114th MAINE LEGISLATURE

SECOND REGULAR SESSION - 1990

Legislative Document **No. 2513**

H.P. 1842 House of Representatives, April 13, 1990

Approved for introduction by a majority of the Legislative Council pursuant to Joint Rule 27.

Reference to the Committee on Judiciary suggested and ordered printed.

EDWIN H. PERT, Clerk

Presented by Representative PARADIS of Augusta.

Cosponsored by Representative MacBRIDE of Presque Isle, Senator HOLLOWAY of Lincoln and Senator GAUVREAU of Androscoggin.

STATE OF MAINE

IN THE YEAR OF OUR LORD
NINETEEN HUNDRED AND NINETY

An Act to Establish the Rural Medical Access Program, the 5-year Medical Liability Demonstration Project, Revise the Rules Regarding Collateral Sources and the Discovery Rule In Medical Liability Cases Without Imposing Caps On Damages.

(AFTER DEADLINE)

Be it enacted by the People of the State of Maine as follows:

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 §2972
58-B. Medicine	Medical Specialty Advisory Committee on Emergency Medicine	Expenses Only	24 MRSA §2972
58-C. Medicine	Medical Specialty Advisory Committee on Obstetrics and Gynecology	Expenses Only	24 MRSA §2972

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 a contract, agreement or plan executed, renewed or implemented on or after the effective date of this Act, including:

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

(2) A contract or agreement of a 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

(3) A 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. After notice and opportunity for an evidentiary hearing, 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 subrogration within the time limit set forth in subsection 6, the court shall reduce that portion of the judgment that represents damages paid or payable by a collateral source.

3. Federal benefits. The court shall also reduce the judgment by the amount of Medicare, Medicaid or Social Security disability benefits paid or payable to the plaintiff for the

plaintiff's expenses or losses, provided that the court enters an order requiring the defendant to indemnify and make whole the plaintiff for any subrogation claim made for those benefits and for the costs, including attorney's fees, for that indemnification claim, as the court finds are reasonably required to enforce this provision.

4. Offsetting reduction. The court may reduce the reduction in subsection 2 by an amount equal to:

A. 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; and

B. The portion of the total costs incurred by the plaintiff in the action, including discovery, witness fees, exhibit expenses and attorney's fees. This 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.

5. Limit. The reduction made under this section may not 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.

6. Notice of claim or verdict required. No later than 10 days after a verdict for the plaintiff, the plaintiff's attorney shall send notice of the claim or 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 notify the court of the lienholder's right to subrogation within 30 days after receipt of the notice, the lienholder loses the right of subrogation.

7. Preexisting obligation required. For purposes of this section, benefits from a collateral source are not considered payable 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.

Sec. 4. 24 MRSA c. 21, sub-c. IX is enacted to read:

SUBCHAPTER IX

MEDICAL LIABILITY DEMONSTRATION PROJECT

§2971. 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.

§2972. 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. The medical specialty advisory committees are made up as follows.

A. The Medical Specialty Advisory Committee on Anesthesiology consists of members with an interest in and knowledge of the specialty area. It consists of 6 members:

(1) One physician who practices in a tertiary hospital, appointed by the Board of Registration in Medicine;

(2) One physician who practices in a medium-sized hospital, appointed by the Board of Registration in Medicine;

(3) One physician who practices primarily in a rural area, appointed by the Board of Registration in Medicine;

(4) One board-certified anesthesiologist, appointed by the Governor in consultation with the Maine Chapter of the American Society of Anesthesiologists; and

(5) Two public members:

(a) One representing the interests of payors of medical costs, appointed by the President of the Senate; and

(b) One representing the interests of consumers, appointed by the Speaker of the House of Representatives.

B. The Medical Specialty Advisory Committee on Emergency Medicine consists of members with an interest in and knowledge of the specialty area. It consists of 9 members:

(1) One physician who practices in a tertiary hospital, appointed by the Board of Registration in Medicine from nominations submitted by the Maine Medical Association;

(2) One physician, appointed by the Board of Osteopathic Examination and Registration from nominations submitted by the Maine Osteopathic Association;

(3) One physician who practices primarily in a rural area, appointed by the Board of Registration in Medicine from nominations submitted by the Maine Medical Association;

(4) One family practice physician, appointed by the Board of Registration in Medicine from nominations submitted by the Maine College of Family Physicians;

(5) Two physicians, appointed by the Governor, at least one of whom is board certified in emergency medicine, appointed in consultation with the Maine Chapter of the American College of Emergency Medicine Physicians; and

(6) Three public members:

(a) One representing the interests of payors of medical costs, appointed by the President of the Senate;

(b) One representing the interests of consumers, appointed by the Speaker of the House of Representatives; and

(c) One representing allied health professionals, appointed by the Governor.

