_____ BILL NO. _____

INTRODUCED BY _____
(Primary Sponsor)

A BILL FOR AN ACT ENTITLED: "AN ACT CREATING THE HEALTH CARE LIABILITY AND INJURED PATIENTS COMPENSATION ACT; REQUIRING THE COMMISSIONER OF INSURANCE TO ESTABLISH A HEALTH CARE LIABILITY INSURANCE PLAN; REQUIRING CERTAIN HEALTH CARE PROVIDERS TO PARTICIPATE IN THE HEALTH CARE LIABILITY INSURANCE PLAN; ALLOWING CERTAIN HEALTH CARE PROVIDERS TO PARTICIPATE IN THE HEALTH CARE LIABILITY INSURANCE PLAN; EXEMPTING CERTAIN HEALTH CARE PROVIDERS FROM PARTICIPATION IN THE HEALTH CARE LIABILITY INSURANCE PLAN; PROVIDING FOR THE ADMINISTRATION OF THE HEALTH CARE LIABILITY INSURANCE PLAN; MAKING CERTAIN HEALTH CARE PROVIDERS AND CERTAIN PERSONS ALLEGING MEDICAL NEGLIGENCE SUBJECT TO THE PROVISIONS OF THE HEALTH CARE LIABILITY AND INJURED PATIENTS COMPENSATION ACT; EXTENDING THE LIMIT ON NONECONOMIC DAMAGES PAYABLE FOR MEDICAL MALPRACTICE TO NONECONOMIC DAMAGES PAYABLE FOR MEDICAL NEGLIGENCE; ESTABLISHING A HEALTH CARE LIABILITY INSURANCE PLAN BOARD OF GOVERNORS AND DESCRIBING THE AUTHORITY, DUTIES, AND RESPONSIBILITIES OF THE BOARD; ESTABLISHING AN INJURED PATIENTS AND FAMILIES COMPENSATION FUND AND PROVIDING FOR THE ADMINISTRATION OF THE FUND, INCLUDING SETTING AND COLLECTING PREMIUMS TO ESTABLISH AND SUSTAIN THE FUND; ESTABLISHING AN INJURED PATIENTS AND FAMILIES COMPENSATION FUND PEER REVIEW COUNCIL AND DESCRIBING THE AUTHORITY, DUTIES, AND RESPONSIBILITIES OF THE COUNCIL; REVISING THE COMPOSITION OF THE BOARD OF MEDICAL EXAMINERS TO INCLUDE THE PRESIDING OFFICER OF THE INJURED PATIENTS AND FAMILIES COMPENSATION FUND PEER REVIEW COUNCIL; REQUIRING THE BOARD OF INVESTMENTS TO INVEST THE ASSETS OF THE INJURED PATIENTS AND FAMILIES COMPENSATION FUND; REVISING CERTAIN PROVISIONS REGARDING THE MONTANA MEDICAL LEGAL PANEL; REVISING THE AUTHORITY, DUTIES, AND RESPONSIBILITIES OF THE INSURANCE COMMISSIONER IN ORDER TO ADMINISTER CERTAIN PROVISIONS OF THE HEALTH CARE LIABILITY AND INJURED PATIENTS COMPENSATION ACT; APPROPRIATING FUNDS FROM THE STATE GENERAL FUND TO THE INJURED PATIENTS AND FAMILIES COMPENSATION FUND FOR THE PURPOSE OF ESTABLISHING AND ADMINISTERING THE HEALTH CARE LIABILITY INSURANCE PLAN; AMENDING SECTIONS 2-15-1731, 17-6-201, 17-6-203, 25-9-402, 25-9-403, 25-9-412, 27-6-103, 27-6-105, 27-6-606,

27-6-703, AND 33-1-311, MCA; PROVIDING FOR TRANSITION AND IMPLEMENTATION; AND PROVIDING EFFECTIVE DATES AND AN APPLICABILITY DATE."

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

NEW SECTION. **Section 1. Short title.** [Sections 1 through 31] may be referred to as the "Health Care Liability and Injured Patients Compensation Act".

