverage for lower limits, including but not limited to all exceptions, exclusions, and endorsements to the lower limits of coverage.

(5) Failure to maintain levels of coverage required under this section or nonrenewal, cancellation, or the elimination of obstetrical coverage for lower limits of coverage constitute disqualification of the physician under the terms of [sections 1 through 26] when the changes become effective with respect to the lower limits of coverage, if at all. The carrier providing lower limits of coverage shall promptly notify the administrator of changes in coverage pertinent to this section in the same manner as required of notice to insureds.

(6) Notwithstanding any other provision of [sections 1 through 26], if the administrator determines that, due to the number and dollar exposure of claims filed against a physician qualified under [sections 1 through 26], the physician presents a material risk of significant future liability to the fund, the administrator is authorized, after notice and an opportunity for hearing, to terminate the liability of the fund for all claims against the physician.

(7) Except as otherwise provided in [sections 1 through 26], Title 33 has no application to [sections 1

through 26]. The following provisions of Title 33 apply to [sections 1 through 26]: 33-15-411; 33-15-504; 33-15-1101 through 33-15-1121; Title 33, chapter 18; Title 33, chapter 19; 33-23-301; and 33-23-302.

NEW SECTION. **Section 18.** **Adequate defense of fund -- notification as to reserves.** The administrator may provide for the defense of the primary and secondary pool of funds against a claimant's claim and may appeal a judgment which affects the funds. The physician or his insurer for qualifying coverage for lower limits shall provide an adequate defense to the claim and is in a fiduciary relationship with the primary or secondary pool of funds with respect to any claim. Any carrier representing a physician subject to [sections 1 through 26] shall immediately notify the administrator of any case upon which it has placed a reserve of $50,000 or more.

NEW SECTION. **Section 19.** **Primary pool of funds not liable for punitive damages.** The primary pool of funds is not liable for punitive or exemplary damages of any kind. This section does not relieve the liability of a physician for punitive or exemplary damages.

NEW SECTION. **Section 20.** **Appointment and recommendations of obstetrical advisory council.** (1) The department shall appoint an obstetrical advisory council, subject to the approval of the governor, composed of seven

people, five of whom must be physicians qualified under [sections 1 through 26]. The council must be funded from the primary pool of funds, and members must be appointed for 4-year terms. A vacancy must be filled for the unexpired portion of the term in the same manner as the original appointment.

(2) The council shall make recommendations regarding:

(a) prenatal and postnatal care, including but not limited to better access to comprehensive obstetrical services, improved professional competency, and peer review and quality assurance in connection with prenatal care, labor, delivery, immediate care of the newborn, and care of the postpartum woman;

(b) risk prevention and other quality of care;

(c) designated compensable events, for which compensation should in all instances be paid, to be included in [section 24];

(d) economic and noneconomic damage schedules which should be included in [sections 1 through 26]; and

(e) the proper implementation or correction of [sections 1 through 26] as the council considers appropriate, pursuant to guidelines provided by the administrator.

NEW SECTION. **Section 21.** **Disciplinary action against physicians.** After [the effective date of this act], upon the

receipt by the board of information from the reports required by 33-23-311(3), 37-3-402, this section, or any other source that a physician has had three or more medical malpractice claims where a Montana medical legal panel result was adverse or indemnity has been paid or is payable in excess of the amount of $10,000 for each claim within the previous 5-year period, the board shall investigate the occurrences upon which the claims were based. The board shall determine if action by the board against the physician is warranted. In 1995 and annually thereafter, the board shall publish a summary of action taken or not taken on claims pursuant to this section. The summary may not identify individual physicians. The summary is in addition to any other requirements of the law and may not limit the obligations otherwise required by law.

NEW SECTION. **Section 22.** **Predictability of damages.** In a trial in district court of any medical malpractice action for damages for injury not including wrongful death where the patient assured compensation fund is a party to the action, the court shall:

(1) upon proper motion of any party subsequent to verdict and before entry of judgment, review an award against any party for noneconomic damages to determine whether the award is clearly excessive or inadequate. If the award is not in substantial accord with a proper award

of damages after considering the factors in subsection (2), the court shall, acting with caution and discretion, modify the award in a manner reasonably consistent with that subsection, unless there is clear and convincing evidence that the interest of justice would not be served by the modification. The court shall give written reasons for a modification or refusal to modify. If the party adversely affected by any modification objects, the court shall order a new trial on the issue of noneconomic damages only. Economic damages awarded and the fact of liability are admissible at the new trial, but factual matters pertaining to liability are not admissible.

(2) in determining whether an award requires modification under subsection (1), consider:

(a) whether the amount awarded indicates prejudice, passion, or corruption on the part of the trier of fact;

(b) whether it clearly appears that the trier of fact ignored the evidence in reaching a verdict or misconceived the merits of the case as to damages recoverable;

(c) whether the trier of fact took improper elements of damages into account or arrived at the amount of damages by speculation and conjecture;

(d) whether the award is reasonably related to the damages proved and the injury suffered pursuant to the guidelines in subsection (3); and

(e) whether the award is supported by the evidence and could be adduced in a logical manner by reasonable persons.

(3) use the guidelines in this subsection in determining whether to modify an award when considering subsection (2)(d). Noneconomic damages are not proportional to the injury received if they exceed the greater of:

(a) weekly wage compensation benefits as computed pursuant to 39-71-701 times the life expectancy in weeks; or

(b) the multiple of economic damages awarded by the jury, pursuant to the severity of the injury as determined by the finder of fact as properly shown by the evidence for purposes of calculation, as follows:

(i) for mental or emotional harm only: 0.5 times the amount of economic damages or $1 million, whichever is greater;

(ii) for physical harm without bodily impairment or disfigurement: an amount equal to the amount of economic damages or $2 million, whichever is greater;

(iii) for bodily impairment or disfigurement: 1.5 times the amount of economic damages or $3 million, whichever is greater.

NEW SECTION. **Section 23.** Contractual right to extended reporting endorsements -- prior acts coverage. (1) Each physician qualified under [sections 1 through 26] has the contractual right, on the same terms and conditions as

that physician has under the qualifying lower limits of coverage, if any, to obtain an extended reporting endorsement for coverage by the primary pool of funds for claims for medical malpractice that occur during the time a physician was qualified under [sections 1 through 26] but that are reported after the physician ceases to be qualified.

(2) The cost of the purchase of an extended reporting endorsement paid by the physician to the fund is equal to a multiple of the current annual surcharge under [section 7]. The multiple is the lesser of the multiple being charged under the qualifying lower limits of coverage at that time or the multiple determined by the fund's actuary.

(3) Prior acts and omissions coverage, provided to the qualified physician upon qualification for coverage by the primary pool of funds for claims that have occurred but have not been made, must be provided only as to claims that are also covered under the terms of a valid and collectible primary policy of insurance coverage carried by the physician, qualified as required by [sections 1 through 26] and any endorsements to the policy. Prior acts and omissions coverage from the fund is subject to the following exclusions and limitations in addition to those contained in [sections 1 through 26]:

(a) The fund may not provide coverage for any

liability to any qualified physician with respect to:

(i) any claim made against a physician qualified under [sections 1 through 26] at any time prior to the date of qualification, regardless of whether or not the claim has been reported to any liability insurer; or

(ii) any potential claim against any qualified physician of which any physician is aware or reasonably should have been aware as of the date of qualification, regardless of whether or not the claim has yet been made or reported to any liability insurer. For purposes of this subsection, a potential claim includes but is not limited to instances where any insured has received an oral or written communication from a legal representative of a patient or a request by or on behalf of a patient for copies of medical records under circumstances reasonably indicative of a potential claim.

(b) The limits of liability of the fund for prior acts claims is the lesser of the limits of liability of the primary pool of funds under [sections 1 through 26] or the limits of liability of any valid and collectible liability insurance carried by the qualified physician prior to qualification.

NEW SECTION. **Section 24.** **Compensation for injuries from medical intervention without regard to fault.** (1) The purpose of this section is to establish a system of prompt,

efficient, and equitable compensation for certain economic damages and attorney fees to those claimants injured through medical intervention in the birthing process or obstetrical care, without regard to negligence of the physician. This section applies only if the patient opts on a voluntary basis to pay a designated premium equivalent and later signs an arbitration agreement to arbitrate the claim before the Montana medical legal panel.

(2) Each physician shall disclose to each patient, at the time of any initial medical treatment related to the birthing process or obstetrical care, the amount of funds on hand in the secondary pool of funds and the designated premium equivalent that will be contained in the fees to be charged by giving the form provided by the administrator to the patient. The initial amount of the designated premium equivalent is $25. The amount is subject to change by the department, by rule, after consideration of the recommendations of the obstetrical advisory council. The administrator shall regularly keep the physicians advised of the amount of money in the secondary pool of funds.

(3) Each patient, at the time the patient is provided the form required in subsection (2), must be given an opportunity not to participate in the secondary pool of funds and to have the designated premium equivalent deducted from the fees to be charged. If the patient cannot afford

the premium and wishes to participate in the secondary pool of funds, the patient shall deliver a signed letter to the physician to that effect and the premium must be waived. The designated premium equivalent must also be waived if prohibited by federal law.

(4) If the patient wishes to participate in the secondary pool of funds:

(a) prior to any claim of injury and prior to any known complications of delivery or pregnancy, the physician shall immediately remit to the department the amount of any required designated premium equivalent or the letter from the patient stating an inability to pay the premium. Failure of the patient to pay or provide the letter disqualifies the patient from any participation in the secondary pool of funds.

(b) subsequent to any claim of injury and subsequent to any known complications of delivery or pregnancy, the patient shall provide the physician with an agreement to arbitrate a claim arising out of the birthing process or obstetrical care, on a form provided by the administrator. The physician and the patient or the patient's representative shall execute the agreement to arbitrate the claim. Upon approval by the administrator, the agreement is binding upon the patient, the patient's representative, any claimant, and the physician for purposes of a claim for

required benefits for compensable injuries under [sections 1 through 26]. An executed copy of the agreement to arbitrate must be provided to the administrator and is subject to his approval as to form and content before it may become effective.

(5) A claim for recovery of required benefits must be filed pursuant to the provisions of Title 27, chapter 6, naming the secondary pool of funds a party, with that chapter and its rules of procedure being applicable to the secondary pool of funds as if it were a health care provider. The claim is governed by Title 27, chapter 6, as if it were a malpractice claim. The arbitration agreement of the parties constitutes a request for recommendation of an award, and the recommended award constitutes an approved settlement agreement pursuant to 27-6-606 and an award pursuant to Title 27, chapter 5.

(6) (a) Except as provided in subsection (6)(b), Title 27, chapter 5, applies to the claim and any award.

(b) The provisions of 27-5-211 through 27-5-218 do not apply to the claim, and any conflict between Title 27, chapter 5, and Title 27, chapter 6, must be resolved in favor of the latter.

(7) The filing of a claim for recovery before the Montana medical legal panel under the arbitration agreement, unless the arbitration agreement has been revoked in writing

by the patient prior to filing of the claim, constitutes:

(a) a valid and binding agreement that the sole matter in controversy is whether there is a compensable injury and, if so, the amount of required benefits available as compensation;

(b) a waiver of trial by jury or the court; and

(c) the sole and exclusive remedy for:

(i) any malpractice claim against a physician qualified under [sections 1 through 26] or a hospital; or

(ii) a claim for required benefits for a compensable injury by the patient, his heirs or representatives, or his parents or next-of-kin, or any other person whose claim is derivative from the incident.

(8) The filing of a malpractice claim in federal court or pursuant to Title 27, chapter 6, against one or more physicians subject to [sections 1 through 26] constitutes a revocation in writing of the arbitration agreement provided for in this section if the claim represents that the claimant has been fully advised in writing by legal counsel of the options available under [sections 1 through 26] and a true and correct copy of the writing is attached to the claim. If the claimant is not represented by counsel in a Montana medical legal panel proceeding, the administrator shall provide the advice in writing and the claimant shall make a written binding election to proceed with the

malpractice claim or to amend the claim for recovery under an arbitration agreement obtained pursuant to subsection (6). The written advice and election must be filed with the Montana medical legal panel.

(9) Claims for required benefits for a compensable injury under a valid arbitration agreement are limited to required benefits and only required benefits may be paid for a compensable injury.

(10) (a) Required benefits under this section are limited to the following items as computed under [sections 1 through 26]:

(i) medical and hospital expenses and future medical and hospital expenses as incurred, computed and paid in the manner provided in 39-71-704 and the rules implementing that section;

(ii) lost earnings and future lost earnings as incurred, computed, and paid in the manner provided in 39-71-701(1) and according to the definition of average weekly wage in 39-71-116 and the rules implementing those sections; and

(iii) reasonable attorney fees for panel proceedings, computed and paid in the manner provided in 39-71-613, 39-71-614, and the rules implementing those sections.

(b) Required benefits do not include medical and hospital expenses for items or services or reimbursement the

patient received or is entitled to receive under the laws of any state or the federal government, except to the extent exclusion of such benefits is prohibited by federal law, or expenses paid by any prepaid health plan, health maintenance organization, or private insuring entity or pursuant to the provisions of any health or sickness insurance policy or other private insurance program.

(c) Proceeds to beneficiaries, as defined in 39-71-116, must be determined pursuant to 39-71-723, and lump-sum payments for future benefits are prohibited.

(11) All awards must be paid from the secondary pool of funds on an annual basis for required benefits that have accrued and pursuant to Title 25, chapter 9, part 4, for future required benefits, and that part applies in all instances to claims for required benefits except as otherwise provided in this section and to the extent the secondary pool of funds has sufficient funds for payments without becoming actuarially unsound. If the secondary pool of funds has insufficient funds with which to pay an award or awards, payments must be made in the same manner, pro rata as to all claims against the secondary pool of funds at the time of the required payment. The unpaid amounts of any award constitute a future obligation of the secondary pool of funds as funds become available. The future obligation is not enforceable by any process of law other than pursuant to

the terms of this section.

(12) All costs of administration of the secondary pool of funds must be paid from the secondary pool of funds, and the costs of administration must be paid prior to the payment of any required benefits or required obligations of the secondary pool of funds provided elsewhere in [sections 1 through 26]. If the secondary pool of funds is insufficient to pay the costs of administration of the secondary pool or any attorney fees required to be paid by the secondary pool, the administrator is authorized to loan the secondary pool sufficient funds for the administration or fee from the primary pool of funds if the loan would not render the primary pool actuarially unsound. The loan is an advance against future distributions pursuant to [section 10] and in lieu of the distributions. The loan plus interest must be repaid to the primary pool of funds upon the future distribution otherwise accruing.

(13) The arbitration agreement form promulgated by the department must include on its face a written notice of the substance of subsections (9) and (10) in red, 10-point type.

(14) The period prescribed for the commencement of an action for relief under this section is within 1 year of the date of injury.

NEW SECTION. **Section 25. Tax exemption.** The fund is exempt from payment of all fees and all taxes levied by this

state or any of its subdivisions.

NEW SECTION. **Section 26. Review.** The administrator shall report to each session of the legislature concerning the effectiveness of [sections 1 through 26] in achieving the stated goals and concerning other matters of importance. The status and operation of the fund must be included in that report.

Section 27. Section 27-6-105, MCA, is amended to read:

"**27-6-105. What claims panel to review.** The panel shall review all malpractice claims or potential claims against health care providers covered by this chapter, ~~except~~ including those claims subject to a valid arbitration agreement allowed by law ~~or upon which suit has been filed prior to April 19, 1977.~~"

Section 28. Section 27-6-602, MCA, is amended to read:

"**27-6-602. Questions panel must decide.** (1) Upon consideration of all the relevant material, the panel shall decide whether there is:

~~(1)~~(a) substantial evidence that the acts complained of occurred and that they constitute malpractice; and

~~(2)~~(b) a reasonable medical probability that the patient was injured thereby.

(2) If the panel decides that the acts complained of did not constitute medical malpractice and if there is an arbitration agreement pursuant to [sections 1 through 26],

the panel shall decide whether there is a compensable injury pursuant to [sections 1 through 26], and, if so, make an award pursuant to [section 24]."

Section 29. Section 33-10-102, MCA, is amended to read:

"**33-10-102. Definitions.** As used in this part, the following definitions apply:

(1) "Association" means the Montana insurance guaranty association created under 33-10-103.

(2) (a) "Covered claim" means an unpaid claim, including one for unearned premiums, or a contractual guaranty for an extended reporting endorsement for claims reported after the expiration of the policy period which arises out of and is within the coverage and not in excess of the applicable limits of an insurance policy to which this part applies issued by an insurer, if such insurer becomes an insolvent insurer after July 1, 1971, and:

(i) the claimant or insured is a resident of this state at the time of the insured event; or

(ii) the property from which the claim arises is permanently located in this state.

(b) "Covered claim" ~~shall~~ does not include any amount due a reinsurer, insurer, insurance pool, or underwriting association, as subrogation recoveries or otherwise.

(3) "Insolvent insurer" means an insurer:

(a) authorized to transact insurance in this state either at the time the policy was issued or when the insured event occurred; and

(b) determined to be insolvent by a court of competent jurisdiction.

(4) "Member insurer" means any person who:

(a) writes any kind of insurance to which this part applies under 33-10-101(3), including the exchange of reciprocal or interinsurance contracts; and

(b) is licensed to transact insurance in this state.

(5) "Net direct written premiums" means direct gross premiums written in this state on insurance policies to which this part applies, less return premiums thereon and dividends paid or credited to policyholders on such direct business. "Net direct written premiums" does not include premiums on contracts between insurers or reinsurers.

(6) "Person" means any individual, corporation, partnership, association, or voluntary organization."

Section 30. Section 33-23-311, MCA, is amended to read:

"**33-23-311. Information required of professional liability insurers -- submission.** (1) For purposes of this section, "profession" means the occupations engaged in by physicians, osteopaths, registered nurses, licensed practical nurses, dentists, optometrists, podiatrists,

chiropractors, hospitals, attorneys, certified public accountants, public accountants, architects, veterinarians, pharmacists, and professional engineers.

(2) Each insurance company engaged in issuing professional liability insurance in the state of Montana shall include the following information, by profession, from its experience in the state of Montana, in its annual statement to the commissioner:

(a) the number of insureds as of December 31 of the calendar year next preceding;

(b) the amount of earned premiums paid by the insureds during the calendar year next preceding;

(c) the number of claims made against the insurer's insureds and the number of claims outstanding as of December 31 of the calendar year next preceding;

(d) the number of claims paid by the insurer during the calendar year next preceding and the total monetary amount thereof;

(e) the number of lawsuits filed against the insurer's insureds and the number of insureds included therein during the calendar year next preceding;

(f) the number of lawsuits previously filed against the insurer's insureds which were dismissed without settlement or trial and the number of insureds included therein during the calendar year next preceding;

(g) the number of lawsuits previously filed against the insurer's insureds which were settled without trial, the total monetary amount paid as settlements in such settled cases, and the number of insureds included therein during the calendar year next preceding;

(h) the number of lawsuits against the insurer's insureds which went to trial during the calendar year next preceding and the number of such cases ending in the following:

(i) judgment or verdict for the plaintiff;

(ii) judgment or verdict for the defendant;

(iii) other;

(i) the total monetary amount paid out, in those lawsuits specified in subsection (h);

(j) the total number of the insurer's insureds included in those lawsuits specified in subsection (h);

(k) the number of new trials granted during the calendar year next preceding;

(l) the number of lawsuits pending on appeal as of December 31 of the next preceding calendar year; and

(m) such other information and statistics as the commissioner considers necessary.

(3) The commissioner shall, ~~within 60 days of request~~ by October 1 of each calendar year, submit in writing to the appropriate licensing authority, in summary report form, the

data and information furnished him pursuant to this section relevant to the particular profession, or facility, or class of facilities and shall likewise make the summary available to the public at the expense of the requestor, which data and information must be retained for at least 10 years."

NEW SECTION. **Section 31.** Extension of authority. Any existing authority to make rules on the subject of the provisions of [this act] is extended to the provisions of [this act].

NEW SECTION. **Section 32.** Nonseverability -- dissolution of fund -- transfer to Montana insurance guaranty association. (1) (a) If any provision of this chapter, any provision of the sections listed in subsection (1)(b), or the application of any one of those provisions to any person or circumstance is held invalid by a decision of the Montana supreme court or the United States supreme court, such invalidity shall render this entire chapter invalid except for this section, whether or not the other provisions or application of this chapter can be given effect without the invalid provision or application.

(b) The provisions of 25-9-401 through 25-9-405, 25-15-202, 27-1-702, 27-1-703, 27-2-205(2), 28-1-301 through 28-1-303, 28-11-311, and this chapter are not severable.

(2) (a) The assets and liabilities of the primary pool of funds must be transferred to the Montana insurance

guaranty association created under 33-10-103 upon the occurrence of any of the following events:

(i) this chapter being rendered invalid because of one or more of the reasons set forth in subsection (1);

(ii) the primary pool of funds not being maintained on an actuarially sound basis for more than 3 years from the time such soundness is required by [this act] and the probability that the primary pool of funds will be exhausted by the payment of all fixed and known obligations that will become final within 3 years.

(b) The liabilities of the fund, including coverage endorsements, constitute covered claims as defined in 33-10-102, and the limit of liability of the Montana insurance guaranty association and any physician against whom a claim has occurred or a judgment has been rendered or with whom a settlement agreement has been entered into is equal to the limits of liability of the Montana insurance guaranty association under 33-10-105.

NEW SECTION. **Section 33.** Applicability. [This act] applies to all causes of action that constitute medical malpractice claims of any nature, whether obstetrical or otherwise, where the cause of action includes one or more physicians who are qualified pursuant to the terms of [this act] and a claim for coverage exists against the patient assured compensation fund. Provided, however, that [section

22] does not affect rights and duties that matured, penalties that were incurred, or proceedings that were begun before [the effective date of this act] and that section applies, if at all, only to causes of action that accrue on or after the date of qualification of a physician under [this act] against whom such a cause of action accrues.

NEW SECTION. **Section 34.** Effective date. [This act] is effective on passage and approval.

-End-

STATE OF MONTANA - FISCAL NOTE
Form BD-15

In compliance with a written request, there is hereby submitted a Fiscal Note for HB699, as introduced.

DESCRIPTION OF PROPOSED LEGISLATION:

"An Act providing for a Patient Assured Compensation Fund above low primary limits of insurance, for the payment of medical liability claims against physicians who deliver babies; providing for the return of dollar savings to original capitalizers and to patients who are injured in the medical system; providing for an obstetrical advisory committee to make recommendations regarding obstetrical care; providing for objective guidelines for noneconomic damages proportionate to the severity of injury or the life expectancy of the injured party; providing for voluntary entry into binding arbitration for obstetrical claims without regard to negligence of the physician; providing for administration by the Montana Medical Legal Panel under the reimbursed supervision of the Department of Health and Environmental Sciences; providing for capitalization by a premium tax on casualty carriers; amending Section 27-6-105, 27-6-602, 33-10-102, and 33-23-311, MCA; and providing an immediate effective date."

ASSUMPTIONS:

1. This Patient Assured Compensation Fund will be funded with a one-time 1.17% surcharge on property and casualty insurance premiums, an annual assessment on participating physicians, and a per baby delivery charge on participating physicians and hospitals.
2. Expenses incurred by the Department of Health and Environmental Sciences and the State Auditor's office will be reimbursed from the fund. There should be a zero net expenditure impact on state agencies.
3. That monies assessed under the 1.17% surcharge will be collected in fiscal year ended June 30, 1989.
4. The annual assessment and the per baby delivery charge on participating physicians will be an on-going revenue source.

FISCAL IMPACT:

	Current Biennium FY89 Current Law	Proposed Law	Difference
Revenues:*	$ -0-	$6,291,000	$6,291,000
Expenditures:**	$ -0-	$ 1,515	$ 1,515
Fund Impact:			
State Special Revenue	$ -0-	$6,289,485	$6,289,485

Ray Shackleford DATE 2/23/89
RAY SHACKLEFORD, BUDGET DIRECTOR
OFFICE OF BUDGET AND PROGRAM PLANNING

Kelly Addy DATE 3/2/89
KELLY ADDY, PRIMARY SPONSOR

Fiscal Note for HB699, as introduced

HR L 99

FISCAL IMPACT:

	FY90			FY91		
	Current Law	Proposed Law	Difference	Current Law	Proposed Law	Difference
Revenues:*	$ -0-	$770,721	$ 770,721	$ -0-	$770,721	$ 770,721
Expenditures:**	$ -0-	$ 19,175	$ 19,175	$ -0-	$ 7,175	$ 7,175
Fund Impact:						
State Special Revenue	$ -0-	$751,546	$ 751,546	$ -0-	$763,546	$ 763,546

* The $6,291,000 is revenue from the one-time 1.17% surcharge on property and casualty insurance premiums in FY89. The $770,721 is revenue from the annual assessment against participating physicians and the per baby delivery charge against participating physicians and hospitals. Revenue from the annual assessment and the per baby delivery charges may increase or decrease from year to year depending upon the number of participating physicians.

**Expenses incurred by state agencies will be reimbursed from the Patient Assured Compensation Fund. FY90 expenses are higher due to start up administrative costs.

APPROVED BY COMMITTEE
ON JUDICIARY

HOUSE BILL NO. 699

INTRODUCED BY ADDY, STICKNEY, CONNELLY, BECK, HALLIGAN

A BILL FOR AN ACT ENTITLED: "AN ACT PROVIDING FOR A PATIENT ASSURED COMPENSATION FUND ABOVE LOW PRIMARY LIMITS OF INSURANCE, FOR THE PAYMENT OF MEDICAL LIABILITY CLAIMS AGAINST PHYSICIANS WHO DELIVER BABIES; PROVIDING FOR THE RETURN OF DOLLAR SAVINGS TO ~~ORIGINAL CAPITALIZERS AND TO~~ PATIENTS WHO ARE INJURED IN THE MEDICAL SYSTEM; PROVIDING FOR AN OBSTETRICAL ADVISORY COMMITTEE TO MAKE RECOMMENDATIONS REGARDING OBSTETRICAL CARE; ~~PROVIDING FOR OBJECTIVE GUIDELINES FOR NONECONOMIC DAMAGES PROPORTIONATE TO THE SEVERITY OF INJURY OR THE LIFE EXPECTANCY OF THE INJURED PARTY;~~ PROVIDING FOR VOLUNTARY ENTRY INTO BINDING ARBITRATION FOR OBSTETRICAL CLAIMS WITHOUT REGARD TO NEGLIGENCE OF THE PHYSICIAN; PROVIDING FOR ADMINISTRATION BY THE MONTANA MEDICAL LEGAL PANEL UNDER THE REIMBURSED SUPERVISION OF THE DEPARTMENT OF HEALTH AND ENVIRONMENTAL SCIENCES; PROVIDING FOR CAPITALIZATION BY A ~~PREMIUM TAX ON CASUALTY CARRIERS~~ TEMPORARY LINE OF CREDIT FROM THE GENERAL FUND, WITH THE ADVANCED MONEY TO BE REPAID; AMENDING SECTIONS 27-6-105, 27-6-602, ~~33-10-102,~~ AND 33-23-311, MCA; AND PROVIDING AN IMMEDIATE EFFECTIVE DATE."

