

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

1 *HOUSE* BILL NO. *699*
 2 INTRODUCED BY *ADDY STEWART CONNELLY, BOCK*
 3 *KALLGA*
 4 A BILL FOR AN ACT ENTITLED: "AN ACT PROVIDING FOR A PATIENT
 5 ASSURED COMPENSATION FUND ABOVE LOW PRIMARY LIMITS OF
 6 INSURANCE, FOR THE PAYMENT OF MEDICAL LIABILITY CLAIMS
 7 AGAINST PHYSICIANS WHO DELIVER BABIES; PROVIDING FOR THE
 8 RETURN OF DOLLAR SAVINGS TO ORIGINAL CAPITALIZERS AND TO
 9 PATIENTS WHO ARE INJURED IN THE MEDICAL SYSTEM; PROVIDING
 10 FOR AN OBSTETRICAL ADVISORY COMMITTEE TO MAKE
 11 RECOMMENDATIONS REGARDING OBSTETRICAL CARE; PROVIDING FOR
 12 OBJECTIVE GUIDELINES FOR NONECONOMIC DAMAGES PROPORTIONATE
 13 TO THE SEVERITY OF INJURY OR THE LIFE EXPECTANCY OF THE
 14 INJURED PARTY; PROVIDING FOR VOLUNTARY ENTRY INTO BINDING
 15 ARBITRATION FOR OBSTETRICAL CLAIMS WITHOUT REGARD TO
 16 NEGLIGENCE OF THE PHYSICIAN; PROVIDING FOR ADMINISTRATION BY
 17 THE MONTANA MEDICAL LEGAL PANEL UNDER THE REIMBURSED
 18 SUPERVISION OF THE DEPARTMENT OF HEALTH AND ENVIRONMENTAL
 19 SCIENCES; PROVIDING FOR CAPITALIZATION BY A PREMIUM TAX ON
 20 CASUALTY CARRIERS; AMENDING SECTIONS 27-6-105, 27-6-602,
 21 33-10-102, AND 33-23-311, MCA; AND PROVIDING AN IMMEDIATE
 22 EFFECTIVE DATE."

23
 24 STATEMENT OF INTENT

25 A statement of intent is required for this bill because

1 it delegates rulemaking authority to the department of
 2 health and environmental sciences. This bill is intended to
 3 expand the authority of the department and to authorize the
 4 writing and adopting of rules in accordance with the Montana
 5 Administrative Procedure Act to:

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

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

13
 14 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

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

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

23 (2) The goals of this legislation are to:

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

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

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

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

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

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

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

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

1 legislature finds that:

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

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

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

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

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

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

25 (a) substantial previous increases in the cost of

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

7 (14) "Hospital" means a hospital as defined in
8 50-5-101.

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

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

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

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

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

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

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

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

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

21 (23) "Physician" means a physician as defined in
22 27-6-103.

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

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

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

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

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

13 NEW SECTION. **Section 5. Purpose** -- attachment to
14 department -- deposit and investment. (1) There is a patient
15 assured compensation fund. Money for the fund collected and
16 received pursuant to [sections 1 through 26] is to be used
17 exclusively for the purposes stated in [sections 1 through
18 26].

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

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

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

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

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

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

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

15 (A) as a family practitioner, an annual surcharge of
16 \$6,313;

17 (B) as an obstetrician, an annual surcharge of
18 \$13,141;

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

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

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

25 (3) Beginning with the first year of operation of

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

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

20 (5) The one-time refundable surcharges for casualty
 21 insurance carriers provided for in this section must be
 22 collected by the commissioner on March 1, 1989, pursuant to
 23 33-2-705 without deferral or installment or within 30 days
 24 of [the effective date of this act], whichever occurs later.
 25 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:

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

5 (b) the secondary pool of funds.

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

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

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

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

25 (2) claims for payment from the primary or secondary

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

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

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

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

15 (b) a duplicate original of a settlement entered into
16 by the administrator on behalf of the primary pool of funds
17 involving a physician qualified under the terms of [sections
18 1 through 26].

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

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

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

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

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

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

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

1 types:

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

3 (ii) other economic loss; and

4 (iii) noneconomic loss.

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

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

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

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

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

14 (i) 30 days after mailing; or

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

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

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

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

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

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

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

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

11 (a) pay all surcharges required by [sections 1 through
 12 26] in a timely manner;

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

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

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

1 some obstetrical privileges;

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

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

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

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

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

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

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

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

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

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

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

1 through 26]. The following provisions of Title 33 apply to
2 [sections 1 through 26]: 33-15-411; 33-15-504; 33-15-1101
3 through 33-15-1121; Title 33, chapter 18; Title 33, chapter
4 19; 33-23-301; and 33-23-302.

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

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

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

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

7 (2) The council shall make recommendations regarding:

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

14 (b) risk prevention and other quality of care;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

22 NEW SECTION. Section 23. Contractual right to
 23 extended reporting endorsements -- prior acts coverage. (1)
 24 Each physician qualified under [sections 1 through 26] has
 25 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,

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

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

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

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

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

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

16 (b) subsequent to any claim of injury and subsequent
17 to any known complications of delivery or pregnancy, the
18 patient shall provide the physician with an agreement to
19 arbitrate a claim arising out of the birthing process or
20 obstetrical care, on a form provided by the administrator.
21 The physician and the patient or the patient's
22 representative shall execute the agreement to arbitrate the
23 claim. Upon approval by the administrator, the agreement is
24 binding upon the patient, the patient's representative, any
25 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

1 the terms of this section.

2 (12) All costs of administration of the secondary pool
3 of funds must be paid from the secondary pool of funds, and
4 the costs of administration must be paid prior to the
5 payment of any required benefits or required obligations of
6 the secondary pool of funds provided elsewhere in [sections
7 1 through 26]. If the secondary pool of funds is
8 insufficient to pay the costs of administration of the
9 secondary pool or any attorney fees required to be paid by
10 the secondary pool, the administrator is authorized to loan
11 the secondary pool sufficient funds for the administration
12 or fee from the primary pool of funds if the loan would not
13 render the primary pool actuarially unsound. The loan is an
14 advance against future distributions pursuant to [section
15 10] and in lieu of the distributions. The loan plus interest
16 must be repaid to the primary pool of funds upon the future
17 distribution otherwise accruing.

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

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

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

1 state or any of its subdivisions.

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

8 **Section 27.** Section 27-6-105, MCA, is amended to read:
9 "27-6-105. What claims panel to review. The panel
10 shall review all malpractice claims or potential claims
11 against health care providers covered by this chapter,
12 except including those claims subject to a valid arbitration
13 agreement allowed by law ~~or upon which suit has been filed~~
14 ~~prior to April 19, 1977.~~"

15 **Section 28.** Section 27-6-602, MCA, is amended to read:
16 "27-6-602. Questions panel must decide. (1) Upon
17 consideration of all the relevant material, the panel shall
18 decide whether there is:

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

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

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

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

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

6 "33-10-102. Definitions. As used in this part, the
 7 following definitions apply:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

21 "33-23-311. Information required of professional
 22 liability insurers -- submission. (1) For purposes of this
 23 section, "profession" means the occupations engaged in by
 24 physicians, osteopaths, registered nurses, licensed
 25 practical nurses, dentists, optometrists, podiatrists,

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

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

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

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

13 (c) the number of claims made against the insurer's
14 insureds and the number of claims outstanding as of December
15 31 of the calendar year next preceding;

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

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

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

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

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

10 (i) judgment or verdict for the plaintiff;

11 (ii) judgment or verdict for the defendant;

12 (iii) other;

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

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

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

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

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

23 (3) The commissioner shall, ~~within 60 days of request~~
24 by October 1 of each calendar year, submit in writing to the
25 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

LC 1269/01

1 22] does not affect rights and duties that matured,
2 penalties that were incurred, or proceedings that were begun
3 before [the effective date of this act] and that section
4 applies, if at all, only to causes of action that accrue on
5 or after the date of qualification of a physician under
6 [this act] against whom such a cause of action accrues.

7 NEW SECTION. **Section 34.** Effective date. [This act]
8 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.

<u>FISCAL IMPACT:</u>	Current Biennium		
		FY89	
	Current	Proposed	Difference
	Law	Law	
<u>Revenues:*</u>	\$ -0-	\$6,291,000	\$6,291,000
<u>Expenditures:**</u>	\$ -0-	\$ 1,515	\$ 1,515
<u>Fund Impact:</u>			
State Special Revenue	\$ -0-	\$6,289,485	\$6,289,485



RAY SHACKLEFORD, BUDGET DIRECTOR
OFFICE OF BUDGET AND PROGRAM PLANNING

DATE 2/23/89



KELLY ADDY, PRIMARY SPONSOR

DATE 3/2/89

Fiscal Note for HB699, as introduced

11/21/99

Fiscal Note Request HB699, as introduced

Form BD-15

Page 2

FISCAL IMPACT:

	Current	<u>FY90</u> Proposed		Current	<u>FY91</u> Proposed	
	<u>Law</u>	<u>Law</u>	<u>Difference</u>	<u>Law</u>	<u>Law</u>	<u>Difference</u>
<u>Revenues:</u> *	\$ -0-	\$770,721	\$ 770,721	\$ -0-	\$770,721	\$ 770,721
<u>Expenditures:</u> **	\$ -0-	\$ 19,175	\$ 19,175	\$ -0-	\$ 7,175	\$ 7,175
<u>Fund Impact:</u>						
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.

HB 699

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.

(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].

1 ~~(6)~~(5) "Commissioner" means the commissioner of
2 insurance provided for in 2-15-1903.

3 ~~(7)~~(6) "Compensable injury" means any physical harm,
4 bodily impairment, disfigurement, or a delay in recovery,
5 under [section 24 22] that:

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

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

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

15 ~~(8)~~(7) "Condition" means the general state of health
16 of the patient prior to medical intervention.

17 ~~(9)~~(8) "Delay in recovery" means any undue additional
18 time spent under care that is not substantially attributable
19 to the condition for which medical intervention occurred and
20 includes consideration of the general health of the patient.

21 ~~(10)~~(9) "Department" means the department of health
22 and environmental sciences provided for in Title 2, chapter
23 15, part 21.