NEW SECTION. **Section 2. Definitions.** As used in [sections 1 through 31], unless the meaning clearly requires otherwise, the following definitions apply:

(1) "Adjacent state" means any of the following states: Idaho, North Dakota, South Dakota, or Wyoming.

(2) "Advanced practice registered nurse" means an advanced practice registered nurse licensed under Title 37, chapter 8, who is certified as an advanced practice registered nurse by the state board of nursing.

(3) "Board" means the board of governors created in [section 20].

(4) "Claimant" means any patient who has a claim, the patient's representative, or any spouse, parent, minor sibling, or child of the patient who has a derivative claim for injury or death because of medical negligence.

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

(6) "Council" means the injured patients and families compensation fund peer review council established in [section 27].

(7) "Department" means the department of public health and human services established in 2-15-2201.

(8) "Fiscal year" means the period beginning on July 1 and ending on the following June 30.

(9) "Fund" means the injured patients and families compensation fund established in [section 18].

(10) "Health care facility" has the meaning provided in 50-5-101.

(11) "Health care professional" means an individual who is licensed, registered, or certified pursuant to Title 37, chapter 3, 4, 6, 8, 10, 11, 12, 13, 14, 17,20, 21, 22, 23, 24, 25, 26, 27, or 28.

(12) "Health care provider" means a person:

(a) to whom [sections 1 through 31] apply under [section 4(1)]; or

(b) who elects to be subject to [sections 1 through 31] under [section 4(2)].

(13) "Medical negligence" means a negligent act or omission of a health care provider acting within the scope of the health care provider's employment or profession while providing health care services.

(14) "Patient" means an individual who received or should have received health care services from a health care provider or from an employee of a health care provider acting within the scope of the employee's employment.

(15) "Physician" has the meaning provided in 37-3-102.

(16) "Plan" means the health care liability insurance plan for health care providers established under [section 3]. The board, the council, and the fund are integral parts of the plan.

(17) "Principal place of practice" means the state in which a health care provider:

(a) furnishes health care services to more than 50% of the health care provider's patients in a fiscal year; or

(b) derives more than 50% of the health care provider's income in a fiscal year from the practice of the health care provider's profession.

(18) "Representative" means the personal representative, spouse, parent, guardian, or attorney or other legal agent of a patient.

NEW SECTION. **Section 3. Health care liability insurance plan.** (1) The commissioner shall promulgate rules establishing a plan of health care liability coverage for health care providers.

(2) The plan must:

(a) operate subject to the supervision and approval of the board;

(b) offer professional health care liability coverage in a standard policy form;

(c) include but not be limited to the following:

(i) rules for the classification of risks and rates that reflect past and prospective loss and expense experience in different areas of practice and of the fund; and

(ii) a rating plan that takes into consideration the loss and expense experience of an individual health care provider, if the experience resulted in the payment of money, by the plan or other sources, for damages arising out of medical negligence; and

(d) include provisions for setting rates for health care professionals who are semiretired or who work only part time.

(3) (a) The part of the plan described in subsection (2)(c)(ii) must provide for an increase in the premium payable by a health care provider, except as provided in subsection (3)(b), if the loss and expense experience of the plan and other sources with respect to the health care provider or an employee of the health care provider

exceeds either a number of claims paid threshold or a dollar volume of claims paid threshold, each as established in the plan. The plan must also specify applicable amounts of increase corresponding to the number of claims paid and the dollar volume of claims paid in excess of the respective thresholds.

(b) The plan must provide that the increase required under subsection (3)(a) does not apply if the board determines that the performance of the council in making recommendations under [section 29(2)] adequately addresses the consideration set forth in subsection (2)(c)(ii) of this section.

(4) (a) The board shall annually determine if the plan has accumulated funds in excess of the surplus required under 33-2-109.

(b) If the board determines that the fund has accumulated funds in excess of the surplus required, the board shall:

(i) specify the method and formula for distributing the excess funds; and

(ii) return the excess funds to the insureds by means of refunds or prospective rate decreases.