STATEMENT OF INTENT

A statement of intent is required for this bill because it delegates rulemaking authority to the department of health and environmental sciences. This bill is intended to expand the authority of the department and to authorize the writing and adopting of rules in accordance with the Montana Administrative Procedure Act to:

(1) qualify or disqualify physicians for participation in the patient assured compensation fund; and

(2) facilitate the collection of assessments and charges for hospitals and participating physicians under the Patient Assured Compensation Act. This bill is intended to reimburse the department for the cost of writing and adopting the rules.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

NEW SECTION. **Section 1.** Short title. [Sections 1 through ~~26~~ 24] may be cited as the "Patient Assured Compensation Act".

NEW SECTION. **Section 2.** Purpose and goals. (1) The purpose of this legislation is to ~~increase the availability~~ ~~of~~ LOWER INSURANCE COSTS FOR PHYSICIANS PROVIDING obstetrical care and TO INCREASE access to that care, especially in rural areas of Montana, and to maintain the availability and accessibility of obstetrical care in urban areas of Montana.

SECOND READING

(2) The goals of this legislation are to:

(a) eliminate from the insurance system any excess insurance money that may be collected because of complex insurance and legal problems related to excess reserves, excess profits, and the use of shared insurance data from states other than Montana;

(b) require the pass through of savings to those who bear the cost for the Patient Assured Compensation Act, including the class of patients and claimants with injuries received in the medical system;

(c) provide ~~more full and fair~~ A NO-FAULT SYSTEM OF compensation to claimants ~~than the current medical insurance legal system does in cases involving physicians who deliver babies;~~

~~(d) provide in advance a reasonable calculation of the actual amounts to be paid in obstetrics related claims so that the funds necessary to pay claims can be properly raised from those who pay for the claims to ensure that damages do not increase exponentially;~~

~~(e)~~(D) provide a funding mechanism that is broader than the available base of funds from obstetricians and family practitioners providing obstetric care by using sources that have an interest in the maintenance of core industries in rural areas and that have benefited from previous civil justice reform legislation; and

~~(f)~~(E) provide an immediate reduction in the total cost of coverage for medical liability insurance for physicians who deliver babies.

NEW SECTION. **Section 3.** **Legislative findings.** The legislature finds that:

(1) there has been an accelerating and substantial reduction in available obstetrical services in Montana, especially in the rural areas, and this process is likely to continue unless appropriate steps are taken;

(2) the reduction in obstetrical services constitutes a SEVERE statewide public health AND ECONOMIC problem ~~of a large magnitude and a statewide economic problem of a severe nature;~~

~~(3) in addition to the direct loss of obstetrical services in rural areas of Montana, there have been and will likely continue to be:~~

~~(a) broader adverse economic impacts to the hospitals in those communities, including the closure of some hospitals with resulting adverse impacts on the communities involved, that flow from a loss of a broad range of basic medical services as physicians who deliver babies retire early or leave the community;~~

~~(b) limitations on the availability and access to obstetrical care in urban areas, especially among lower income women, brought about by increased pressures on~~

~~limited--resources--in-urban-areas-from-women-in-rural-areas who--wish--to--obtain--replacement---obstetrical---services,~~ ESPECIALLY IN RURAL AREAS, THAT MAY WELL CONTINUE UNLESS APPROPRIATE STEPS ARE TAKEN;

~~(4)~~(3) the impacts referred to in subsection~~--(3)~~ SUBSECTIONS (1) AND (2) are strongly associated with, among other things:

(a) substantial previous increases in the cost of medical liability insurance, a high level of current costs of medical liability insurance, and anticipated increases in the future cost of medical liability insurance to the point where the income from the delivery of babies does not justify the current or future cost of medical liability coverage;

(b) substantial previous increases in the number of PHYSICIANS INVOLVED IN OBSTETRICAL medical liability claims ~~against--physicians~~, with an increased likelihood that each physician will be periodically involved in a number of legal claims;

(c) inducements for early retirement, relocation to another area, or the elimination or limitation of obstetrical services by doctors who deliver babies;

~~(5)~~(4) the medical-insurance-legal system, because of its unpredictability and high cost, often ~~deprives~~ CAN DEPRIVE the most seriously injured and the least seriously

injured of even their out-of-pocket economic damages or provides compensation for intangible damages disproportionate to the severity of the injury or the life expectancy of the injured party.

NEW SECTION. **Section 4.** Definitions. As used in [sections 1 through ~~26~~ 24], the following definitions apply:

(1) "Actuarially sound basis" means that the probability of insolvency of the primary pool of funds has been lowered to a level of risk that is prudent to accept, as determined by an actuary hired by the fund, who is a member of the American academy of actuaries or the casualty actuarial society.

(2) "Administrator" means the administrator of the primary and secondary pool of funds, who is the director of the Montana medical legal panel provided for in 27-6-201.

(3) "Board" means the Montana state board of medical examiners provided for in 2-15-1841.

~~(4)--"Bodily--impairment"--means-temporary-or-permanent impairment-or-loss-of-bodily-functions-or-bodily-parts.--The term--does--not-include-other-impairments,-including-but-not limited-to--mental--or--emotional--processes--or--behavioral controls.~~

~~(5)~~(4) "Claimant" means a person claiming damages for injury from medical malpractice or required benefits for compensable injuries under [sections 1 through ~~26~~ 24].

~~(6)~~(5) "Commissioner" means the commissioner of insurance provided for in 2-15-1903.

~~(7)~~(6) "Compensable injury" means any physical harm, bodily impairment, disfigurement, or a delay in recovery, under [section ~~24~~ 22] that:

(a) is associated with or connected to the birthing process or the rendering of obstetrical care by a physician qualified under the terms of [sections 1 through ~~26~~ 24];

(b) is associated in whole or in part with medical intervention rather than with the condition for which the intervention occurred; and

(c) is not consistent with or reasonably expected as a consequence of medical intervention or is a result of medical intervention to which the patient did not consent.

~~(8)~~(7) "Condition" means the general state of health of the patient prior to medical intervention.

~~(9)~~(8) "Delay in recovery" means any undue additional time spent under care that is not substantially attributable to the condition for which medical intervention occurred and includes consideration of the general health of the patient.

~~(10)~~(9) "Department" means the department of health and environmental sciences provided for in Title 2, chapter 15, part 21.

~~(11)~~(10) "Designated premium equivalent" means the dollar amount paid by a patient to a physician ~~or deducted from the charges of a physician~~ under [section ~~24~~ 22].

~~(12) "Disfigurement" means scars or adverse changes in bodily appearance beyond those that are medically required.~~

~~(13) "Economic damages" means those compensatory damages payable as a result of a medical malpractice claim against a physician or a physician and other parties, that are objectively determinable and verifiable compensatory damages, including but not limited to medical expenses and care, rehabilitation services, custodial care, loss of earnings and earning capacity, loss of income, funeral or burial expenses, loss of use of property, costs of repair or replacement of property, costs of obtaining substitute domestic services, loss of employment, loss of business or employment opportunities, and any other objectively determinable and verifiable pecuniary or monetary damages.~~

~~(14)~~(11) "Hospital" means a hospital as defined in 50-5-101.

~~(15)~~(12) "Malpractice claim" means a malpractice claim as defined in 27-6-103.

~~(16)~~(13) "Medical intervention" means the rendering as well as the omission of any care, treatment, or services provided within the course of treatment administered by or under the control of a physician or hospital.

~~(17)~~(14) "Montana medical legal panel" means the panel provided for in 27-6-104.

HB 0699/02

~~(18) "Noneconomic damages" means those damages payable as a result of a medical malpractice claim against a physician or a physician and other parties that are subjectively determined to be nonmonetary or nonpecuniary damages, including but not limited to pain, suffering, inconvenience, grief, physical impairment, disfigurement, mental suffering or anguish, emotional distress, loss of society and companionship, loss of consortium, fear of loss, fear of illness, fear of injury, injury to reputation, humiliation, and any other subjectively determined nonmonetary or nonpecuniary damages.~~

~~(19)~~(15) "Obstetrical advisory council" means an advisory council created pursuant to 2-15-122 by the department and provided for in [section ~~20~~ 19].

~~(20)~~(16) "Patient" means an individual who receives or should have received care from a physician and includes any person OR ENTITY having a ~~claim of any kind, whether derivative or otherwise, as a result of alleged medical malpractice on the part of a physician or having a compensable injury. Derivative claims include but are not limited to the claim of a parent or parents, guardian, trustee, child, relative, attorney, or any other representative of a patient, including claims for economic damages, noneconomic damages, attorney fees or expenses, and all similar claims~~ RIGHT OF ACTION UNDER 27-1-501.

~~(21)~~(17) "Patient assured compensation fund" or "fund" means the fund created under [section 5] and comprised of a primary pool of funds and a secondary pool of funds.

~~(22) "Physical harm" means a wound, infection, disease, or death.~~

~~(23)~~(18) "Physician" means a physician as defined in 27-6-103.

~~(24)~~(19) "Primary pool of funds" means that separate and segregated portion of the fund established for the payment of claims, expenses, and other allowed and required expenditures pursuant to [sections 1 through ~~26~~ 24], except for money payable from the secondary pool of funds.

~~(25)~~(20) "Representative" means the spouse, parent, guardian, trustee, attorney, or other legal agent of the patient.

~~(26)~~(21) "Secondary pool of funds" means that separate and segregated portion of the fund established for the payment of compensation, expenses, and other allowed and required expenditures pursuant to [section ~~24~~ 22].

~~(27)~~(22) "Surplus" means the excess of total assets minus liabilities of the primary pool of funds as defined by standard accounting practices for insurance carriers.

NEW SECTION. **Section 5.** ~~Purpose~~ FUND CREATED -- attachment to department -- deposit and investment. (1) There is a patient assured compensation fund. Money for the

fund collected and received pursuant to [sections 1 through ~~26~~ 24] is to be used exclusively for the purposes stated in [sections 1 through ~~26~~ 24].

(2) The fund is attached to the department for administrative purposes only, pursuant to 2-15-121, except as otherwise provided in [sections 1 through ~~26~~ 24]. The department may promulgate rules and regulations implementing [sections 1 through ~~26~~ 24].

(3) The primary and secondary pool of funds and any income from those funds must be held in trust. The funds must be deposited in segregated accounts (one for the primary pool of funds and one for the secondary pool of funds), invested, and reinvested by the department AS A FIDUCIARY, pursuant to law. The fund may not become a part of or revert to the general fund of the state.

NEW SECTION. **Section 6.** **Reimbursement to ~~department~~ DEPARTMENTS.** The department AND THE DEPARTMENT OF INSURANCE must be reimbursed from the primary pool of funds for any expenses incurred in the administration of [sections 1 through ~~26~~ 24].

NEW SECTION. **Section 7.** **Capitalization and maintenance of primary pool of funds and secondary pool of funds -- surcharge.** (1) To capitalize the primary pool of funds and the secondary pool of funds, there is ~~levied and collected on all insurance carriers authorized to write and engaged in writing casualty insurance pursuant to 33 1 206 in this state during 1987 and engaged in writing casualty insurance as of December 31, 1988, a one time refundable surcharge in the form of a 1.17% premium tax surcharge based on 1987 carrier annual reports made pursuant to 33 2 705. A total of $100,000 of the surcharge forms the capitalization of the secondary pool of funds and the balance of the surcharge forms the capitalization of the primary pool of funds. If the su charges provided for in this section are refunded, the refund must be made in the method and manner provided for in [section 10].~~ A LOAN OF $6,300,000 FROM THE STATE GENERAL FUND TO THE PRIMARY POOL OF FUNDS AND A LOAN OF $100,000 FROM THE STATE GENERAL FUND TO THE SECONDARY POOL OF FUNDS. THE LOANS ARE NOT APPROPRIATIONS AND MUST BE REPAID UNDER [SECTION 10], WITHOUT INTEREST.

(2) Except as otherwise provided in this section, the ~~primary pool of funds is fully nonassessable~~ PARTICIPATING PHYSICIANS ARE NOT SUBJECT TO ASSESSMENT. In order to maintain the primary pool of funds, the following annual surcharges must be levied against physicians qualified under [section ~~16~~ 15]:

(a) (i) for coverage from the primary pool of funds from $100,000 per occurrence and $300,000 in the annual aggregate up to $1 million per occurrence and $3 million in the annual aggregate for all claims made during the policy

period of the qualifying physician's primary policy of insurance required by [sections 1 through ~~26~~ 24] and pursuant to that primary policy, as to physicians insured for purposes of at least some obstetrical privileges with an insurer authorized under [sections 1 through ~~26~~ 24]~~:~~

~~(A) as a family practitioner, an annual surcharge of $6,313;~~

~~(B) as an obstetrician, an annual surcharge of $13,141~~, AN ANNUAL SURCHARGE THAT WILL KEEP THE PRIMARY POOL OF FUNDS ACTUARIALLY SOUND. THE STATUTORY LIMITATIONS AND REQUIREMENTS ON RATE CHANGES BY PRIMARY MEDICAL MALPRACTICE CARRIERS APPLY TO THE DETERMINATION OF SURCHARGES;

(ii) an annual surcharge, separately and additionally paid by any professional service corporation, partnership, or other business entity and its employees desiring to qualify as physicians under [sections 1 through ~~26~~ 24] in the same manner as charges are levied by the carrier providing primary coverage, at a rate to be determined by the actuary hired by the administrator;

(b) for each physician subject to the terms of [sections 1 through ~~26~~ 24] who, after January 1, 1990, has an adverse ruling as to any medical malpractice claim by the Montana medical legal panel or a judgment or settlement as to a claim in excess of $25,000 and less than $50,000, the one-time sum of $500 because of the claim. If the amount of

the judgment or settlement as to the claim is $50,000 or more, the one-time sum of $1,000 because of the claim. Any insurer required to report to the board pursuant to 37-3-402 shall also provide the report to the administrator and shall include in the report the amount of each settlement or judgment for each physician for whom a report is made. The certificate of authority of the insurer must be suspended by the commissioner pursuant to 33-2-119 if the reports are not provided to the administrator as required by 37-3-402 or within a reasonable time thereafter.

(c) after January 1, 1990, $5 from each physician subject to the provisions of [sections 1 through ~~26~~ 24] for each baby delivered by that physician and $5 from each hospital for each baby delivered at the hospital. As a basis for the surcharge, by January 31, 1991, and on January 31 each year thereafter, each physician and each hospital shall report to the administrator the number of babies delivered by them during the preceding calendar year.

~~(3) Beginning with the first year of operation of [sections 1 through 26], the annual surcharges for physicians provided for in subsection (2)(a) are subject to annual adjustment by the administrator, based upon requirements for the actuarial soundness of the primary pool of funds, under the same limitations and with the same requirements as a rate change undertaken by the primary~~

~~carrier-of-the-physician.~~

~~(4)~~(3) The first annual surcharge for physicians provided for in this section must be collected by the Montana medical legal panel pursuant to 27-6-206 or within 30 days of [the effective date of this act], whichever occurs later. Beginning in 1990 and in each year thereafter, all subsequent annual surcharges for physicians provided for in this section and beginning in 1991, all surcharges provided for physicians in subsection (2)(b) and for physicians and hospitals in subsection (2)(c) must be collected by the Montana medical legal panel pursuant to 27-6-206. All collections must be remitted to the department within 14 days of receipt.

~~(5)--The--one-time--refundable--surcharges-for-casualty insurance-carriers-provided-for--in--this--section--must--be collected--by-the-commissioner-on-March-1,-1989,-pursuant-to 33-2-705-without-deferral-or-installment-or-within--30--days of-[the-effective-date-of-this-act],-whichever-occurs-later. The--surcharge--must--be--remitted--to-the-department-by-the commissioner-within-14-days-of-receipt,-and-if-the-surcharge is--not--timely--paid--as--provided--in--this--section,--the certificate-of-authority-of-the-insurer-must-be-suspended-by the-commissioner-pursuant-to-33-2-119-until-the-surcharge-is paid.~~

~~(6)~~(4) The secondary pool of funds must be maintained

solely through the surcharges on physicians and hospitals pursuant to subsections (2)(b) and (2)(c), distribution from excess surplus pursuant to [section 10], the collection of designated premium equivalents pursuant to [section ~~24~~ 22], and the revenues from any other source dedicated to the purposes of the secondary pool of funds.

NEW SECTION. **Section 8.** **Actuarial soundness of primary pool of funds.** (1) The fund's primary pool of funds must be maintained on an actuarially sound basis and may not become operational until a statement is prepared by an actuary, hired by the administrator, who is a member of the American academy of actuaries or the casualty actuarial society certifying that the primary pool of funds is expected to be actuarially sound.

(2) If the primary pool of funds would at any time be rendered insolvent by payment of all fixed and known obligations that will become final within 2 years from that time, the amount of future noneconomic damages payable within that calendar year must be prorated among existing claimants at the time of the determination in a manner sufficient to eliminate or reduce the insolvent circumstance to the extent possible. Any amount due and unpaid at the end of the 2-year period must be paid in the following 1-year period, WITH INTEREST AT THE JUDGMENT RATE FROM THE TIME OF DEFERRAL UNTIL PAYMENT, and must be paid before the

obligations FOR ADMINISTRATION OF THE PRIMARY POOL AND FOR NONECONOMIC DAMAGES that become final during that year may be paid. THE ADMINISTRATOR SHALL INCREASE THE ANNUAL SURCHARGE FOR THE PRIMARY POOL IN ORDER TO ENSURE THAT PRORATION OF NONECONOMIC DAMAGES DOES NOT OCCUR FOR MORE THAN 3 YEARS.

NEW SECTION. **Section 9.** **Staff.** The administrator, using money from the fund as considered necessary, appropriate, or desirable by the department, may purchase the services of persons, firms, and corporations to aid in protecting the fund against claims, fully administering [sections 1 through ~~26~~ 24], determining the actuarial soundness of the primary pool of funds, and determining the return of savings to persons and entities paying any portion of the original capitalization of the primary pool of funds~~, as well as for making recommendations to subsequent legislative sessions~~.

NEW SECTION. **Section 10.** **Return of savings.** (1) On July 1, 1993, and on July 1 of each year thereafter, if the primary pool of funds is actuarially sound, all surplus in the primary pool of funds in excess of $1 million over the sum of the amount necessary to make that fund actuarially sound ~~and the amount of the original annual surcharge set by [sections 1 through 26] times the number of qualified physicians~~ must be distributed equally ~~among~~ BETWEEN:

~~(a) the casualty insurance carriers who have paid surcharges into the primary pool of funds, pro rata and proportionate to their original contributions~~ THE GENERAL FUND, AS REPAYMENT OF AMOUNTS WITHDRAWN UNDER THE TEMPORARY LINE OF CREDIT, until such ~~contributions~~ AMOUNTS have been repaid; and

(b) the secondary pool of funds.

(2) The administrator, upon receipt of capital contributions pursuant to [sections 1 through ~~26~~ 24], shall issue the person or entity paying the capital contribution a certificate representing the contribution and containing the terms of repayment, if any. The collection of capital contributions or the prospects of a return of savings may not be considered to be an unregistered investment contract or otherwise require registration as a security under the securities laws of Montana.

NEW SECTION. **Section 11.** **Reinsurance authority.** The fund ~~has the power to~~ SHALL negotiate for, contract for, and purchase reinsurance~~, subject to the control of the department~~.

NEW SECTION. **Section 12.** **Claims for payment.** Except as otherwise provided in [sections 8(2) and ~~24~~ 22]:

~~(1)~~, claims for payment from the primary or secondary pool of funds that become final ~~during the first 6 months of the calendar year must be computed on June 30 and must be~~

~~paid no later than the following July 15; and~~

~~(2) claims for payment from the primary or secondary pool of funds that become final during the last 6 months of the calendar year must be computed on December 31 and must be paid no later than the following January 15~~ MUST BE PAID WITHIN 30 DAYS.

NEW SECTION. **Section 13.** **Claims against fund -- procedure.** (1) The department shall issue a warrant in the amount of each claim, in the manner required for payment under [sections 1 through ~~26~~ 24], submitted to it against the primary OR SECONDARY pool of funds on ~~June 30 and December 31 of each year~~ THE FIRST DAY OF THE FOLLOWING MONTH.

(2) ~~The only claim against~~ A PAYMENT FROM the primary pool of funds ~~must~~ MAY be MADE ONLY UPON a voucher or other appropriate request by the administrator, submitted along with:

(a) a certified copy of a final judgment against the fund; or

(b) a duplicate original of a settlement entered into by the administrator on behalf of the primary pool of funds involving a physician qualified under the terms of [sections 1 through ~~26~~ 24].

(3) ~~The only claim against~~ A PAYMENT FROM the secondary pool of funds ~~must~~ MAY be MADE ONLY UPON a voucher

or other appropriate request by the administrator, submitted along with:

(a) a certified copy of a final judgment OR AWARD of entitlement to the benefits of [section ~~24~~ 22]; or

(b) ~~a certified copy of a settlement for the benefits of [section 24] approved by the Montana medical legal panel~~ DUPLICATE ORIGINAL OF A SETTLEMENT ENTERED INTO BY THE ADMINISTRATOR ON BEHALF OF THE SECONDARY POOL OF FUNDS.

NEW SECTION. **Section 14.** **Payment from primary pool of funds after exhaustion of insurance coverage -- excess claims -- procedure.** (1) If a physician qualified under [sections 1 through ~~26~~ 24] or his insurer as UNDER INSURANCE required by [section ~~16~~ 15] has agreed to settle liability on a claim by payment of its policy limits and the claimant is demanding an amount in excess of the policy limits or if the annual aggregate under the insurance for the physician has been paid by or on behalf of the physician, the claimant shall notify the administrator ~~in the manner provided in subsection (2) and receive a reply from the administrator as a condition precedent to recovery from the primary pool of funds~~.

(2) The claimant shall provide the administrator in writing~~, postage prepaid by certified mail,~~ a short and plain statement of the nature of the claim and the additional amount for which the claimant will settle. ~~The~~

statement must include, separately stated, the amounts previously paid and the additional amounts demanded with respect to the damages as a whole without regard to any previous payment. The statement must also include:

(a) the amount of any past damages, itemized as to economic and noneconomic damages; and

(b) any future damages and the periods over which they will accrue, on an annual basis, for each of the following types:

(i) medical and other costs of health care;

(ii) other economic loss; and

(iii) noneconomic loss.

(3) The calculation of future damages under subsection (2) must be based on the costs and losses during the period of time the claimant will sustain those costs and losses unless a claim of wrongful death is involved. In wrongful death claims, future damages must be based on the losses during the period of time the injured party would have lived but for the injury upon which the claim is based, and the claimed future damages must be expressed in current values without regard to future changes in the earning power or purchasing power of the dollar.

(4) If a claim of wrongful death is not involved, the statement under subsection (2) must state the claimed severity of the injury and whether the injury is limited to

mental or emotional harm or involves physical harm. If the injury involves physical harm, the claimant shall state whether the physical harm includes bodily impairment or disfigurement.

(5) The statement under subsection (2) must also specify what percentage of the claimed damages are alleged to be the responsibility of each physician against whom a claim is made.

(6) If, within 30 days after receipt of the statement, the administrator has not accepted the offer of settlement in writing, the claimant may proceed with any claim against the physician. The patient assured compensation fund must be named as a necessary and proper party in any state or federal court proceeding for all causes of action arising after {the effective date of this act}.

(7) (a) The statute of limitations with respect to any medical malpractice claim against a qualified physician under {sections 1 through 26} is tolled by the deposit in the United States mail of the writing required by this section and does not begin to run again until the greater of:

(i) 30 days after mailing; or

(ii) the running of the applicable limitation period under 27-6-702.

(b) The time period of tolling is not computed as part

of the period within which the action may be brought.

NEW SECTION. **Section 15.** Discharge of obligation to pay amount from funds. The obligation to pay an amount from the primary or secondary pool of funds may be discharged, unless otherwise required or permitted by law, through:

(1) payment in one lump sum for accrued damages;

(2) an agreement requiring periodic payments from the primary or secondary pool of funds over a period of years;

(3) the purchase of an annuity payable to the claimant, with the administrator having the power to contract with those insurers permitted under 25-9-403(4); or

(4) any combination of the payment plans in subsections (1) through (3).

NEW SECTION. **Section 15.** Qualifications for physician. (1) In order to become and remain qualified under the provisions of [sections 1 through ~~26~~ 24], in addition to the procedures established by the department for regulation of application for qualification, a physician must:

(a) pay all surcharges required by [sections 1 through ~~26~~ 24] in a timely manner;

(b) at the time of qualification, irrevocably agree in writing to be bound by the results of any arbitration provided for in [section ~~24~~ 22];

(c) (i) if acting as an individual physician, be insured and continue to be insured by an authorized insurer

under a valid and collectible policy of medical liability insurance in at least the amounts required by subsection (2), for purposes of at least some obstetrical privileges as an obstetrician or as a family practitioner; or

(ii) if a member of a professional service corporation, partnership, or other business entity desiring to qualify as a physician, have one or more BE A MEMBER OF ONE THAT HAS MORE THAN 50% OF THE members of the business entity insured as an obstetrician or as a family practitioner with some obstetrical privileges;

(d) establish proof of qualifying coverage for lower limits and proof of specialty.

(2) Proof under subsection (1) may be established by the physician's insurance carrier annually filing with the administrator proof that the physician is insured by a policy of malpractice liability insurance in the amount of at least $100,000 per occurrence and $300,000 in the annual aggregate for all claims made during the policy period, along with the specialty under which such policy was issued. Any insurer offering such a policy may offer a policy with deductible options of up to one-half of the limits. The administrator may require a professional corporation seeking to qualify to provide information necessary to determine if the corporation is eligible as a physician.