24 ~~(11)~~(10) "Designated premium equivalent" means the
25 dollar amount paid by a patient to a physician or deducted

1 from-the-charges-of-a-physician under [section 24 22].

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

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

16 ~~(14)~~(11) "Hospital" means a hospital as defined in
17 50-5-101.

18 ~~(15)~~(12) "Malpractice claim" means a malpractice claim
19 as defined in 27-6-103.

20 ~~(16)~~(13) "Medical intervention" means the rendering as
21 well as the omission of any care, treatment, or services
22 provided within the course of treatment administered by or
23 under the control of a physician or hospital.

24 ~~(17)~~(14) "Montana medical legal panel" means the panel
25 provided for in 27-6-104.

1 ~~{18}~~-"Noneconomic--damages"--means--those--damages--payable
 2 as--a--result--of--a--medical--malpractice--claim--against--a
 3 physician--or--a--physician--and--other--parties--that--are
 4 subjectively--determined--to--be--nonmonetary--or--nonpecuniary
 5 damages--including--but--not--limited--to--pain--suffering--
 6 inconvenience--grief--physical--impairment--disfigurement--
 7 mental--suffering--or--anguish--emotional--distress--loss--of
 8 society--and--companionship--loss--of--consortium--fear--of--loss--
 9 fear--of--illness--fear--of--injury--injury--to--reputation--
 10 humiliation--and--any--other--subjectively--determined
 11 nonmonetary--or--nonpecuniary--damages--

12 ~~{19}~~(15) "Obstetrical advisory council" means an
 13 advisory council created pursuant to 2-15-122 by the
 14 department and provided for in [section 20 19].

15 ~~{20}~~(16) "Patient" means an individual who receives or
 16 should have received care from a physician and includes any
 17 person OR ENTITY having a claim--of--any--kind--whether
 18 derivative--or--otherwise--as--a--result--of--alleged--medical
 19 malpractice--on--the--part--of--a--physician--or--having--a
 20 compensable--injury--Derivative--claims--include--but--are--not
 21 limited--to--the--claim--of--a--parent--or--parents--guardian--
 22 trustee--child--relative--attorney--or--any--other
 23 representative--of--a--patient--including--claims--for--economic
 24 damages--noneconomic--damages--attorney--fees--or--expenses--and
 25 all--similar--claims RIGHT OF ACTION UNDER 27-1-501.

1 ~~{21}~~(17) "Patient assured compensation fund" or "fund"
 2 means the fund created under [section 5] and comprised of a
 3 primary pool of funds and a secondary pool of funds.

4 ~~{22}~~-"Physical-harm"--means--a--wound--infection--disease--
 5 or--death--

6 ~~{23}~~(18) "Physician" means a physician as defined in
 7 27-6-103.

8 ~~{24}~~(19) "Primary pool of funds" means that separate
 9 and segregated portion of the fund established for the
 10 payment of claims, expenses, and other allowed and required
 11 expenditures pursuant to [sections 1 through 26 21], except
 12 for money payable from the secondary pool of funds.

13 ~~{25}~~(20) "Representative" means the spouse, parent,
 14 guardian, trustee, attorney, or other legal agent of the
 15 patient.

16 ~~{26}~~(21) "Secondary pool of funds" means that separate
 17 and segregated portion of the fund established for the
 18 payment of compensation, expenses, and other allowed and
 19 required expenditures pursuant to [section 24 22].

20 ~~{27}~~(22) "Surplus" means the excess of total assets
 21 minus liabilities of the primary pool of funds as defined by
 22 standard accounting practices for insurance carriers.

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

1 fund collected and received pursuant to [sections 1 through
2 26 24] is to be used exclusively for the purposes stated in
3 [sections 1 through 26 24].

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

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

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

21 NEW SECTION. Section 7. Capitalization and
22 maintenance of primary pool of funds and secondary pool of
23 funds -- surcharge. (1) To capitalize the primary pool of
24 funds and the secondary pool of funds, there is levied-and
25 collected-on-all-insurance-carriers-authorized-to-write--and

1 engaged--in--writing-casualty-insurance-pursuant-to-33-i-206
2 in-this-state-during-1987-and-engaged--in--writing--casualty
3 insurance--as--of--December--31,--1988,--a-one-time-refundable
4 surcharge-in-the-form-of-a-1.17%-premium-tax-surcharge-based
5 on-1987-carrier-annual-reports-made-pursuant-to-33-2-785,--A
6 total--of--\$100,000-of-the-surcharge-forms-the-capitalization
7 of-the-secondary-pool--of--funds--and--the--balance--of--the
8 surcharge--forms--the--capitalization-of-the-primary-pool-of
9 funds.--If-the-surcharges-provided-for-in--this--section--are
10 refunded,--the--refund-must-be-made-in-the-method-and-manner
11 provided-for-in-[section-10]. A LOAN OF \$6,300,000 FROM THE
12 STATE GENERAL FUND TO THE PRIMARY POOL OF FUNDS AND A LOAN
13 OF \$100,000 FROM THE STATE GENERAL FUND TO THE SECONDARY
14 POOL OF FUNDS. THE LOANS ARE NOT APPROPRIATIONS AND MUST BE
15 REPAID UNDER [SECTION 10], WITHOUT INTEREST.

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

22 (a) (i) for coverage from the primary pool of funds
23 from \$100,000 per occurrence and \$300,000 in the annual
24 aggregate up to \$1 million per occurrence and \$3 million in
25 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-17-1989--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

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

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

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

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

7 (b) the secondary pool of funds.

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

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

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

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

1 paid no later than the following July 15; and

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

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

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

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

20 (b) a duplicate original of a settlement entered into
21 by the administrator on behalf of the primary pool of funds
22 involving a physician qualified under the terms of [sections
23 1 through 26 24].

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

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

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

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

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

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

1 statement--must--include--separately--stated--the--amounts
2 previously-paid-and-the--additional--amounts--demanded--with
3 respect--to--the--damages--as--a-whole-without-regard-to-any
4 previous-payment--The-statement-must-also-include:

5 {a}--the-amount-of-any-past-damages--itemized--as--to
6 economic-and-noneconomic-damages--and

7 {b}--any-future-damages-and-the-periods-over-which-they
8 will-accrue--on-an-annual-basis--for-each-of-the-following
9 types:

10 {i}--medical-and-other-costs-of-health-care;

11 {ii}--other-economic-loss--and

12 {iii}--noneconomic-loss.

13 {3}--The-calculation-of-future-damages-under-subsection
14 {2}--must-be-based-on-the-costs-and-losses-during-the--period
15 of--time--the--claimant--will-sustain-those-costs-and-losses
16 unless-a-claim-of-wrongful-death-is--involved--In-wrongful
17 death-claims--future-damages--must-be-based-on-the-losses
18 during-the-period-of-time-the-injured-party-would-have-lived
19 but-for-the-injury-upon-which-the-claim-is--based--and--the
20 claimed--future--damages-must-be-expressed-in-current-values
21 without-regard-to-future-changes-in--the--earning--power--or
22 purchasing-power-of-the-dollar.

23 {4}--If--a-claim-of-wrongful-death-is-not-involved--the
24 statement--under--subsection--{2}--must--state--the--claimed
25 severity--of-the-injury-and-whether-the-injury-is-limited-to

1 mental-or-emotional-harm-or-involves-physical-harm--if--the
2 injury--involves--physical--harm--the--claimant-shall-state
3 whether-the-physical--harm--includes--bodily--impairment--or
4 disfigurement.

5 {5}--The-statement--under--subsection--{2}--must--also
6 specify-what-percentage-of-the-claimed-damages--are--alleged
7 to--be--the--responsibility-of-each-physician-against-whom-a
8 claim-is-made.

9 {6}--If--within-30-days-after-receipt-of-the-statement,
10 the-administrator-has-not-accepted-the-offer--of--settlement
11 in--writing--the-claimant-may-proceed-with-any-claim-against
12 the-physician--The-patient-assured-compensation-fund-must-be
13 named-as-a-necessary--and--proper--party--in--any--state--or
14 federal--court--proceeding--for-all-causes-of-action-arising
15 after--{the-effective-date-of-this-act}.

16 {7}--{a}--The-statute-of-limitations-with-respect-to-any
17 medical-malpractice-claim--against--a--qualified--physician
18 under--{sections--1--through-26}--is-tolled-by-the-deposit-in
19 the-United-States-mail--of--the--writing--required--by--this
20 section--and--does--not-begin-to-run-again-until--the-greater
21 of:

22 {i}--30-days-after-mailing--or

23 {ii}--the-running-of-the--applicable--limitation--period
24 under-27-6-702.

25 {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

1 qualify for change of coverage -- limits of liability of
 2 fund -- rights and duties of physician. (1) A physician who
 3 fails to qualify under [sections 1 through 26 24] or who
 4 becomes disqualified is not covered by the provisions of
 5 [sections 1 through 26 24] after the date of
 6 disqualification and is subject to liability under the law
 7 without regard to the provisions of [sections 1 through 26
 8 24], EXCEPT FOR CLAIMS MADE WHILE THE PHYSICIAN WAS
 9 QUALIFIED. If a physician does not qualify, the claimant's
 10 remedy will not be affected by the terms and provisions of
 11 [sections 1 through 26 24]. The primary pool of funds is not
 12 liable for any amounts up to the limits of qualifying
 13 coverage of a physician established in [section 16 15]. The
 14 secondary pool of funds is liable only up to the amounts
 15 contained in that fund in the manner provided in [section 24
 16 22].

