L.D. 762

(Filing No. H-1105)

STATE OF MAINE
HOUSE OF REPRESENTATIVES
114TH LEGISLATURE
SECOND REGULAR SESSION

HOUSE AMENDMENT "A" to S.P. 289, L.D. 762, Bill, "An Act to Establish the Maine Medical Malpractice Act"

Amend the bill by striking out everything after the enacting clause and before the statement of fact and inserting in its place the following:

'**Sec. 1. 5 MRSA §12004-I, sub-§§58-A, 58-B and 58-C** are enacted to read:

58-A. Medicine	Medical Specialty Advisory Committee on Anesthesiology	Expenses Only	24 MRSA §2982
58-B. Medicine	Medical Specialty Advisory Committee on Emergency Medicine	Expenses Only	24 MRSA §2982
58-C. Medicine	Medical Specialty Advisory Committee on Obstetrics and Gynecology	Expenses Only	24 MRSA §2982

Sec. 2. 24 MRSA §2857, sub-§3 is enacted to read:

3. Discovery; subsequent court action. The Maine Rules of Civil Procedure govern discovery conducted under this subchapter. The chair has the same authority to rule upon discovery matters as a Superior Court Justice. Notwithstanding subsection 1, in a subsequent Superior Court action all discovery conducted during the prelitigation screening panel proceedings is deemed discovery conducted as a part of that court action.

This subsection applies to all claims of professional negligence in which the notice of claim is served or filed on or after January 1, 1991.

Sec. 3. 24 MRSA §2906 is enacted to read:

§2906. Collateral sources

1. Definitions. As used in this section, unless the context otherwise indicates, the following terms have the following meanings.

A. "Claimant" means any person who brings a personal injury action and, if such an action is brought through or on behalf of an estate, the term includes the decedent or, if such an action is brought through or on behalf of a minor, the term includes the minor's parent or guardian.

B. "Collateral source" means a benefit paid or payable to the claimant or on the claimant's behalf under, from or pursuant to:

(1) The federal Social Security Act;

(2) Any state or federal income replacement, disability, workers' compensation or other law designed to provide partial or full wage or income replacement;

(3) Any accident, health or sickness insurance, income or wage replacement insurance, income disability insurance, casualty or property insurance, including automobile accident and homeowner's insurance benefits, or any other insurance benefits, except life insurance benefits;

(4) Any contract or agreement of any group, organization, partnership or corporation to provide, pay for or reimburse the cost of medical, hospital, dental or other health care services or provide similar benefits; or

(5) Any contractual or voluntary wage continuation plan or payments made pursuant to such a plan provided

by an employer or otherwise or any other system intended to provide wages during a period of disability.

C. "Damages" means economic losses paid or payable by collateral sources for wage losses, medical costs, rehabilitation costs, services and other out-of-pocket costs incurred by or on behalf of a claimant for which that party is claiming recovery through a tort suit.

2. Collateral source payment reductions. In all actions for professional negligence, as defined in section 2502, evidence to establish that the plaintiff's expense of medical care, rehabilitation services, loss of earnings, loss of earning capacity or other economic loss was paid or is payable, in whole or in part, by a collateral source is admissible to the court in which the action is brought after a verdict for the plaintiff and before a judgment is entered on the verdict. Subject to subsection 4, if the court determines that all or part of the plaintiff's expense or loss has been paid or is payable by a collateral source and the collateral source has not exercised its right to subrogation within the time limit set forth in subsection 3, the court shall reduce that portion of the judgment that represents damages paid or payable by a collateral source. The court shall reduce that reduction by an amount equal to the claimant's payments over the 2-year period immediately predating the personal injury to the collateral source in the form of payroll deductions, insurance premiums or other direct payments by the claimant, as determined by the court to be appropriate in each case. The reduction made under this subsection may exceed the amount of the judgment for economic loss or that portion of the verdict that represents damages paid or payable by a collateral source.

3. Notice of verdict required. Within 10 days after a verdict for the plaintiff, the plaintiff's attorney shall send notice of the verdict by registered mail to all persons known to the attorney who are entitled by contract or law to a lien against the proceeds of the plaintiff's recovery. If a lienholder does not exercise the lienholder's right to subrogation within 30 days after receipt of the notice of the verdict, the lienholder shall lose the right of subrogation. This subsection applies only to contracts executed or renewed on or after the effective date of this section.