NEW SECTION. **Section 16.** Failure of physician to

qualify for change of coverage -- limits of liability of fund -- rights and duties of physician. (1) A physician who fails to qualify under [sections 1 through ~~26~~ 24] or who becomes disqualified is not covered by the provisions of [sections 1 through ~~26~~ 24] after the date of disqualification and is subject to liability under the law without regard to the provisions of [sections 1 through ~~26~~ 24], EXCEPT FOR CLAIMS MADE WHILE THE PHYSICIAN WAS QUALIFIED. If a physician does not qualify, the claimant's remedy will not be affected by the terms and provisions of [sections 1 through ~~26~~ 24]. The primary pool of funds is not liable for any amounts up to the limits of qualifying coverage of a physician established in [section ~~16~~ 15]. The secondary pool of funds is liable only up to the amounts contained in that fund in the manner provided in [section ~~24~~ 22].

(2) Within 14 business days of receipt of the information required for qualification of a physician, the administrator shall notify the physician whether the physician is qualified, and if so, the date he became qualified.

(3) The primary pool of funds is not liable for any amounts until the limits of the qualifying coverage for lower limits of the physician have been paid or are payable and then only above those limits of coverage. The maximum

liability of the primary pool of funds is $1 million per occurrence and $3 million in the annual aggregate AS TO EACH QUALIFIED PHYSICIAN for all claims made during the policy period of the coverage for lower limits. The claimant's remedy for amounts over the limits of the primary pool of funds are not affected by the terms and provisions of [sections 1 through ~~26~~ 24], except as otherwise provided.

(4) Except as otherwise provided in [sections 1 through ~~26~~ 24], the rights and duties of a physician qualifying under [sections 1 through ~~26~~ 24], including but not limited to the nature, extent, and limits of coverage of the primary pool of funds, are the same as the rights and duties of that physician under his qualifying coverage for lower limits, including but not limited to all exceptions, exclusions, and endorsements to the lower limits of coverage.

(5) Failure to maintain levels of coverage required under this section or nonrenewal, cancellation, or the elimination of obstetrical coverage for lower limits of coverage ~~constitute~~ CONSTITUTES disqualification of the physician under the terms of [sections 1 through ~~26~~ 24] when the changes become effective with respect to the lower limits of coverage, if at all. The carrier providing lower limits of coverage shall promptly notify the administrator of changes in coverage pertinent to this section in the same

manner as required of notice to insureds.

~~(6)--Notwithstanding any other provision of [sections 1 through 26],--if--the administrator determines that,-due-to the number and dollar exposure of--claims--filed--against--a physician--qualified--under--[sections--1--through--26],-the physician presents a material--risk--of--significant--future liability--to--the--fund,--the--administrator is authorized, after notice and an opportunity for--hearing,--to--terminate the--liability--of--the--fund--for--all--claims--against the physician.~~

~~(7)~~(6) Except as otherwise provided in [sections 1 through ~~26~~ 24], Title 33 has no application to [sections 1 through ~~26~~ 24]. The following provisions of Title 33 apply to [sections 1 through ~~26~~ 24]: 33-15-411; 33-15-504; 33-15-1101 through 33-15-1121; Title 33, chapter 18; Title 33, chapter 19; 33-23-301; and 33-23-302.

NEW SECTION. **Section 17.** **Adequate defense of fund -- notification as to reserves.** The administrator may provide for the defense of the primary and secondary pool of funds against a claimant's claim ~~and may appeal a--judgment--which affects---the--funds~~. The physician or his insurer for qualifying coverage for lower limits shall provide an adequate defense to the claim and is in a fiduciary relationship with the primary or secondary pool of funds with respect to any claim. Any carrier representing a

physician subject to [sections 1 through ~~26~~ 24] shall immediately notify the administrator of any case upon which it has placed a reserve of $50,000 or more.

NEW SECTION. **Section 18.** **Primary pool of funds not liable for punitive damages.** The primary pool of funds is not liable for punitive or exemplary damages of any kind. This section does not relieve the liability of a physician for punitive or exemplary damages.

NEW SECTION. **Section 19.** **Appointment and recommendations of obstetrical advisory council.** (1) The department shall appoint an obstetrical advisory council, subject to the approval of the governor, composed of seven people, ~~five~~ FOUR of whom must be physicians qualified under [sections 1 through ~~26~~ 24]. ~~The~~ EXPENSES FOR TRAVEL AND LODGING AND THE ADMINISTRATION OF THE council must be funded from the primary pool of funds, and members must be appointed for 4-year terms. A vacancy must be filled for the unexpired portion of the term in the same manner as the original appointment.

(2) The council shall make recommendations regarding:

(a) prenatal and postnatal care, including but not limited to better access to comprehensive obstetrical services, improved professional competency, and peer review and quality assurance in connection with prenatal care, labor, delivery, immediate care of the newborn, and care of

the postpartum woman;

(b) risk prevention and other quality of care;

(c) designated compensable events, for which compensation should in all instances be paid, to be included in [section ~~24~~ 22];

(d) economic and noneconomic damage schedules which should be included in [sections 1 through ~~26~~ 24]; and

(e) the proper implementation or correction of [sections 1 through ~~26~~ 24] as the council considers appropriate, pursuant to guidelines provided by the administrator.

NEW SECTION. **Section 20.** **Disciplinary action against physicians.** After [the effective date of this act], upon the receipt by the board of information from the reports required by 33-23-311(3), 37-3-402, this section, or any other source that a physician has had three or more medical malpractice claims where a Montana medical legal panel result was adverse or indemnity has been paid or is payable in excess of the amount of $10,000 for each claim within the previous 5-year period, the board shall investigate the occurrences upon which the claims were based. The board shall determine if action by the board against the physician is warranted UNDER 37-3-323 THROUGH 37-3-328 AND MAY TAKE ACTION UNDER THOSE SECTIONS. In 1995 and annually thereafter, the board shall publish a summary of action

taken or not taken on claims pursuant to this section. The summary may not identify individual physicians. The summary is in addition to any other requirements of the law and may not limit the obligations otherwise required by law.

~~NEW SECTION. Section 22. Predictability of damages. In a trial in district court of any medical malpractice action for damages for injury not including wrongful death where the patient assured compensation fund is a party to the action, the court shall:~~

~~(1) upon proper motion of any party subsequent to verdict and before entry of judgment, review an award against any party for noneconomic damages to determine whether the award is clearly excessive or inadequate. If the award is not in substantial accord with a proper award of damages after considering the factors in subsection (2), the court shall, acting with caution and discretion, modify the award in a manner reasonably consistent with that subsection, unless there is clear and convincing evidence that the interest of justice would not be served by the modification. The court shall give written reasons for a modification or refusal to modify. If the party adversely affected by any modification objects, the court shall order a new trial on the issue of noneconomic damages only. Economic damages awarded and the fact of liability are admissible at the new trial, but factual matters pertaining~~

~~to liability are not admissible.~~

~~(2) in determining whether an award requires modification under subsection (1), consider:~~

~~(a) whether the amount awarded indicates prejudice, passion, or corruption on the part of the trier of fact;~~

~~(b) whether it clearly appears that the trier of fact ignored the evidence in reaching a verdict or misconceived the merits of the case as to damages recoverable;~~

~~(c) whether the trier of fact took improper elements of damages into account or arrived at the amount of damages by speculation and conjecture;~~

~~(d) whether the award is reasonably related to the damages proved and the injury suffered pursuant to the guidelines in subsection (3); and~~

~~(e) whether the award is supported by the evidence and could be adduced in a logical manner by reasonable persons.~~

~~(3) use the guidelines in this subsection in determining whether to modify an award when considering subsection (2)(d). Noneconomic damages are not proportional to the injury received if they exceed the greater of:~~

~~(a) weekly wage compensation benefits as computed pursuant to 39-71-701 times the life expectancy in weeks; or~~

~~(b) the multiple of economic damages awarded by the jury, pursuant to the severity of the injury as determined by the finder of fact as properly shown by the evidence for~~

~~purposes of calculation, as follows:~~

~~(i) for mental or emotional harm only: 0.5 times the amount of economic damages or $1 million, whichever is greater;~~

~~(ii) for physical harm without bodily impairment or disfigurement: an amount equal to the amount of economic damages or $2 million, whichever is greater;~~

~~(iii) for bodily impairment or disfigurement: 1.5 times the amount of economic damages or $3 million, whichever is greater.~~

NEW SECTION. **Section 21.** Contractual right to extended reporting endorsements -- prior acts coverage. (1) Each physician qualified under [sections 1 through ~~26~~ 24] has the contractual right, on the same terms and conditions as that physician has under the qualifying lower limits of coverage, if any, to obtain an extended reporting endorsement for coverage by the primary pool of funds for claims for medical malpractice that occur during the time a physician was qualified under [sections 1 through ~~26~~ 24] but that are reported after the physician ceases to be qualified.

(2) The cost of the purchase of an extended reporting endorsement paid by the physician to the fund is equal to a multiple of the current annual surcharge under [section 7]. The multiple is the lesser of the multiple being charged

under the qualifying lower limits of coverage at that time or the multiple determined by the fund's actuary.

(3) Prior acts and omissions coverage, provided to the qualified physician upon qualification for coverage by the primary pool of funds for claims that have occurred but have not been made, must be provided only as to claims that are also covered under the terms of a valid and collectible primary policy of insurance coverage carried by the physician, qualified as required by [sections 1 through ~~26~~ 24] and any endorsements to the policy. Prior acts and omissions coverage from the fund is subject to the following exclusions and limitations in addition to those contained in [sections 1 through ~~26~~ 24]:

(a) The fund may not provide coverage for any liability to any qualified physician with respect to:

(i) any claim made against a physician qualified under [sections 1 through ~~26~~ 24] at any time prior to the date of qualification, regardless of whether or not the claim has been reported to any liability insurer; or

(ii) any potential claim against any qualified physician of which any physician is aware or reasonably should have been aware as of the date of qualification, regardless of whether or not the claim has yet been made or reported to any liability insurer. For purposes of this subsection, a potential claim includes but is not limited to

instances where any insured has received an oral or written communication from a legal representative of a patient or a request by or on behalf of a patient for copies of medical records under circumstances reasonably indicative of a potential claim.

(b) The limits of liability of the fund for prior acts claims is the lesser of the limits of liability of the primary pool of funds under [sections 1 through ~~26~~ 24] or the limits of liability of any valid and collectible liability insurance carried by the qualified physician prior to qualification.

NEW SECTION. **Section 22.** Compensation for injuries from medical intervention without regard to fault. (1) The purpose of this section is to establish a system of prompt, efficient, and equitable compensation for certain economic damages and attorney fees to those claimants injured through medical intervention in the birthing process or obstetrical care, without regard to negligence of the physician. ~~This section applies only if the patient opts on a voluntary basis to pay a designated premium equivalent and later signs an arbitration agreement to arbitrate the claim before the Montana medical legal panel.~~

(2) ~~Each physician shall disclose to each patient, at~~ AT the time of any initial medical treatment BY A PARTICIPATING PHYSICIAN related to the birthing process or

obstetrical care, ~~the--amount--of--funds--on--hand--in-the secondary--pool--of--funds--and---the---designated---premium equivalent--that-will-be-contained-in-the-fees-to-be-charged by-giving-the-form-provided--by--the--administrator--to~~ the patient IS ELIGIBLE TO PARTICIPATE IN THE SECONDARY POOL AND BECOMES LIABLE FOR THE PAYMENT OF A DESIGNATED PREMIUM EQUIVALENT. The initial amount of the designated premium equivalent is $25.~~--The--amount,~~ IS NONREFUNDABLE, AND is subject to change by the department, by rule, after consideration of the recommendations of the obstetrical advisory council. ~~The-administrator-shall-regularly-keep-the physicians-advised-of-the-amount-of-money-in--the--secondary pool-of-funds.~~

(3) Each patient, at the time ~~the-patient-is-provided the-form-required--in--subsection--(2),--must--be--given--an opportunity--not--to--participate--in--the-secondary-pool-of funds-and-to-have-the-designated-premium-equivalent-deducted from-the-fees-to-be-charged~~ OF INITIAL MEDICAL TREATMENT RELATED TO THE BIRTHING PROCESS OR OBSTETRICAL CARE, MUST BE INFORMED BY THE PHYSICIAN OF THE PROVISIONS OF SUBSECTION (2) AND THIS SUBSECTION. THE PHYSICIAN SHALL AT THAT TIME GIVE THE PATIENT A PAMPHLET THAT CLEARLY AND ADEQUATELY DESCRIBES THE PROVISIONS OF [SECTIONS 1 THROUGH 24] AND ADVISES THE PATIENT TO CONTACT AN ATTORNEY IF THE PATIENT BELIEVES THE PATIENT HAS A MALPRACTICE CLAIM RELATED TO THE

BIRTHING PROCESS OR OBSTETRICAL CARE. THE PAMPHLET MUST BE WRITTEN BY THE STATE BAR OF MONTANA, AND THE PRIMARY POOL SHALL PAY THE COST OF PUBLISHING AND DISTRIBUTING THE PAMPHLET. THE PHYSICIAN SHALL ADD THE DESIGNATED PREMIUM EQUIVALENT TO THE FIRST BILL SENT TO THE PATIENT AND INFORM THE PATIENT AT THE TIME OF THE INITIAL MEDICAL TREATMENT THAT THE AMOUNT WILL BE ADDED TO THE BILL. If the patient cannot afford the premium ~~and-wishes-to-participate--in--the secondary--pool-of-funds~~, the patient shall deliver a signed letter to the physician to that effect and the premium must be waived. The designated premium equivalent must also be waived if prohibited by federal law.

(4) ~~If--the--patient--wishes--to--participate--in--the secondary-pool-of-funds:~~

(a) ~~prior--to--any--claim--of--injury-and-prior-to-any known--complications--of--delivery--or--pregnancy,--the~~ THE physician shall immediately, WITHIN 30 DAYS OF THE TIME OF INITIAL MEDICAL TREATMENT, remit to the department the amount of any required designated premium equivalent or the letter from the patient stating an inability to pay the premium. ~~Failure-of-the-patient-to-pay-or-provide-the-letter disqualifies--the--patient--from--any--participation--in-the secondary-pool-of-funds.~~

(b) ~~subsequent~~ SUBSEQUENT to any claim of injury and subsequent to any known complications of delivery or

pregnancy, the patient ~~shall~~ MAY provide the physician with an agreement to arbitrate a claim arising out of the birthing process or obstetrical care, on a form provided by the administrator. The physician and the patient or the patient's representative shall execute the agreement to arbitrate the claim. ~~Upon approval by the administrator, the agreement is binding upon the patient, the patient's representative, any claimant, and the physician for purposes of a claim for required benefits for compensable injuries under [sections 1 through 26]. An executed copy of the agreement to arbitrate must be provided to the administrator and is subject to his approval as to form and content before it may become effective.~~

(5) A claim for recovery of required benefits must be filed pursuant to the provisions of Title 27, chapter 6, naming the secondary pool of funds a party, with that chapter and its rules of procedure being applicable to the secondary pool of funds as if it were a health care provider. The claim is governed by Title 27, chapter 6, as if it were a malpractice claim. THE ARBITRATION PANEL MUST BE COMPOSED OF AN ATTORNEY, A PHYSICIAN, AND A PROFESSIONAL ARBITRATOR. THE PROFESSIONAL ARBITRATOR MUST BE KNOWLEDGEABLE IN WORKERS' COMPENSATION LAW AND IS THE CHAIRMAN OF THE PANEL. The arbitration agreement of the parties constitutes a request for recommendation of an

award, and the recommended award constitutes an approved settlement agreement pursuant to 27-6-606 and an award pursuant to Title 27, chapter 5.

(6) (a) Except as provided in subsection (6)(b), Title 27, chapter 5, applies to the claim and any award.

(b) The provisions of 27-5-211 through 27-5-218 do not apply to the claim, and any conflict between Title 27, chapter 5, and Title 27, chapter 6, must be resolved in favor of the latter.

(7) The filing of a claim for recovery before the Montana medical legal panel under the arbitration agreement, ~~unless the arbitration agreement has been revoked in writing by the patient prior to filing of the claim,~~ constitutes:

(a) a valid and binding agreement that the sole matter in controversy is whether there is a compensable injury and, if so, the amount of required benefits available as compensation;

(b) a waiver of trial by jury or the court; and

(c) the sole and exclusive remedy for:

(i) any malpractice claim against a physician qualified under [sections 1 through ~~26~~ 24] ~~or a hospital~~; or

(ii) a claim for required benefits for a compensable injury by the patient, ~~his heirs or representatives, or his parents or next of kin, or any other person whose claim is derivative from the incident.~~

(8) ~~The~~ IF A CLAIM HAS NOT BEEN FILED UNDER SUBSECTION (7), THE filing of a malpractice claim in federal court or pursuant to Title 27, chapter 6, against one or more physicians subject to [sections 1 through ~~26~~ 24] constitutes a revocation in writing of the arbitration agreement provided for in this section ~~if-the-claim-represents-that the-claimant-has-been-fully--advised--in--writing--by--legal counsel--of--the-options-available-under-[sections-1-through 26]-and-a-true-and-correct-copy-of-the-writing--is--attached to--the-claim.-If-the-claimant-is-not-represented-by-counsel in--a--Montana---medical---legal---panel---proceeding,---the administrator--shall--provide--the-advice-in-writing-and-the claimant-shall-make-a-written-binding--election--to--proceed with--the--malpractice--claim--or--to--amend--the--claim-for recovery-under-an-arbitration-agreement-obtained-pursuant-to subsection-(6).-The-written--advice--and--election--must--be filed-with-the-Montana-medical-legal-panel~~.

(9) Claims for required benefits for a compensable injury under a valid arbitration agreement are limited to required benefits and only required benefits may be paid for a compensable injury.

(10) (a) Required benefits under this section are~~: limited-to-the-following-items-as-computed-under-[sections-1 through-26]:~~

~~(i)--medical-and-hospital-expenses-and--future--medical and--hospital-expenses-as-incurred,-computed-and-paid-in-the manner-provided-in-39-71-704-and-the-rules-implementing-that section;~~

~~(ii)-lost--earnings--and--future---lost---earnings---as incurred,--computed,--and--paid--in--the--manner-provided-in 39-71-701(1)-and-according--to--the--definition--of--average weekly--wage--in--39-71-116-and-the-rules-implementing-those sections;-and~~

~~(iii)-reasonable-attorney-fees-for--panel--proceedings, computed--and--paid--in--the--manner--provided-in-39-71-613, 39-71-614,-and-the-rules-implementing-those-sections.~~

(I) MEDICAL, PARAMEDICAL, AND HOSPITAL EXPENSES INCURRED TO THE DATE OF THE AWARD;

(II) FUTURE MEDICAL, PARAMEDICAL, AND HOSPITAL EXPENSES, COMPUTED IN THE MANNER PROVIDED IN 39-71-704 AND RULES IMPLEMENTING THAT SECTION;

(III) A SUM EQUAL TO ONE AND ONE-HALF TIMES THE STATE'S AVERAGE WEEKLY WAGE FOR THE PERIOD OF THE DISABILITY; AND

(IV) REASONABLE ATTORNEY FEES INCURRED IN BRINGING THE CLAIM BEFORE THE ARBITRATION PANEL, NOT TO EXCEED $125 PER HOUR.

(b) Required benefits do not include medical and hospital expenses for items or services or reimbursement the patient received ~~or-is-entitled-to-receive~~ under the laws of any state or the federal government, except to the extent

HB 0699/02

exclusion of such benefits is prohibited by federal law, or expenses paid by any prepaid health plan, health maintenance organization, or private insuring entity or pursuant to the provisions of any health or sickness insurance policy or other private insurance program.

~~(c)--Proceeds---to---beneficiaries;---as---defined---in 39-71-116;--must--be--determined--pursuant-to-39-71-723;-and lump-sum-payments-for-future-benefits-are-prohibited.~~

(11) All awards must be paid from the secondary pool of funds on ~~an-annual~~ A MONTHLY basis for required benefits that have accrued and pursuant to Title 25, chapter 9, part 4, for future required benefits, and that part applies in all instances to claims for required benefits except as otherwise provided in this section and to the extent the secondary pool of funds has sufficient funds for payments without becoming actuarially unsound. If the secondary pool of funds has insufficient funds with which to pay an award or awards, payments must be made in the same manner, pro rata as to all claims against the secondary pool of funds at the time of the required payment. The unpaid amounts of any award constitute a future obligation of the secondary pool of funds as funds become available. The future obligation is not enforceable by any process of law other than pursuant to the terms of this section.

(12) All costs of administration of the secondary pool

of funds must be paid from the secondary pool of funds, and the costs of administration must be paid prior to the payment of any required benefits or required obligations of the secondary pool of funds provided elsewhere in [sections 1 through ~~26~~ 24]. If the secondary pool of funds is insufficient to pay the costs of administration of the secondary pool or any attorney fees required to be paid by the secondary pool, the administrator is authorized to loan the secondary pool sufficient funds for the administration or fee from the primary pool of funds if the loan would not render the primary pool actuarially unsound. The loan is an advance against future distributions pursuant to [section 10] and in lieu of the distributions. The loan plus interest must be repaid to the primary pool of funds upon the future distribution otherwise accruing.

(13) The arbitration agreement form promulgated by the department must include on its face a written notice of the substance of subsections ~~(9)~~ and (7) THROUGH (10) in red, 10-point type.

(14) The period prescribed for the commencement of an action for relief under this section is ~~within-1-year-of-the date-of-injury~~ THE PERIOD PROVIDED IN 27-2-205.

NEW SECTION. **Section 23.** **Tax exemption.** The fund is exempt from payment of all fees and all taxes levied by this state or any of its subdivisions.

NEW SECTION. **Section 24.** Review. The administrator shall report IN WRITING to each REGULAR session of the legislature concerning the effectiveness of [sections 1 through ~~26~~ 24] in achieving the stated goals and concerning other matters of importance. The status and operation of the fund must be included in that report.

Section 25. Section 27-6-105, MCA, is amended to read:

"27-6-105. What claims panel to review. The panel shall review all malpractice claims or potential claims against health care providers covered by this chapter, except including those claims subject to a valid arbitration agreement allowed by law ~~or upon which suit has been filed prior to April 19, 1977~~."

Section 26. Section 27-6-602, MCA, is amended to read:

"27-6-602. Questions panel must decide. (1) Upon consideration of all the relevant material, the panel shall decide whether there is:

~~(1)~~(a) substantial evidence that the acts complained of occurred and that they constitute malpractice; and

~~(2)~~(b) a reasonable medical probability that the patient was injured thereby.

(2) If ~~the panel decides that the acts complained of did not constitute medical malpractice and if~~ there is an arbitration agreement pursuant to [sections 1 through ~~26~~ 24], the panel shall decide whether there is a compensable

injury pursuant to [sections 1 through ~~26~~ 24], and, if so, make an award pursuant to [section ~~24~~ 22]."

~~**Section 29.** Section 33-10-102, MCA, is amended to read:~~

~~"33-10-102. Definitions. As used in this part, the following definitions apply:~~

~~(1) "Association" means the Montana insurance guaranty association created under 33-10-103.~~

~~(2) (a) "Covered claim" means an unpaid claim, including one for unearned premiums, or a contractual guaranty for an extended reporting endorsement for claims reported after the expiration of the policy period which arises out of and is within the coverage and not in excess of the applicable limits of an insurance policy to which this part applies issued by an insurer, if such insurer becomes an insolvent insurer after July 1, 1971, and:~~

~~(i) the claimant or insured is a resident of this state at the time of the insured event; or~~

~~(ii) the property from which the claim arises is permanently located in this state.~~

~~(b) "Covered claim" shall does not include any amount due a reinsurer, insurer, insurance pool, or underwriting association, as subrogation recoveries or otherwise.~~

~~(3) "Insolvent insurer" means an insurer:~~

~~(a) authorized to transact insurance in this state~~

either at the time the policy was issued or when the insured event occurred; and

(b) determined to be insolvent by a court of competent jurisdiction.

(4) "Member insurer" means any person who:

(a) writes any kind of insurance to which this part applies under 33-10-101(3), including the exchange of reciprocal or interinsurance contracts; and

(b) is licensed to transact insurance in this state.

(5) "Net direct written premiums" means direct gross premiums written in this state on insurance policies to which this part applies, less return premiums thereon and dividends paid or credited to policyholders on such direct business. "Net direct written premiums" does not include premiums on contracts between insurers or reinsurers.

(6) "Person" means any individual, corporation, partnership, association, or voluntary organization."

Section 27. Section 33-23-311, MCA, is amended to read:

"33-23-311. Information required of professional liability insurers -- submission. (1) For purposes of this section, "profession" means the occupations engaged in by physicians, osteopaths, registered nurses, licensed practical nurses, dentists, optometrists, podiatrists, chiropractors, hospitals, attorneys, certified public

accountants, public accountants, architects, veterinarians, pharmacists, and professional engineers.

(2) Each insurance company engaged in issuing professional liability insurance in the state of Montana shall include the following information, by profession, from its experience in the state of Montana, in its annual statement to the commissioner:

(a) the number of insureds as of December 31 of the calendar year next preceding;

(b) the amount of earned premiums paid by the insureds during the calendar year next preceding;

(c) the number of claims made against the insurer's insureds and the number of claims outstanding as of December 31 of the calendar year next preceding;

(d) the number of claims paid by the insurer during the calendar year next preceding and the total monetary amount thereof;

(e) the number of lawsuits filed against the insurer's insureds and the number of insureds included therein during the calendar year next preceding;

(f) the number of lawsuits previously filed against the insurer's insureds which were dismissed without settlement or trial and the number of insureds included therein during the calendar year next preceding;

(g) the number of lawsuits previously filed against

the insurer's insureds which were settled without trial, the total monetary amount paid as settlements in such settled cases, and the number of insureds included therein during the calendar year next preceding;

(h) the number of lawsuits against the insurer's insureds which went to trial during the calendar year next preceding and the number of such cases ending in the following:

(i) judgment or verdict for the plaintiff;

(ii) judgment or verdict for the defendant;

(iii) other;

(i) the total monetary amount paid out, in those lawsuits specified in subsection (h);

(j) the total number of the insurer's insureds included in those lawsuits specified in subsection (h);

(k) the number of new trials granted during the calendar year next preceding;

(l) the number of lawsuits pending on appeal as of December 31 of the next preceding calendar year; and

(m) such other information and statistics as the commissioner considers necessary.