(5) The state or the board may not be held liable for any obligation of the plan or of the fund.

(6) (a) If the commissioner determines that a health care provider is not required to participate in the plan under [section 4], the commissioner may, with the approval of the board, promulgate rules permitting the health care provider and all other similarly situated health care providers to obtain coverage under the plan.

(b) A health care provider that obtains coverage pursuant to subsection (6)(a) is subject to the provisions of [sections 1 through 31] in the same manner as a health care provider that is specifically subject to [sections 1 through 31].

(7) If the plan established under this section is dissolved for any reason, any assets of the plan that exceed the incurred liabilities of the plan accrue to the state general fund.

NEW SECTION. **Section 4. Participation -- when required -- optional.** (1) Except as provided in [section 5], [sections 1 through 31] apply to the following:

(a) a physician or an advanced practice registered nurse for whom this state is a principal place of practice and who practices the profession for which the physician or advanced practice registered nurse is licensed in this state for 240 hours or more in a fiscal year;

(b) a physician or an advanced practice registered nurse for whom an adjacent state is a principal place of practice, if the physician or advanced practice registered nurse:

(i) is a resident of this state;

(ii) practices the profession for which the physician or advanced practice registered nurse is licensed in this state, in an adjacent state, or both, for 240 hours or more in a fiscal year; and

(iii) performs more procedures in an adjacent-state health care facility than in any other health care facility;

(c) a physician or an advanced practice registered nurse who is exempt under [section 5(1)(a) or (1)(c)] but who practices the profession for which the physician or advanced practice registered nurse is licensed outside the scope of the exemption and who fulfills the requirements under subsection (1)(a) of this section in relation to that practice outside the scope of the exemption. For a physician or an advanced practice registered nurse who is, under this section, subject to [sections 1 through 31], [sections 1 through 31] apply only to claims arising out of a practice that is outside the scope of the exemption under [section 5(1)(a) or (1)(c)].

(d) a partnership composed of physicians or advanced practice registered nurses, or both, and organized and operated in this state for the primary purpose of providing the medical services of physicians or advanced practice registered nurses;

(e) a corporation organized and operated in this state for the primary purpose of providing the medical services of physicians or advanced practice registered nurses, or both;

(f) a hospital facility, as defined in 7-34-2102, that operates in this state;

(g) a health care facility that operates in this state;

(h) an entity operated in this state that is an affiliate of a health care facility and that provides diagnosis or treatment of or care for patients of the health care facility; and

(i) a long-term care facility, as defined in 50-5-101, whose operations are combined as a single entity with a health care facility described in subsection (1)(g) of this section, whether or not the operations of the long-term care facility are physically separate from the health care facility operations.

(2) The following individuals may elect, in the manner designated by the commissioner by rule, to be subject to [sections 1 through 31]:

(a) a physician or an advanced practice registered nurse:

(i) for whom this state is a principal place of practice; and

(ii) who practices the profession for which the physician or advanced practice registered nurse is licensed for fewer than 240 hours in a fiscal year or a portion of a fiscal year;

(b) a physician or an advanced practice registered nurse for whom this state is not a principal place of practice for a fiscal year or a portion of a fiscal year during which the physician or advanced practice registered

nurse practices the profession for which the physician or advanced practice registered nurse is licensed in this state.

(3) For a health care provider that elects, under this section, to be subject to [sections 1 through 31], [sections 1 through 31] apply only to claims arising out of a practice that is in this state and that is outside the scope of an exemption under [section 5(1)(a) or (1)(c)].

NEW SECTION. **Section 5. Exemptions.** (1) Except as provided in [section 4(1)(c)], [sections 1 through 31] do not apply to a health care provider that is any of the following:

(a) a physician or an advanced practice registered nurse who is:

(i) a state, county, or municipal employee and who is acting within the scope of the employee's employment or contractual duties; or

(ii) a federal employee or a contractor covered under the Federal Tort Claims Act and who is acting within the scope of the employee's employment or contractual duties;

(b) a health care facility that is operated by a governmental agency; or

(c) a physician or an advanced practice registered nurse who provides, on a voluntary basis, professional services for which the physician or advanced practice registered nurse is licensed.