4. Preexisting obligation required. For purposes of this section, benefits from a collateral source are not considered payable or receivable unless the court makes a determination that there is a previously existing contractual or statutory obligation on the part of the collateral source to pay the benefits.

5. Reduction of repayment to collateral source. The amount payable by a plaintiff to any collateral source is reduced by a portion of the total costs incurred by the plaintiff in the action, including discovery, witness fees, exhibit expenses and attorney's fees. The reduction is calculated as the amount that is the same percentage of the total costs incurred by the plaintiff in the action as the amount paid or payable by the collateral source is of the total verdict. This subsection applies only to contracts executed or renewed on or after the effective date of this section.

Sec. 4. 24 MRSA c. 21, sub-cc. IX and X are enacted to read:

SUBCHAPTER IX

LIMITS ON NONECONOMIC DAMAGES

§2971. Limits on noneconomic damages

1. Limitation. In an action for professional negligence as defined in section 2502, the noneconomic damages awarded to a prevailing party may not exceed $250,000. If the trial of the action is to a jury, the jury may not be informed of the damage award limitation established in this subsection. If the jury awards total damages in excess of $250,000, the court shall direct the jury to establish the portion of the total damages awarded that is noneconomic damages. If the portion that is noneconomic damages exceeds $250,000, the court shall reduce the noneconomic damages awarded to that amount, unless a further reduction is warranted by exercise of the powers described in subsection 3.

The limit of $250,000 on noneconomic damages is a single limit applicable to all causes of action, by one or more parties, arising out of the same occurrence or circumstances. The noneconomic damages limitation established by this subchapter does not apply to claims for punitive damages.

2. Definition. As used in this subchapter, unless the context otherwise indicates, "noneconomic damages" means subjective, nonpecuniary damages arising from pain, suffering, inconvenience, physical impairment, disfigurement, mental anguish, emotional stress, loss of society and companionship, loss of consortium, injury to reputation, humiliation, other nonpecuniary damages and any other theory of damages such as ear of loss, illness or injury.

3. Court's powers. Nothing in this section is intended to eliminate the court's powers of additur and remittitur with regard to all damages, except to the extent that the power of additur is limited with regard to noneconomic damages beyond the limitation established in subsection 1.

4. Adjustment of cap. Effective February 1st of every year, beginning in the year 1992, the Superintendent of Insurance shall automatically increase the cap on noneconomic damages by a percentage amount equal to the percentage rise in the federal Consumer Price Index for January 1st of that year over the level of the index for January 1st of the previous year. The superintendent shall report the adjustment and the actual change in the index to the Legislature every February 1st.

For purposes of this subsection, "Consumer Price Index" means the Consumer Price Index for Urban Wage Earners and Clerical Workers: United States City Average, All items, 1967=100, as compiled by the United States Department of Labor, Bureau of Labor Statistics or, if the index is revised or superseded, the Consumer Price Index is the index represented by the Bureau of Labor Statistics as reflecting most accurately changes in the purchasing power of the dollar by consumers.

5. Application. This section applies to all cases in which notices of claim are filed after the effective date of this section.

SUBCHAPTER X

MEDICAL LIABILITY DEMONSTRATION PROJECT

§2981. Medical liability demonstration project

The Bureau of Insurance and the Board of Registration in Medicine shall, by January 1, 1992, establish a medical liability demonstration project as provided in this subchapter.

§2982. Medical specialty advisory committees established

1. Medical specialty areas. The Medical Specialty Advisory Committee on Anesthesiology, in accordance with Title 5, section 12004-I, subsection 58-A; the Medical Specialty Advisory Committee on Emergency Medicine, in accordance with Title 5, section 12004-I, subsection 58-B; and the Medical Specialty Advisory Committee on Obstetrics and Gynecology, in accordance with Title 5, section 12004-I, subsection 58-C are established and shall develop practice parameters and risk management protocols for their respective medical specialty areas.