(3) The commissioner shall, ~~within 60 days of request~~ by October 1 of each calendar year, submit in writing to the appropriate licensing authority, in summary report form, the data and information furnished him pursuant to this section

relevant to the particular profession, or facility, or class of facilities and shall likewise make the summary available to the public at the expense of the requestor, which data and information must be retained for at least 10 years."

NEW SECTION. **Section 28.** Extension of authority. Any existing authority to make rules on the subject of the provisions of [this act] is extended to the provisions of [this act].

NEW SECTION. **Section 29.** ~~Nonseverability~~ ~~dissolution~~ DISSOLUTION of fund -- transfer to Montana insurance guaranty association. ~~(1) (a) If any provision of this chapter, any provision of the sections listed in subsection (1)(b), or the application of any one of those provisions to any person or circumstance is held invalid by a decision of the Montana supreme court or the United States supreme court, such invalidity shall render this entire chapter invalid except for this section, whether or not the other provisions or application of this chapter can be given effect without the invalid provision or application.~~

~~(b) The provisions of 25-9-401 through 25-9-405, 25-15-202, 27-1-702, 27-1-703, 27-2-205(2), 28-1-301 through 28-1-303, 28-11-311, and this chapter are not severable.~~

~~(2)~~ (a) (1) The assets and liabilities of the primary pool of funds must be transferred to the Montana insurance guaranty association created under 33-10-103 upon the

occurrence of any of the following events:

~~(i)~~(A) [this ~~chapter~~ ACT] being rendered invalid because of one or more of the reasons set forth in subsection (1);

~~(ii)~~(B) the primary pool of funds not being maintained on an actuarially sound basis for more than 3 years from the time such soundness is required by [this act] and the probability that the primary pool of funds will be exhausted by the payment of all fixed and known obligations that will become final within 3 years.

~~(b)~~(2) The liabilities of the fund, including coverage endorsements, constitute covered claims as defined in 33-10-102, and the limit of liability of the Montana insurance guaranty association and any physician against whom a claim has occurred or a judgment has been rendered or with whom a settlement agreement has been entered into is equal to the limits of liability of the Montana insurance guaranty association under 33-10-105.

NEW SECTION. **Section 30.** **Applicability.** [This act] applies to all causes of action that constitute medical malpractice claims of any nature, whether obstetrical or otherwise, where the cause of action includes one or more physicians who are qualified pursuant to the terms of [this act] and a claim for coverage exists against the patient assured compensation fund. ~~Provided, however, that [section~~

~~22] does not affect rights and duties that matured, penalties that were incurred, or proceedings that were begun before [the effective date of this act] and that section applies, if at all, only to causes of action that accrue on or after the date of qualification of a physician under [this act] against whom such a cause of action accrues.~~

NEW SECTION. **Section 31.** **Effective date.** [This act] is effective on passage and approval.

-End-

RE-REFERRED AND
APPROVED BY COMMITTEE
ON APPROPRIATIONS
AS AMENDED

HOUSE BILL NO. 699

INTRODUCED BY ADDY, STICKNEY, CONNELLY, BECK, HALLIGAN

A BILL FOR AN ACT ENTITLED: "AN ACT PROVIDING FOR A PATIENT ASSURED COMPENSATION FUND ABOVE LOW PRIMARY LIMITS OF INSURANCE, FOR THE PAYMENT OF MEDICAL LIABILITY CLAIMS AGAINST PHYSICIANS WHO DELIVER BABIES; PROVIDING FOR THE RETURN OF DOLLAR SAVINGS TO ~~ORIGINAL CAPITALIZERS AND TO~~ PATIENTS WHO ARE INJURED IN THE MEDICAL SYSTEM; PROVIDING FOR AN OBSTETRICAL ADVISORY COMMITTEE TO MAKE RECOMMENDATIONS REGARDING OBSTETRICAL CARE; ~~PROVIDING FOR OBJECTIVE GUIDELINES FOR NONECONOMIC DAMAGES PROPORTIONATE TO THE SEVERITY OF INJURY OR THE LIFE EXPECTANCY OF THE INJURED PARTY;~~ PROVIDING FOR VOLUNTARY ENTRY INTO BINDING ARBITRATION FOR OBSTETRICAL CLAIMS WITHOUT REGARD TO NEGLIGENCE OF THE PHYSICIAN; PROVIDING FOR ADMINISTRATION BY THE MONTANA MEDICAL LEGAL PANEL UNDER THE REIMBURSED SUPERVISION OF THE DEPARTMENT OF HEALTH AND ENVIRONMENTAL SCIENCES; PROVIDING FOR CAPITALIZATION BY A ~~PREMIUM TAX ON CASUALTY CARRIERS~~ TEMPORARY LINE OF CREDIT FROM THE GENERAL FUND, WITH THE ADVANCED MONEY TO BE REPAID PREMIUM TAX ON PROPERTY AND CASUALTY CARRIERS; AMENDING SECTIONS 27-6-105, 27-6-602, ~~33-18-102,~~ AND 33-23-311, MCA; AND PROVIDING AN IMMEDIATE EFFECTIVE DATE."

STATEMENT OF INTENT

A statement of intent is required for this bill because it delegates rulemaking authority to the department of health and environmental sciences. This bill is intended to expand the authority of the department and to authorize the writing and adopting of rules in accordance with the Montana Administrative Procedure Act to:

(1) qualify or disqualify physicians for participation in the patient assured compensation fund; and

(2) facilitate the collection of assessments and charges for hospitals and participating physicians under the Patient Assured Compensation Act. This bill is intended to reimburse the department for the cost of writing and adopting the rules.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

NEW SECTION. **Section 1.** Short title. [Sections 1 through ~~26~~ 24] may be cited as the "Patient Assured Compensation Act".

NEW SECTION. **Section 2.** Purpose and goals. (1) The purpose of this legislation is to ~~increase the availability of~~ LOWER INSURANCE COSTS FOR PHYSICIANS PROVIDING obstetrical care and TO INCREASE access to that care, especially in rural areas of Montana, and to maintain the availability and accessibility of obstetrical care in urban

areas of Montana.

(2) The goals of this legislation are to:

(a) eliminate from the insurance system any excess insurance money that may be collected because of complex insurance and legal problems related to excess reserves, excess profits, and the use of shared insurance data from states other than Montana;

(b) require the pass through of savings to those who bear the cost for the Patient Assured Compensation Act, including the class of patients and claimants with injuries received in the medical system;

(c) provide ~~more-full-and-fair~~ A NO-FAULT SYSTEM OF compensation to claimants ~~than----the----current medical-insurance-legal--system--does--in--cases---involving physicians-who-deliver-babies;~~

~~(d)--provide-in-advance-a-reasonable-calculation-of-the actual--amounts--to--be-paid-in-obstetrics-related-claims-so that-the-funds-necessary--to--pay--claims--can--be--properly raised--from--those--who--pay--for-the-claims-to-ensure-that damages-do-not-increase-exponentially;~~

~~(e)~~(D) provide a funding mechanism that is broader than the available base of funds from obstetricians and family practitioners providing obstetric care by using sources that have an interest in the maintenance of core industries in rural areas and that have benefited from

previous civil justice reform legislation; and

~~(f)~~(E) provide an immediate reduction in the total cost of coverage for medical liability insurance for physicians who deliver babies.

NEW SECTION. **Section 3.** Legislative findings. The legislature finds that:

(1) there has been an accelerating and substantial reduction in available obstetrical services in Montana, especially in the rural areas, and this process is likely to continue unless appropriate steps are taken;

(2) the reduction in obstetrical services constitutes a SEVERE statewide public health AND ECONOMIC problem ~~of-a large-magnitude-and-a-statewide-economic-problem-of-a-severe nature;~~

~~(3)--in-addition-to--the--direct--loss--of--obstetrical services-in-rural-areas-of-Montana,-there-have-been-and-will likely-continue-to-be:~~

~~(a)--broader--adverse-economic-impacts-to-the-hospitals in--those--communities,--including--the--closure---of---some hospitals--with-resulting-adverse-impacts-on-the-communities involved,-that-flow-from-a-loss-of-a-broad--range--of--basic medical--services--as--physicians--who-deliver-babies-retire early-or-leave-the-community;~~

~~(b)--limitations-on--the--availability--and--access--to obstetrical---care---in---urban---areas,---especially--among~~

~~lower-income-women,-brought-about-by-increased-pressures--on limited--resources--in-urban-areas-from-women-in-rural-areas who--wish--to--obtain--replacement---obstetrical---services,~~ ESPECIALLY IN RURAL AREAS, THAT MAY WELL CONTINUE UNLESS APPROPRIATE STEPS ARE TAKEN;

~~(4)~~(3) the impacts referred to in ~~subsection--(3)~~ SUBSECTIONS (1) AND (2) are strongly associated with, among other things:

(a) substantial previous increases in the cost of medical liability insurance, a high level of current costs of medical liability insurance, and anticipated increases in the future cost of medical liability insurance to the point where the income from the delivery of babies does not justify the current or future cost of medical liability coverage;

(b) substantial previous increases in the number of PHYSICIANS INVOLVED IN OBSTETRICAL medical liability claims ~~against--physicians~~, with an increased likelihood that each physician will be periodically involved in a number of legal claims;

(c) inducements for early retirement, relocation to another area, or the elimination or limitation of obstetrical services by doctors who deliver babies;

~~(5)~~(4) the medical-insurance-legal system, because of its unpredictability and high cost, often ~~deprives~~ CAN

DEPRIVE the most seriously injured and the least seriously injured of even their out-of-pocket economic damages or provides compensation for intangible damages disproportionate to the severity of the injury or the life expectancy of the injured party.

NEW SECTION. **Section 4.** Definitions. As used in [sections 1 through ~~26~~ 24], the following definitions apply:

(1) "Actuarially sound basis" means that the probability of insolvency of the primary pool of funds has been lowered to a level of risk that is prudent to accept, as determined by an actuary hired by the fund, who is a member of the American academy of actuaries or the casualty actuarial society.

(2) "Administrator" means the administrator of the primary and secondary pool of funds, who is the director of the Montana medical legal panel provided for in 27-6-201.

(3) "Board" means the Montana state board of medical examiners provided for in 2-15-1841.

~~(4)--"Bodily--impairment"--means-temporary-or-permanent impairment-or-loss-of-bodily-functions-or-bodily-parts.--The term--does--not-include-other-impairments,-including-but-not limited-to--mental--or--emotional--processes--or--behavioral controls.~~

~~(5)~~(4) "Claimant" means a person claiming damages for injury from medical malpractice or required benefits for

compensable injuries under [sections 1 through ~~26~~ 24].

~~(6)~~(5) "Commissioner" means the commissioner of insurance provided for in 2-15-1903.

~~(7)~~(6) "Compensable injury" means any physical harm, bodily impairment, disfigurement, or a delay in recovery, under [section ~~24~~ 22] that:

(a) is associated with or connected to the birthing process or the rendering of obstetrical care by a physician qualified under the terms of [sections 1 through ~~26~~ 24];

(b) is associated in whole or in part with medical intervention rather than with the condition for which the intervention occurred; and

(c) is not consistent with or reasonably expected as a consequence of medical intervention or is a result of medical intervention to which the patient did not consent.

~~(8)~~(7) "Condition" means the general state of health of the patient prior to medical intervention.

~~(9)~~(8) "Delay in recovery" means any undue additional time spent under care that is not substantially attributable to the condition for which medical intervention occurred and includes consideration of the general health of the patient.

~~(10)~~(9) "Department" means the department of health and environmental sciences provided for in Title 2, chapter 15, part 21.

~~(11)~~(10) "Designated premium equivalent" means the

dollar amount paid by a patient to a physician ~~or deducted from the charges of a physician~~ under [section ~~24~~ 22].

~~(12) "Disfigurement" means scars or adverse changes in bodily appearance beyond those that are medically required.~~

~~(13) "Economic damages" means those compensatory damages payable as a result of a medical malpractice claim against a physician or a physician and other parties, that are objectively determinable and verifiable compensatory damages, including but not limited to medical expenses and care, rehabilitation services, custodial care, loss of earnings and earning capacity, loss of income, funeral or burial expenses, loss of use of property, costs of repair or replacement of property, costs of obtaining substitute domestic services, loss of employment, loss of business or employment opportunities, and any other objectively determinable and verifiable pecuniary or monetary damages.~~

~~(14)~~(11) "Hospital" means a hospital as defined in 50-5-101.

~~(15)~~(12) "Malpractice claim" means a malpractice claim as defined in 27-6-103.

~~(16)~~(13) "Medical intervention" means the rendering as well as the omission of any care, treatment, or services provided within the course of treatment administered by or under the control of a physician or hospital.

~~(17)~~(14) "Montana medical legal panel" means the panel

provided for in 27-6-104.

~~(18) "Noneconomic damages" means those damages payable as a result of a medical malpractice claim against a physician or a physician and other parties that are subjectively determined to be nonmonetary or nonpecuniary damages, including but not limited to pain, suffering, inconvenience, grief, physical impairment, disfigurement, mental suffering or anguish, emotional distress, loss of society and companionship, loss of consortium, fear of loss, fear of illness, fear of injury, injury to reputation, humiliation, and any other subjectively determined nonmonetary or nonpecuniary damages.~~

~~(19)~~ (15) "Obstetrical advisory council" means an advisory council created pursuant to 2-15-122 by the department and provided for in [section ~~20~~ 19].

~~(20)~~ (16) "Patient" means an individual who receives or should have received care from a physician and includes any person OR ENTITY having a ~~claim of any kind, whether derivative or otherwise, as a result of alleged medical malpractice on the part of a physician or having a compensable injury. Derivative claims include but are not limited to the claim of a parent or parents, guardian, trustee, child, relative, attorney, or any other representative of a patient, including claims for economic damages, noneconomic damages, attorney fees or expenses, and all similar claims~~ RIGHT OF ACTION UNDER 27-1-501.

~~(21)~~ (17) "Patient assured compensation fund" or "fund" means the fund created under [section 5] and comprised of a primary pool of funds and a secondary pool of funds.

~~(22) "Physical harm" means a wound, infection, disease, or death.~~

~~(23)~~ (18) "Physician" means a physician as defined in 27-6-103.

~~(24)~~ (19) "Primary pool of funds" means that separate and segregated portion of the fund established for the payment of claims, expenses, and other allowed and required expenditures pursuant to [sections 1 through ~~26~~ 24], except for money payable from the secondary pool of funds.

~~(25)~~ (20) "Representative" means the spouse, parent, guardian, trustee, attorney, or other legal agent of the patient.

~~(26)~~ (21) "Secondary pool of funds" means that separate and segregated portion of the fund established for the payment of compensation, expenses, and other allowed and required expenditures pursuant to [section ~~24~~ 22].

~~(27)~~ (22) "Surplus" means the excess of total assets minus liabilities of the primary pool of funds as defined by standard accounting practices for insurance carriers.

NEW SECTION. **Section 5.** ~~Purpose~~ FUND CREATED -- attachment to department -- deposit and investment. (1)

There is a patient assured compensation fund. Money for the fund collected and received pursuant to [sections 1 through ~~26~~ 24] is to be used exclusively for the purposes stated in [sections 1 through ~~26~~ 24].

(2) The fund is attached to the department for administrative purposes only, pursuant to 2-15-121, except as otherwise provided in [sections 1 through ~~26~~ 24]. The department may promulgate rules and regulations implementing [sections 1 through ~~26~~ 24].

(3) The primary and secondary pool of funds and any income from those funds must be held in trust. The funds must be deposited in segregated accounts (one for the primary pool of funds and one for the secondary pool of funds), invested, and reinvested by the department AS A FIDUCIARY, pursuant to law. The fund may not become a part of or revert to the general fund of the state.

NEW SECTION. **Section 6.** Reimbursement to ~~department~~ DEPARTMENTS. The department AND THE DEPARTMENT OF INSURANCE must be reimbursed from the primary pool of funds for any expenses incurred in the administration of [sections 1 through ~~26~~ 24].

NEW SECTION. **Section 7.** Capitalization and maintenance of primary pool of funds and secondary pool of funds -- surcharge. (1) To capitalize the primary pool of funds and the secondary pool of funds, there is ~~levied and collected on all insurance carriers authorized to write and engaged in writing casualty insurance pursuant to 33-1-206 in this state during 1987 and engaged in writing casualty insurance as of December 31, 1988, a one-time refundable surcharge in the form of a 1.17% premium tax surcharge based on 1987 carrier annual reports made pursuant to 33-2-705. A total of $100,000 of the surcharge forms the capitalization of the secondary pool of funds and the balance of the surcharge forms the capitalization of the primary pool of funds. If the surcharges provided for in this section are refunded, the refund must be made in the method and manner provided for in [section 10].~~ A LOAN OF $6,300,000 FROM THE STATE GENERAL FUND TO THE PRIMARY POOL OF FUNDS AND A LOAN OF $100,000 FROM THE STATE GENERAL FUND TO THE SECONDARY POOL OF FUNDS. THE LOANS ARE NOT APPROPRIATIONS AND MUST BE REPAID UNDER [SECTION 10], WITHOUT INTEREST. LEVIED AND COLLECTED ON ALL PROPERTY AND CASUALTY CARRIERS AUTHORIZED TO WRITE AND ENGAGED IN WRITING PROPERTY AND CASUALTY INSURANCE UNDER 33-1-206 OR 33-1-210 IN THIS STATE DURING 1987 AND ENGAGED IN WRITING PROPERTY AND CASUALTY INSURANCE AS OF DECEMBER 31, 1988, A ONE-TIME REFUNDABLE SURCHARGE IN THE FORM OF A 1.17% PREMIUM TAX SURCHARGE BASED ON 1987 CARRIER ANNUAL REPORTS MADE UNDER 33-2-705. A TOTAL OF $100,000 OF THE SURCHARGE FORMS THE CAPITALIZATION OF THE SECONDARY POOL OF FUNDS, AND THE BALANCE OF THE SURCHARGE

FORMS THE CAPITALIZATION OF THE PRIMARY POOL OF FUNDS. IF THE SURCHARGE IS REFUNDED, THE REFUND MUST BE MADE IN THE MANNER PROVIDED IN [SECTION 10].

(2) Except as otherwise provided in this section, the ~~primary--pool--of-funds-is-fully-nonassessable~~ PARTICIPATING PHYSICIANS ARE NOT SUBJECT TO ASSESSMENT. In order to maintain the primary pool of funds, the following annual surcharges must be levied against physicians qualified under [section ~~16~~ 15]:

(a) (i) for coverage from the primary pool of funds from $100,000 per occurrence and $300,000 in the annual aggregate up to $1 million per occurrence and $3 million in the annual aggregate for all claims made during the policy period of the qualifying physician's primary policy of insurance required by [sections 1 through ~~26~~ 24] and pursuant to that primary policy, as to physicians insured for purposes of at least some obstetrical privileges with an insurer authorized under [sections 1 through ~~26~~ 24]:

~~(A)--as--a--family-practitioner,-an-annual-surcharge-of $6,313;~~

~~(B)--as--an--obstetrician,--an--annual---surcharge---of $13,141~~, AN ANNUAL SURCHARGE THAT WILL KEEP THE PRIMARY POOL OF FUNDS ACTUARIALLY SOUND. THE STATUTORY LIMITATIONS AND REQUIREMENTS ON RATE CHANGES BY PRIMARY MEDICAL MALPRACTICE CARRIERS APPLY TO THE DETERMINATION OF SURCHARGES;

(ii) an annual surcharge, separately and additionally paid by any professional service corporation, partnership, or other business entity and its employees desiring to qualify as physicians under [sections 1 through ~~26~~ 24] in the same manner as charges are levied by the carrier providing primary coverage, at a rate to be determined by the actuary hired by the administrator;

(b) for each physician subject to the terms of [sections 1 through ~~26~~ 24] who, after January 1, 1990, has an adverse ruling as to any medical malpractice claim by the Montana medical legal panel or a judgment or settlement as to a claim in excess of $25,000 and less than $50,000, the one-time sum of $500 because of the claim. If the amount of the judgment or settlement as to the claim is $50,000 or more, the one-time sum of $1,000 because of the claim. Any insurer required to report to the board pursuant to 37-3-402 shall also provide the report to the administrator and shall include in the report the amount of each settlement or judgment for each physician for whom a report is made. The certificate of authority of the insurer must be suspended by the commissioner pursuant to 33-2-119 if the reports are not provided to the administrator as required by 37-3-402 or within a reasonable time thereafter.

(c) after January 1, 1990, $5 from each physician subject to the provisions of [sections 1 through ~~26~~ 24] for

each baby delivered by that physician and $5 from each hospital for each baby delivered at the hospital. As a basis for the surcharge, by January 31, 1991, and on January 31 each year thereafter, each physician and each hospital shall report to the administrator the number of babies delivered by them during the preceding calendar year.

~~(3)--Beginning with the first year of operation of [sections 1 through 26], the annual surcharges for physicians provided for in subsection (2)(a) are subject to annual adjustment by the administrator, based upon requirements for the actuarial soundness of the primary pool of funds, under the same limitations and with the same requirements as a rate change undertaken by the primary carrier of the physician.~~

~~(4)~~(3) The first annual surcharge for physicians provided for in this section must be collected by the Montana medical legal panel pursuant to 27-6-206 or within 30 days of [the effective date of this act], whichever occurs later. Beginning in 1990 and in each year thereafter, all subsequent annual surcharges for physicians provided for in this section and beginning in 1991, all surcharges provided for physicians in subsection (2)(b) and for physicians and hospitals in subsection (2)(c) must be collected by the Montana medical legal panel pursuant to 27-6-206. All collections must be remitted to the

department within 14 days of receipt.

~~(5)--The one-time refundable surcharges for casualty insurance carriers provided for in this section must be collected by the commissioner on March 1, 1989, pursuant to 33-2-705 without deferral or installment or within 30 days of [the effective date of this act], whichever occurs later. The surcharge must be remitted to the department by the commissioner within 14 days of receipt, and if the surcharge is not timely paid as provided in this section, the certificate of authority of the insurer must be suspended by the commissioner pursuant to 33-2-119 until the surcharge is paid.~~ THE ONE-TIME REFUNDABLE SURCHARGE FOR PROPERTY AND CASUALTY INSURANCE CARRIERS PROVIDED FOR IN THIS SECTION MUST BE COLLECTED BY THE COMMISSIONER ON MARCH 1, 1989, UNDER 33-2-705 WITHOUT DEFERRAL OR INSTALLMENT OR WITHIN 30 DAYS OF [THE EFFECTIVE DATE OF THIS ACT], WHICHEVER OCCURS LATER. THE SURCHARGE MUST BE REMITTED TO THE DEPARTMENT BY THE COMMISSIONER WITHIN 14 DAYS OF RECEIPT, AND IF THE SURCHARGE IS NOT TIMELY PAID AS PROVIDED IN THIS SECTION, THE CERTIFICATE OF AUTHORITY OF THE INSURER MUST BE SUSPENDED BY THE COMMISSIONER UNDER 33-2-119 UNTIL THE SURCHARGE IS PAID.

~~(6)~~(4) The secondary pool of funds must be maintained solely through the surcharges on physicians and hospitals pursuant to subsections (2)(b) and (2)(c), distribution from

excess surplus pursuant to [section 10], the collection of designated premium equivalents pursuant to [section ~~24~~ 22], and the revenues from any other source dedicated to the purposes of the secondary pool of funds.

NEW SECTION. **Section 8. Actuarial soundness of primary pool of funds.** (1) The fund's primary pool of funds must be maintained on an actuarially sound basis and may not become operational until a statement is prepared by an actuary, hired by the administrator, who is a member of the American academy of actuaries or the casualty actuarial society certifying that the primary pool of funds is expected to be actuarially sound.

(2) If the primary pool of funds would at any time be rendered insolvent by payment of all fixed and known obligations that will become final within 2 years from that time, the amount of future noneconomic damages payable within that calendar year must be prorated among existing claimants at the time of the determination in a manner sufficient to eliminate or reduce the insolvent circumstance to the extent possible. Any amount due and unpaid at the end of the 2-year period must be paid in the following 1-year period, WITH INTEREST AT THE JUDGMENT RATE FROM THE TIME OF DEFERRAL UNTIL PAYMENT, and must be paid before the obligations FOR ADMINISTRATION OF THE PRIMARY POOL AND FOR NONECONOMIC DAMAGES that become final during that year may

be paid. THE ADMINISTRATOR SHALL INCREASE THE ANNUAL SURCHARGE FOR THE PRIMARY POOL IN ORDER TO ENSURE THAT PRORATION OF NONECONOMIC DAMAGES DOES NOT OCCUR FOR MORE THAN 3 YEARS.

NEW SECTION. **Section 9. Staff.** The administrator, using money from the fund as considered necessary, appropriate, or desirable by the department, may purchase the services of persons, firms, and corporations to aid in protecting the fund against claims, fully administering [sections 1 through ~~26~~ 24], determining the actuarial soundness of the primary pool of funds, and determining the return of savings to persons and entities paying any portion of the original capitalization of the primary pool of funds~~, as well as for making recommendations to subsequent legislative sessions~~.

NEW SECTION. **Section 10. Return of savings.** (1) On July 1, 1993, and on July 1 of each year thereafter, if the primary pool of funds is actuarially sound, all surplus in the primary pool of funds in excess of $1 million over the sum of the amount necessary to make that fund actuarially sound ~~and the amount of the original annual surcharge set by [sections 1 through 26] times the number of qualified~~ physicians must be distributed equally among BETWEEN:

(a) ~~the casualty insurance carriers who have paid surcharges into the primary pool of funds, pro rata and~~

proportionate-to-their-original--contributions THE--GENERAL FUND,--AS-REPAYMENT-OF-AMOUNTS-WITHDRAWN-UNDER-THE-TEMPORARY LINE-OF-CREDIT THE PROPERTY AND CASUALTY INSURANCE CARRIERS WHO HAVE PAID A SURCHARGE INTO THE PRIMARY POOL OF FUNDS, PRO RATA AND PROPORTIONATE TO THEIR ORIGINAL CONTRIBUTIONS, until such contributions AMOUNTS CONTRIBUTIONS have been repaid; and

(b) the secondary pool of funds.