(2) The exemption provided in subsection (1)(c) applies only while the physician or advanced practice registered nurse is voluntarily providing the professional services for which the physician or advanced practice registered nurse is licensed and is not a general exemption from [sections 1 through 31] for any other professional services performed.

NEW SECTION. **Section 6. Applicability to claimants.** (1) For injury or death that is due to medical negligence, the following individuals are subject to [sections 1 through 31]:

(a) a patient who has a claim or the patient's representative; or

(b) a spouse, parent, minor sibling, or child of the patient who has a claim or a derivative claim.

(2) The plan provides coverage for claims for medical negligence against the health care provider or the employee of the health care provider. However, this subsection (2) does not apply to:

(a) an employee of a health care provider if the employee is a direct-entry midwife, as defined in 37-27-103, who is providing direct-entry midwifery services that are not in collaboration with a physician or under the direction and supervision of a physician or an advanced practice registered nurse; or

(b) a professional service corporation organized under Title 35, chapter 4, by health care professionals if the board determines that providing the medical services of physicians or advanced practice registered nurses is not the primary purpose of the professional service corporation. The board may not determine under this subsection (2)(b) that the primary purpose of a professional service corporation is not to provide the medical services of physicians or advanced practice registered nurses unless more than 50% of the shareholders of the professional service corporation are not physicians or advanced practice registered nurses.

(3) Subsection (2) does not affect the liability of a health care provider described in [section 4(1)(d), (1)(e), or (1)(f)] for the acts of its employees.

NEW SECTION. **Section 7. Remedy limited.** [Sections 1 through 31] do not apply to injury or death that:

(1) occurred from medical negligence or services rendered prior to [the applicability date of this section]; or

(2) was caused by a crime intentionally committed by a health care provider or an employee of a health care provider, whether or not the criminal conduct is the basis for a medical negligence claim.

NEW SECTION. **Section 8. Claim by minor sibling.** Subject to [section 12], a sibling of a person who dies as a result of medical negligence has a cause of action for damages for loss of society and companionship if the sibling was a minor at the time of the deceased sibling's death. This section does not affect any other claim available under [sections 1 through 31].

NEW SECTION. **Section 9. Action to recover damages.** An action to recover damages for medical negligence must comply with the following:

(1) The complaint in an action regarding medical negligence may not specify the amount of money to which the plaintiff claims to be entitled.

(2) The court or jury, whichever is applicable, shall determine the amounts of medical expense payments previously incurred and for future medical expense payments.

(3) Venue in a court action under [sections 1 through 31] is:

(a) if the claimant is a resident of this state, in the county in which the claimant resides; or

(b) if the claimant is not a resident of this state, in the county, at the claimant's discretion:

(i) in which the claim arose; or

(ii) in which the defendant resides in this state or does the majority of the defendant's business in this state.

NEW SECTION. **Section 10. Forms.** Except as otherwise specifically provided for in [sections 1 through 31], the commissioner shall prepare, have printed if necessary, and furnish, upon request, the forms and material that the commissioner considers to be necessary to promote the efficient administration of [sections 1 through 31]. The commissioner may make the forms and material required under this section available by electronic means.

NEW SECTION. **Section 11. Payment for future medical expenses.** (1) If a settlement, arbitration award, or judgment under [sections 1 through 31] that results from medical negligence that occurred on or after [the applicability date of this section] provides for future medical expense payments in excess of $100,000, that portion of future medical expense payments in excess of $100,000, plus an amount sufficient to pay the costs of collection, including attorney fees reduced to present value, attributable to the future medical expense payments must be paid into the fund.

(2) The commissioner shall, by rule:

(a) specify the criteria to be used to determine the medical expenses related to the settlement, arbitration award, or judgment, taking into consideration developments in the provision of health care; and

(b) develop a system for managing and disbursing the money deposited under subsection (1) through payments for the expenses, including a provision for the creation of a separate account within the fund for each claimant's payments and for crediting each claimant's account with a proportionate share of all interest and other income earned by the fund, based on that account's proportionate share of the fund.