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

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

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

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

17 (5) Failure to maintain levels of coverage required
 18 under this section or nonrenewal, cancellation, or the
 19 elimination of obstetrical coverage for lower limits of
 20 coverage constitute CONSTITUTES disqualification of the
 21 physician under the terms of [sections 1 through 26 24] when
 22 the changes become effective with respect to the lower
 23 limits of coverage, if at all. The carrier providing lower
 24 limits of coverage shall promptly notify the administrator
 25 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

1 the postpartum woman;

2 (b) risk prevention and other quality of care;

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

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

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

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

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

5 NEW-SECTION,--Section-22,--Predictability--of--damages,--
6 in--a--trial--in--district--court--of--any--medical--malpractice
7 action--for--damages--for--injury--not--including--wrongful--death
8 where--the--patient--assured--compensation--fund--is--a--party--to
9 the--action,--the--court--shall:

10 {1}--upon--proper--motion--of--any--party--subsequent--to
11 verdict--and--before--entry--of--judgment,--review--an--award
12 against--any--party--for--noneconomic--damages--to--determine
13 whether--the--award--is--clearly--excessive--or--inadequate,--if
14 the--award--is--not--in--substantial--accord--with--a--proper--award
15 of--damages--after--considering--the--factors--in--subsection--(2),
16 the--court--shall,--acting--with--caution--and--discretion,--modify
17 the--award--in--a--manner--reasonably--consistent--with--that
18 subsection,--unless--there--is--clear--and--convincing--evidence
19 that--the--interest--of--justice--would--not--be--served--by--the
20 modification,--The--court--shall--give--written--reasons--for--a
21 modification--or--refusal--to--modify,--if--the--party--adversely
22 affected--by--any--modification--objects,--the--court--shall--order
23 a--new--trial--on--the--issue--of--noneconomic--damages--only,--
24 Economic--damages--awarded--and--the--fact--of--liability--are
25 admissible--at--the--new--trial,--but--factual--matters--pertaining

1 to-liability-are-not-admissible;
 2 {2}--in---determining---whether---an---award---requires
 3 modification-under-subsection-{1},-consider:
 4 {a}--whether--the--amount--awarded-indicates-prejudice,
 5 passion,-or-corruption-on-the-part-of-the-trier-of-fact;
 6 {b}--whether-it-clearly-appears-that-the-trier-of--fact
 7 ignored--the--evidence-in-reaching-a-verdict-or-misconceived
 8 the-merits-of-the-case-as-to-damages-recoverable;
 9 {c}--whether-the-trier-of-fact-took--improper--elements
 10 of--damages-into-account-or-arrived-at-the-amount-of-damages
 11 by-speculation-and-conjecture;
 12 {d}--whether-the-award-is--reasonably--related--to--the
 13 damages--proved--and--the--injury--suffered--pursuant-to-the
 14 guidelines-in-subsection-{3},-and
 15 {e}--whether-the-award-is-supported-by-the-evidence-and
 16 could-be-adduced-in-a-logical-manner-by-reasonable--persons;
 17 {3}--use---the---guidelines---in---this--subsection--in
 18 determining-whether-to--modify--an--award--when--considering
 19 subsection--{2}{d};-Noneconomic-damages-are-not-proportional
 20 to-the-injury-received-if-they-exceed-the-greater-of:
 21 {a}--weekly--wage--compensation--benefits--as--computed
 22 pursuant-to-39-71-701-times-the-life-expectancy-in-weeks;-or
 23 {b}--the--multiple--of--economic-damages-awarded-by-the
 24 jury,-pursuant-to-the-severity-of-the-injury--as--determined
 25 by--th- finder-of-fact-as-properly-shown-by-the-evidence-for

1 purposes-of-calculation;-as-follows:
 2 {i}--for-mental-or-emotional-harm-only;-0.5--times--the
 3 amount--of--economic--damages--or--\$1--million;-whichever-is
 4 greater;
 5 {ii}--for-physical-harm--without--bodily--impairment--or
 6 disfigurement:-an--amount--equal--to-the-amount-of-economic
 7 damages-or-\$2-million;-whichever-is-greater;
 8 {iii}--for-bodily-impairment-or-disfigurement;-1.5-times
 9 the-amount-of-economic-damages-or-\$3-million;-whichever--is
 10 greater;
 11 NEW SECTION. Section 21. Contractual right to
 12 extended reporting endorsements -- prior acts coverage. (1)
 13 Each physician qualified under [sections 1 through 26 24]
 14 has the contractual right, on the same terms and conditions
 15 as that physician has under the qualifying lower limits of
 16 coverage, if any, to obtain an extended reporting
 17 endorsement for coverage by the primary pool of funds for
 18 claims for medical malpractice that occur during the time a
 19 physician was qualified under [sections 1 through 26 24] but
 20 that are reported after the physician ceases to be
 21 qualified.
 22 (2) The cost of the purchase of an extended reporting
 23 endorsement paid by the physician to the fund is equal to a
 24 multiple of the current annual surcharge under [section 7].
 25 The multiple is the lesser of the multiple being charged

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

3 (3) Prior acts and omissions coverage, provided to the
4 qualified physician upon qualification for coverage by the
5 primary pool of funds for claims that have occurred but have
6 not been made, must be provided only as to claims that are
7 also covered under the terms of a valid and collectible
8 primary policy of insurance coverage carried by the
9 physician, qualified as required by [sections 1 through 26
10 24] and any endorsements to the policy. Prior acts and
11 omissions coverage from the fund is subject to the following
12 exclusions and limitations in addition to those contained in
13 [sections 1 through 26 24]:

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

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

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

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

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

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

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

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

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

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

13 (4) if the patient wishes to participate in the
 14 secondary pool of funds:

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

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

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

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

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

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

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

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

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

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

19 (c) the sole and exclusive remedy for:

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

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

1 (8) THE IF A CLAIM HAS NOT BEEN FILED UNDER SUBSECTION
 2 (7), THE filing of a malpractice claim in federal court or
 3 pursuant to Title 27, chapter 6, against one or more
 4 physicians subject to [sections 1 through 26 24] constitutes
 5 a revocation in writing of the arbitration agreement
 6 provided for in this section ~~if the claim represents that~~
 7 ~~the claimant has been fully advised in writing by legal~~
 8 ~~counsel of the options available under {sections 1 through~~
 9 ~~26} and a true and correct copy of the writing is attached~~
 10 ~~to the claim. If the claimant is not represented by counsel~~
 11 ~~in a Montana medical legal panel proceeding, the~~
 12 ~~administrator shall provide the advice in writing and the~~
 13 ~~claimant shall make a written binding election to proceed~~
 14 ~~with the malpractice claim or to amend the claim for~~
 15 ~~recovery under an arbitration agreement obtained pursuant to~~
 16 ~~subsection (6). The written advice and election must be~~
 17 ~~filed with the Montana medical legal panel.~~

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

22 (10) (a) Required benefits under this section are:
 23 ~~limited to the following items as computed under {sections 1~~
 24 ~~through 26}:~~

25 ~~(i) medical and hospital expenses and future medical~~

1 ~~and hospital expenses as incurred, computed and paid in the~~
 2 ~~manner provided in 39-71-704 and the rules implementing that~~
 3 ~~section;~~

4 ~~(ii) lost earnings and future lost earnings as~~
 5 ~~incurred, computed, and paid in the manner provided in~~
 6 ~~39-71-701(1) and according to the definition of average~~
 7 ~~weekly wage in 39-71-116 and the rules implementing those~~
 8 ~~sections; and~~

9 ~~(iii) reasonable attorney fees for panel proceedings,~~
 10 ~~computed and paid in the manner provided in 39-71-613,~~
 11 ~~39-71-614, and the rules implementing those sections.~~

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

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

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

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

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

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

6 ~~{c)--Proceeds---to---beneficiaries;---as---defined---in~~
 7 ~~39-71-116;--must--be--determined--pursuant-to-39-71-723;--and~~
 8 ~~lump-sum-payments-for-future-benefits-are-prohibited;.~~

9 (11) All awards must be paid from the secondary pool of
 10 funds on ~~an-annual~~ A MONTHLY basis for required benefits
 11 that have accrued and pursuant to Title 25, chapter 9, part
 12 4, for future required benefits, and that part applies in
 13 all instances to claims for required benefits except as
 14 otherwise provided in this section and to the extent the
 15 secondary pool of funds has sufficient funds for payments
 16 without becoming actuarially unsound. If the secondary pool
 17 of funds has insufficient funds with which to pay an award
 18 or awards, payments must be made in the same manner, pro
 19 rata as to all claims against the secondary pool of funds at
 20 the time of the required payment. The unpaid amounts of any
 21 award constitute a future obligation of the secondary pool
 22 of funds as funds become available. The future obligation is
 23 not enforceable by any process of law other than pursuant to
 24 the terms of this section.

25 (12) All costs of administration of the secondary pool

1 of funds must be paid from the secondary pool of funds, and
 2 the costs of administration must be paid prior to the
 3 payment of any required benefits or required obligations of
 4 the secondary pool of funds provided elsewhere in {sections
 5 1 through 26 24}. If the secondary pool of funds is
 6 insufficient to pay the costs of administration of the
 7 secondary pool or any attorney fees required to be paid by
 8 the secondary pool, the administrator is authorized to loan
 9 the secondary pool sufficient funds for the administration
 10 or fee from the primary pool of funds if the loan would not
 11 render the primary pool actuarially unsound. The loan is an
 12 advance against future distributions pursuant to {section
 13 10} and in lieu of the distributions. The loan plus interest
 14 must be repaid to the primary pool of funds upon the future
 15 distribution otherwise accruing.

16 (13) The arbitration agreement form promulgated by the
 17 department must include on its face a written notice of the
 18 substance of subsections {9}-and (7) THROUGH (10) in red,
 19 10-point type.

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

23 NEW SECTION. Section 23. Tax exemption. The fund is
 24 exempt from payment of all fees and all taxes levied by this
 25 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 28. ~~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

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

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

9 (i) judgment or verdict for the plaintiff;

10 (ii) judgment or verdict for the defendant;

11 (iii) other;

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

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

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

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

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

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

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

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

9 NEW SECTION. Section 29. Nonseverability-----
10 DISSOLUTION of fund -- transfer to Montana
11 insurance guaranty association. ~~{1}-{a}-If-any-provision-of~~
12 ~~this--chapter--any--provision--of--the--sections--listed-in~~
13 ~~subsection-{1}{b}, or the application of any one of those~~
14 ~~provisions--to-any-person-or-circumstance-is-held-invalid-by~~
15 ~~a-decision-of-the-Montana-supreme-court-or-the-United-States~~
16 ~~supreme-court, such--invalidity--shall--render--this--entire~~
17 ~~chapter--invalid-except-for-this-section, whether or not the~~
18 ~~other-provisions-or-application-of-this-chapter-can-be-given~~
19 ~~effect-without-the-invalid-provision-or-application.~~

20 ~~{b}-The-provisions-of--25-9-401--through--25-9-405,~~
21 ~~25-15-202, 27-1-702, 27-1-703, 27-2-205{2}, 28-1-301-through~~
22 ~~28-1-303, 28-11-311, and this chapter are not severable.~~

23 ~~{2}-{a} {1}~~ The assets and liabilities of the primary
24 pool of funds must be transferred to the Montana insurance
25 guaranty association created under 33-10-103 upon the

1 occurrence of any of the following events:

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

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

11 ~~{b}~~(2) The liabilities of the fund, including coverage
12 endorsements, constitute covered claims as defined in
13 33-10-102, and the limit of liability of the Montana
14 insurance guaranty association and any physician against
15 whom a claim has occurred or a judgment has been rendered or
16 with whom a settlement agreement has been entered into is
17 equal to the limits of liability of the Montana insurance
18 guaranty association under 33-10-105.