2. Membership. Each medical specialty advisory committee consists of 5 members:

A. One physician who practices in a tertiary teaching hospital, appointed by the Board of Registration in Medicine;

B. One physician who practices in a tertiary nonteaching hospital, appointed by the Board of Registration in Medicine;

C. One physician who practices in a medium-size hospital, appointed by the Board of Registration in Medicine;

D. One physician whose practice is substantially in rural areas, appointed by the Board of Registration in Medicine; and

E. One family practice physician, appointed by the Board of Registration in Medicine.

3. Terms. Each member serves a term of 3 years.

4. Proceedings. The medical specialty advisory committees shall conduct all proceedings pursuant to the Maine Administrative Procedure Act.

5. Board of Registration in Medicine; administration and funding. The Board of Registration in Medicine shall provide funding and administrative support to the medical specialty advisory committees. The Board of Registration in Medicine may accept funds from outside sources to help finance the operation of the medical specialty advisory committees.

§2983. Practice parameters; risk management protocols

Each medical specialty advisory committee shall develop practice parameters and risk management protocols in the medical specialty area relating to that committee. The practice parameters must define appropriate clinical indications and methods of treatment within that specialty. The risk management protocols must establish standards of practice designed to avoid malpractice claims and increase the defensibility of the malpractice claims that are pursued. The parameters and protocols must be consistent with appropriate standards of care and levels of quality. The Board of Registration in Medicine shall review the parameters and protocols, approve the parameters and protocols appropriate for each medical specialty area and adopt them as rules under the Maine Administrative Procedure Act.

§2984. Report to Legislature

By January 10, 1992, each medical specialty advisory committee shall provide a report to the joint standing committee of the Legislature having jurisdiction over judiciary matters and the Office of the Executive Director of the Legislative Council setting forth the parameters and protocols developed by that medical specialty advisory committee and adopted by the Board of Registration in Medicine. The medical specialty advisory

committees also shall report the extent to which the risk management protocols reduce the practice of defensive medicine.

§2985. Application to professional negligence claims

1. Introduced by defendant. In any claim for professional negligence against a physician or the employer of a physician participating in the project established by this subchapter in which a violation of a standard of care is alleged, only the physician or the physician's employer may introduce into evidence, as an affirmative defense, the existence of the practice parameters and risk management protocols developed and adopted pursuant to section 2983 for that medical specialty area.

2. Burden of proof; parameters and protocols. Any physician or physician's employer who pleads compliance with the practice parameters and risk management protocols as an affirmative defense to a claim for professional negligence has the burden of proving that the physician's conduct was consistent with those parameters and protocols in order to rely upon the affirmative defense as the basis for a determination that the physician's conduct did not constitute professional negligence. This subsection does not affect the plaintiff's burden to prove the plaintiff's cause of action by a preponderance of the evidence as otherwise provided by law.

3. No change in burden of proof. Nothing in this subchapter alters the burdens of proof in existence as of December 31, 1991, in professional negligence proceedings.

4. Application. This section applies to causes of action accruing between January 1, 1992 and December 31, 1996.

§2986. Physician participation

Any physicians practicing in a medical specialty area for which practice parameters and risk management protocols have been developed and adopted pursuant to section 2983, shall file notice with the Board of Registration in Medicine prior to November 1, 1991, indicating whether they elect to participate in the project. The medical liability demonstration project authorized by this subchapter does not begin with respect to a medical specialty area unless at least 50% of the physicians licensed in the State and practicing in that specialty area elect to participate. Continuation of a project is not dependent on the level of participation.

§2987. Evidence; inadmissibility

Unless independently developed from a source other than the demonstration project, the practice parameters and risk

management protocols are not admissible in evidence in a lawsuit against any physician who is not a participant in the demonstration project or against any physician participating in the project who is defending against a lawsuit initiated before January 1, 1992 or after December 31, 1996.