C. The Medical Specialty Advisory Committee on Obstetrics and Gynecology consists of members with an interest in and knowledge of the specialty area. It consists of 9 members:

(1) One physician who practices in a tertiary hospital, appointed by the Board of Registration in Medicine from nominations submitted by the Maine Medical Association;

(2) One physician who practices in a medium-sized hospital appointed by the Board of Osteopathic Examination and Registration from nominations submitted by the Maine Osteopathic Association;

(3) One physician who practices primarily in a rural area, appointed by the Board of Registration in Medicine from nominations submitted by the Maine Medical Association;

(4) One physician who practices primarily in a rural area, appointed by the Board of Osteopathic Examination and Registration from nominations submitted by the Maine Osteopathic Association;

(5) One family practice physician, appointed by the Board of Registration in Medicine from nominations submitted by the Maine Academy of Family Physicians;

(6) One board-certified physician, appointed by the Governor in consultation with the Maine Chapter of the American College of Obstetricians and Gynecologists; and

(7) Three public members:

(a) One representing the interests of payors of medical costs, appointed by the President of the Senate;

(b) One representing the interests of consumers, appointed by the Speaker of the House of Representatives; and

(c) One representing allied health professionals, appointed by the Governor.

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, including the Board of Osteopathic Examination and Registration, to help finance the operation of the medical specialty advisory committees.

§2973. 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 and the Board of Osteopathic Examination and Registration 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.

§2974. Report to Legislature

By March 1, 1991, 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 and the Board of Osteopathic Examination and Registration. The medical specialty advisory committees also shall report the extent to which the risk management protocols reduce the practice of defensive medicine.

§2975. 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 2973 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. If the physician or the physician's employer introduces at trial evidence of compliance with the parameters and protocols, then the plaintiff may introduce evidence on the issue of compliance. 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.

§2976. 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 2973, shall file notice with the Board of Registration in Medicine or the Board of Osteopathic Examination and Registration 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.

§2977. 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 cause of action accruing before January 1, 1992 or after December 31, 1996.

§2978. 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 2972 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 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 2972. 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 2972. 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 2972, 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 2973. 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 2972. 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 Governor and to the joint standing committees of the Legislature having jurisdiction over insurance and judiciary matters and to the Office of the Executive Director of the Legislative Council 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, the Board of Osteopathic Examination and Registration and its agents and employees and the Board of Registration in Medicine and its agents or employees, including members of the medical specialty advisory committees established under section 2972, 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 or the Board of Osteopathic Examination and Registration. 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 otherwise indicates, 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. Physician's employer. "Physician's employer" means any hospital, health care facility, clinic or other entity that employs a physician and pays for or otherwise provides professional liability insurance for the physician.

3. Self-insured. "Self-insured" means any physician, hospital or physician's employer insured against the physician's professional negligence or the hospital's professional liability 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, hospitals and physician's employers located in the State.

1. Assessment from policyholders and self-insureds. With respect to professional liability insurance policies for physicians and hospitals issued on or after July 1, 1990, each insurer shall collect an assessment from each policyholder. With respect to professional liability insurance for self-insureds issued on or after July 1, 1990, each self-insured shall pay an assessment as directed by the superintendent. 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 laws of this State relating to cancellation or nonrenewal of insurance coverage and the determination of hospital financial requirements under Title 22, chapter 107.

2. Required support. Every insured and self-insured physician, hospital, and physician's employer shall support the Rural Medical Access Program as provided in this chapter. Any physician, hospital or physician's employer 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, 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 or physician's employer and in identifying those hospitals and physician's employers 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 and the Department of Human Services, Division of Licensure and Certification, and the assessment receipts of the malpractice insurers, the superintendent shall certify those physicians, hospitals and physicians' employers that have paid the required assessments.

§6305. Amount of assessment determined

1. Determination of assessment based on anticipated savings. The amount of the assessment is calculated as follows.

A. For policy years beginning on or after July 1, 1990, the superintendent shall determine the amount of the savings in professional liability insurance claims and claim settlement costs to insurers anticipated in each 12-month period as a result of the Medical Liability Demonstration Project established in Title 24, chapter 21, subchapter IX and reform of the collateral source rule.

B. The amount of the assessment for policy years beginning on or after July 1, 1990, but before July 1, 1991, is equal to the total of:

(1) One hundred percent of the first $250,000 of savings determined under paragraph A;

(2) No portion of the savings determined under paragraph A that exceeds $250,000 but does not exceed $500,000; and

(3) Fifty percent of the portion of the savings determined under paragraph A that exceeds $500,000 but does not exceed $1,000,000.

C. The amount of the assessment for policy years beginning on or after July 1, 1991, is 50% of the amount of the savings determined under paragraph A, but not exceeding $500,000.

D. 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 and hospitals bears to the total Maine premium volume of all insurers and self-insureds for that coverage.

E. 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.

F. Every self-insured physician or physician's employer and every self-insured hospital shall remit the assessment required by this section to the principal writer of physicians 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, hospitals and physicians' employers.