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

1 ~~22} --does--not--affect--rights--and--duties--that---matured,~~
2 ~~penalties--that--were--incurred,--or--proceedings--that--were--begun~~
3 ~~before--{the--effective--date--of--this--act}--and--that--section~~
4 ~~applies,--if--at--all,--only--to--causes--of--action--that--accrue--on~~
5 ~~or--after--the--date--of--qualification--of--a--physician--under~~
6 ~~{this--act}--against--whom--such--a--cause--of--action--accrues,~~

7 NEW SECTION. Section 31. Effective date. [This act]
8 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, 33-10-102, 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

1 areas of Montana.

2 (2) The goals of this legislation are to:

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

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

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

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

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

1 previous civil justice reform legislation; and

2 ~~{f}{E}~~ provide an immediate reduction in the total
3 cost of coverage for medical liability insurance for
4 physicians who deliver babies.

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

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

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

15 ~~{3}--in-addition-to-the-direct-loss-of-obstetrical~~
16 ~~services-in-rural-areas-of-Montana,there-have-been-and-will~~
17 ~~likely-continue-to-be;~~

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

24 ~~{b}--limitations-on-the-availability-and-access-to~~
25 ~~obstetrical-care-in-urban-areas,especially-among~~

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

6 ~~{4}{3}~~ the impacts referred to in subsection ~~{3}~~
 7 SUBSECTIONS (1) AND (2) are strongly associated with, among
 8 other things:

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

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

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

24 ~~{5}{4}~~ the medical insurance legal system, because of
 25 its unpredictability and high cost, often ~~deprives~~ CAN

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

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

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

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

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

19 ~~{4}--"Bodily impairment"--means temporary or permanent~~
 20 ~~impairment or loss of bodily functions or bodily parts--The~~
 21 ~~term does not include other impairments, including but not~~
 22 ~~limited to mental or emotional processes or behavioral~~
 23 ~~controls.~~

24 ~~{5}{4}~~ "Claimant" means a person claiming damages for
 25 injury from medical malpractice or required benefits for

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

2 {6}{5} "Commissioner" means the commissioner of
3 insurance provided for in 2-15-1903.

4 {7}{6} "Compensable injury" means any physical harm,
5 bodily impairment, disfigurement, or a delay in recovery,
6 under [section 24 22] that:

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

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

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

16 {8}{7} "Condition" means the general state of health
17 of the patient prior to medical intervention.

18 {9}{8} "Delay in recovery" means any undue additional
19 time spent under care that is not substantially attributable
20 to the condition for which medical intervention occurred and
21 includes consideration of the general health of the patient.

22 {10}{9} "Department" means the department of health
23 and environmental sciences provided for in Title 2, chapter
24 15, part 21.

25 {11}{10} "Designated premium equivalent" means the

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

3 {12} "Disfigurement" means scars or adverse changes in
4 bodily appearance beyond those that are medically required.

5 {13} "Economic damages" means those compensatory
6 damages payable as a result of a medical malpractice claim
7 against a physician or a physician and other parties that
8 are objectively determinable and verifiable compensatory
9 damages, including but not limited to medical expenses and
10 care, rehabilitation services, custodial care, loss of
11 earnings and earning capacity, loss of income, funeral or
12 burial expenses, loss of use of property, costs of repair or
13 replacement of property, costs of obtaining substitute
14 domestic services, loss of employment, loss of business or
15 employment opportunities, and any other objectively
16 determinable and verifiable pecuniary or monetary damages.

17 {14}{11} "Hospital" means a hospital as defined in
18 50-5-101.

19 {15}{12} "Malpractice claim" means a malpractice claim
20 as defined in 27-6-103.

21 {16}{13} "Medical intervention" means the rendering as
22 well as the omission of any care, treatment, or services
23 provided within the course of treatment administered by or
24 under the control of a physician or hospital.

25 {17}{14} "Montana medical legal panel" means the panel

1 provided for in 27-6-104.

2 ~~{18}~~ "Noneconomic--damages"--means--those--damages--payable
3 as--a--result--of--a--medical--malpractice--claim--against--a
4 physician--or--a--physician--and--other--parties--that--are
5 subjectively--determined--to--be--nonmonetary--or--nonpecuniary
6 damages;--including--but--not--limited--to--pain;--suffering;
7 inconvenience;--grief;--physical--impairment;--disfigurement;
8 mental--suffering--or--anguish;--emotional--distress;--loss--of
9 society--and--companionship;--loss--of--consortium;--fear--of--loss;
10 fear--of--illness;--fear--of--injury;--injury--to--reputation;
11 humiliation;--and--any--other--subjectively--determined
12 nonmonetary--or--nonpecuniary--damages.

13 ~~{19}~~(15) "Obstetrical advisory council" means an
14 advisory council created pursuant to 2-15-122 by the
15 department and provided for in [section 20 19].

16 ~~{20}~~(16) "Patient" means an individual who receives or
17 should have received care from a physician and includes any
18 person OR ENTITY having a claim--of--any--kind;--whether
19 derivative--or--otherwise;--as--a--result--of--alleged--medical
20 malpractice--on--the--part--of--a--physician--or--having--a
21 compensable--injury;--Derivative--claims--include--but--are--not
22 limited--to--the--claim--of--a--parent--or--parents;--guardian;
23 trustee;--child;--relative;--attorney;--or--any--other
24 representative--of--a--patient;--including--claims--for--economic
25 damages;--noneconomic--damages;--attorney--fees--or--expenses;--and

1 ~~all-similar-claims~~ RIGHT OF ACTION UNDER 27-1-501.

2 ~~{21}~~(17) "Patient assured compensation fund" or "fund"
3 means the fund created under [section 5] and comprised of a
4 primary pool of funds and a secondary pool of funds.

5 ~~{22}~~ "Physical harm"--means--a--wound;--infection;--disease;
6 or--death.

7 ~~{23}~~(18) "Physician" means a physician as defined in
8 27-6-103.

9 ~~{24}~~(19) "Primary pool of funds" means that separate
10 and segregated portion of the fund established for the
11 payment of claims, expenses, and other allowed and required
12 expenditures pursuant to [sections 1 through 26 24], except
13 for money payable from the secondary pool of funds.

14 ~~{25}~~(20) "Representative" means the spouse, parent,
15 guardian, trustee, attorney, or other legal agent of the
16 patient.

17 ~~{26}~~(21) "Secondary pool of funds" means that separate
18 and segregated portion of the fund established for the
19 payment of compensation, expenses, and other allowed and
20 required expenditures pursuant to [section 24 22].

21 ~~{27}~~(22) "Surplus" means the excess of total assets
22 minus liabilities of the primary pool of funds as defined by
23 standard accounting practices for insurance carriers.

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

1 There is a patient assured compensation fund. Money for the
2 fund collected and received pursuant to [sections 1 through
3 26 24] is to be used exclusively for the purposes stated in
4 [sections 1 through 26 24].

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

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

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

22 NEW SECTION. Section 7. Capitalization and
23 maintenance of primary pool of funds and secondary pool of
24 funds -- surcharge. (1) To capitalize the primary pool of
25 funds and the secondary pool of funds, there is levied and

1 collected on all insurance carriers authorized to write and
2 engaged in writing casualty insurance pursuant to 33-1-206
3 in this state during 1987 and engaged in writing casualty
4 insurance as of December 31, 1988, a one-time refundable
5 surcharge in the form of a 1.17% premium tax surcharge based
6 on 1987 carrier annual reports made pursuant to 33-2-705. A
7 total of \$100,000 of the surcharge forms the capitalization
8 of the secondary pool of funds and the balance of the
9 surcharge forms the capitalization of the primary pool of
10 funds; if the surcharges provided for in this section are
11 refunded, the refund must be made in the method and manner
12 provided for in [section 10]. A LOAN OF \$6,300,000 FROM THE
13 STATE GENERAL FUND TO THE PRIMARY POOL OF FUNDS AND A LOAN
14 OF \$100,000 FROM THE STATE GENERAL FUND TO THE SECONDARY
15 POOL OF FUNDS. THE LOANS ARE NOT APPROPRIATIONS AND MUST BE
16 REPAID UNDER [SECTION 10], WITHOUT INTEREST. LEVIED AND
17 COLLECTED ON ALL PROPERTY AND CASUALTY CARRIERS AUTHORIZED
18 TO WRITE AND ENGAGED IN WRITING PROPERTY AND CASUALTY
19 INSURANCE UNDER 33-1-206 OR 33-1-210 IN THIS STATE DURING
20 1987 AND ENGAGED IN WRITING PROPERTY AND CASUALTY INSURANCE
21 AS OF DECEMBER 31, 1988, A ONE-TIME REFUNDABLE SURCHARGE IN
22 THE FORM OF A 1.17% PREMIUM TAX SURCHARGE BASED ON 1987
23 CARRIER ANNUAL REPORTS MADE UNDER 33-2-705. A TOTAL OF
24 \$100,000 OF THE SURCHARGE FORMS THE CAPITALIZATION OF THE
25 SECONDARY POOL OF FUNDS, AND THE BALANCE OF THE SURCHARGE

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

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

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

19 ~~{A}--as--a--family-practitioner,--an--annual--surcharge--of~~
 20 ~~\$6,313;~~

21 ~~{B}--as--an--obstetrician,--an--annual--surcharge--of~~
 22 ~~\$13,141,~~ AN ANNUAL SURCHARGE THAT WILL KEEP THE PRIMARY POOL
 23 OF FUNDS ACTUARIALLY SOUND. THE STATUTORY LIMITATIONS AND
 24 REQUIREMENTS ON RATE CHANGES BY PRIMARY MEDICAL MALPRACTICE
 25 CARRIERS APPLY TO THE DETERMINATION OF SURCHARGES;

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

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

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

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

7 {3}--Beginning-with-the--first--year--of--operation--of
 8 {sections---1---through---26},--the--annual--surcharges--for
 9 physicians-provided-for-in-subsection-(2)(a)-are-subject--to
 10 annual---adjustment---by---the---administrator,--based-upon
 11 requirements-for-the-actuarial-soundness-of-the-primary-pool
 12 of-funds,--under-the--same--limitations--and--with--the--same
 13 requirements--as--a--rate--change--undertaken-by-the-primary
 14 carrier-of-the-physician.