(3) Payments to be made under this section continue until the claimant's account is exhausted or the patient dies, whichever occurs first.

NEW SECTION. **Section 12. Limits on noneconomic damages.** The amount of noneconomic damages recoverable by a claimant or plaintiff under [sections 1 through 31] for medical negligence is subject to the limits established in 25-9-411.

NEW SECTION. **Section 13. Information needed to set premiums, assessments, or fees.** Upon request of the commissioner, all information on health care facility bed capacity, occupancy rates, and other information available within the limitations on disclosure imposed under 42 U.S.C. 1320d, et seq., that is determined by the commissioner to be necessary to set premiums, assessments, or fees under [sections 1 through 31] must be submitted by:

(1) the department;

(2) the Montana medical legal panel established in 27-6-104; or

(3) any other entity determined by the commissioner to have necessary information.

NEW SECTION. **Section 14. Insurance policy forms.** (1) An insurer may not enter into or issue a policy of health care liability insurance until the insurer's policy form has been submitted to and approved by the commissioner as provided in Title 33, chapter 1, part 5.

(2) The filing of a policy form by an insurer with the commissioner for approval constitutes, on the part of the insurer, a conclusive and unqualified acceptance of all of the provisions of [sections 1 through 31] and an agreement by the insurer to be bound under the provisions of [sections 1 through 31] as to a policy issued by the insurer to a health care provider.

(3) Notwithstanding subsections (1) and (2), the issuance of a policy of health care liability insurance by an insurer to a health care provider constitutes, on the part of the insurer, a conclusive and unqualified acceptance of all of the provisions of [sections 1 through 31] and an agreement by the insurer to be bound under the provisions of [sections 1 through 31] as to any policy issued by the insurer to a health care provider.

(4) A policy issued under [sections 1 through 31] must provide:

(a) that the insurer agrees to pay in full all of the following:

(i) attorney fees and other costs incurred in the settlement or defense of a claim;

(ii) a settlement, arbitration award, or judgment imposed against the insured up to a maximum amount specified in the policy; and

(iii) any portion or all of the interest, as determined by the board, on an amount recovered against the insured under [sections 1 through 31] for which the insured is liable;

(b) that any termination of the policy by cancellation or nonrenewal is not effective as to a patient claiming medical negligence against the health care provider covered by the policy unless the insured has been notified as provided in Title 33, chapter 15, part 11, except that an insurer may cancel a health care provider's

policy under 33-15-1103 if the health care provider is no longer licensed to practice the profession or provide the medical service; and

(c) a statement that if a settlement, arbitration award, or judgment recovered under [sections 1 through 31] is:

(i) $1 million or less, the health care provider or the health care provider's insurer incurs liability for the total amount of the settlement, arbitration award, or judgment and the plan incurs no liability; or

(ii) more than $1 million and:

(A) the health care provider's coverage has a maximum liability limit of $1 million or less, the health care provider or the health care provider's insurer pays $1 million and the plan incurs liability for the amount of the settlement, arbitration award, or judgment that exceeds $1 million;

(B) is less than the maximum liability limit stated in the policy, the health care provider or the health care provider's insurer incurs liability for the total amount of the settlement, arbitration award, or judgment and the plan incurs no liability; or

(C) the health care provider's coverage has a maximum liability limit of more than $1 million, the health care provider or the health care provider's insurer incurs liability for the amount that equals the health care provider's maximum liability limit as stated in the health care provider's policy and the plan incurs liability for the amount of the settlement, arbitration award, or judgment that exceeds the health care provider's maximum liability limit.

(5) The insurer shall, upon termination of a policy of health care liability insurance issued under [sections 1 through 31] by cancellation or nonrenewal, notify the commissioner of the termination.

NEW SECTION. **Section 15. Insurance policy limitations.** (1) A health care liability insurance policy may not allow a health care provider to reject a settlement agreed upon between the claimant and the insurer.