(2) The administrator, upon receipt of capital contributions pursuant to [sections 1 through 26 24], shall issue the person or entity paying the capital contribution a certificate representing the contribution and containing the terms of repayment, if any. The collection of capital contributions or the prospects of a return of savings may not be considered to be an unregistered investment contract or otherwise require registration as a security under the securities laws of Montana.

NEW SECTION. **Section 11.** Reinsurance authority. The fund has-the-power-to SHALL negotiate for, contract for, and purchase reinsurance,---subject--to--the--control--of--the department.

NEW SECTION. **Section 12.** Claims for payment. Except as otherwise provided in [sections 8(2) and 24 22],

(1), claims for payment from the primary or secondary pool of funds that become final during-the-first-6-months-of

the-calendar-year-must-be-computed-on-June-30--and--must--be paid-no-later-than-the-following-July-15;-and

(2)--claims--for--payment-from-the-primary-or-secondary pool-of-funds-that-become-final-during-the-last-6-months--of the--calendar--year-must-be-computed-on-December-31-and-must be-paid-no-later-than-the-following-January-15 MUST BE PAID WITHIN 30 DAYS.

NEW SECTION. **Section 13.** Claims against fund -- procedure. (1) The department shall issue a warrant in the amount of each claim, in the manner required for payment under [sections 1 through 26 24], submitted to it against the primary OR SECONDARY pool of funds on June-30-and December-31-of-each-year THE FIRST DAY OF THE FOLLOWING MONTH.

(2) The--only-claim-against A PAYMENT FROM the primary pool of funds must MAY be MADE ONLY UPON a voucher or other appropriate request by the administrator, submitted along with:

(a) a certified copy of a final judgment against the fund; or

(b) a duplicate original of a settlement entered into by the administrator on behalf of the primary pool of funds involving a physician qualified under the terms of [sections 1 through 26 24].

(3) The---only---claim--against A PAYMENT FROM the

secondary pool of funds ~~must~~ MAY be MADE ONLY UPON a voucher or other appropriate request by the administrator, submitted along with:

(a) a certified copy of a final judgment OR AWARD of entitlement to the benefits of [section ~~24~~ 22]; or

(b) a ~~certified copy of a settlement for the benefits of [section 24] approved by the Montana medical legal panel~~ DUPLICATE ORIGINAL OF A SETTLEMENT ENTERED INTO BY THE ADMINISTRATOR ON BEHALF OF THE SECONDARY POOL OF FUNDS.

NEW SECTION. **Section 14.** **Payment from primary pool of funds after exhaustion of insurance coverage -- excess claims -- procedure.** (1) If a physician qualified under [sections 1 through ~~26~~ 24] or his insurer ~~as~~ UNDER INSURANCE required by [section ~~16~~ 15] has agreed to settle liability on a claim by payment of its policy limits and the claimant is demanding an amount in excess of the policy limits or if the annual aggregate under the insurance for the physician has been paid by or on behalf of the physician, the claimant shall notify the administrator ~~in the manner provided in subsection (2) and receive a reply from the administrator as a condition precedent to recovery from the primary pool of funds.~~

(2) The claimant shall provide the administrator in writing~~, postage prepaid by certified mail,~~ a short and plain statement of the nature of the claim and the

additional amount for which the claimant will settle. ~~The statement must include, separately stated, the amounts previously paid and the additional amounts demanded with respect to the damages as a whole without regard to any previous payment. The statement must also include:~~

~~(a) the amount of any past damages, itemized as to economic and noneconomic damages; and~~

~~(b) any future damages and the periods over which they will accrue, on an annual basis, for each of the following types:~~

~~(i) medical and other costs of health care;~~

~~(ii) other economic loss; and~~

~~(iii) noneconomic loss.~~

~~(3) The calculation of future damages under subsection (2) must be based on the costs and losses during the period of time the claimant will sustain those costs and losses unless a claim of wrongful death is involved. In wrongful death claims, future damages must be based on the losses during the period of time the injured party would have lived but for the injury upon which the claim is based, and the claimed future damages must be expressed in current values without regard to future changes in the earning power or purchasing power of the dollar.~~

~~(4) If a claim of wrongful death is not involved, the statement under subsection (2) must state the claimed~~

~~severity of the injury and whether the injury is limited to mental or emotional harm or involves physical harm. If the injury involves physical harm, the claimant shall state whether the physical harm includes bodily impairment or disfigurement.~~

~~(5) The statement under subsection (2) must also specify what percentage of the claimed damages are alleged to be the responsibility of each physician against whom a claim is made.~~

~~(6) If, within 30 days after receipt of the statement, the administrator has not accepted the offer of settlement in writing, the claimant may proceed with any claim against the physician. The patient assured compensation fund must be named as a necessary and proper party in any state or federal court proceeding for all causes of action arising after [the effective date of this act].~~

~~(7) (a) The statute of limitations with respect to any medical malpractice claim against a qualified physician under [sections 1 through 26] is tolled by the deposit in the United States mail of the writing required by this section and does not begin to run again until the greater of:~~

~~(i) 30 days after mailing; or~~

~~(ii) the running of the applicable limitation period under 27-6-702.~~

~~(b) The time period of tolling is not computed as part of the period within which the action may be brought.~~

~~NEW SECTION. Section 15. Discharge of obligation to pay amount from funds. The obligation to pay an amount from the primary or secondary pool of funds may be discharged, unless otherwise required or permitted by law, through:~~

~~(1) payment in one lump sum for accrued damages;~~

~~(2) an agreement requiring periodic payments from the primary or secondary pool of funds over a period of years;~~

~~(3) the purchase of an annuity payable to the claimant, with the administrator having the power to contract with those insurers permitted under 25-9-403(4); or~~

~~(4) any combination of the payment plans in subsections (1) through (3).~~

NEW SECTION. **Section 15.** Qualifications for physician. (1) In order to become and remain qualified under the provisions of [sections 1 through ~~26~~ 24], in addition to the procedures established by the department for regulation of application for qualification, a physician must:

(a) pay all surcharges required by [sections 1 through ~~26~~ 24] in a timely manner;

(b) at the time of qualification, irrevocably agree in writing to be bound by the results of any arbitration provided for in [section ~~24~~ 22];

(c) (i) if acting as an individual physician, be

insured and continue to be insured by an authorized insurer under a valid and collectible policy of medical liability insurance in at least the amounts required by subsection (2), for purposes of at least some obstetrical privileges as an obstetrician or as a family practitioner; or

(ii) if a member of a professional service corporation, partnership, or other business entity desiring to qualify as a physician, ~~have one or more~~ BE A MEMBER OF ONE THAT HAS MORE THAN 50% OF THE members of the business entity insured as an obstetrician or as a family practitioner with some obstetrical privileges;

(d) establish proof of qualifying coverage for lower limits and proof of specialty.

(2) Proof under subsection (1) may be established by the physician's insurance carrier annually filing with the administrator proof that the physician is insured by a policy of malpractice liability insurance in the amount of at least $100,000 per occurrence and $300,000 in the annual aggregate for all claims made during the policy period, along with the specialty under which such policy was issued. ~~Any insurer offering such a policy may offer a policy with deductible options of up to one-half of the limits.~~ The administrator may require a professional corporation seeking to qualify to provide information necessary to determine if the corporation is eligible as a physician.

NEW SECTION. **Section 16.** **Failure of physician to qualify for change of coverage -- limits of liability of fund -- rights and duties of physician.** (1) A physician who fails to qualify under [sections 1 through ~~26~~ 24] or who becomes disqualified is not covered by the provisions of [sections 1 through ~~26~~ 24] after the date of disqualification and is subject to liability under the law without regard to the provisions of [sections 1 through ~~26~~ 24], EXCEPT FOR CLAIMS MADE WHILE THE PHYSICIAN WAS QUALIFIED. If a physician does not qualify, the claimant's remedy will not be affected by the terms and provisions of [sections 1 through ~~26~~ 24]. The primary pool of funds is not liable for any amounts up to the limits of qualifying coverage of a physician established in [section ~~16~~ 15]. The secondary pool of funds is liable only up to the amounts contained in that fund in the manner provided in [section ~~24~~ 22].

(2) Within 14 business days of receipt of the information required for qualification of a physician, the administrator shall notify the physician whether the physician is qualified, and if so, the date he became qualified.

(3) The primary pool of funds is not liable for any amounts until the limits of the qualifying coverage for lower limits of the physician have been paid or are payable

and then only above those limits of coverage. The maximum liability of the primary pool of funds is $1 million per occurrence and $3 million in the annual aggregate AS TO EACH QUALIFIED PHYSICIAN for all claims made during the policy period of the coverage for lower limits. The claimant's remedy for amounts over the limits of the primary pool of funds are not affected by the terms and provisions of [sections 1 through ~~26~~ 24], except as otherwise provided.

(4) Except as otherwise provided in [sections 1 through ~~26~~ 24], the rights and duties of a physician qualifying under [sections 1 through ~~26~~ 24], including but not limited to the nature, extent, and limits of coverage of the primary pool of funds, are the same as the rights and duties of that physician under his qualifying coverage for lower limits, including but not limited to all exceptions, exclusions, and endorsements to the lower limits of coverage.

(5) Failure to maintain levels of coverage required under this section or nonrenewal, cancellation, or the elimination of obstetrical coverage for lower limits of coverage ~~constitute~~ CONSTITUTES disqualification of the physician under the terms of [sections 1 through ~~26~~ 24] when the changes become effective with respect to the lower limits of coverage, if at all. The carrier providing lower limits of coverage shall promptly notify the administrator

of changes in coverage pertinent to this section in the same manner as required of notice to insureds.

~~(6)--Notwithstanding-any-other-provision-of-[sections-1 through-26],-if-the-administrator-determines--that,--due--to the--number--and--dollar--exposure-of-claims-filed-against-a physician-qualified--under--[sections--1--through--26],--the physician--presents--a--material--risk-of-significant-future liability-to-the--fund,--the--administrator--is--authorized, after--notice--and--an-opportunity-for-hearing,-to-terminate the-liability--of--the--fund--for--all--claims--against--the physician.~~

~~(7)~~(6) Except as otherwise provided in [sections 1 through ~~26~~ 24], Title 33 has no application to [sections 1 through ~~26~~ 24]. The following provisions of Title 33 apply to [sections 1 through ~~26~~ 24]: 33-15-411; 33-15-504; 33-15-1101 through 33-15-1121; Title 33, chapter 18; Title 33, chapter 19; 33-23-301; and 33-23-302.

NEW SECTION. **Section 17.** **Adequate defense of fund -- notification as to reserves.** The administrator may provide for the defense of the primary and secondary pool of funds against a claimant's claim ~~and-may-appeal-a-judgment-which affects--the--funds~~. The physician or his insurer for qualifying coverage for lower limits shall provide an adequate defense to the claim and is in a fiduciary relationship with the primary or secondary pool of funds

with respect to any claim. Any carrier representing a physician subject to [sections 1 through ~~26~~ 24] shall immediately notify the administrator of any case upon which it has placed a reserve of $50,000 or more.

NEW SECTION. **Section 18.** **Primary pool of funds not liable for punitive damages.** The primary pool of funds is not liable for punitive or exemplary damages of any kind. This section does not relieve the liability of a physician for punitive or exemplary damages.

NEW SECTION. **Section 19.** **Appointment and recommendations of obstetrical advisory council.** (1) The department shall appoint an obstetrical advisory council, subject to the approval of the governor, composed of seven people, ~~five~~ FOUR of whom must be physicians qualified under [sections 1 through ~~26~~ 24]. ~~The~~ EXPENSES FOR TRAVEL AND LODGING AND THE ADMINISTRATION OF THE council must be funded from the primary pool of funds, and members must be appointed for 4-year terms. A vacancy must be filled for the unexpired portion of the term in the same manner as the original appointment.

(2) The council shall make recommendations regarding:

(a) prenatal and postnatal care, including but not limited to better access to comprehensive obstetrical services, improved professional competency, and peer review and quality assurance in connection with prenatal care,

labor, delivery, immediate care of the newborn, and care of the postpartum woman;

(b) risk prevention and other quality of care;

(c) designated compensable events, for which compensation should in all instances be paid, to be included in [section ~~24~~ 22];

(d) economic and noneconomic damage schedules which should be included in [sections 1 through ~~26~~ 24]; and

(e) the proper implementation or correction of [sections 1 through ~~26~~ 24] as the council considers appropriate, pursuant to guidelines provided by the administrator.

NEW SECTION. **Section 20.** **Disciplinary action against physicians.** After [the effective date of this act], upon the receipt by the board of information from the reports required by 33-23-311(3), 37-3-402, this section, or any other source that a physician has had three or more medical malpractice claims where a Montana medical legal panel result was adverse or indemnity has been paid or is payable in excess of the amount of $10,000 for each claim within the previous 5-year period, the board shall investigate the occurrences upon which the claims were based. The board shall determine if action by the board against the physician is warranted UNDER 37-3-323 THROUGH 37-3-328 AND MAY TAKE ACTION UNDER THOSE SECTIONS. In 1995 and annually

thereafter, the board shall publish a summary of action taken or not taken on claims pursuant to this section. The summary may not identify individual physicians. The summary is in addition to any other requirements of the law and may not limit the obligations otherwise required by law.

NEW SECTION. **Section 22.** Predictability of damages. In a trial in district court of any medical malpractice action for damages for injury not including wrongful death where the patient assured compensation fund is a party to the action, the court shall:

(1) upon proper motion of any party subsequent to verdict and before entry of judgment, review an award against any party for noneconomic damages to determine whether the award is clearly excessive or inadequate. If the award is not in substantial accord with a proper award of damages after considering the factors in subsection (2), the court shall, acting with caution and discretion, modify the award in a manner reasonably consistent with that subsection, unless there is clear and convincing evidence that the interest of justice would not be served by the modification. The court shall give written reasons for a modification or refusal to modify. If the party adversely affected by any modification objects, the court shall order a new trial on the issue of noneconomic damages only. Economic damages awarded and the fact of liability are

admissible at the new trial, but factual matters pertaining to liability are not admissible.

(2) In determining whether an award requires modification under subsection (1), consider:

(a) whether the amount awarded indicates prejudice, passion, or corruption on the part of the trier of fact;

(b) whether it clearly appears that the trier of fact ignored the evidence in reaching a verdict or misconceived the merits of the case as to damages recoverable;

(c) whether the trier of fact took improper elements of damages into account or arrived at the amount of damages by speculation and conjecture;

(d) whether the award is reasonably related to the damages proved and the injury suffered pursuant to the guidelines in subsection (3); and

(e) whether the award is supported by the evidence and could be adduced in a logical manner by reasonable persons.

(3) use the guidelines in this subsection in determining whether to modify an award when considering subsection (2)(d). Noneconomic damages are not proportional to the injury received if they exceed the greater of:

(a) weekly wage compensation benefits as computed pursuant to 39-71-701 times the life expectancy in weeks; or

(b) the multiple of economic damages awarded by the jury, pursuant to the severity of the injury as determined

~~by-the-finder-of-fact-as-properly-shown-by-the-evidence--for purposes-of-calculation,-as-follows:~~

~~(i)--for--mental--or-emotional-harm-only:-0.5-times-the amount-of-economic--damages--or--$1--million,--whichever--is greater;~~

~~(ii)-for--physical--harm--without--bodily-impairment-or disfigurement:-an-amount-equal-to--the--amount--of--economic damages-or-$2-million,-whichever-is-greater;~~

~~(iii)-for-bodily-impairment-or-disfigurement:-1.5-times the--amount--of-economic-damages-or-$3-million,-whichever-is greater.~~

NEW SECTION. **Section 21.** Contractual right to extended reporting endorsements -- prior acts coverage. (1) Each physician qualified under [sections 1 through ~~26~~ 24] has the contractual right, on the same terms and conditions as that physician has under the qualifying lower limits of coverage, if any, to obtain an extended reporting endorsement for coverage by the primary pool of funds for claims for medical malpractice that occur during the time a physician was qualified under [sections 1 through ~~26~~ 24] but that are reported after the physician ceases to be qualified.

(2) The cost of the purchase of an extended reporting endorsement paid by the physician to the fund is equal to a multiple of the current annual surcharge under [section 7].

The multiple is the lesser of the multiple being charged under the qualifying lower limits of coverage at that time or the multiple determined by the fund's actuary.

(3) Prior acts and omissions coverage, provided to the qualified physician upon qualification for coverage by the primary pool of funds for claims that have occurred but have not been made, must be provided only as to claims that are also covered under the terms of a valid and collectible primary policy of insurance coverage carried by the physician, qualified as required by [sections 1 through ~~26~~ 24] and any endorsements to the policy. Prior acts and omissions coverage from the fund is subject to the following exclusions and limitations in addition to those contained in [sections 1 through ~~26~~ 24]:

(a) The fund may not provide coverage for any liability to any qualified physician with respect to:

(i) any claim made against a physician qualified under [sections 1 through ~~26~~ 24] at any time prior to the date of qualification, regardless of whether or not the claim has been reported to any liability insurer; or

(ii) any potential claim against any qualified physician of which any physician is aware or reasonably should have been aware as of the date of qualification, regardless of whether or not the claim has yet been made or reported to any liability insurer. For purposes of this

subsection, a potential claim includes but is not limited to instances where any insured has received an oral or written communication from a legal representative of a patient or a request by or on behalf of a patient for copies of medical records under circumstances reasonably indicative of a potential claim.

(b) The limits of liability of the fund for prior acts claims is the lesser of the limits of liability of the primary pool of funds under [sections 1 through ~~26~~ 24] or the limits of liability of any valid and collectible liability insurance carried by the qualified physician prior to qualification.

NEW SECTION. **Section 22.** **Compensation for injuries from medical intervention without regard to fault.** (1) The purpose of this section is to establish a system of prompt, efficient, and equitable compensation for certain economic damages and attorney fees to those claimants injured through medical intervention in the birthing process or obstetrical care, without regard to negligence of the physician. ~~This section applies only if the patient opts on a voluntary basis to pay a designated premium equivalent and later signs an arbitration agreement to arbitrate the claim before the Montana medical legal panel.~~

(2) ~~Each physician shall disclose to each patient, at~~ AT the time of any initial medical treatment BY A

PARTICIPATING PHYSICIAN related to the birthing process or obstetrical care, ~~the amount of funds on hand in the secondary pool of funds and the designated premium equivalent that will be contained in the fees to be charged by giving the form provided by the administrator to the~~ patient IS ELIGIBLE TO PARTICIPATE IN THE SECONDARY POOL AND BECOMES LIABLE FOR THE PAYMENT OF A DESIGNATED PREMIUM EQUIVALENT. The initial amount of the designated premium equivalent is $25~~. The amount~~, IS NONREFUNDABLE, AND is subject to change by the department, by rule, after consideration of the recommendations of the obstetrical advisory council. ~~The administrator shall regularly keep the physicians advised of the amount of money in the secondary pool of funds.~~

(3) Each patient, at the time ~~the patient is provided the form required in subsection (2), must be given an opportunity not to participate in the secondary pool of funds and to have the designated premium equivalent deducted from the fees to be charged~~ OF INITIAL MEDICAL TREATMENT RELATED TO THE BIRTHING PROCESS OR OBSTETRICAL CARE, MUST BE INFORMED BY THE PHYSICIAN OF THE PROVISIONS OF SUBSECTION (2) AND THIS SUBSECTION. THE PHYSICIAN SHALL AT THAT TIME GIVE THE PATIENT A PAMPHLET THAT CLEARLY AND ADEQUATELY DESCRIBES THE PROVISIONS OF [SECTIONS 1 THROUGH 24] AND ADVISES THE PATIENT TO CONTACT AN ATTORNEY IF THE PATIENT

BELIEVES THE PATIENT HAS A MALPRACTICE CLAIM RELATED TO THE BIRTHING PROCESS OR OBSTETRICAL CARE. THE PAMPHLET MUST BE WRITTEN BY THE STATE BAR OF MONTANA, AND THE PRIMARY POOL SHALL PAY THE COST OF PUBLISHING AND DISTRIBUTING THE PAMPHLET. THE PHYSICIAN SHALL ADD THE DESIGNATED PREMIUM EQUIVALENT TO THE FIRST BILL SENT TO THE PATIENT AND INFORM THE PATIENT AT THE TIME OF THE INITIAL MEDICAL TREATMENT THAT THE AMOUNT WILL BE ADDED TO THE BILL. If the patient cannot afford the premium ~~and wishes to participate in the secondary pool of funds~~, the patient shall deliver a signed letter to the physician to that effect and the premium must be waived. The designated premium equivalent must also be waived if prohibited by federal law.

~~(4) If the patient wishes to participate in the secondary pool of funds:~~

~~(a)~~ ~~prior to any claim of injury and prior to any known complications of delivery or pregnancy,~~ the THE physician shall immediately, WITHIN 30 DAYS OF THE TIME OF INITIAL MEDICAL TREATMENT, remit to the department the amount of any required designated premium equivalent or the letter from the patient stating an inability to pay the premium. ~~Failure of the patient to pay or provide the letter disqualifies the patient from any participation in the secondary pool of funds.~~

~~(b)~~ ~~subsequent~~ SUBSEQUENT to any claim of injury and

subsequent to any known complications of delivery or pregnancy, the patient ~~shall~~ MAY provide the physician with an agreement to arbitrate a claim arising out of the birthing process or obstetrical care, on a form provided by the administrator. The physician and the patient or the patient's representative shall execute the agreement to arbitrate the claim. ~~Upon approval by the administrator, the agreement is binding upon the patient, the patient's representative, any claimant, and the physician for purposes of a claim for required benefits for compensable injuries under [sections 1 through 26]. An executed copy of the agreement to arbitrate must be provided to the administrator and is subject to his approval as to form and content before it may become effective.~~

(5) A claim for recovery of required benefits must be filed pursuant to the provisions of Title 27, chapter 6, naming the secondary pool of funds a party, with that chapter and its rules of procedure being applicable to the secondary pool of funds as if it were a health care provider. The claim is governed by Title 27, chapter 6, as if it were a malpractice claim. THE ARBITRATION PANEL MUST BE COMPOSED OF AN ATTORNEY, A PHYSICIAN, AND A PROFESSIONAL ARBITRATOR. THE PROFESSIONAL ARBITRATOR MUST BE KNOWLEDGEABLE IN WORKERS' COMPENSATION LAW AND IS THE CHAIRMAN OF THE PANEL. The arbitration agreement of the

parties constitutes a request for recommendation of an award, and the recommended award constitutes an approved settlement agreement pursuant to 27-6-606 and an award pursuant to Title 27, chapter 5.

(6) (a) Except as provided in subsection (6)(b), Title 27, chapter 5, applies to the claim and any award.

(b) The provisions of 27-5-211 through 27-5-218 do not apply to the claim, and any conflict between Title 27, chapter 5, and Title 27, chapter 6, must be resolved in favor of the latter.

(7) The filing of a claim for recovery before the Montana medical legal panel under the arbitration agreement~~, unless the arbitration agreement has been revoked in writing by the patient prior to filing of the claim~~, constitutes:

(a) a valid and binding agreement that the sole matter in controversy is whether there is a compensable injury and, if so, the amount of required benefits available as compensation;

(b) a waiver of trial by jury or the court; and

(c) the sole and exclusive remedy for:

(i) any malpractice claim against a physician qualified under [sections 1 through ~~26~~ 24] ~~or a hospital~~; or

(ii) a claim for required benefits for a compensable injury by the patient~~, his heirs or representatives, or his parents or next of kin, or any other person whose claim is derivative from the incident~~.

(8) ~~The~~ IF A CLAIM HAS NOT BEEN FILED UNDER SUBSECTION (7), THE filing of a malpractice claim in federal court or pursuant to Title 27, chapter 6, against one or more physicians subject to [sections 1 through ~~26~~ 24] constitutes a revocation in writing of the arbitration agreement provided for in this section ~~if the claim represents that the claimant has been fully advised in writing by legal counsel of the options available under [sections 1 through 26] and a true and correct copy of the writing is attached to the claim. If the claimant is not represented by counsel in a Montana medical legal panel proceeding, the administrator shall provide the advice in writing and the claimant shall make a written binding election to proceed with the malpractice claim or to amend the claim for recovery under an arbitration agreement obtained pursuant to subsection (6). The written advice and election must be filed with the Montana medical legal panel~~.

(9) Claims for required benefits for a compensable injury under a valid arbitration agreement are limited to required benefits and only required benefits may be paid for a compensable injury.

(10) (a) Required benefits under this section are~~: limited to the following items as computed under [sections 1 through 26]~~:

~~(i)--medical--and--hospital-expenses-and-future-medical and-hospital-expenses-as-incurred,-computed-and-paid-in--the manner-provided-in-39-71-704-and-the-rules-implementing-that section;~~

~~(ii)-lost---earnings---and---future--lost--earnings--as incurred,-computed,-and--paid--in--the--manner--provided--in 39-71-701(1)--and--according--to--the--definition-of-average weekly-wage-in-39-71-116-and-the--rules--implementing--those sections;-and~~

~~(iii)-reasonable--attorney--fees-for-panel-proceedings, computed-and-paid--in--the--manner--provided--in--39-71-613, 39-71-614,-and-the-rules-implementing-those-sections.~~

(I) MEDICAL, PARAMEDICAL, AND HOSPITAL EXPENSES INCURRED TO THE DATE OF THE AWARD;

(II) FUTURE MEDICAL, PARAMEDICAL, AND HOSPITAL EXPENSES, COMPUTED IN THE MANNER PROVIDED IN 39-71-704 AND RULES IMPLEMENTING THAT SECTION;

(III) A SUM EQUAL TO ONE AND ONE-HALF TIMES THE STATE'S AVERAGE WEEKLY WAGE FOR THE PERIOD OF THE DISABILITY; AND

(IV) REASONABLE ATTORNEY FEES INCURRED IN BRINGING THE CLAIM BEFORE THE ARBITRATION PANEL, NOT TO EXCEED $125 PER HOUR.

(b) Required benefits do not include medical and hospital expenses for items or services or reimbursement the patient received ~~or-is-entitled-to-receive~~ under the laws of

any state or the federal government, except to the extent exclusion of such benefits is prohibited by federal law, or expenses paid by any prepaid health plan, health maintenance organization, or private insuring entity or pursuant to the provisions of any health or sickness insurance policy or other private insurance program.