15 {4}{3} The first annual surcharge for physicians
 16 provided for in this section must be collected by the
 17 Montana medical legal panel pursuant to 27-6-206 or within
 18 30 days of [the effective date of this act], whichever
 19 occurs later. Beginning in 1990 and in each year thereafter,
 20 all subsequent annual surcharges for physicians provided for
 21 in this section and beginning in 1991, all surcharges
 22 provided for physicians in subsection (2)(b) and for
 23 physicians and hospitals in subsection (2)(c) must be
 24 collected by the Montana medical legal panel pursuant to
 25 27-6-206. All collections must be remitted to the

1 department within 14 days of receipt.

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

23 {6}{4} The secondary pool of funds must be maintained
 24 solely through the surcharges on physicians and hospitals
 25 pursuant to subsections (2)(b) and (2)(c), distribution from

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

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

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

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

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

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

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

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

8 (b) the secondary pool of funds.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

13 ~~(iii) noneconomic loss;~~

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

24 ~~(4) if a claim of wrongful death is not involved, the~~
25 ~~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:

{1}--30-days-after-mailing; or

{11}--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

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

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

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

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

1 NEW SECTION. Section 16. Failure of physician to
2 qualify for change of coverage -- limits of liability of
3 fund -- rights and duties of physician. (1) A physician who
4 fails to qualify under [sections 1 through 26 24] or who
5 becomes disqualified is not covered by the provisions of
6 [sections 1 through 26 24] after the date of
7 disqualification and is subject to liability under the law
8 without regard to the provisions of [sections 1 through 26
9 24], EXCEPT FOR CLAIMS MADE WHILE THE PHYSICIAN WAS
10 QUALIFIED. If a physician does not qualify, the claimant's
11 remedy will not be affected by the terms and provisions of
12 [sections 1 through 26 24]. The primary pool of funds is not
13 liable for any amounts up to the limits of qualifying
14 coverage of a physician established in [section 16 15]. The
15 secondary pool of funds is liable only up to the amounts
16 contained in that fund in the manner provided in [section 24
17 22].

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

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

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

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

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

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

3 ~~{6}--Notwithstanding any other provision of {sections 1~~
 4 ~~through 26}, if the administrator determines that, due to~~
 5 ~~the number and dollar exposure of claims filed against a~~
 6 ~~physician qualified under {sections 1 through 26}, the~~
 7 ~~physician presents a material risk of significant future~~
 8 ~~liability to the fund, the administrator is authorized,~~
 9 ~~after notice and an opportunity for hearing, to terminate~~
 10 ~~the liability of the fund for all claims against the~~
 11 ~~physician.~~

12 ~~{7}{6}~~ Except as otherwise provided in [sections 1
 13 through 26 24], Title 33 has no application to [sections 1
 14 through 26 24]. The following provisions of Title 33 apply
 15 to [sections 1 through 26 24]: 33-15-411; 33-15-504;
 16 33-15-1101 through 33-15-1121; Title 33, chapter 18; Title
 17 33, chapter 19; 33-23-301; and 33-23-302.

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

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

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

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

21 (2) The council shall make recommendations regarding:

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

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

3 (b) risk prevention and other quality of care;

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

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

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

13 NEW SECTION. Section 20. Disciplinary action against
 14 physicians. After [the effective date of this act], upon the
 15 receipt by the board of information from the reports
 16 required by 33-23-311(3), 37-3-402, this section, or any
 17 other source that a physician has had three or more medical
 18 malpractice claims where a Montana medical legal panel
 19 result was adverse or indemnity has been paid or is payable
 20 in excess of the amount of \$10,000 for each claim within the
 21 previous 5-year period, the board shall investigate the
 22 occurrences upon which the claims were based. The board
 23 shall determine if action by the board against the physician
 24 is warranted UNDER 37-3-323 THROUGH 37-3-328 AND MAY TAKE
 25 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

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

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

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

9 (iii)--for--bodily--impairment--or--disfigurement--1.5-times
10 the--amount--of--economic--damages--or--\$3--million,--whichever-is
11 greater;

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

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

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

4 (3) Prior acts and omissions coverage, provided to the
5 qualified physician upon qualification for coverage by the
6 primary pool of funds for claims that have occurred but have
7 not been made, must be provided only as to claims that are
8 also covered under the terms of a valid and collectible
9 primary policy of insurance coverage carried by the
10 physician, qualified as required by [sections 1 through 26
11 24] and any endorsements to the policy. Prior acts and
12 omissions coverage from the fund is subject to the following
13 exclusions and limitations in addition to those contained in
14 [sections 1 through 26 24]:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

15 (5) A claim for recovery of required benefits must be
 16 filed pursuant to the provisions of Title 27, chapter 6,
 17 naming the secondary pool of funds a party, with that
 18 chapter and its rules of procedure being applicable to the
 19 secondary pool of funds as if it were a health care
 20 provider. The claim is governed by Title 27, chapter 6, as
 21 if it were a malpractice claim. THE ARBITRATION PANEL MUST
 22 BE COMPOSED OF AN ATTORNEY, A PHYSICIAN, AND A PROFESSIONAL
 23 ARBITRATOR. THE PROFESSIONAL ARBITRATOR MUST BE
 24 KNOWLEDGEABLE IN WORKERS' COMPENSATION LAW AND IS THE
 25 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}:

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

5 ~~(ii) lost earnings and future lost earnings as~~
 6 ~~incurred, computed, and paid in the manner provided in~~
 7 ~~39-71-701(i) and according to the definition of average~~
 8 ~~weekly wage in 39-71-116 and the rules implementing those~~
 9 ~~sections; and~~

10 ~~(iii) reasonable attorney fees for panel proceedings,~~
 11 ~~computed and paid in the manner provided in 39-71-613,~~
 12 ~~39-71-614, and the rules implementing those sections;~~

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

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

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

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

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

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

7 ~~(c) Proceeds to beneficiaries, as defined in~~
 8 ~~39-71-116, must be determined pursuant to 39-71-723, and~~
 9 ~~lump-sum payments for future benefits are prohibited;~~

10 (11) All awards must be paid from the secondary pool of
 11 funds on an ~~annual~~ A MONTHLY basis for required benefits
 12 that have accrued and pursuant to Title 25, chapter 9, part
 13 4, for future required benefits, and that part applies in
 14 all instances to claims for required benefits except as
 15 otherwise provided in this section and to the extent the
 16 secondary pool of funds has sufficient funds for payments
 17 without becoming actuarially unsound. If the secondary pool
 18 of funds has insufficient funds with which to pay an award
 19 or awards, payments must be made in the same manner, pro
 20 rata as to all claims against the secondary pool of funds at
 21 the time of the required payment. The unpaid amounts of any
 22 award constitute a future obligation of the secondary pool
 23 of funds as funds become available. The future obligation is
 24 not enforceable by any process of law other than pursuant to
 25 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 1, 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

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

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

6 ~~"33-10-102. Definitions. As used in this part, the~~
 7 ~~following definitions apply:~~

8 ~~{i} "Association" means the Montana insurance guaranty~~
 9 ~~association created under 33-10-103;~~

10 ~~{2} (a) "Covered claim" means an unpaid claim,~~
 11 ~~including one for unearned premiums, or a contractual~~
 12 ~~guaranty for an extended reporting endorsement for claims~~
 13 ~~reported after the expiration of the policy period which~~
 14 ~~arises out of and is within the coverage and not in excess~~
 15 ~~of the applicable limits of an insurance policy to which~~
 16 ~~this part applies issued by an insurer, if such insurer~~
 17 ~~becomes an insolvent insurer after July 17, 1971; and:~~

18 ~~{i} the claimant or insured is a resident of this~~
 19 ~~state at the time of the insured event; or~~

20 ~~{ii} the property from which the claim arises is~~
 21 ~~permanently located in this state;~~

22 ~~{b} "Covered claim" shall does not include any amount~~
 23 ~~due a reinsurer, insurer, insurance pool, or underwriting~~
 24 ~~association, as subrogation recoveries or otherwise;~~

25 ~~{3} "Insolvent insurer" means an insurer;~~

1 ~~{a} authorized to transact insurance in this state~~
 2 ~~either at the time the policy was issued or when the insured~~
 3 ~~event occurred; and~~

4 ~~{b} determined to be insolvent by a court of competent~~
 5 ~~jurisdiction;~~

6 ~~{4} "Member insurer" means any person who:~~

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

10 ~~{b} is licensed to transact insurance in this state;~~

11 ~~{5} "Net direct written premiums" means direct gross~~
 12 ~~premiums written in this state on insurance policies to~~
 13 ~~which this part applies, less return premiums thereon and~~
 14 ~~dividends paid or credited to policyholders on such direct~~
 15 ~~business. "Net direct written premiums" does not include~~
 16 ~~premiums on contracts between insurers or reinsurers;~~

17 ~~{6} "Person" means any individual, corporation,~~
 18 ~~partnership, association, or voluntary organization."~~

19 **Section 27.** ~~Section 33-23-311, MCA, is amended to~~
 20 ~~read:~~

21 ~~"33-23-311. Information required of professional~~
 22 ~~liability insurers -- submission. (1) For purposes of this~~
 23 ~~section, "profession" means the occupations engaged in by~~
 24 ~~physicians, osteopaths, registered nurses, licensed~~
 25 ~~practical nurses, dentists, optometrists, podiatrists,~~

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

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

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

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

13 (c) the number of claims made against the insurer's
14 insureds and the number of claims outstanding as of December
15 31 of the calendar year next preceding;

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

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

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

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

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

10 (i) judgment or verdict for the plaintiff;

11 (ii) judgment or verdict for the defendant;

12 (iii) other;

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

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

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

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

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

23 (3) The commissioner shall, ~~within 60 days of request~~
24 by October 1 of each calendar year, submit in writing to the
25 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.** (i)-(a)-if any provision--of--this--chapter,--any-provision-of-the-sections listed-in-subsection-(i)(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) (i) 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 (i);

(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.