§2988. Information and reports

1. Reports by insurers. Any insurance company providing professional, malpractice or any other form of liability insurance for any physician practicing in a medical specialty area described in section 2982 or for any hospital in which that practice has taken place shall provide to the Bureau of Insurance in a format established by the Superintendent of Insurance the following:

A. A report of each claim alleging malpractice during the 5-year period ending December 31, 1991, involving any physician practicing in a medical specialty area described in section 2982. Each report must include the name of the insured, policy number, classification of risk, medical specialty, date of claim and the results of the claim, including defense costs and indemnity payments as a result of settlement or verdict, as well as any awards paid in excess of policy limits. For any claim still open, the report must include the amount of any funds allocated as reserve or paid out. The insurance company shall annually report on any claims that have remained open;

B. For the 5-year period ending December 31, 1991, an annualized breakdown of the medical liability premiums earned for physicians practicing in the medical specialty areas described in section 2982. This information must be provided according to a schedule established by the Bureau of Insurance;

C. A report of each claim brought against any physician practicing in a medical specialty area described in section 2982, alleging malpractice as a result of incidents occurring on or after January 1, 1992 and before January 1, 1997, that includes, but is not limited to, the name of the insured, policy number, classification of risk, medical specialty, date of claim and the results of each claim, including defense costs and indemnity payments as a result of settlement or verdict, any awards or amounts paid in excess of policy limits and any finding, if made, of whether the physician's practice was consistent with the parameters and protocols developed and adopted under section 2983. These reports must be provided not less than semiannually according to a schedule established by the Bureau of Insurance. At the discretion of the Bureau of Insurance, reports must be provided until all claims are closed; and

D. An annualized breakdown of the medical liability premiums earned, as of January 1, 1992, for physicians practicing in the medical specialty areas described in section 2982. This information must be provided according to a schedule established by the Bureau of Insurance.

2. Reports by Bureau of Insurance and Board of Registration in Medicine. The Bureau of Insurance and the Board of Registration in Medicine shall report the results of the project to the Legislature by December 1, 1997. The report must include the following.

A. The Bureau of Insurance shall report:

(1) The number of claims brought against physicians in the project alleging malpractice as a result of incidents occurring on or after January 1, 1992;

(2) The results of any closed claims described in this section, including defense costs and indemnity payments as a result of settlement or verdict;

(3) The status of all open claims described in this section, including defense costs, indemnity payments and any amounts held in reserve; and

(4) The effect of the project on the medical liability claims experience and premiums of those physicians in the project.

B. The Board of Registration in Medicine shall quantify and report on any identifiable impact of the project on the cost of the practice of defensive medicine.

(1) The Board of Registration in Medicine shall establish an economic advisory committee to establish the methodology for evaluating the effect of the project on the cost, utilization and the practice of defensive medicine. The economic advisory committee shall report the methodology developed to the Board of Registration in Medicine by January 1, 1992.

3. Immunity. All insurers reporting under this section and their agents or employees, the superintendent and the superintendent's representatives, and the Board of Registration in Medicine and its agents or employees, including members of the medical specialty advisory committees established under section 2982, are immune from liability for any action taken by them pursuant to this subchapter.

4. Confidentiality. Reports made to the superintendent and report records kept by the superintendent are not subject to discovery and are not admissible in any trial, civil or criminal, other than proceedings brought before or by the Board of Registration in Medicine. The superintendent shall maintain the reports filed in accordance with this section and all information derived from the reports that identifies or permits identification of the insured or the incident for which a claim was made as strictly confidential records. Information derived from reports filed in accordance with this section that does not identify or permit identification of any insured or incident for which a claim was made may be released by the superintendent or otherwise made available to the public.

5. Rules. The superintendent and the Board of Registration in Medicine may adopt rules necessary to implement this subchapter.

Sec. 5. 24-A MRSA c. 75 is enacted to read:

CHAPTER 75

RURAL MEDICAL ACCESS PROGRAM

§6301. Short title

This chapter is known and may be cited as the "Rural Medical Access Program."

§6302. Purpose

The purpose of this chapter is to promote, through financial incentives to physicians who practice in underserved areas of the State, the availability of physicians who deliver babies in those areas.

§6303. Definitions

For purposes of this chapter, unless the context indicates otherwise, the following terms have the following meanings.

1. Insurer. "Insurer" means any insurer authorized to transact insurance in this State and any insurer authorized as a surplus lines insurer pursuant to chapter 19.

2. Self-insured. "Self-insured" means any physician or hospital insured against professional negligence through any entity other than an insurer as defined in subsection 1.

§6304. Assessments authorized

To provide funds for the Rural Medical Access Program, insurers may collect pursuant to this chapter assessments from physicians, surgeons, osteopaths and hospitals located in the State.