~~(c)--Proceeds---to---beneficiaries,---as---defined---in 39-71-116,-must-be-determined--pursuant--to--39-71-723,--and lump-sum-payments-for-future-benefits-are-prohibited.~~

(11) All awards must be paid from the secondary pool of funds on ~~an--annual~~ A MONTHLY basis for required benefits that have accrued and pursuant to Title 25, chapter 9, part 4, for future required benefits, and that part applies in all instances to claims for required benefits except as otherwise provided in this section and to the extent the secondary pool of funds has sufficient funds for payments without becoming actuarially unsound. If the secondary pool of funds has insufficient funds with which to pay an award or awards, payments must be made in the same manner, pro rata as to all claims against the secondary pool of funds at the time of the required payment. The unpaid amounts of any award constitute a future obligation of the secondary pool of funds as funds become available. The future obligation is not enforceable by any process of law other than pursuant to the terms of this section.

(12) All costs of administration of the secondary pool of funds must be paid from the secondary pool of funds, and the costs of administration must be paid prior to the payment of any required benefits or required obligations of the secondary pool of funds provided elsewhere in [sections 1 through ~~26~~ 24]. If the secondary pool of funds is insufficient to pay the costs of administration of the secondary pool or any attorney fees required to be paid by the secondary pool, the administrator is authorized to loan the secondary pool sufficient funds for the administration or fee from the primary pool of funds if the loan would not render the primary pool actuarially unsound. The loan is an advance against future distributions pursuant to [section 10] and in lieu of the distributions. The loan plus interest must be repaid to the primary pool of funds upon the future distribution otherwise accruing.

(13) The arbitration agreement form promulgated by the department must include on its face a written notice of the substance of subsections ~~(9)~~ and (7) THROUGH (10) in red, 10-point type.

(14) The period prescribed for the commencement of an action for relief under this section is ~~within 1 year of the date of injury~~ THE PERIOD PROVIDED IN 27-2-205.

NEW SECTION. **Section 23.** Tax exemption. The fund is exempt from payment of all fees and all taxes levied by this

state or any of its subdivisions.

NEW SECTION. **Section 24.** Review. The administrator shall report IN WRITING to each REGULAR session of the legislature concerning the effectiveness of [sections 1 through ~~26~~ 24] in achieving the stated goals and concerning other matters of importance. The status and operation of the fund must be included in that report.

Section 25. Section 27-6-105, MCA, is amended to read:

"**27-6-105. What claims panel to review.** The panel shall review all malpractice claims or potential claims against health care providers covered by this chapter, except including those claims subject to a valid arbitration agreement allowed by law ~~or upon which suit has been filed prior to April 19, 1977~~."

Section 26. Section 27-6-602, MCA, is amended to read:

"**27-6-602. Questions panel must decide.** (1) Upon consideration of all the relevant material, the panel shall decide whether there is:

~~(1)~~(a) substantial evidence that the acts complained of occurred and that they constitute malpractice; and

~~(2)~~(b) a reasonable medical probability that the patient was injured thereby.

(2) If ~~the panel decides that the acts complained of did not constitute medical malpractice~~ and if there is an arbitration agreement pursuant to [sections 1 through ~~26~~

24], the panel shall decide whether there is a compensable injury pursuant to [sections 1 through ~~26~~ 24], and, if so, make an award pursuant to [section ~~24~~ 22]."

~~Section 29.~~ ~~Section 33-10-102, MCA, is amended to read:~~

~~"33-10-102. Definitions. As used in this part, the following definitions apply:~~

~~(1) "Association" means the Montana insurance guaranty association created under 33-10-103.~~

~~(2) (a) "Covered claim" means an unpaid claim, including one for unearned premiums, or a contractual guaranty for an extended reporting endorsement for claims reported after the expiration of the policy period which arises out of and is within the coverage and not in excess of the applicable limits of an insurance policy to which this part applies issued by an insurer, if such insurer becomes an insolvent insurer after July 1, 1971, and:~~

~~(i) the claimant or insured is a resident of this state at the time of the insured event; or~~

~~(ii) the property from which the claim arises is permanently located in this state.~~

~~(b) "Covered claim" shall does not include any amount due a reinsurer, insurer, insurance pool, or underwriting association, as subrogation recoveries or otherwise.~~

~~(3) "Insolvent insurer" means an insurer:~~

~~(a) authorized to transact insurance in this state either at the time the policy was issued or when the insured event occurred; and~~

~~(b) determined to be insolvent by a court of competent jurisdiction.~~

~~(4) "Member insurer" means any person who:~~

~~(a) writes any kind of insurance to which this part applies under 33-10-101(3), including the exchange of reciprocal or interinsurance contracts; and~~

~~(b) is licensed to transact insurance in this state.~~

~~(5) "Net direct written premiums" means direct gross premiums written in this state on insurance policies to which this part applies, less return premiums thereon and dividends paid or credited to policyholders on such direct business. "Net direct written premiums" does not include premiums on contracts between insurers or reinsurers.~~

~~(6) "Person" means any individual, corporation, partnership, association, or voluntary organization."~~

Section 27. Section 33-23-311, MCA, is amended to read:

"33-23-311. Information required of professional liability insurers -- submission. (1) For purposes of this section, "profession" means the occupations engaged in by physicians, osteopaths, registered nurses, licensed practical nurses, dentists, optometrists, podiatrists,

chiropractors, hospitals, attorneys, certified public accountants, public accountants, architects, veterinarians, pharmacists, and professional engineers.

(2) Each insurance company engaged in issuing professional liability insurance in the state of Montana shall include the following information, by profession, from its experience in the state of Montana, in its annual statement to the commissioner:

(a) the number of insureds as of December 31 of the calendar year next preceding;

(b) the amount of earned premiums paid by the insureds during the calendar year next preceding;

(c) the number of claims made against the insurer's insureds and the number of claims outstanding as of December 31 of the calendar year next preceding;

(d) the number of claims paid by the insurer during the calendar year next preceding and the total monetary amount thereof;

(e) the number of lawsuits filed against the insurer's insureds and the number of insureds included therein during the calendar year next preceding;

(f) the number of lawsuits previously filed against the insurer's insureds which were dismissed without settlement or trial and the number of insureds included therein during the calendar year next preceding;

(g) the number of lawsuits previously filed against the insurer's insureds which were settled without trial, the total monetary amount paid as settlements in such settled cases, and the number of insureds included therein during the calendar year next preceding;

(h) the number of lawsuits against the insurer's insureds which went to trial during the calendar year next preceding and the number of such cases ending in the following:

(i) judgment or verdict for the plaintiff;

(ii) judgment or verdict for the defendant;

(iii) other;

(i) the total monetary amount paid out, in those lawsuits specified in subsection (h);

(j) the total number of the insurer's insureds included in those lawsuits specified in subsection (h);

(k) the number of new trials granted during the calendar year next preceding;

(l) the number of lawsuits pending on appeal as of December 31 of the next preceding calendar year; and

(m) such other information and statistics as the commissioner considers necessary.

(3) The commissioner shall, ~~within 60 days of request~~ by October 1 of each calendar year, submit in writing to the appropriate licensing authority, in summary report form, the

data and information furnished him pursuant to this section relevant to the particular profession, or facility, or class of facilities and shall likewise make the summary available to the public at the expense of the requestor, which data and information must be retained for at least 10 years."

NEW SECTION. **Section 28.** Extension of authority. Any existing authority to make rules on the subject of the provisions of [this act] is extended to the provisions of [this act].

NEW SECTION. **Section 29.** ~~Nonseverability dissolution DISSOLUTION of fund transfer to Montana insurance guaranty association.~~ SEVERABILITY. ~~(1)(a) If any provision of this chapter, any provision of the sections listed in subsection (1)(b), or the application of any one of those provisions to any person or circumstance is held invalid by a decision of the Montana supreme court or the United States supreme court, such invalidity shall render this entire chapter invalid except for this section, whether or not the other provisions or application of this chapter can be given effect without the invalid provision or application.~~

~~(b) The provisions of 25-9-401 through 25-9-405, 25-15-202, 27-1-702, 27-1-703, 27-2-205(2), 28-1-301 through 28-1-303, 28-11-311, and this chapter are not severable.~~

~~(2) (a)~~ (1) ~~The assets and liabilities of the primary pool of funds must be transferred to the Montana insurance guaranty association created under 33-10-103 upon the occurrence of any of the following events:~~

~~(i)~~(A) ~~this chapter~~ ACT being ~~rendered invalid because of one or more of the reasons set forth in subsection (1);~~

~~(ii)~~(B) ~~the primary pool of funds not being maintained on an actuarially sound basis for more than 3 years from the time such soundness is required by this act and the probability that the primary pool of funds will be exhausted by the payment of all fixed and known obligations that will become final within 3 years;~~

~~(b)~~(2) ~~The liabilities of the fund, including coverage endorsements, constitute covered claims as defined in 33-10-102, and the limit of liability of the Montana insurance guaranty association and any physician against whom a claim has occurred or a judgment has been rendered or with whom a settlement agreement has been entered into is equal to the limits of liability of the Montana insurance guaranty association under 33-10-105~~ (1) IF A PART OF [THIS ACT] IS INVALID, ALL VALID PARTS THAT ARE SEVERABLE FROM THE INVALID PART REMAIN IN EFFECT. IF A PART OF [THIS ACT] IS INVALID IN ONE OR MORE OF ITS APPLICATIONS, THE PART REMAINS IN EFFECT IN ALL VALID APPLICATIONS THAT ARE SEVERABLE FROM THE INVALID APPLICATIONS.

HB 0699/03

(2) THE ADMINISTRATOR MAY PETITION THE DISTRICT COURT OF THE FIRST JUDICIAL DISTRICT TO TERMINATE [THIS ACT] IF A PART OR ONE OR MORE APPLICATIONS OF A PART ARE INVALID AND:

(A) THE PRIMARY POOL OF FUNDS CANNOT BE MAINTAINED ON AN ACTUARIALLY SOUND BASIS FOR MORE THAN 3 YEARS FROM THE TIME SUCH SOUNDNESS IS REQUIRED BY [THIS ACT]; OR

(B) THE PRIMARY POOL OF FUNDS WILL BE EXHAUSTED BY THE PAYMENT OF ALL FIXED AND KNOWN OBLIGATIONS.

(3) ALL CLAIMANTS, PARTICIPATING PHYSICIANS, AND HOSPITALS, AS DEFINED IN [THIS ACT], HAVE STANDING TO APPEAR IN ANY COURT PROCEEDING INSTITUTED BY THE ADMINISTRATOR UNDER SUBSECTION (2).

(4) IF THE COURT FINDS THAT THE CONDITIONS DESCRIBED IN EITHER SUBSECTION (2)(A) OR (2)(B), OR BOTH, HAVE OCCURRED, [THIS ACT] TERMINATES. UPON THE ENTRY OF AN ORDER OF TERMINATION THE COURT SHALL DIRECT THE ADMINISTRATOR TO TAKE POSSESSION OF THE ASSETS AND TO ADMINISTER THEM UNDER THE GENERAL SUPERVISION OF THE COURT.

(5) UPON AN ORDER OF TERMINATION, NO PERSON MAY SUBMIT A CLAIM UNDER [THIS ACT]. THE ADMINISTRATOR MAY NOT MAKE PAYMENTS TO CLAIMANTS UNTIL A DISTRIBUTION PLAN IS APPROVED BY THE COURT OR UPON PETITION OF AN INDIVIDUAL CLAIMANT ON THE BASIS OF HARDSHIP AND A SHOWING THAT IN ALL LIKELIHOOD THEY WOULD SHARE IN ANY DISTRIBUTION.

(6) WITHIN 30 DAYS OF THE TERMINATION ORDER THE

ADMINISTRATOR SHALL SUBMIT TO THE COURT A PLAN OF DISTRIBUTION OF THE ASSETS. THE PLAN OF DISTRIBUTION MUST GIVE PRIORITY TO CLAIMANTS AND DISTRIBUTE THE FUNDS IN AN EQUITABLE MANNER.

(7) ALL CLAIMANTS WHO HAVE NOT RECEIVED A FINAL AWARD DETERMINATION BY THE PANEL ON THE DATE [THIS ACT] IS TERMINATED BY COURT ORDER ARE NOT BOUND BY THE PROVISIONS OF [THIS ACT].

NEW SECTION. **Section 30.** Applicability. [This act] applies to all causes of action that constitute medical malpractice claims of any nature, whether obstetrical or otherwise, where the cause of action includes one or more physicians who are qualified pursuant to the terms of [this act] and a claim for coverage exists against the patient assured compensation fund. ~~Provided, however, that [section 22] does not affect rights and duties that matured, penalties that were incurred, or proceedings that were begun before [the effective date of this act] and that section applies, if at all, only to causes of action that accrue on or after the date of qualification of a physician under [this act] against whom such a cause of action accrues.~~

NEW SECTION. **Section 31.** Effective date. [This act] is effective on passage and approval.

-End-

HOUSE BILL NO. 699

INTRODUCED BY ADDY, STICKNEY, CONNELLY, BECK, HALLIGAN

A BILL FOR AN ACT ENTITLED: "AN ACT PROVIDING FOR A PATIENT ASSURED COMPENSATION FUND ABOVE LOW PRIMARY LIMITS OF INSURANCE, FOR THE PAYMENT OF MEDICAL LIABILITY CLAIMS AGAINST PHYSICIANS WHO DELIVER BABIES; PROVIDING FOR THE RETURN OF DOLLAR SAVINGS TO ~~ORIGINAL-CAPITALIZERS-AND-TO~~ PATIENTS WHO ARE INJURED IN THE MEDICAL SYSTEM; PROVIDING FOR AN OBSTETRICAL ADVISORY COMMITTEE TO MAKE RECOMMENDATIONS REGARDING OBSTETRICAL CARE; ~~PROVIDING--FOR OBJECTIVE--GUIDELINES--FOR-NONECONOMIC-DAMAGES-PROPORTIONATE TO-THE-SEVERITY-OF-INJURY-OR--THE--LIFE--EXPECTANCY--OF--THE INJURED--PARTY;~~ PROVIDING FOR VOLUNTARY ENTRY INTO BINDING ARBITRATION FOR OBSTETRICAL CLAIMS WITHOUT REGARD TO NEGLIGENCE OF THE PHYSICIAN; PROVIDING FOR ADMINISTRATION BY THE MONTANA MEDICAL LEGAL PANEL UNDER THE REIMBURSED SUPERVISION OF THE DEPARTMENT OF HEALTH AND ENVIRONMENTAL SCIENCES; PROVIDING FOR CAPITALIZATION BY A ~~PREMIUM-TAX-ON CASUALTY-CARRIERS~~ TEMPORARY LINE OF CREDIT FROM THE GENERAL FUND, WITH THE ADVANCED MONEY TO BE REPAID PREMIUM TAX ON PROPERTY AND CASUALTY CARRIERS TEMPORARY LINE OF CREDIT FROM THE BOARD OF INVESTMENTS, WITH THE ADVANCED MONEY TO BE REPAID; AMENDING SECTIONS 17-6-202, 27-6-105, 27-6-602, ~~33-10-102~~ AND 33-23-311, MCA; AND PROVIDING AN IMMEDIATE EFFECTIVE DATE."

STATEMENT OF INTENT

A statement of intent is required for this bill because it delegates rulemaking authority to the department of health and environmental sciences. This bill is intended to expand the authority of the department and to authorize the writing and adopting of rules in accordance with the Montana Administrative Procedure Act to:

(1) qualify or disqualify physicians for participation in the patient assured compensation fund; and

(2) facilitate the collection of assessments and charges for hospitals and participating physicians under the Patient Assured Compensation Act. This bill is intended to reimburse the department for the cost of writing and adopting the rules.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

NEW SECTION. **Section 1.** Short title. [Sections 1 through ~~26~~ 24] may be cited as the "Patient Assured Compensation Act".

NEW SECTION. **Section 2.** Purpose and goals. (1) The purpose of this legislation is to ~~increase-the--availability~~ of LOWER INSURANCE COSTS FOR PHYSICIANS PROVIDING obstetrical care and TO INCREASE access to that care,

especially in rural areas of Montana, and to maintain the availability and accessibility of obstetrical care in urban areas of Montana.

(2) The goals of this legislation are to:

(a) eliminate from the insurance system any excess insurance money that may be collected because of complex insurance and legal problems related to excess reserves, excess profits, and the use of shared insurance data from states other than Montana;

(b) require the pass through of savings to those who bear the cost for the Patient Assured Compensation Act, including the class of patients and claimants with injuries received in the medical system;

(c) provide ~~more full and fair~~ A NO-FAULT SYSTEM OF compensation to claimants ~~than the current medical insurance legal system does in cases involving physicians who deliver babies;~~

~~(d) provide in advance a reasonable calculation of the actual amounts to be paid in obstetrics related claims so that the funds necessary to pay claims can be properly raised from those who pay for the claims to ensure that damages do not increase exponentially;~~

~~(e)~~(D) provide a funding mechanism that is broader than the available base of funds from obstetricians and family practitioners providing obstetric care by using

sources that have an interest in the maintenance of core industries in rural areas and that have benefited from previous civil justice reform legislation; and

~~(f)~~(E) provide an immediate reduction in the total cost of coverage for medical liability insurance for physicians who deliver babies.

NEW SECTION. **Section 3.** Legislative findings. The legislature finds that:

(1) there has been an accelerating and substantial reduction in available obstetrical services in Montana, especially in the rural areas, and this process is likely to continue unless appropriate steps are taken;

(2) the reduction in obstetrical services constitutes a SEVERE statewide public health AND ECONOMIC problem ~~of a large magnitude and a statewide economic problem of a severe nature;~~

~~(3) in addition to the direct loss of obstetrical services in rural areas of Montana, there have been and will likely continue to be:~~

~~(a) broader adverse economic impacts to the hospitals in those communities, including the closure of some hospitals with resulting adverse impacts on the communities involved, that flow from a loss of a broad range of basic medical services as physicians who deliver babies retire early or leave the community;~~

~~(b)--limitations-on--the--availability--and--access--to obstetrical---care---in---urban---areas,---especially--among lower-income-women,-brought-about-by-increased-pressures--on limited--resources--in-urban-areas-from-women-in-rural-areas who--wish--to--obtain--replacement---obstetrical---services,~~ ESPECIALLY IN RURAL AREAS, THAT MAY WELL CONTINUE UNLESS APPROPRIATE STEPS ARE TAKEN;

~~(4)~~(3) the impacts referred to in ~~subsection--(3)~~ SUBSECTIONS (1) AND (2) are strongly associated with, among other things:

(a) substantial previous increases in the cost of medical liability insurance, a high level of current costs of medical liability insurance, and anticipated increases in the future cost of medical liability insurance to the point where the income from the delivery of babies does not justify the current or future cost of medical liability coverage;

(b) substantial previous increases in the number of PHYSICIANS INVOLVED IN OBSTETRICAL medical liability claims ~~against--physicians,~~ with an increased likelihood that each physician will be periodically involved in a number of legal claims;

(c) inducements for early retirement, relocation to another area, or the elimination or limitation of obstetrical services by doctors who deliver babies;

~~(5)~~(4) the medical-insurance-legal system, because of its unpredictability and high cost, often ~~deprives~~ CAN DEPRIVE the most seriously injured and the least seriously injured of even their out-of-pocket economic damages or provides compensation for intangible damages disproportionate to the severity of the injury or the life expectancy of the injured party.

NEW SECTION. **Section 4.** Definitions. As used in [sections 1 through ~~26~~ 24], the following definitions apply:

(1) "Actuarially sound basis" means that the probability of insolvency of the primary pool of funds has been lowered to a level of risk that is prudent to accept, as determined by an actuary hired by the fund, who is a member of the American academy of actuaries or the casualty actuarial society.

(2) "Administrator" means the administrator of the primary and secondary pool of funds, who is the director of the Montana medical legal panel provided for in 27-6-201.

(3) "Board" means the Montana state board of medical examiners provided for in 2-15-1841.

~~(4)--"Bodily--impairment"--means-temporary-or-permanent impairment-or-loss-of-bodily-functions-or-bodily-parts.--The term--does--not-include-other-impairments,-including-but-not limited-to--mental--or--emotional--processes--or--behavioral controls.~~

~~(5)~~(4) "Claimant" means a person claiming damages for injury from medical malpractice or required benefits for compensable injuries under [sections 1 through ~~26~~ 24].

~~(6)~~(5) "Commissioner" means the commissioner of insurance provided for in 2-15-1903.

~~(7)~~(6) "Compensable injury" means any physical harm, bodily impairment, disfigurement, or a delay in recovery, under [section ~~24~~ 22] that:

(a) is associated with or connected to the birthing process or the rendering of obstetrical care by a physician qualified under the terms of [sections 1 through ~~26~~ 24];

(b) is associated in whole or in part with medical intervention rather than with the condition for which the intervention occurred; and

(c) is not consistent with or reasonably expected as a consequence of medical intervention or is a result of medical intervention to which the patient did not consent.

~~(8)~~(7) "Condition" means the general state of health of the patient prior to medical intervention.

~~(9)~~(8) "Delay in recovery" means any undue additional time spent under care that is not substantially attributable to the condition for which medical intervention occurred and includes consideration of the general health of the patient.

~~(10)~~(9) "Department" means the department of health and environmental sciences provided for in Title 2, chapter

15, part 21.

~~(11)~~(10) "Designated premium equivalent" means the dollar amount paid by a patient to a physician ~~or deducted from the charges of a physician~~ under [section ~~24~~ 22].

~~(12) "Disfigurement" means scars or adverse changes in bodily appearance beyond those that are medically required.~~

~~(13) "Economic damages" means those compensatory damages payable as a result of a medical malpractice claim against a physician or a physician and other parties, that are objectively determinable and verifiable compensatory damages, including but not limited to medical expenses and care, rehabilitation services, custodial care, loss of earnings and earning capacity, loss of income, funeral or burial expenses, loss of use of property, costs of repair or replacement of property, costs of obtaining substitute domestic services, loss of employment, loss of business or employment opportunities, and any other objectively determinable and verifiable pecuniary or monetary damages.~~

~~(14)~~(11) "Hospital" means a hospital as defined in 50-5-101.

~~(15)~~(12) "Malpractice claim" means a malpractice claim as defined in 27-6-103.

~~(16)~~(13) "Medical intervention" means the rendering as well as the omission of any care, treatment, or services provided within the course of treatment administered by or

under the control of a physician or hospital.

~~(17)~~(14) "Montana medical legal panel" means the panel provided for in 27-6-104.

~~(18) "Noneconomic damages" means those damages payable as a result of a medical malpractice claim against a physician or a physician and other parties that are subjectively determined to be nonmonetary or nonpecuniary damages, including but not limited to pain, suffering, inconvenience, grief, physical impairment, disfigurement, mental suffering or anguish, emotional distress, loss of society and companionship, loss of consortium, fear of loss, fear of illness, fear of injury, injury to reputation, humiliation, and any other subjectively determined nonmonetary or nonpecuniary damages.~~

~~(19)~~(15) "Obstetrical advisory council" means an advisory council created pursuant to 2-15-122 by the department and provided for in [section ~~20~~ 19].

~~(20)~~(16) "Patient" means an individual who receives or should have received care from a physician and includes any person OR ENTITY having a ~~claim of any kind, whether derivative or otherwise, as a result of alleged medical malpractice on the part of a physician or having a compensable injury. Derivative claims include but are not limited to the claim of a parent or parents, guardian, trustee, child, relative, attorney, or any other representative of a patient, including claims for economic damages, noneconomic damages, attorney fees or expenses, and all similar claims~~ RIGHT OF ACTION UNDER 27-1-501.

~~(21)~~(17) "Patient assured compensation fund" or "fund" means the fund created under [section 5] and comprised of a primary pool of funds and a secondary pool of funds.

~~(22) "Physical harm" means a wound, infection, disease, or death.~~

~~(23)~~(18) "Physician" means a physician as defined in 27-6-103.

~~(24)~~(19) "Primary pool of funds" means that separate and segregated portion of the fund established for the payment of claims, expenses, and other allowed and required expenditures pursuant to [sections 1 through ~~26~~ 24], except for money payable from the secondary pool of funds.

~~(25)~~(20) "Representative" means the spouse, parent, guardian, trustee, attorney, or other legal agent of the patient.

~~(26)~~(21) "Secondary pool of funds" means that separate and segregated portion of the fund established for the payment of compensation, expenses, and other allowed and required expenditures pursuant to [section ~~24~~ 22].

~~(27)~~(22) "Surplus" means the excess of total assets minus liabilities of the primary pool of funds as defined by standard accounting practices for insurance carriers.

NEW SECTION. **Section 5.** ~~Purpose~~ FUND CREATED -- attachment to department -- deposit and investment. (1) There is a patient assured compensation fund. Money for the fund collected and received pursuant to [sections 1 through ~~26~~ 24] is to be used exclusively for the purposes stated in [sections 1 through ~~26~~ 24].

(2) The fund is attached to the department for administrative purposes only, pursuant to 2-15-121, except as otherwise provided in [sections 1 through ~~26~~ 24]. The department may promulgate rules and regulations implementing [sections 1 through ~~26~~ 24].

(3) The primary and secondary pool of funds and any income from those funds must be held in trust. The funds must be deposited in segregated accounts (one for the primary pool of funds and one for the secondary pool of funds), invested, and reinvested by the department AS A FIDUCIARY, pursuant to law. The fund may not become a part of or revert to the general fund of the state.

NEW SECTION. **Section 6.** Reimbursement to ~~department~~ DEPARTMENTS. The department AND THE DEPARTMENT OF INSURANCE must be reimbursed from the primary pool of funds for any expenses incurred in the administration of [sections 1 through ~~26~~ 24].