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

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

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

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

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

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

25 (6) WITHIN 30 DAYS OF THE TERMINATION ORDER THE

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

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

9 NEW SECTION. Section 30. Applicability. [This act]
 10 applies to all causes of action that constitute medical
 11 malpractice claims of any nature, whether obstetrical or
 12 otherwise, where the cause of action includes one or more
 13 physicians who are qualified pursuant to the terms of [this
 14 act] and a claim for coverage exists against the patient
 15 assured compensation fund. Provided, however, that--{section
 16 22}--does--not--affect--rights--and--duties--that--matured,
 17 penalties--that--were--incurred,--or--proceedings--that--were--begun
 18 before--{the--effective--date--of--this--act}--and--that--section
 19 applies,--if--at--all,--only--to--causes--of--action--that--accrue--on
 20 or--after--the--date--of--qualification--of--a--physician--under
 21 {this--act}--against--whom--such--a--cause--of--action--accrues.

22 NEW SECTION. Section 31. Effective date. [This act]
 23 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, 33-10-1027 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,



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

4 (2) The goals of this legislation are to:

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

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

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

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

23 {e}{D} provide a funding mechanism that is broader
24 than the available base of funds from obstetricians and
25 family practitioners providing obstetric care by using

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

4 {f}{E} provide an immediate reduction in the total
5 cost of coverage for medical liability insurance for
6 physicians who deliver babies.

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

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

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

17 {3}--in-addition-to--the--direct--loss--of--obstetrical
18 services-in-rural-areas-of-Montana,--there-have-been-and-will
19 likely-continue-to-be:

20 {a}--broader--adverse-economic-impacts-to-the-hospitals
21 in--those--communities,--including--the--closure--of--some
22 hospitals--with-resulting-adverse-impacts-on-the-communities
23 involved,--that-flow-from-a-loss-of-a-broad--range--of--basic
24 medical--services--as--physicians--who-deliver-babies-retire
25 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--~~

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

4 ~~{6}~~{5} "Commissioner" means the commissioner of
5 insurance provided for in 2-15-1903.

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

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

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

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

18 ~~{8}~~{7} "Condition" means the general state of health
19 of the patient prior to medical intervention.

20 ~~{9}~~{8} "Delay in recovery" means any undue additional
21 time spent under care that is not substantially attributable
22 to the condition for which medical intervention occurred and
23 includes consideration of the general health of the patient.

24 ~~{10}~~{9} "Department" means the department of health
25 and environmental sciences provided for in Title 2, chapter

1 15, part 21.

2 ~~{11}~~{10} "Designated premium equivalent" means the
3 dollar amount paid by a patient to a physician or deducted
4 from the charges of a physician under [section 24 22].

5 ~~{12}~~ "Disfigurement" means scars or adverse changes in
6 bodily appearance beyond those that are medically required.

7 ~~{13}~~ "Economic damages" means those compensatory
8 damages payable as a result of a medical malpractice claim
9 against a physician or a physician and other parties that
10 are objectively determinable and verifiable compensatory
11 damages, including but not limited to medical expenses and
12 care, rehabilitation services, custodial care, loss of
13 earnings and earning capacity, loss of income, funeral or
14 burial expenses, loss of use of property, costs of repair or
15 replacement of property, costs of obtaining substitute
16 domestic services, loss of employment, loss of business or
17 employment opportunities, and any other objectively
18 determinable and verifiable pecuniary or monetary damages.

19 ~~{14}~~{11} "Hospital" means a hospital as defined in
20 50-5-101.

21 ~~{15}~~{12} "Malpractice claim" means a malpractice claim
22 as defined in 27-6-103.

23 ~~{16}~~{13} "Medical intervention" means the rendering as
24 well as the omission of any care, treatment, or services
25 provided within the course of treatment administered by or

1 under the control of a physician or hospital.

2 {17}(14) "Montana medical legal panel" means the panel
3 provided for in 27-6-104.

4 {18}"Noneconomic--damages"--means--those--damages--payable
5 as--a--result--of--a--medical--malpractice--claim--against--a
6 physician--or--a--physician--and--other--parties--that--are
7 subjectively--determined--to--be--nonmonetary--or--nonpecuniary
8 damages,--including--but--not--limited--to--pain,--suffering,
9 inconvenience,--grief,--physical--impairment,--disfigurement,
10 mental--suffering--or--anguish,--emotional--distress,--loss--of
11 society--and--companionship,--loss--of--consortium,--fear--of--loss,
12 fear--of--illness,--fear--of--injury,--injury--to--reputation,
13 humiliation,--and--any--other--subjectively--determined
14 nonmonetary--or--nonpecuniary--damages.

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

18 {20}(16) "Patient" means an individual who receives or
19 should have received care from a physician and includes any
20 person OR ENTITY having a claim--of--any--kind,--whether
21 derivative--or--otherwise,--as--a--result--of--alleged--medical
22 malpractice--on--the--part--of--a--physician--or--having--a
23 compensable--injury,--Derivative--claims--include--but--are--not
24 limited--to--the--claim--of--a--parent--or--parents,--guardian,
25 trustee,--child,--relative,--attorney,--or--any--other

1 representative--of--a--patient,--including--claims--for--economic
2 damages,--noneconomic--damages,--attorney--fees--or--expenses,--and
3 all--similar--claims RIGHT OF ACTION UNDER 27-1-501.

4 {21}(17) "Patient assured compensation fund" or "fund"
5 means the fund created under [section 5] and comprised of a
6 primary pool of funds and a secondary pool of funds.

7 {22}"Physical--harm"--means--a--wound,--infection,--disease,
8 or--death.

9 {23}(18) "Physician" means a physician as defined in
10 27-6-103.

11 {24}(19) "Primary pool of funds" means that separate
12 and segregated portion of the fund established for the
13 payment of claims, expenses, and other allowed and required
14 expenditures pursuant to [sections 1 through 26 24], except
15 for money payable from the secondary pool of funds.

16 {25}(20) "Representative" means the spouse, parent,
17 guardian, trustee, attorney, or other legal agent of the
18 patient.

19 {26}(21) "Secondary pool of funds" means that separate
20 and segregated portion of the fund established for the
21 payment of compensation, expenses, and other allowed and
22 required expenditures pursuant to [section 24 22].

23 {27}(22) "Surplus" means the excess of total assets
24 minus liabilities of the primary pool of funds as defined by
25 standard accounting practices for insurance carriers.

1 NEW SECTION. Section 5. Purpose FUND CREATED --
 2 attachment to department -- deposit and investment. (1)
 3 There is a patient assured compensation fund. Money for the
 4 fund collected and received pursuant to [sections 1 through
 5 26 24] is to be used exclusively for the purposes stated in
 6 [sections 1 through 26 24].

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

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

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

24 NEW SECTION. Section 7. Capitalization and
 25 maintenance of primary pool of funds and secondary pool of

1 funds -- surcharge. (1) To capitalize the primary pool of
 2 funds and the secondary pool of funds, there is levied and
 3 collected on all insurance carriers authorized to write and
 4 engaged in writing casualty insurance pursuant to 33-1-206
 5 in this state during 1987 and engaged in writing casualty
 6 insurance as of December 31, 1988, a one-time refundable
 7 surcharge in the form of a 1.17% premium tax surcharge based
 8 on 1987 carrier annual reports made pursuant to 33-2-705. A
 9 total of \$100,000 of the surcharge forms the capitalization
 10 of the secondary pool of funds and the balance of the
 11 surcharge forms the capitalization of the primary pool of
 12 funds. If the surcharges provided for in this section are
 13 refunded, the refund must be made in the method and manner
 14 provided for in [section 10]. A LOAN OF \$6,300,000 FROM THE
 15 STATE GENERAL FUND TO THE PRIMARY POOL OF FUNDS AND A LOAN
 16 OF \$100,000 FROM THE STATE GENERAL FUND TO THE SECONDARY
 17 POOL OF FUNDS, THE LOANS ARE NOT APPROPRIATIONS AND MUST BE
 18 REPAID UNDER [SECTION 10], WITHOUT INTEREST, LEVIED AND
 19 COLLECTED ON ALL PROPERTY AND CASUALTY CARRIERS AUTHORIZED
 20 TO WRITE AND ENGAGED IN WRITING PROPERTY AND CASUALTY
 21 INSURANCE UNDER 33-1-206 OR 33-1-210 IN THIS STATE DURING
 22 1987 AND ENGAGED IN WRITING PROPERTY AND CASUALTY INSURANCE
 23 AS OF DECEMBER 31, 1988, A ONE-TIME REFUNDABLE SURCHARGE IN
 24 THE FORM OF A 1.17% PREMIUM TAX SURCHARGE BASED ON 1987
 25 CARRIER ANNUAL REPORTS MADE UNDER 33-2-705. A TOTAL OF

1 ~~\$100,000 OF THE SURCHARGE FORMS THE CAPITALIZATION OF THE~~
 2 ~~SECONDARY POOL OF FUNDS, AND THE BALANCE OF THE SURCHARGE~~
 3 ~~FORMS THE CAPITALIZATION OF THE PRIMARY POOL OF FUNDS, IF~~
 4 ~~THE SURCHARGE IS REPUNDED, THE REPUND MUST BE MADE IN THE~~
 5 ~~MANNER PROVIDED IN [SECTION 10]; A LOAN OF \$7,250,000 FROM~~
 6 ~~THE BOARD OF INVESTMENTS TO THE PRIMARY POOL OF FUNDS AND A~~
 7 ~~LOAN OF \$100,000 FROM THE BOARD OF INVESTMENTS TO THE~~
 8 ~~SECONDARY POOL OF FUNDS. THE LOANS ARE NOT APPROPRIATIONS~~
 9 ~~AND MUST BE REPAID UNDER [SECTION 10], WITH INTEREST AT 4%~~
 10 ~~PER YEAR.~~