1. Assessment from policyholders. With respect to professional liability insurance policies for physicians, surgeons, osteopaths and hospitals issued on or after September 1, 1991, each insurer shall collect an assessment from each policyholder. The superintendent shall determine the amount of the assessment in accordance with this chapter. Notwithstanding any provision of law, assessments made and collected pursuant to this chapter do not constitute premium, as defined in section 2403, for purposes of any laws of this State relating to taxation, filing of insurance rates or assessment purposes other than as expressly provided under this chapter. The assessments are considered as premium only for purposes of any law of this State relating to cancellation or nonrenewal of insurance coverage.

2. Required support. Every insured and self-insured allopathic and osteopathic physician and hospital shall support the Rural Medical Access Program as provided in this chapter. Any physician or hospital that fails to pay the assessment required by this chapter is subject to a civil penalty not to exceed $2,000, payable to the Bureau of Insurance, to be recovered in a civil action.

3. Assistance from boards and Department of Human Services; insure through other means. The Board of Registration in Medicine and the Board of Osteopathic Examination and Registration shall assist the superintendent in identifying those physicians who insure against professional negligence by means other than through insurers defined in section 6303. The Department of Human Services, Division of Licensure and Certification, shall assist the superintendent in determining the insuring entity for any licensed hospital and in identifying those hospitals that insure against professional negligence by means other than through insurers defined in section 6303.

4. Certification of assessments paid. After review of the records provided by the Board of Registration in Medicine; the Board of Osteopathic Examination and Registration; the Department of Human Services, Division of Licensure and Certification; and the assessment receipts of the malpractice insurers, the superintendent shall certify those physicians and hospitals that have paid the required assessments.

§6305. Amount of assessment determined

1. Determination of assessment based on anticipated savings. This subsection governs the determination and payment of assessments.

A. Beginning in 1991, the superintendent shall determine the savings in professional liability insurance claims and claim settlement costs to insurers anticipated in each 12-month period as a result of imposition of a legal limit on noneconomic damages, as established in Title 24, section 2971, and reform of the collateral source rule.

B. The superintendent shall order a total assessment to be collected each year beginning in 1991 equal to the lesser of 1/2 of the savings determined or $1,000,000, but not less than $500,000.

C. The superintendent shall order each insurer to assess its policyholders the percentage of the total assessment ordered that the insurer's Maine premium volume for professional liability insurance for physicians, surgeons, osteopaths and hospital bears to the total Maine premium volume of all insurers and self-insureds for that coverage.

D. Each insurer shall assess the surcharge against its insureds as a percentage of premium unless the superintendent prescribes a different basis by rule or order.

E. Every self-insured allopathic or osteopathic physician and every self-insured hospital shall remit the assessment required by this section to the principal writer of physicians and surgeons malpractice insurance in this State. Remittance by self-insured physicians or hospitals may be made on their behalf by a self-insurer. The superintendent shall prescribe by rule a method to calculate and collect the assessment from self-insured physicians and hospitals.

2. Final evaluation of savings in 1995. The final evaluation of the savings in professional liability insurance claims and claim settlement costs to insurers must be determined by the superintendent in 1995. Insurers shall continue to assess policyholders after 1995 based on the final determination, but the total assessment may not be more than $1,000,000 per year.

§6306. Funds held by insurers

Insurers may invest assessments collected subject to chapter 13. Interest earned on investments must be credited to the Rural Medical Access Program.

§6307. Qualifications for premium assistance

1. Eligibility qualifications. A physician is a qualified physician eligible to receive professional liability premium assistance if that physician:

A. Is licensed to practice medicine in the State;

B. Accepts and serves Medicaid patients;

C. Provides services for the delivery of babies; and

D. Practices at least 50% of the time in areas of the State that are underserved areas for obstetrical medical services as recommended by the Department of Human Services.

The Department of Human Services shall determine those physicians who meet the requirements of this subsection.

2. Ineligible if premium owed. Any physician who owes premiums to any insurer for any policy year prior to the year for which assistance is sought is not eligible for assistance.

§6308. Premium assistance

Each qualified physician as determined in section 6307 is entitled to an annual premium credit equal to the same percentage of that physician's professional liability insurance annual premium as the total amount of assessments collected and investment income earned with respect to those assessments bears to the total amount of premiums paid by all qualified physicians.