NEW SECTION. **Section 7.** Capitalization and maintenance of primary pool of funds and secondary pool of

funds -- surcharge. (1) To capitalize the primary pool of funds and the secondary pool of funds, there is ~~levied and collected on all insurance carriers authorized to write and engaged in writing casualty insurance pursuant to 33-1-206 in this state during 1987 and engaged in writing casualty insurance as of December 31, 1988, a one-time refundable surcharge in the form of a 1.17% premium tax surcharge based on 1987 carrier annual reports made pursuant to 33-2-705. A total of $100,000 of the surcharge forms the capitalization of the secondary pool of funds and the balance of the surcharge forms the capitalization of the primary pool of funds. If the surcharges provided for in this section are refunded, the refund must be made in the method and manner provided for in [section 10].~~ A LOAN OF $6,300,000 FROM THE STATE GENERAL FUND TO THE PRIMARY POOL OF FUNDS AND A LOAN OF $100,000 FROM THE STATE GENERAL FUND TO THE SECONDARY POOL OF FUNDS. THE LOANS ARE NOT APPROPRIATIONS AND MUST BE REPAID UNDER [SECTION 10], WITHOUT INTEREST. LEVIED AND COLLECTED ON ALL PROPERTY AND CASUALTY CARRIERS AUTHORIZED TO WRITE AND ENGAGED IN WRITING PROPERTY AND CASUALTY INSURANCE UNDER 33-1-206 OR 33-1-210 IN THIS STATE DURING 1987 AND ENGAGED IN WRITING PROPERTY AND CASUALTY INSURANCE AS OF DECEMBER 31, 1988, A ONE-TIME REFUNDABLE SURCHARGE IN THE FORM OF A 1.17% PREMIUM TAX SURCHARGE BASED ON 1987 CARRIER ANNUAL REPORTS MADE UNDER 33-2-705. A TOTAL OF

~~$100,000 OF THE SURCHARGE FORMS THE CAPITALIZATION OF THE SECONDARY POOL OF FUNDS AND THE BALANCE OF THE SURCHARGE FORMS THE CAPITALIZATION OF THE PRIMARY POOL OF FUNDS. IF THE SURCHARGE IS REFUNDED, THE REFUND MUST BE MADE IN THE MANNER PROVIDED IN [SECTION 10].~~ A LOAN OF $7,250,000 FROM THE BOARD OF INVESTMENTS TO THE PRIMARY POOL OF FUNDS AND A LOAN OF $100,000 FROM THE BOARD OF INVESTMENTS TO THE SECONDARY POOL OF FUNDS. THE LOANS ARE NOT APPROPRIATIONS AND MUST BE REPAID UNDER [SECTION 10], WITH INTEREST AT 4% PER YEAR.

(2) Except as otherwise provided in this section, the ~~primary pool of funds is fully nonassessable~~ PARTICIPATING PHYSICIANS ARE NOT SUBJECT TO ASSESSMENT. In order to maintain the primary pool of funds, the following annual surcharges must be levied against physicians qualified under [section ~~16~~ 15]:

(a) (i) for coverage from the primary pool of funds from $100,000 per occurrence and $300,000 in the annual aggregate up to $1 million per occurrence and $3 million in the annual aggregate for all claims made during the policy period of the qualifying physician's primary policy of insurance required by [sections 1 through ~~26~~ 24] and pursuant to that primary policy, as to physicians insured for purposes of at least some obstetrical privileges with an insurer authorized under [sections 1 through ~~26~~ 24]:

~~(A) as a family practitioner, an annual surcharge of $6,313;~~

~~(B) as an obstetrician, an annual surcharge of $13,141~~, AN ANNUAL SURCHARGE THAT WILL KEEP THE PRIMARY POOL OF FUNDS ACTUARIALLY SOUND. THE STATUTORY LIMITATIONS AND REQUIREMENTS ON RATE CHANGES BY PRIMARY MEDICAL MALPRACTICE CARRIERS APPLY TO THE DETERMINATION OF SURCHARGES;

(ii) an annual surcharge, separately and additionally paid by any professional service corporation, partnership, or other business entity and its employees desiring to qualify as physicians under [sections 1 through ~~26~~ 24] in the same manner as charges are levied by the carrier providing primary coverage, at a rate to be determined by the actuary hired by the administrator;

(b) for each physician subject to the terms of [sections 1 through ~~26~~ 24] who, after January 1, 1990, has an adverse ruling as to any medical malpractice claim by the Montana medical legal panel or a judgment or settlement as to a claim in excess of $25,000 and less than $50,000, the one-time sum of $500 because of the claim. If the amount of the judgment or settlement as to the claim is $50,000 or more, the one-time sum of $1,000 because of the claim. Any insurer required to report to the board pursuant to 37-3-402 shall also provide the report to the administrator and shall include in the report the amount of each settlement or

judgment for each physician for whom a report is made. The certificate of authority of the insurer must be suspended by the commissioner pursuant to 33-2-119 if the reports are not provided to the administrator as required by 37-3-402 or within a reasonable time thereafter.

(c) after January 1, 1990, $5 from each physician subject to the provisions of [sections 1 through ~~26~~ 24] for each baby delivered by that physician and $5 from each hospital for each baby delivered at the hospital. As a basis for the surcharge, by January 31, 1991, and on January 31 each year thereafter, each physician and each hospital shall report to the administrator the number of babies delivered by them during the preceding calendar year.

~~(3)--Beginning--with--the--first--year--of--operation--of [sections--1--through--26],--the---annual---surcharges---for physicians--provided--for--in--subsection--(2)(a)--are--subject--to annual--adjustment--by---the---administrator,---based---upon requirements--for--the--actuarial--soundness--of--the--primary--pool of--funds,--under--the--same--limitations--and--with--the--same requirements--as--a--rate--change--undertaken--by--the--primary carrier--of--the--physician.~~

~~(4)~~[3] The first annual surcharge for physicians provided for in this section must be collected by the Montana medical legal panel pursuant to 27-6-206 or within 30 days of [the effective date of this act], whichever

occurs later. Beginning in 1990 and in each year thereafter, all subsequent annual surcharges for physicians provided for in this section and beginning in 1991, all surcharges provided for physicians in subsection (2)(b) and for physicians and hospitals in subsection (2)(c) must be collected by the Montana medical legal panel pursuant to 27-6-206. All collections must be remitted to the department within 14 days of receipt.

~~(5)--The--one--time--refundable--surcharges--for--casualty insurance--carriers--provided--for--in--this--section--must--be collected--by--the--commissioner--on--March--1,--1989,--pursuant--to 33-2-705--without--deferral--or--installment--or--within--30--days of--[the--effective--date--of--this--act],--whichever--occurs--later. The--surcharge--must--be--remitted--to--the--department--by--the commissioner--within--14--days--of--receipt,--and--if--the--surcharge is--not--timely--paid--as--provided--in--this--section,--the certificate--of--authority--of--the--insurer--must--be--suspended--by the--commissioner--pursuant--to--33--2--119--until--the--surcharge--is paid.~~ THE ONE-TIME REFUNDABLE SURCHARGE FOR PROPERTY AND CASUALTY INSURANCE CARRIERS PROVIDED FOR IN THIS SECTION MUST BE COLLECTED BY THE COMMISSIONER ON MARCH 1, 1989, UNDER 33-2-705 WITHOUT DEFERRAL OR INSTALLMENT OR WITHIN 30 DAYS OF [THE EFFECTIVE DATE OF THIS ACT], WHICHEVER OCCURS LATER. THE SURCHARGE MUST BE REMITTED TO THE DEPARTMENT BY THE COMMISSIONER WITHIN 14 DAYS OF RECEIPT, AND IF THE

~~SURCHARGE--IS--NOT--TIMELY-PAID-AS-PROVIDED-IN-THIS-SECTION, THE--CERTIFICATE--OF--AUTHORITY--OF--THE--INSURER--MUST---BE SUSPENDED--BY--THE--COMMISSIONER--UNDER--33-2-119--UNTIL-THE SURCHARGE-IS-PAID.~~

~~(6)~~(4) The secondary pool of funds must be maintained solely through the surcharges on physicians and hospitals pursuant to subsections (2)(b) and (2)(c), distribution from excess surplus pursuant to [section 10], the collection of designated premium equivalents pursuant to [section ~~24~~ 22], and the revenues from any other source dedicated to the purposes of the secondary pool of funds.

NEW SECTION. **Section 8.** Actuarial soundness of primary pool of funds. (1) The fund's primary pool of funds must be maintained on an actuarially sound basis and may not become operational until a statement is prepared by an actuary, hired by the administrator, who is a member of the American academy of actuaries or the casualty actuarial society certifying that the primary pool of funds is expected to be actuarially sound.

(2) If the primary pool of funds would at any time be rendered insolvent by payment of all fixed and known obligations that will become final within 2 years from that time, the amount of future noneconomic damages payable within that calendar year must be prorated among existing claimants at the time of the determination in a manner

sufficient to eliminate or reduce the insolvent circumstance to the extent possible. Any amount due and unpaid at the end of the 2-year period must be paid in the following 1-year period, WITH INTEREST AT THE JUDGMENT RATE FROM THE TIME OF DEFERRAL UNTIL PAYMENT, and must be paid before the obligations FOR ADMINISTRATION OF THE PRIMARY POOL AND FOR NONECONOMIC DAMAGES that become final during that year may be paid. THE ADMINISTRATOR SHALL INCREASE THE ANNUAL SURCHARGE FOR THE PRIMARY POOL IN ORDER TO ENSURE THAT PRORATION OF NONECONOMIC DAMAGES DOES NOT OCCUR FOR MORE THAN 3 YEARS.

NEW SECTION. **Section 9.** Staff. The administrator, using money from the fund as considered necessary, appropriate, or desirable by the department, may purchase the services of persons, firms, and corporations to aid in protecting the fund against claims, fully administering [sections 1 through ~~26~~ 24], determining the actuarial soundness of the primary pool of funds, and determining the return of savings to persons and entities paying any portion of the original capitalization of the primary pool of funds, ~~as--well--as--for--making--recommendations---to---subsequent legislative-sessions.~~

NEW SECTION. **Section 10.** Return of savings. (1) On July 1, 1993, and on July 1 of each year thereafter, if the primary pool of funds is actuarially sound, all surplus in

the primary pool of funds in excess of $1 million over the sum of the amount necessary to make that fund actuarially sound ~~and-the-amount-of-the-original-annual-surcharge-set-by-[sections-1--through--26]--times--the--number--of--qualified~~ physicians must be distributed equally ~~among~~ BETWEEN:

(a) ~~the--casualty--insurance--carriers--who--have-paid-surcharges-into-the-primary-pool--of--funds,--pro--rata--and-proportionate--to--their--original-contributions~~ THE GENERAL FUND, AS REPAYMENT OF AMOUNTS WITHDRAWN UNDER THE TEMPORARY LINE OF CREDIT THE PROPERTY AND CASUALTY INSURANCE CARRIERS WHO HAVE PAID A SURCHARGE INTO THE PRIMARY POOL OF FUNDS, PRO RATA AND PROPORTIONATE TO THEIR ORIGINAL CONTRIBUTIONS THE BOARD OF INVESTMENTS, AS REPAYMENT OF AMOUNTS WITHDRAWN UNDER THE TEMPORARY LINE OF CREDIT, until such ~~contributions~~ AMOUNTS CONTRIBUTIONS AMOUNTS have been repaid; and

(b) the secondary pool of funds.

(2) The administrator, upon receipt of capital contributions pursuant to [sections 1 through ~~26~~ 24], shall issue the person or entity paying the capital contribution a certificate representing the contribution and containing the terms of repayment, if any. The collection of capital contributions or the prospects of a return of savings may not be considered to be an unregistered investment contract or otherwise require registration as a security under the securities laws of Montana.

NEW SECTION. **Section 11.** Reinsurance authority. The fund ~~has-the-power-to~~ SHALL negotiate for, contract for, and purchase reinsurance~~,--subject--to--the--control---of---the~~ department.

NEW SECTION. **Section 12.** Claims for payment. Except as otherwise provided in [sections 8(2) and ~~24~~ 22]~~:~~

~~(1)~~, claims for payment from the primary or secondary pool of funds that become final ~~during-the-first-6-months-of-the--calendar--year--must-be-computed-on-June-30-and-must-be-paid-no-later-than-the-following-July-15;-and~~

~~(2)--claims-for-payment-from-the-primary--or--secondary-pool--of-funds-that-become-final-during-the-last-6-months-of-the-calendar-year-must-be-computed-on-December-31--and--must-be--paid-no-later-than-the-following-January-15~~ MUST BE PAID WITHIN 30 DAYS.

NEW SECTION. **Section 13.** Claims against fund -- procedure. (1) The department shall issue a warrant in the amount of each claim, in the manner required for payment under [sections 1 through ~~26~~ 24], submitted to it against the primary OR SECONDARY pool of funds on ~~June--30--and-December--31--of--each--year~~ THE FIRST DAY OF THE FOLLOWING MONTH.

(2) ~~The-only-claim-against~~ A PAYMENT FROM the primary pool of funds ~~must~~ MAY be MADE ONLY UPON a voucher or other appropriate request by the administrator, submitted along

with:

(a) a certified copy of a final judgment against the fund; or

(b) a duplicate original of a settlement entered into by the administrator on behalf of the primary pool of funds involving a physician qualified under the terms of [sections 1 through ~~26~~ 24].

(3) ~~The only claim against~~ A PAYMENT FROM the secondary pool of funds ~~must~~ MAY be MADE ONLY UPON a voucher or other appropriate request by the administrator, submitted along with:

(a) a certified copy of a final judgment OR AWARD of entitlement to the benefits of [section ~~24~~ 22]; or

(b) ~~a certified copy of a settlement for the benefits of [section 24] approved by the Montana medical legal panel~~ DUPLICATE ORIGINAL OF A SETTLEMENT ENTERED INTO BY THE ADMINISTRATOR ON BEHALF OF THE SECONDARY POOL OF FUNDS.

NEW SECTION. **Section 14.** **Payment from primary pool of funds after exhaustion of insurance coverage -- excess claims -- procedure.** (1) If a physician qualified under [sections 1 through ~~26~~ 24] or his insurer as UNDER INSURANCE required by [section ~~16~~ 15] has agreed to settle liability on a claim by payment of its policy limits and the claimant is demanding an amount in excess of the policy limits or if the annual aggregate under the insurance for the physician

has been paid by or on behalf of the physician, the claimant shall notify the administrator ~~in the manner provided in subsection (2) and receive a reply from the administrator as a condition precedent to recovery from the primary pool of funds.~~

(2) The claimant shall provide the administrator in writing~~, postage prepaid by certified mail,~~ a short and plain statement of the nature of the claim and the additional amount for which the claimant will settle. ~~The statement must include, separately stated, the amounts previously paid and the additional amounts demanded with respect to the damages as a whole without regard to any previous payment. The statement must also include:~~

~~(a) the amount of any past damages, itemized as to economic and noneconomic damages; and~~

~~(b) any future damages and the periods over which they will accrue, on an annual basis, for each of the following types:~~

~~(i) medical and other costs of health care;~~

~~(ii) other economic loss; and~~

~~(iii) noneconomic loss.~~

~~(3) The calculation of future damages under subsection (2) must be based on the costs and losses during the period of time the claimant will sustain those costs and losses unless a claim of wrongful death is involved. In wrongful~~

death--claims,--future--damages--must-be-based-on-the-losses during-the-period-of-time-the-injured-party-would-have-lived but-for-the-injury-upon-which-the-claim-is--based,--and--the claimed--future--damages-must-be-expressed-in-current-values without-regard-to-future-changes-in--the--earning--power--or purchasing-power-of-the-dollar.

(4)--If--a-claim-of-wrongful-death-is-not-involved,-the statement--under--subsection--(2)--must--state--the--claimed severity--of-the-injury-and-whether-the-injury-is-limited-to mental-or-emotional-harm-or-involves-physical-harm.--If--the injury--involves--physical--harm,--the--claimant-shall-state whether-the-physical--harm--includes--bodily--impairment--or disfigurement.

(5)--The--statement--under--subsection--(2)--must--also specify-what-percentage-of-the-claimed-damages--are--alleged to--be--the--responsibility-of-each-physician-against-whom-a claim-is-made.

(6)--If,-within-30-days-after-receipt-of-the-statement, the-administrator-has-not-accepted-the-offer--of--settlement in--writing,-the-claimant-may-proceed-with-any-claim-against the-physician.-The-patient-assured-compensation-fund-must-be named-as-a-necessary--and--proper--party--in--any--state--or federal--court--proceeding--for-all-causes-of-action-arising after-[the-effective-date-of-this-act].

(7)--(a)-The-statute-of-limitations-with-respect-to-any

medical-malpractice--claim--against--a--qualified--physician under--[sections--1--through-26]-is-tolled-by-the-deposit-in the-United-States-mail--of--the--writing--required--by--this section--and--does--not-begin-to-run-again-until-the-greater of:

(i)--30-days-after-mailing;-or

(ii)-the-running-of-the--applicable--limitation--period under-27-6-702.

(b)--The-time-period-of-tolling-is-not-computed-as-part of-the-period-within-which-the-action-may-be-brought.

NEW-SECTION.--**Section 15.**--Discharge--of--obligation-to pay-amount-from-funds.--The-obligation-to-pay-an-amount-from the-primary-or-secondary-pool-of-funds--may--be--discharged, unless-otherwise-required-or-permitted-by-law,-through:

(1)--payment-in-one-lump-sum-for-accrued-damages;

(2)--an--agreement-requiring-periodic-payments-from-the primary-or-secondary-pool-of-funds-over-a-period--of--years;

(3)--the---purchase---of--an--annuity--payable--to--the claimant,--with--the--administrator--having--the--power---to contract-with-those-insurers-permitted-under-25-9-403(4);-or

(4)--any---combination---of---the---payment---plans--in subsections-(1)-through-(3).

NEW SECTION. **Section 15.** Qualifications for physician. (1) In order to become and remain qualified under the provisions of [sections 1 through ~~26~~ 24], in addition to

the procedures established by the department for regulation of application for qualification, a physician must:

(a) pay all surcharges required by [sections 1 through ~~26~~ 24] in a timely manner;

(b) at the time of qualification, irrevocably agree in writing to be bound by the results of any arbitration provided for in [section ~~24~~ 22];

(c) (i) if acting as an individual physician, be insured and continue to be insured by an authorized insurer under a valid and collectible policy of medical liability insurance in at least the amounts required by subsection (2), for purposes of at least some obstetrical privileges as an obstetrician or as a family practitioner; or

(ii) if a member of a professional service corporation, partnership, or other business entity desiring to qualify as a physician, ~~have one or more~~ BE A MEMBER OF ONE THAT HAS MORE THAN 50% OF THE members of the business entity insured as an obstetrician or as a family practitioner with some obstetrical privileges;

(d) establish proof of qualifying coverage for lower limits and proof of specialty.

(2) Proof under subsection (1) may be established by the physician's insurance carrier annually filing with the administrator proof that the physician is insured by a policy of malpractice liability insurance in the amount of

at least $100,000 per occurrence and $300,000 in the annual aggregate for all claims made during the policy period, along with the specialty under which such policy was issued. ~~Any insurer offering such a policy may offer a policy with deductible options of up to one-half of the limits.~~ The administrator may require a professional corporation seeking to qualify to provide information necessary to determine if the corporation is eligible as a physician.

NEW SECTION. **Section 16.** Failure of physician to qualify for change of coverage -- limits of liability of fund -- rights and duties of physician. (1) A physician who fails to qualify under [sections 1 through ~~26~~ 24] or who becomes disqualified is not covered by the provisions of [sections 1 through ~~26~~ 24] after the date of disqualification and is subject to liability under the law without regard to the provisions of [sections 1 through ~~26~~ 24], EXCEPT FOR CLAIMS MADE WHILE THE PHYSICIAN WAS QUALIFIED. If a physician does not qualify, the claimant's remedy will not be affected by the terms and provisions of [sections 1 through ~~26~~ 24]. The primary pool of funds is not liable for any amounts up to the limits of qualifying coverage of a physician established in [section ~~16~~ 15]. The secondary pool of funds is liable only up to the amounts contained in that fund in the manner provided in [section ~~24~~ 22].

(2) Within 14 business days of receipt of the information required for qualification of a physician, the administrator shall notify the physician whether the physician is qualified, and if so, the date he became qualified.

(3) The primary pool of funds is not liable for any amounts until the limits of the qualifying coverage for lower limits of the physician have been paid or are payable and then only above those limits of coverage. The maximum liability of the primary pool of funds is $1 million per occurrence and $3 million in the annual aggregate AS TO EACH QUALIFIED PHYSICIAN for all claims made during the policy period of the coverage for lower limits. The claimant's remedy for amounts over the limits of the primary pool of funds are not affected by the terms and provisions of [sections 1 through ~~26~~ 24], except as otherwise provided.

(4) Except as otherwise provided in [sections 1 through ~~26~~ 24], the rights and duties of a physician qualifying under [sections 1 through ~~26~~ 24], including but not limited to the nature, extent, and limits of coverage of the primary pool of funds, are the same as the rights and duties of that physician under his qualifying coverage for lower limits, including but not limited to all exceptions, exclusions, and endorsements to the lower limits of coverage.

(5) Failure to maintain levels of coverage required under this section or nonrenewal, cancellation, or the elimination of obstetrical coverage for lower limits of coverage ~~constitute~~ CONSTITUTES disqualification of the physician under the terms of [sections 1 through ~~26~~ 24] when the changes become effective with respect to the lower limits of coverage, if at all. The carrier providing lower limits of coverage shall promptly notify the administrator of changes in coverage pertinent to this section in the same manner as required of notice to insureds.

~~(6)--Notwithstanding-any-other-provision-of-[sections-1 through--26],--if--the-administrator-determines-that,-due-to the-number-and-dollar-exposure-of--claims--filed--against--a physician--qualified--under--[sections--1--through--26],-the physician-presents-a-material--risk--of--significant--future liability--to--the--fund,--the--administrator-is-authorized, after-notice-and-an-opportunity-for--hearing,--to--terminate the--liability--of--the--fund--for--all--claims--against-the physician.~~

~~(7)~~(6) Except as otherwise provided in [sections 1 through ~~26~~ 24], Title 33 has no application to [sections 1 through ~~26~~ 24]. The following provisions of Title 33 apply to [sections 1 through ~~26~~ 24]: 33-15-411; 33-15-504; 33-15-1101 through 33-15-1121; Title 33, chapter 18; Title 33, chapter 19; 33-23-301; and 33-23-302.

NEW SECTION. **Section 17.** **Adequate defense of fund -- notification as to reserves.** The administrator may provide for the defense of the primary and secondary pool of funds against a claimant's claim ~~and may appeal a judgment which affects the funds~~. The physician or his insurer for qualifying coverage for lower limits shall provide an adequate defense to the claim and is in a fiduciary relationship with the primary or secondary pool of funds with respect to any claim. Any carrier representing a physician subject to [sections 1 through ~~26~~ 24] shall immediately notify the administrator of any case upon which it has placed a reserve of $50,000 or more.

NEW SECTION. **Section 18.** **Primary pool of funds not liable for punitive damages.** The primary pool of funds is not liable for punitive or exemplary damages of any kind. This section does not relieve the liability of a physician for punitive or exemplary damages.

NEW SECTION. **Section 19.** **Appointment and recommendations of obstetrical advisory council.** (1) The department shall appoint an obstetrical advisory council, subject to the approval of the governor, composed of seven people, ~~five~~ FOUR of whom must be physicians qualified under [sections 1 through ~~26~~ 24]. ~~The~~ EXPENSES FOR TRAVEL AND LODGING AND THE ADMINISTRATION OF THE council must be funded from the primary pool of funds, and members must be

appointed for 4-year terms. A vacancy must be filled for the unexpired portion of the term in the same manner as the original appointment.

(2) The council shall make recommendations regarding:

(a) prenatal and postnatal care, including but not limited to better access to comprehensive obstetrical services, improved professional competency, and peer review and quality assurance in connection with prenatal care, labor, delivery, immediate care of the newborn, and care of the postpartum woman;

(b) risk prevention and other quality of care;

(c) designated compensable events, for which compensation should in all instances be paid, to be included in [section ~~24~~ 22];

(d) economic and noneconomic damage schedules which should be included in [sections 1 through ~~26~~ 24]; and

(e) the proper implementation or correction of [sections 1 through ~~26~~ 24] as the council considers appropriate, pursuant to guidelines provided by the administrator.

NEW SECTION. **Section 20.** **Disciplinary action against physicians.** After [the effective date of this act], upon the receipt by the board of information from the reports required by 33-23-311(3), 37-3-402, this section, or any other source that a physician has had three or more medical

malpractice claims where a Montana medical legal panel result was adverse or indemnity has been paid or is payable in excess of the amount of $10,000 for each claim within the previous 5-year period, the board shall investigate the occurrences upon which the claims were based. The board shall determine if action by the board against the physician is warranted UNDER 37-3-323 THROUGH 37-3-328 AND MAY TAKE ACTION UNDER THOSE SECTIONS. In 1995 and annually thereafter, the board shall publish a summary of action taken or not taken on claims pursuant to this section. The summary may not identify individual physicians. The summary is in addition to any other requirements of the law and may not limit the obligations otherwise required by law.

NEW SECTION. **Section 22.** Predictability of damages. In a trial in district court of any medical malpractice action for damages for injury not including wrongful death where the patient assured compensation fund is a party to the action, the court shall:

(1) upon proper motion of any party subsequent to verdict and before entry of judgment, review an award against any party for noneconomic damages to determine whether the award is clearly excessive or inadequate. If the award is not in substantial accord with a proper award of damages after considering the factors in subsection (2), the court shall, acting with caution and discretion, modify

the award in a manner reasonably consistent with that subsection, unless there is clear and convincing evidence that the interest of justice would not be served by the modification. The court shall give written reasons for a modification or refusal to modify. If the party adversely affected by any modification objects, the court shall order a new trial on the issue of noneconomic damages only. Economic damages awarded and the fact of liability are admissible at the new trial, but factual matters pertaining to liability are not admissible.

(2) in determining whether an award requires modification under subsection (1), consider:

(a) whether the amount awarded indicates prejudice, passion, or corruption on the part of the trier of fact;

(b) whether it clearly appears that the trier of fact ignored the evidence in reaching a verdict or misconceived the merits of the case as to damages recoverable;

(c) whether the trier of fact took improper elements of damages into account or arrived at the amount of damages by speculation and conjecture;

(d) whether the award is reasonably related to the damages proved and the injury suffered pursuant to the guidelines in subsection (3); and

(e) whether the award is supported by the evidence and could be adduced in a logical manner by reasonable persons.