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

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

1 {A}--as-a-family-practitioner,-an-annual--surcharge--of
 2 \$6,313;

3 {B}--as--an--obstetrician,-an-annual--surcharge--of
 4 \$13,141, AN ANNUAL SURCHARGE THAT WILL KEEP THE PRIMARY POOL
 5 OF FUNDS ACTUARIALLY SOUND. THE STATUTORY LIMITATIONS AND
 6 REQUIREMENTS ON RATE CHANGES BY PRIMARY MEDICAL MALPRACTICE
 7 CARRIERS APPLY TO THE DETERMINATION OF SURCHARGES;

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

15 (b) for each physician subject to the terms of
 16 [sections 1 through 26 24] who, after January 1, 1990, has
 17 an adverse ruling as to any medical malpractice claim by the
 18 Montana medical legal panel or a judgment or settlement as
 19 to a claim in excess of \$25,000 and less than \$50,000, the
 20 one-time sum of \$500 because of the claim. If the amount of
 21 the judgment or settlement as to the claim is \$50,000 or
 22 more, the one-time sum of \$1,000 because of the claim. Any
 23 insurer required to report to the board pursuant to 37-3-402
 24 shall also provide the report to the administrator and shall
 25 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--17--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--17--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

1 with:

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

4 (b) a duplicate original of a settlement entered into
5 by the administrator on behalf of the primary pool of funds
6 involving a physician qualified under the terms of [sections
7 1 through 26 24].

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

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

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

18 NEW SECTION. Section 14. Payment from primary pool of
19 funds after exhaustion of insurance coverage -- excess
20 claims -- procedure. (1) If a physician qualified under
21 [sections 1 through 26 24] or his insurer as UNDER INSURANCE
22 required by [section 16 15] has agreed to settle liability
23 on a claim by payment of its policy limits and the claimant
24 is demanding an amount in excess of the policy limits or if
25 the annual aggregate under the insurance for the physician

1 has been paid by or on behalf of the physician, the claimant
2 shall notify the administrator ~~in the manner provided in~~
3 ~~subsection (2) and receive a reply from the administrator as~~
4 ~~a condition precedent to recovery from the primary pool of~~
5 ~~funds.~~

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

14 ~~{a} the amount of any past damages, itemized as to~~
15 ~~economic and noneconomic damages; and~~

16 ~~{b} any future damages and the periods over which they~~
17 ~~will accrue, on an annual basis, for each of the following~~
18 ~~types:~~

19 ~~{i} medical and other costs of health care;~~

20 ~~{ii} other economic loss; and~~

21 ~~{iii} noneconomic loss.~~

22 ~~{3} The calculation of future damages under subsection~~
23 ~~{2} must be based on the costs and losses during the period~~
24 ~~of time the claimant will sustain those costs and losses~~
25 ~~unless a claim of wrongful death is involved, in wrongful~~

1 death--claims,--future--damages--must--be--based--on--the--losses
2 during--the--period--of--time--the--injured--party--would--have--lived
3 but--for--the--injury--upon--which--the--claim--is--based,--and--the
4 claimed--future--damages--must--be--expressed--in--current--values
5 without--regard--to--future--changes--in--the--earning--power--or
6 purchasing--power--of--the--dollar.

7 {4}--If--a--claim--of--wrongful--death--is--not--involved,--the
8 statement--under--subsection--{2}--must--state--the--claimed
9 severity--of--the--injury--and--whether--the--injury--is--limited--to
10 mental--or--emotional--harm--or--involves--physical--harm.--If--the
11 injury--involves--physical--harm,--the--claimant--shall--state
12 whether--the--physical--harm--includes--bodily--impairment--or
13 disfigurement.

14 {5}--The--statement--under--subsection--{2}--must--also
15 specify--what--percentage--of--the--claimed--damages--are--alleged
16 to--be--the--responsibility--of--each--physician--against--whom--a
17 claim--is--made.

18 {6}--If,--within--30--days--after--receipt--of--the--statement,
19 the--administrator--has--not--accepted--the--offer--of--settlement
20 in--writing,--the--claimant--may--proceed--with--any--claim--against
21 the--physician. The--patient--assured--compensation--fund--must--be
22 named--as--a--necessary--and--proper--party--in--any--state--or
23 federal--court--proceeding--for--all--causes--of--action--arising
24 after--{the--effective--date--of--this--act}.

25 {7}--{a}--The--statute--of--limitations--with--respect--to--any

1 medical--malpractice--claim--against--a--qualified--physician
2 under--{sections--1--through--26}--is--tolled--by--the--deposit--in
3 the--United--States--mail--of--the--writing--required--by--this
4 section--and--does--not--begin--to--run--again--until--the--greater
5 of:

6 {i}--30--days--after--mailing;--or
7 {ii}--the--running--of--the--applicable--limitation--period
8 under--27-6-702.

9 {b}--The--time--period--of--tolling--is--not--computed--as--part
10 of--the--period--within--which--the--action--may--be--brought.

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

15 {1}--payment--in--one--lump--sum--for--accrued--damages;
16 {2}--an--agreement--requiring--periodic--payments--from--the
17 primary--or--secondary--pool--of--funds--over--a--period--of--years;
18 {3}--the--purchase--of--an--annuity--payable--to--the

19 claimant,--with--the--administrator--having--the--power--to
20 contract--with--those--insurers--permitted--under--25-9-403{4};--or

21 {4}--any--combination--of--the--payment--plans--in
22 subsections--{1}--through--{3}.

23 NEW SECTION. Section 15. Qualifications for
24 physician. (1) In order to become and remain qualified under
25 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.

1 NEW SECTION. **Section 17.** Adequate defense of fund --
 2 notification as to reserves. The administrator may provide
 3 for the defense of the primary and secondary pool of funds
 4 against a claimant's claim ~~and may appeal a judgment which~~
 5 ~~affects the funds.~~ The physician or his insurer for
 6 qualifying coverage for lower limits shall provide an
 7 adequate defense to the claim and is in a fiduciary
 8 relationship with the primary or secondary pool of funds
 9 with respect to any claim. Any carrier representing a
 10 physician subject to [sections 1 through 26 24] shall
 11 immediately notify the administrator of any case upon which
 12 it has placed a reserve of \$50,000 or more.

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

18 NEW SECTION. **Section 19.** Appointment and
 19 recommendations of obstetrical advisory council. (1) The
 20 department shall appoint an obstetrical advisory council,
 21 subject to the approval of the governor, composed of seven
 22 people, ~~five~~ FOUR of whom must be physicians qualified under
 23 [sections 1 through 26 24]. The EXPENSES FOR TRAVEL AND
 24 LODGING AND THE ADMINISTRATION OF THE council must be funded
 25 from the primary pool of funds, and members must be

1 appointed for 4-year terms. A vacancy must be filled for the
 2 unexpired portion of the term in the same manner as the
 3 original appointment.

4 (2) The council shall make recommendations regarding:
 5 (a) prenatal and postnatal care, including but not
 6 limited to better access to comprehensive obstetrical
 7 services, improved professional competency, and peer review
 8 and quality assurance in connection with prenatal care,
 9 labor, delivery, immediate care of the newborn, and care of
 10 the postpartum woman;

11 (b) risk prevention and other quality of care;

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

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

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

21 NEW SECTION. **Section 20.** Disciplinary action against
 22 physicians. After [the effective date of this act], upon the
 23 receipt by the board of information from the reports
 24 required by 33-23-311(3), 37-3-402, this section, or any
 25 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 if 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.

1 ~~{3}--use--the--guidelines--in--this--subsection--in~~
 2 ~~determining-whether-to--modify--an--award--when--considering~~
 3 ~~subsection--{2}{d}--Noneconomic-damages-are-not-proportional~~
 4 ~~to-the-injury-received-if-they-exceed-the-greater-of:~~

5 ~~{a}--weekly--wage--compensation--benefits--as--computed~~
 6 ~~pursuant-to-39-71-701-times-the-life-expectancy-in-weeks;-or~~

7 ~~{b}--the--multiple--of--economic-damages-awarded-by-the~~
 8 ~~jury;-pursuant-to-the-severity-of-the-injury--as--determined~~
 9 ~~by--the-finder-of-fact-as-properly-shown-by-the-evidence-for~~
 10 ~~purposes-of-calculation;-as-follows:~~

11 ~~{i}--for-mental-or-emotional-harm-only;-0.5--times--the~~
 12 ~~amount--of--economic--damages--or--\$1--million;-whichever-is~~
 13 ~~greater;~~

14 ~~{ii}--for-physical-harm--without--bodily--impairment--or~~
 15 ~~disfigurement;-an--amount--equal--to-the-amount-of-economic~~
 16 ~~damages-or-\$2-million;-whichever-is-greater;~~

17 ~~{iii}--for-bodily-impairment-or-disfigurement;-1.5-times~~
 18 ~~the-amount-of-economic-damages-or-\$3-million;-whichever--is~~
 19 ~~greater;~~

20 **NEW SECTION. Section 21.** Contractual right to
 21 extended reporting endorsements -- prior acts coverage. (1)
 22 Each physician qualified under [sections 1 through 26 24]
 23 has the contractual right, on the same terms and conditions
 24 as that physician has under the qualifying lower limits of
 25 coverage, if any, to obtain an extended reporting

1 endorsement for coverage by the primary pool of funds for
 2 claims for medical malpractice that occur during the time a
 3 physician was qualified under [sections 1 through 26 24] but
 4 that are reported after the physician ceases to be
 5 qualified.