§6309. Intercorporate transfers

The superintendent may order intercorporate transfers of funds to balance assessments and premium credits on an equitable basis among insurers and to provide for credits to eligible self-insureds.

§6310. Appeals

1. Assessments. Physicians aggrieved by an insurer's application of the assessment provided for in this chapter may request a hearing before the superintendent. The hearing must be held in accordance with chapter 3, the Maine Administrative Procedure Act and procedural rules of the Bureau of Insurance.

2. Eligibility. Physicians aggrieved by an eligibility determination by the Department of Human Services under section 6307 may request a hearing under the Maine Administrative Procedure Act.

§6311. Rules

The superintendent and the Commissioner of Human Services may adopt rules in accordance with the Maine Administrative Procedure Act to carry out this chapter.

FISCAL NOTE

The Department of Human Services, the Bureau of Insurance and the Board of Registration in Medicine will each incur some additional costs that can be absorbed within the existing budgeted resources of the respective agencies.'

STATEMENT OF FACT

This amendment revises the use of discovery in medical malpractice prelitigation screening panel proceedings and subsequent court actions. Once the panel has issued its findings, no party may make further discovery requests in a subsequent court action unless that party can show good cause as determined by the court. Current law provides confidentiality for all evidence used in a panel proceeding. This provision permits the use of discovery made before the panel to be used in court, thereby eliminating costly duplication of discovery.

This amendment sets a limit of $250,000 on noneconomic damages in medical malpractice liability actions. A plaintiff would still be entitled to reimbursement for the full economic loss, including all medical expenses, rehabilitation services, custodial care, loss of earnings and earning capacity, loss of income and any other objectively verifiable monetary losses. The cap does not apply to punitive damages.

Beginning in 1992, the cap will be adjusted annually based on rises in the Consumer Price Index.

Under Maine case law, if a plaintiff is compensated in whole or in part for damages by some source independent of the defendant, the plaintiff is still permitted to recover the same damages against the defendant. Unless a right of subrogation exists on behalf of the person, company or agency making the collateral payment, a double recovery takes place, thereby giving the plaintiff a windfall. Evidence of the collateral source payment is not admissible at trial. This amendment requires the judge, after verdict, to automatically decrease the verdict by the amount of any collateral source payment.

This amendment does not reduce the recovery if a contractual or statutory lien exists on the proceeds, as long as the lien is exercised in a timely fashion. The amendment reduces a plaintiff's damages only when those damages have already been

paid by a 3rd party and when that 3rd party is not seeking to recover what was paid.

This amendment includes an "offset" to the reduction in a personal injury judgment that would otherwise be attributable to payments of damages from "collateral sources." The amount of the offset would be an amount equal to the amount paid by the claimant over the 2-year period predating the injury for the coverage afforded by the collateral payment source in the form of payroll deductions, insurance premiums or other direct payments by the claimant. The court shall determine this calculation on a case-by-case basis.

This amendment also requires the collateral source to share in the plaintiff's costs of pursuing the action. Specifically, the amendment reduces the amount payable by the plaintiff to the collateral source by a pro rata portion of the plaintiff's costs of the action, including attorney's fees.

This amendment authorizes the establishment of a 5-year medical liability demonstration project within the medical specialty areas of anesthesiology, emergency medicine and obstetrics and gynecology. As part of the project, the Board of Registration in Medicine and specialty advisory committees will develop practice parameters and risk management protocols that may be used by a physician as an affirmative defense in a claim for professional negligence.

This amendment establishes the Rural Medical Access Program to increase access to physicians who deliver babies in underserved areas of the State. This program is funded through the projected savings in medical malpractice liability insurance premiums projected to be the result of the cap on noneconomic damages and the revision of the collateral source rule. Starting in 1991, the Superintendent of Insurance will determine the assessment due from each insured or self-insured hospital or allopathic or osteopathic physician. The assessments will be collected by insurers and deposited in a separate fund. The superintendent will determine the amount of premium assistance to be paid to each physician delivering babies in underserved areas by comparing each physician's medical malpractice liability insurance premium with the total amount of premiums for all physicians qualified to participate. Beginning in 1995, the superintendent will base the assessments on actual savings resulting from the imposition of the cap and the revision of the collateral source rule.

Filed by Rep. Richards of Hampden
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