~~(3)--use---the---guidelines---in---this--subsection--in determining-whether-to--modify--an--award--when--considering subsection--(2)(d):-Noneconomic-damages-are-not-proportional to-the-injury-received-if-they-exceed-the-greater-of:~~

~~(a)--weekly--wage--compensation--benefits--as--computed pursuant-to-39-71-701-times-the-life-expectancy-in-weeks;-or~~

~~(b)--the--multiple--of--economic-damages-awarded-by-the jury,-pursuant-to-the-severity-of-the-injury--as--determined by--the-finder-of-fact-as-properly-shown-by-the-evidence-for purposes-of-calculation,-as-follows:~~

~~(i)--for-mental-or-emotional-harm-only:-0.5--times--the amount--of--economic--damages--or--$1--million,-whichever-is greater;~~

~~(ii)-for-physical-harm--without--bodily--impairment--or disfigurement:--an--amount--equal--to-the-amount-of-economic damages-or-$2-million,-whichever-is-greater;~~

~~(iii)-for-bodily-impairment-or-disfigurement:-1.5-times the-amount-of-economic-damages-or-$3-million,--whichever--is greater.~~

NEW SECTION. **Section 21.** Contractual right to extended reporting endorsements -- prior acts coverage. (1) Each physician qualified under [sections 1 through ~~26~~ 24] has the contractual right, on the same terms and conditions as that physician has under the qualifying lower limits of coverage, if any, to obtain an extended reporting

endorsement for coverage by the primary pool of funds for claims for medical malpractice that occur during the time a physician was qualified under [sections 1 through ~~26~~ 24] but that are reported after the physician ceases to be qualified.

(2) The cost of the purchase of an extended reporting endorsement paid by the physician to the fund is equal to a multiple of the current annual surcharge under [section 7]. The multiple is the lesser of the multiple being charged under the qualifying lower limits of coverage at that time or the multiple determined by the fund's actuary.

(3) Prior acts and omissions coverage, provided to the qualified physician upon qualification for coverage by the primary pool of funds for claims that have occurred but have not been made, must be provided only as to claims that are also covered under the terms of a valid and collectible primary policy of insurance coverage carried by the physician, qualified as required by [sections 1 through ~~26~~ 24] and any endorsements to the policy. Prior acts and omissions coverage from the fund is subject to the following exclusions and limitations in addition to those contained in [sections 1 through ~~26~~ 24]:

(a) The fund may not provide coverage for any liability to any qualified physician with respect to:

(i) any claim made against a physician qualified under

[sections 1 through ~~26~~ 24] at any time prior to the date of qualification, regardless of whether or not the claim has been reported to any liability insurer; or

(ii) any potential claim against any qualified physician of which any physician is aware or reasonably should have been aware as of the date of qualification, regardless of whether or not the claim has yet been made or reported to any liability insurer. For purposes of this subsection, a potential claim includes but is not limited to instances where any insured has received an oral or written communication from a legal representative of a patient or a request by or on behalf of a patient for copies of medical records under circumstances reasonably indicative of a potential claim.

(b) The limits of liability of the fund for prior acts claims is the lesser of the limits of liability of the primary pool of funds under [sections 1 through ~~26~~ 24] or the limits of liability of any valid and collectible liability insurance carried by the qualified physician prior to qualification.

NEW SECTION. **Section 22.** **Compensation for injuries from medical intervention without regard to fault.** (1) The purpose of this section is to establish a system of prompt, efficient, and equitable compensation for certain economic damages and attorney fees to those claimants injured through

medical intervention in the birthing process or obstetrical care, without regard to negligence of the physician. ~~This section applies only if the patient opts on a voluntary basis to pay a designated premium equivalent and later signs an arbitration agreement to arbitrate the claim before the Montana medical legal panel.~~

(2) ~~Each physician shall disclose to each patient, at~~ AT the time of any initial medical treatment BY A PARTICIPATING PHYSICIAN related to the birthing process or obstetrical care, ~~the amount of funds on hand in the secondary pool of funds and the designated premium equivalent that will be contained in the fees to be charged by giving the form provided by the administrator to~~ the patient IS ELIGIBLE TO PARTICIPATE IN THE SECONDARY POOL AND BECOMES LIABLE FOR THE PAYMENT OF A DESIGNATED PREMIUM EQUIVALENT. The initial amount of the designated premium equivalent is $25. ~~The amount~~, IS NONREFUNDABLE, AND is subject to change by the department, by rule, after consideration of the recommendations of the obstetrical advisory council. ~~The administrator shall regularly keep the physicians advised of the amount of money in the secondary pool of funds.~~

(3) Each patient, at the time ~~the patient is provided the form required in subsection (2),~~ must be given an opportunity not to participate in the secondary pool of

~~funds-and-to-have-the-designated-premium-equivalent-deducted from-the-fees-to-be-charged~~ OF INITIAL MEDICAL TREATMENT RELATED TO THE BIRTHING PROCESS OR OBSTETRICAL CARE, MUST BE INFORMED BY THE PHYSICIAN OF THE PROVISIONS OF SUBSECTION (2) AND THIS SUBSECTION. THE PHYSICIAN SHALL AT THAT TIME GIVE THE PATIENT A PAMPHLET THAT CLEARLY AND ADEQUATELY DESCRIBES THE PROVISIONS OF [SECTIONS 1 THROUGH 24] AND ADVISES THE PATIENT TO CONTACT AN ATTORNEY IF THE PATIENT BELIEVES THE PATIENT HAS A MALPRACTICE CLAIM RELATED TO THE BIRTHING PROCESS OR OBSTETRICAL CARE. THE PAMPHLET MUST BE WRITTEN BY THE STATE BAR OF MONTANA, AND THE PRIMARY POOL SHALL PAY THE COST OF PUBLISHING AND DISTRIBUTING THE PAMPHLET. THE PHYSICIAN SHALL ADD THE DESIGNATED PREMIUM EQUIVALENT TO THE FIRST BILL SENT TO THE PATIENT AND INFORM THE PATIENT AT THE TIME OF THE INITIAL MEDICAL TREATMENT THAT THE AMOUNT WILL BE ADDED TO THE BILL. If the patient cannot afford the premium ~~and-wishes-to-participate--in--the secondary--pool-of-funds~~, the patient shall deliver a signed letter to the physician to that effect and the premium must be waived. The designated premium equivalent must also be waived if prohibited by federal law.

~~(4) If--the--patient--wishes--to--participate--in--the secondary-pool-of-funds:~~

~~(a) prior--to--any--claim--of--injury-and-prior-to-any known--complications--of--delivery--or--pregnancy,--the~~ THE

physician shall immediately, WITHIN 30 DAYS OF THE TIME OF INITIAL MEDICAL TREATMENT, remit to the department the amount of any required designated premium equivalent or the letter from the patient stating an inability to pay the premium. ~~Failure-of-the-patient-to-pay-or-provide-the-letter disqualifies--the--patient--from--any--participation--in-the secondary-pool-of-funds:~~

(b) ~~subsequent~~ SUBSEQUENT to any claim of injury and subsequent to any known complications of delivery or pregnancy, the patient ~~shall~~ MAY provide the physician with an agreement to arbitrate a claim arising out of the birthing process or obstetrical care, on a form provided by the administrator. The physician and the patient or the patient's representative shall execute the agreement to arbitrate the claim. ~~Upon-approval-by-the-administrator,-the agreement---is--binding--upon--the--patient,--the--patient's representative,-any-claimant,-and-the-physician-for-purposes of-a-claim-for-required-benefits--for--compensable--injuries under--[sections--1--through--26].----An-executed-copy-of-the agreement-to-arbitrate-must-be-provided-to-the-administrator and-is-subject-to-his-approval-as-to-form-and-content-before it-may-become-effective:~~

(5) A claim for recovery of required benefits must be filed pursuant to the provisions of Title 27, chapter 6, naming the secondary pool of funds a party, with that

chapter and its rules of procedure being applicable to the secondary pool of funds as if it were a health care provider. The claim is governed by Title 27, chapter 6, as if it were a malpractice claim. THE ARBITRATION PANEL MUST BE COMPOSED OF AN ATTORNEY, A PHYSICIAN, AND A PROFESSIONAL ARBITRATOR. THE PROFESSIONAL ARBITRATOR MUST BE KNOWLEDGEABLE IN WORKERS' COMPENSATION LAW AND IS THE CHAIRMAN OF THE PANEL. The arbitration agreement of the parties constitutes a request for recommendation of an award, and the recommended award constitutes an approved settlement agreement pursuant to 27-6-606 and an award pursuant to Title 27, chapter 5.

(6) (a) Except as provided in subsection (6)(b), Title 27, chapter 5, applies to the claim and any award.

(b) The provisions of 27-5-211 through 27-5-218 do not apply to the claim, and any conflict between Title 27, chapter 5, and Title 27, chapter 6, must be resolved in favor of the latter.

(7) The filing of a claim for recovery before the Montana medical legal panel under the arbitration agreement~~, unless the arbitration agreement has been revoked in writing by the patient prior to filing of the claim,~~ constitutes:

(a) a valid and binding agreement that the sole matter in controversy is whether there is a compensable injury and, if so, the amount of required benefits available as

compensation;

(b) a waiver of trial by jury or the court; and

(c) the sole and exclusive remedy for:

(i) any malpractice claim against a physician qualified under [sections 1 through ~~26~~ 24] ~~or a hospital~~; or

(ii) a claim for required benefits for a compensable injury by the patient~~, his heirs or representatives, or his parents or next of kin, or any other person whose claim is derivative from the incident~~.

(8) ~~The~~ IF A CLAIM HAS NOT BEEN FILED UNDER SUBSECTION (7), THE filing of a malpractice claim in federal court or pursuant to Title 27, chapter 6, against one or more physicians subject to [sections 1 through ~~26~~ 24] constitutes a revocation in writing of the arbitration agreement provided for in this section ~~if the claim represents that the claimant has been fully advised in writing by legal counsel of the options available under [sections 1 through 26] and a true and correct copy of the writing is attached to the claim. If the claimant is not represented by counsel in a Montana medical legal panel proceeding, the administrator shall provide the advice in writing and the claimant shall make a written binding election to proceed with the malpractice claim or to amend the claim for recovery under an arbitration agreement obtained pursuant to subsection (6). The written advice and election must be~~

~~filed with the Montana medical legal panel.~~

(9) Claims for required benefits for a compensable injury under a valid arbitration agreement are limited to required benefits and only required benefits may be paid for a compensable injury.

(10) (a) Required benefits under this section are~~:~~ ~~limited to the following items as computed under [sections 1 through 26]:~~

~~(i) medical and hospital expenses and future medical and hospital expenses as incurred, computed and paid in the manner provided in 39-71-704 and the rules implementing that section;~~

~~(ii) lost earnings and future lost earnings as incurred, computed, and paid in the manner provided in 39-71-701(1) and according to the definition of average weekly wage in 39-71-116 and the rules implementing those sections; and~~

~~(iii) reasonable attorney fees for panel proceedings, computed and paid in the manner provided in 39-71-613, 39-71-614, and the rules implementing those sections:~~

(I) MEDICAL, PARAMEDICAL, AND HOSPITAL EXPENSES INCURRED TO THE DATE OF THE AWARD;

(II) FUTURE MEDICAL, PARAMEDICAL, AND HOSPITAL EXPENSES, COMPUTED IN THE MANNER PROVIDED IN 39-71-704 AND RULES IMPLEMENTING THAT SECTION;

(III) A SUM EQUAL TO ONE AND ONE-HALF TIMES THE STATE'S AVERAGE WEEKLY WAGE FOR THE PERIOD OF THE DISABILITY; AND

(IV) REASONABLE ATTORNEY FEES INCURRED IN BRINGING THE CLAIM BEFORE THE ARBITRATION PANEL, NOT TO EXCEED $125 PER HOUR.

(b) Required benefits do not include medical and hospital expenses for items or services or reimbursement the patient received ~~or is entitled to receive~~ under the laws of any state or the federal government, except to the extent exclusion of such benefits is prohibited by federal law, or expenses paid by any prepaid health plan, health maintenance organization, or private insuring entity or pursuant to the provisions of any health or sickness insurance policy or other private insurance program.

~~(c) Proceeds to beneficiaries, as defined in 39-71-116, must be determined pursuant to 39-71-723, and lump sum payments for future benefits are prohibited.~~

(11) All awards must be paid from the secondary pool of funds on ~~an annual~~ A MONTHLY basis for required benefits that have accrued and pursuant to Title 25, chapter 9, part 4, for future required benefits, and that part applies in all instances to claims for required benefits except as otherwise provided in this section and to the extent the secondary pool of funds has sufficient funds for payments without becoming actuarially unsound. If the secondary pool

of funds has insufficient funds with which to pay an award or awards, payments must be made in the same manner, pro rata as to all claims against the secondary pool of funds at the time of the required payment. The unpaid amounts of any award constitute a future obligation of the secondary pool of funds as funds become available. The future obligation is not enforceable by any process of law other than pursuant to the terms of this section.

(12) All costs of administration of the secondary pool of funds must be paid from the secondary pool of funds, and the costs of administration must be paid prior to the payment of any required benefits or required obligations of the secondary pool of funds provided elsewhere in [sections 1 through ~~26~~ 24]. If the secondary pool of funds is insufficient to pay the costs of administration of the secondary pool or any attorney fees required to be paid by the secondary pool, the administrator is authorized to loan the secondary pool sufficient funds for the administration or fee from the primary pool of funds if the loan would not render the primary pool actuarially unsound. The loan is an advance against future distributions pursuant to [section 10] and in lieu of the distributions. The loan plus interest must be repaid to the primary pool of funds upon the future distribution otherwise accruing.

(13) The arbitration agreement form promulgated by the

department must include on its face a written notice of the substance of subsections ~~(9) and~~ (7) THROUGH (10) in red, 10-point type.

(14) The period prescribed for the commencement of an action for relief under this section is ~~within 1 year of the date of injury~~ THE PERIOD PROVIDED IN 27-2-205.

NEW SECTION. **Section 23.** Tax exemption. The fund is exempt from payment of all fees and all taxes levied by this state or any of its subdivisions.

NEW SECTION. **Section 24.** Review. The administrator shall report IN WRITING to each REGULAR session of the legislature concerning the effectiveness of [sections 1 through ~~26~~ 24] in achieving the stated goals and concerning other matters of importance. The status and operation of the fund must be included in that report.

Section 25. Section 27-6-105, MCA, is amended to read:

"27-6-105. What claims panel to review. The panel shall review all malpractice claims or potential claims against health care providers covered by this chapter, ~~except~~ including those claims subject to a valid arbitration agreement allowed by law ~~or upon which suit has been filed prior to April 19, 1977~~."

Section 26. Section 27-6-602, MCA, is amended to read:

"27-6-602. Questions panel must decide. (1) Upon consideration of all the relevant material, the panel shall

decide whether there is:

~~(1)~~(a) substantial evidence that the acts complained of occurred and that they constitute malpractice; and

~~(2)~~(b) a reasonable medical probability that the patient was injured thereby.

(2) If ~~the panel decides that the acts complained of did not constitute medical malpractice and if~~ there is an arbitration agreement pursuant to [sections 1 through ~~26~~ 24], the panel shall decide whether there is a compensable injury pursuant to [sections 1 through ~~26~~ 24], and, if so, make an award pursuant to [section ~~24~~ 22]."

~~**Section 29.** Section 33-10-102, MCA, is amended to read:~~

~~"33-10-102. Definitions. As used in this part, the following definitions apply:~~

~~(1) "Association" means the Montana insurance guaranty association created under 33-10-103.~~

~~(2) (a) "Covered claim" means an unpaid claim, including one for unearned premiums, or a contractual guaranty for an extended reporting endorsement for claims reported after the expiration of the policy period which arises out of and is within the coverage and not in excess of the applicable limits of an insurance policy to which this part applies issued by an insurer, if such insurer becomes an insolvent insurer after July 1, 1971, and~~

~~(i) the claimant or insured is a resident of this state at the time of the insured event; or~~

~~(ii) the property from which the claim arises is permanently located in this state.~~

~~(b) "Covered claim" shall does not include any amount due a reinsurer, insurer, insurance pool, or underwriting association, as subrogation recoveries or otherwise.~~

~~(3) "Insolvent insurer" means an insurer:~~

~~(a) authorized to transact insurance in this state either at the time the policy was issued or when the insured event occurred; and~~

~~(b) determined to be insolvent by a court of competent jurisdiction.~~

~~(4) "Member insurer" means any person who:~~

~~(a) writes any kind of insurance to which this part applies under 33-10-101(3), including the exchange of reciprocal or interinsurance contracts; and~~

~~(b) is licensed to transact insurance in this state.~~

~~(5) "Net direct written premiums" means direct gross premiums written in this state on insurance policies to which this part applies, less return premiums thereon and dividends paid or credited to policyholders on such direct business. "Net direct written premiums" does not include premiums on contracts between insurers or reinsurers.~~

~~(6) "Person" means any individual, corporation,~~

~~partnership, association, or voluntary organization.~~"

Section 27. Section 33-23-311, MCA, is amended to read:

"33-23-311. Information required of professional liability insurers -- submission. (1) For purposes of this section, "profession" means the occupations engaged in by physicians, osteopaths, registered nurses, licensed practical nurses, dentists, optometrists, podiatrists, chiropractors, hospitals, attorneys, certified public accountants, public accountants, architects, veterinarians, pharmacists, and professional engineers.

(2) Each insurance company engaged in issuing professional liability insurance in the state of Montana shall include the following information, by profession, from its experience in the state of Montana, in its annual statement to the commissioner:

(a) the number of insureds as of December 31 of the calendar year next preceding;

(b) the amount of earned premiums paid by the insureds during the calendar year next preceding;

(c) the number of claims made against the insurer's insureds and the number of claims outstanding as of December 31 of the calendar year next preceding;

(d) the number of claims paid by the insurer during the calendar year next preceding and the total monetary

amount thereof;

(e) the number of lawsuits filed against the insurer's insureds and the number of insureds included therein during the calendar year next preceding;

(f) the number of lawsuits previously filed against the insurer's insureds which were dismissed without settlement or trial and the number of insureds included therein during the calendar year next preceding;

(g) the number of lawsuits previously filed against the insurer's insureds which were settled without trial, the total monetary amount paid as settlements in such settled cases, and the number of insureds included therein during the calendar year next preceding;

(h) the number of lawsuits against the insurer's insureds which went to trial during the calendar year next preceding and the number of such cases ending in the following:

(i) judgment or verdict for the plaintiff;

(ii) judgment or verdict for the defendant;

(iii) other;

(i) the total monetary amount paid out, in those lawsuits specified in subsection (h);

(j) the total number of the insurer's insureds included in those lawsuits specified in subsection (h);

(k) the number of new trials granted during the

calendar year next preceding;

(l) the number of lawsuits pending on appeal as of December 31 of the next preceding calendar year; and

(m) such other information and statistics as the commissioner considers necessary.

(3) The commissioner shall, ~~within 60 days of request~~ by October 1 of each calendar year, submit in writing to the appropriate licensing authority, in summary report form, the data and information furnished him pursuant to this section relevant to the particular profession, ~~or~~ facility, or class of facilities and shall likewise make the summary available to the public at the expense of the requestor, which data and information must be retained for at least 10 years."

SECTION 28. SECTION 17-6-202, MCA, IS AMENDED TO READ:

"17-6-202. Investment funds -- general provisions. (1) For each treasury fund account into which state funds are segregated by the department of administration pursuant to 17-2-106, individual transactions and totals of all investments shall be separately recorded to the extent directed by the department.

(2) However, the securities purchased and cash on hand for all treasury fund accounts not otherwise specifically designated by law or by the provisions of a gift, donation, grant, legacy, bequest, or devise from which the fund account originates to be invested shall be pooled in an

account to be designated "treasury cash account" and placed in one of the investment funds designated in 17-6-203. The share of the income for this account shall be credited to the general fund.

(3) If, within the list in 17-6-203 of separate investment funds, more than one investment fund is included which may be held jointly with others under the same separate listing, all investments purchased for that separate investment fund shall be held jointly for all the accounts participating therein, which shall share all capital gains and losses and income pro rata.

(4) The board of investments may loan the patient assured compensation fund up to $7,350,000 from funds in its control as provided in [section 7]. The loan must bear interest at 4% per year. The board shall credit the payments received pursuant to [section 10] to the funds from which the loan was made."

NEW SECTION. **Section 29.** Extension of authority. Any existing authority to make rules on the subject of the provisions of [this act] is extended to the provisions of [this act].

NEW SECTION. **Section 30.** ~~Nonseverability dissolution~~ DISSOLUTION ~~of fund transfer to Montana insurance guaranty association.~~ SEVERABILITY. ~~(1) (a) If any provision of this chapter, any provision of the sections~~

~~listed--in--subsection-(1)(b),-or-the-application-of-any-one of-those-provisions-to-any-person-or--circumstance--is--held invalid--by--a--decision-of-the-Montana-supreme-court-or-the United-States-supreme-court,-such--invalidity--shall--render this-entire-chapter-invalid-except-for-this-section,-whether or--not--the-other-provisions-or-application-of-this-chapter can--be--given--effect--without--the--invalid--provision--or application.~~

~~(b)--The---provisions--of--25-9-401--through--25-9-405, 25-15-202,-27-1-702,-27-1-703,-27-2-205(2),-28-1-301-through 28-1-303,-28-11-311,-and-this-chapter-are-not-severable.~~

~~(2)--(a)~~ (1) ~~The-assets-and-liabilities-of-the--primary pool--of--funds-must-be-transferred-to-the-Montana-insurance guaranty--association--created--under--33-10-103--upon---the occurrence-of-any-of-the-following-events:~~

~~(i)~~(A) ~~--(this chapter~~ ACT~~)~~ being--rendered--invalid because--of--one--or--more--of--the--reasons--set--forth--in subsection-(1);~~

~~(ii)~~(B) ~~--the-primary-pool-of-funds-not-being-maintained on-an-actuarially-sound-basis-for-more-than-3-years-from-the time--such--soundness--is--required--by--(this--act)-and-the probability-that-the-primary-pool-of-funds-will-be-exhausted by-the-payment-of-all-fixed-and-known-obligations-that--will become-final-within-3-years.~~

~~(b)~~(2) ~~--The-liabilities-of-the-fund,-including-coverage endorsements,---constitute--covered--claims--as--defined--in 33-10-102,--and--the--limit--of--liability--of--the--Montana insurance--guaranty--association--and--any-physician-against whom-a-claim-has-occurred-or-a-judgment-has-been-rendered-or with-whom-a-settlement-agreement-has-been--entered--into--is equal--to--the--limits-of-liability-of-the-Montana-insurance guaranty-association-under-33-10-105~~ (1) IF A PART OF [THIS ACT] IS INVALID, ALL VALID PARTS THAT ARE SEVERABLE FROM THE INVALID PART REMAIN IN EFFECT. IF A PART OF [THIS ACT] IS INVALID IN ONE OR MORE OF ITS APPLICATIONS, THE PART REMAINS IN EFFECT IN ALL VALID APPLICATIONS THAT ARE SEVERABLE FROM THE INVALID APPLICATIONS.

(2) THE ADMINISTRATOR MAY PETITION THE DISTRICT COURT OF THE FIRST JUDICIAL DISTRICT TO TERMINATE [THIS ACT] IF A PART OR ONE OR MORE APPLICATIONS OF A PART ARE INVALID AND:

(A) THE PRIMARY POOL OF FUNDS CANNOT BE MAINTAINED ON AN ACTUARIALLY SOUND BASIS FOR MORE THAN 3 YEARS FROM THE TIME SUCH SOUNDNESS IS REQUIRED BY [THIS ACT]; OR

(B) THE PRIMARY POOL OF FUNDS WILL BE EXHAUSTED BY THE PAYMENT OF ALL FIXED AND KNOWN OBLIGATIONS.

(3) ALL CLAIMANTS, PARTICIPATING PHYSICIANS, AND HOSPITALS, AS DEFINED IN [THIS ACT], HAVE STANDING TO APPEAR IN ANY COURT PROCEEDING INSTITUTED BY THE ADMINISTRATOR UNDER SUBSECTION (2).

(4) IF THE COURT FINDS THAT THE CONDITIONS DESCRIBED

IN EITHER SUBSECTION (2)(A) OR (2)(B), OR BOTH, HAVE OCCURRED, [THIS ACT] TERMINATES. UPON THE ENTRY OF AN ORDER OF TERMINATION THE COURT SHALL DIRECT THE ADMINISTRATOR TO TAKE POSSESSION OF THE ASSETS AND TO ADMINISTER THEM UNDER THE GENERAL SUPERVISION OF THE COURT.

(5) UPON AN ORDER OF TERMINATION, NO PERSON MAY SUBMIT A CLAIM UNDER [THIS ACT]. THE ADMINISTRATOR MAY NOT MAKE PAYMENTS TO CLAIMANTS UNTIL A DISTRIBUTION PLAN IS APPROVED BY THE COURT OR UPON PETITION OF AN INDIVIDUAL CLAIMANT ON THE BASIS OF HARDSHIP AND A SHOWING THAT IN ALL LIKELIHOOD THEY WOULD SHARE IN ANY DISTRIBUTION.

(6) WITHIN 30 DAYS OF THE TERMINATION ORDER THE ADMINISTRATOR SHALL SUBMIT TO THE COURT A PLAN OF DISTRIBUTION OF THE ASSETS. THE PLAN OF DISTRIBUTION MUST GIVE PRIORITY TO CLAIMANTS AND DISTRIBUTE THE FUNDS IN AN EQUITABLE MANNER.

(7) ALL CLAIMANTS WHO HAVE NOT RECEIVED A FINAL AWARD DETERMINATION BY THE PANEL ON THE DATE [THIS ACT] IS TERMINATED BY COURT ORDER ARE NOT BOUND BY THE PROVISIONS OF [THIS ACT].

NEW SECTION. **Section 31.** **Applicability.** [This act] applies to all causes of action that constitute medical malpractice claims of any nature, whether obstetrical or otherwise, where the cause of action includes one or more physicians who are qualified pursuant to the terms of [this

act] and a claim for coverage exists against the patient assured compensation fund. ~~Provided, however, that [section 22] does not affect rights and duties that matured, penalties that were incurred, or proceedings that were begun before [the effective date of this act] and that section applies, if at all, only to causes of action that accrue on or after the date of qualification of a physician under [this act] against whom such a cause of action accrues.~~

NEW SECTION. **Section 32.** **Effective date.** [This act] is effective on passage and approval.

-End-