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

12 (3) Prior acts and omissions coverage, provided to the
 13 qualified physician upon qualification for coverage by the
 14 primary pool of funds for claims that have occurred but have
 15 not been made, must be provided only as to claims that are
 16 also covered under the terms of a valid and collectible
 17 primary policy of insurance coverage carried by the
 18 physician, qualified as required by [sections 1 through 26
 19 24] and any endorsements to the policy. Prior acts and
 20 omissions coverage from the fund is subject to the following
 21 exclusions and limitations in addition to those contained in
 22 [sections 1 through 26 24]:

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

25 (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 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

1 ~~funds-and-to-have-the-designated-premium-equivalent-deducted~~
 2 ~~from-the-fees-to-be-charged~~ OF INITIAL MEDICAL TREATMENT
 3 ~~RELATED TO THE BIRTHING PROCESS OR OBSTETRICAL CARE, MUST BE~~
 4 ~~INFORMED BY THE PHYSICIAN OF THE PROVISIONS OF SUBSECTION~~
 5 ~~(2) AND THIS SUBSECTION. THE PHYSICIAN SHALL AT THAT TIME~~
 6 ~~GIVE THE PATIENT A PAMPHLET THAT CLEARLY AND ADEQUATELY~~
 7 ~~DESCRIBES THE PROVISIONS OF [SECTIONS 1 THROUGH 24] AND~~
 8 ~~ADVISES THE PATIENT TO CONTACT AN ATTORNEY IF THE PATIENT~~
 9 ~~BELIEVES THE PATIENT HAS A MALPRACTICE CLAIM RELATED TO THE~~
 10 ~~BIRTHING PROCESS OR OBSTETRICAL CARE. THE PAMPHLET MUST BE~~
 11 ~~WRITTEN BY THE STATE BAR OF MONTANA, AND THE PRIMARY POOL~~
 12 ~~SHALL PAY THE COST OF PUBLISHING AND DISTRIBUTING THE~~
 13 ~~PAMPHLET. THE PHYSICIAN SHALL ADD THE DESIGNATED PREMIUM~~
 14 ~~EQUIVALENT TO THE FIRST BILL SENT TO THE PATIENT AND INFORM~~
 15 ~~THE PATIENT AT THE TIME OF THE INITIAL MEDICAL TREATMENT~~
 16 ~~THAT THE AMOUNT WILL BE ADDED TO THE BILL. If the patient~~
 17 ~~cannot afford the premium and-wishes-to-participate--in--the~~
 18 ~~secondary--pool-of-funds, the patient shall deliver a signed~~
 19 ~~letter to the physician to that effect and the premium must~~
 20 ~~be waived. The designated premium equivalent must also be~~
 21 ~~waived if prohibited by federal law.~~

22 (4) ~~if--the--patient--wishes--to--participate--in--the~~
 23 ~~secondary-pool-of-funds;~~

24 (a) ~~prior--to--any--claim--of--injury-and-prior-to-any~~
 25 ~~known--complications--of--delivery--or--pregnancy;--the~~ THE

1 physician shall immediately, WITHIN 30 DAYS OF THE TIME OF
 2 INITIAL MEDICAL TREATMENT, remit to the department the
 3 amount of any required designated premium equivalent or the
 4 letter from the patient stating an inability to pay the
 5 premium. ~~Failure-of-the-patient-to-pay-or-provide-the-letter~~
 6 ~~disqualifies--the--patient--from--any--participation--in--the~~
 7 ~~secondary-pool-of-funds.~~

8 (b) subsequent SUBSEQUENT to any claim of injury and
 9 subsequent to any known complications of delivery or
 10 pregnancy, the patient shall MAY provide the physician with
 11 an agreement to arbitrate a claim arising out of the
 12 birthing process or obstetrical care, on a form provided by
 13 the administrator. The physician and the patient or the
 14 patient's representative shall execute the agreement to
 15 arbitrate the claim. ~~Upon-approval-by-the-administrator,--the~~
 16 ~~agreement---is---binding---upon---the---patient;---the---patient's~~
 17 ~~representative,--any--claimant,--and--the--physician--for--purposes~~
 18 ~~of--a--claim--for--required--benefits--for--compensable--injuries~~
 19 ~~under--{sections--1--through--26};---An-executed-copy-of-the~~
 20 ~~agreement-to-arbitrate-must-be-provided-to-the-administrator~~
 21 ~~and-is-subject-to-his-approval-as-to-form-and-content-before~~
 22 ~~it-may-become-effective;~~

23 (5) A claim for recovery of required benefits must be
 24 filed pursuant to the provisions of Title 27, chapter 6,
 25 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~~

1 ~~filed with the Montana medical-legal panel.~~

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

6 (10) (a) Required benefits under this section are:
7 ~~limited to the following items as computed under {sections 1~~
8 ~~through 26}:~~

9 ~~{i}--medical and hospital expenses and--future--medical~~
10 ~~and--hospital expenses as incurred, computed and paid in the~~
11 ~~manner provided in 39-71-704 and the rules implementing that~~
12 ~~section;~~

13 ~~{ii}--lost--earnings--and--future--lost--earnings--as~~
14 ~~incurred, computed, and paid in the manner provided in~~
15 ~~39-71-701{1} and according to the definition of average~~
16 ~~weekly wage in 39-71-116 and the rules implementing those~~
17 ~~sections; and~~

18 ~~{iii}--reasonable attorney fees for--panel--proceedings,~~
19 ~~computed and paid in the manner provided in 39-71-613,~~
20 ~~39-71-614, and the rules implementing those sections;~~

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

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

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

3 (IV) REASONABLE ATTORNEY FEES INCURRED IN BRINGING THE
4 CLAIM BEFORE THE ARBITRATION PANEL, NOT TO EXCEED \$125 PER
5 HOURL.

6 (b) Required benefits do not include medical and
7 hospital expenses for items or services or reimbursement the
8 patient received or is entitled to receive under the laws of
9 any state or the federal government, except to the extent
10 exclusion of such benefits is prohibited by federal law, or
11 expenses paid by any prepaid health plan, health maintenance
12 organization, or private insuring entity or pursuant to the
13 provisions of any health or sickness insurance policy or
14 other private insurance program.

15 ~~{c}--Proceeds--to--beneficiaries,--as--defined--in~~
16 ~~39-71-116,--must--be--determined--pursuant to 39-71-723, and~~
17 ~~lump-sum payments for future benefits are prohibited;~~

18 (11) All awards must be paid from the secondary pool of
19 funds on an annual A MONTHLY basis for required benefits
20 that have accrued and pursuant to Title 25, chapter 9, part
21 4, for future required benefits, and that part applies in
22 all instances to claims for required benefits except as
23 otherwise provided in this section and to the extent the
24 secondary pool of funds has sufficient funds for payments
25 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 a 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 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

1 decide whether there is:

2 {1}(a) substantial evidence that the acts complained
3 of occurred and that they constitute malpractice; and

4 {2}(b) a reasonable medical probability that the
5 patient was injured thereby.

6 (2) If the panel decides that the acts complained of
7 did not constitute medical malpractice and if there is an
8 arbitration agreement pursuant to [sections 1 through 26
9 24], the panel shall decide whether there is a compensable
10 injury pursuant to [sections 1 through 26 24], and, if so,
11 make an award pursuant to [section 24 22]."

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

14 "33-10-102. Definitions. As used in this part, the
15 following definitions apply:

16 {1} "Association" means the Montana insurance guaranty
17 association created under 33-10-103;

18 {2} {a} "Covered claim" means an unpaid claim,
19 including one for unearned premiums, or a contractual
20 guaranty for an extended reporting endorsement for claims
21 reported after the expiration of the policy period which
22 arises out of and is within the coverage and not in excess
23 of the applicable limits of an insurance policy to which
24 this part applies issued by an insurer, if such insurer
25 becomes an insolvent insurer after July 17, 1971, and;

1 {i} the claimant or insured is a resident of this
2 state at the time of the insured event; or

3 {ii} the property from which the claim arises is
4 permanently located in this state;

5 {b} "Covered claim" shall does not include any amount
6 due a reinsurer, insurer, insurance pool, or underwriting
7 association, as subrogation recoveries or otherwise;

8 {3} "Insolvent insurer" means an insurer;

9 {a} authorized to transact insurance in this state
10 either at the time the policy was issued or when the insured
11 event occurred; and

12 {b} determined to be insolvent by a court of competent
13 jurisdiction;

14 {4} "Member insurer" means any person who:

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

18 {b} is licensed to transact insurance in this state;

19 {5} "Net direct written premiums" means direct gross
20 premiums written in this state on insurance policies to
21 which this part applies, less return premiums thereon and
22 dividends paid or credited to policyholders on such direct
23 business. "Net direct written premiums" does not include
24 premiums on contracts between insurers or reinsurers;

25 {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;

(1) 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~~

1 listed--in--subsection-(1)(b), or the application of any one
2 of those provisions to any person or circumstance is held
3 invalid by a decision of the Montana supreme court or the
4 United States supreme court, such invalidity shall render
5 this entire chapter invalid except for this section, whether
6 or not the other provisions or application of this chapter
7 can be given effect without the invalid provision or
8 application.

9 (b) The provisions of 25-9-401 through 25-9-405,
10 25-15-202, 27-1-702, 27-1-703, 27-2-205(2), 28-1-301 through
11 28-1-303, 28-11-311, and this chapter are not severable.

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

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

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

25 (b)(2) The liabilities of the fund, including coverage

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

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

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

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

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

25 (4) IF THE COURT FINDS THAT THE CONDITIONS DESCRIBED

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

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

12 (6) WITHIN 30 DAYS OF THE TERMINATION ORDER THE
 13 ADMINISTRATOR SHALL SUBMIT TO THE COURT A PLAN OF
 14 DISTRIBUTION OF THE ASSETS. THE PLAN OF DISTRIBUTION MUST
 15 GIVE PRIORITY TO CLAIMANTS AND DISTRIBUTE THE FUNDS IN AN
 16 EQUITABLE MANNER.

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

21 NEW SECTION. Section 31. Applicability. [This act]
 22 applies to all causes of action that constitute medical
 23 malpractice claims of any nature, whether obstetrical or
 24 otherwise, where the cause of action includes one or more
 25 physicians who are qualified pursuant to the terms of [this

1 act] and a claim for coverage exists against the patient
 2 assured compensation fund. Provided, however, that [section
 3 22] does not affect rights and duties that matured,
 4 penalties that were incurred, or proceedings that were begun
 5 before [the effective date of this act] and that section
 6 applies, if at all, only to causes of action that accrue on
 7 or after the date of qualification of a physician under
 8 [this act] against whom such a cause of action accrues.

9 NEW SECTION. Section 32. Effective date. [This act]
 10 is effective on passage and approval.

-End-