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 $500,000 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 complete obstetrical care for patients, including prenatal care and delivery, provided that physicians in an underserved area without a facility for obstetrical delivery are still eligible if they provide only prenatal care and have referral agreements for delivery with a physician meeting the requirements of paragraphs A and B; and

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

The Commissioner of Human Services shall determine those physicians who meet the requirements of this subsection. The commissioner shall adopt rules, pursuant to the Maine Administrative Procedure Act, determining underserved areas with respect to obstetrical and prenatal care. "Underserved areas" includes Medically Underserved Areas, Health Manpower Shortage Areas and other priority areas determined by the commissioner. The commissioner may adopt rules pursuant to the Maine Administrative Procedure Act defining the scope of services that must be provided to meet the requirements of paragraphs B and C and the method of prioritizing underserved areas for purposes of distribution of the assistance authorized by this section.

2. Ineligible if premium owed. Any physician or physician's employer 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

The amount of premium assistance is determined as follows.

1. Available funds. The amount available for premium assistance for policy years beginning on or after July 1, 1990, but before July 1, 1991, is 1/2 of the amount of the assessment

determined under section 6305 for that year. For policy years beginning on or after July 1, 1991, but before July 1, 1992, the amount available for premium assistance is the remainder of the amount determined under section 6305 that is not used in the first year that assistance is available added to the amount of the assessment determined for that year. For subsequent policy years the amount available for premium assistance is the amount of the assessment determined under section 6305 for that year.

2. Determination of recipients of assistance. The superintendent shall apply the standards of prioritization adopted by the Commissioner of Human Services to determine the physicians who will receive premium assistance. Each qualified physician is entitled to an annual premium credit equal to the difference between the physician's medical malpractice insurance premiums with obstetrical care coverage and the physician's premiums without obstetrical care coverage; however, the amount of premium assistance must be at least $5,000 but not more than $10,000 as determined by the superintendent.

§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, hospitals and physicians' employers 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.

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.

Sec. 6. Medical Demonstration Project Advisory Committee.

The Medical Demonstration Project Advisory Committee is established to review the medical liability demonstration project established by the Maine Revised Statutes, Title 24, chapter 21,

subchapter IX and make recommendations to the Governor and the Legislature regarding the project.

1. The Medical Demonstration Project Advisory Committee consists of the following 14 members:

A. The Chair of the Board of Registration in Medicine or a designee;

B. The Chair of the Board of Osteopathic Examination and Registration or a designee;

C. The President of the Maine Medical Association or a designee;

D. The President of the Maine Osteopathic Association or a designee;

E. The President of the Maine Academy of Family Practice Physicians or a designee;

F. The President of the Maine State Bar Association or a designee;

G. The President of the Maine Trial Lawyers Association or a designee;

H. A representative of a tertiary hospital, to be appointed by the Governor;

I. A representative of an insurer providing medical malpractice insurance in the State, to be appointed by the Governor;

J. A representative of a profit or nonprofit health insurer, to be appointed jointly by the President of the Senate and the Speaker of the House of Representatives;

K. The Superintendent of Insurance or a designee; and

L. Three public members, one to be appointed by the Governor, one to be appointed by the President of the Senate and one to be appointed by the Speaker of the House of Representatives.

The appointing authorities shall make the appointments no later than August 1, 1990, and shall report the names of the members to the Office of the Executive Director of the Legislative Council. The Chair of the Legislative Council shall call the first meeting on or before October 1, 1990.

2. The committee shall annually elect a chair from among the members.

3. The committee may review Title 24, chapter 21, subchapter IX, consult with interested parties and develop recommendations to be submitted to the Legislature, the Governor and the Executive Director of the Legislative Council concerning the medical liability demonstration project, including the levels of participation and other participation requirements.

4. The committee may submit any implementing legislation it prepares pursuant to this section to the Joint Standing Committee on Judiciary and the Office of the Executive Director of the Legislative Council. The committee members shall serve without legislative staff assistance.

5. All members of the committee shall serve without compensation and are not entitled to reimbursement for expenses.

6. This section is repealed on December 31, 1996.

FISCAL NOTE

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

STATEMENT OF FACT

This bill 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.

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 bill requires the judge, after verdict, to decrease automatically the verdict by the amount of any collateral source payment.

This bill 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 bill 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 bill 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 will determine this calculation on a case-by-case basis.

This bill also requires the collateral source to share in the plaintiff's costs of pursuing the action. Specifically, the bill 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 bill 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, the Board of Osteopathic Examination and Registration 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 bill establishes the Rural Medical Access Program to increase access to physicians who provide obstetrical and prenatal medical services in underserved areas of the State. This program is funded through a portion of the projected savings in professional liability insurance claims and claim settlement costs attributable to the medical liability demonstration project and the revision of the collateral source rule. The Superintendent of Insurance will determine the assessment due from each insured or self-insured hospital, physician or physician's employer. 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 qualifying physician by comparing each physician's medical malpractice liability insurance premium with obstetrical care coverage with the cost of coverage without obstetrical coverage. Beginning in 1995, the superintendent will base the assessments on actual savings resulting from the revision of the collateral source rule and the medical liability demonstration project.