(2) A health care liability insurance policy may allow the insurer to make payments for medical expenses prior to any determination of fault. A payment made under this subsection (2):

(a) is not an admission of fault;

(b) may be deducted from a settlement, arbitration award, or judgment; and

(c) is not to be repaid regardless of the settlement, arbitration award, or judgment.

(3) Nothing in this section restricts the insurer's right of comparative contribution or indemnity in accordance with the laws of this state.

NEW SECTION. **Section 16. Availability and effectiveness of health care liability insurance.** The liability coverage provided to a health care provider by the health care liability insurance plan established pursuant to [section 3] must be renewed and may not be canceled unless:

(1) the health care provider fails to pay the premium established pursuant to [section 22]; or

(2) the health care provider's license is revoked by the appropriate licensing authority.

NEW SECTION. **Section 17. Rulemaking authority.** The department or commissioner may promulgate rules that are necessary to enable the department or commissioner to perform their respective responsibilities under [sections 1 through 31].

NEW SECTION. **Section 18. Injured patients and families compensation fund established -- integrity.** (1) There is an injured patients and families compensation fund within the state treasury.

(2) (a) Except as provided in [section 21(3)(e)] and subsection (3) of this section, all premiums paid for coverage under the plan and all other money paid to the fund, all property and securities acquired through the use of money belonging to the fund, and all interest, dividends, and other income earned on money belonging to the fund are the property of the fund and:

(i) may be used only for the operations and obligations of the plan and the fund; and

(ii) may not be:

(A) used for any purpose other than the operations and obligations of the plan and the fund;

(B) transferred by the legislature to other funds; or

(C) used for other programs.

(b) Except as provided in 17-6-201(7), all money in the fund must be invested by the board of investments, provided for in 2-15-1808, and the earnings on investments are the sole property of the fund.

(3) The expenditure of money from the fund for administration of the plan, the fund, the board, and the council is considered to be operations of the fund for the purposes of subsection (2).

NEW SECTION. **Section 19. Purpose of fund.** (1) The fund is established to mitigate the rising costs and declining availability of medical liability insurance by assuming part of the risk associated with insuring health care providers and financing part of the liability incurred by health care providers as a result of medical

negligence claims and to ensure that proper claims made for medical negligence are satisfied. The purpose of the fund is to pay for:

(a) a portion or all of the amount of a settlement, arbitration award, or judgment that is not the liability of a health care provider or of the insurer, other than the plan, of a health care provider under [sections 1 through 31];

(b) future medical expense payments payable under [section 11]; and

(c) claims payable under [section 24].

(2) The fund provides occurrence coverage for:

(a) a claim against a health care provider that has complied with [sections 1 through 31]; and

(b) a claim against an employee of a health care provider that has complied with [sections 1 through 31].

(3) The coverage provided by the plan, under which payment from the fund may be made, begins [the applicability date of this section].

NEW SECTION. **Section 20. Board of governors -- appointments -- compensation.** (1) There is a health care liability insurance plan board of governors.

(2) The board is allocated to the insurance department established in 2-15-1902 for administrative purposes only, as prescribed in 2-15-121.

(3) The board is composed of:

(a) three representatives of the insurance industry appointed by and to serve at the pleasure of the commissioner;

(b) one person to be named by the state bar of Montana;

(c) one person to be named by the Montana trial lawyers association;

(d) two persons to be named by the Montana medical association;

(e) one person to be named by the Montana hospital association;

(f) the commissioner or the commissioner's designated representative. If the commissioner appoints a designated representative, the representative must be employed by the office of the commissioner. The commissioner or the commissioner's representative serves as the presiding officer of the board.

(g) four public members, at least two of whom are not attorneys or physicians and are not professionally affiliated with any health care facility, health care professional, health care provider, or insurance company, to

be appointed by the governor.

(4) (a) Except as provided in subsections (4)(b) and (5), each member of the board, except the commissioner or the commissioner's designee, serves for a term of 3 years and may not serve for more than two consecutive terms.

(b) A vacancy on the board must be filled in the same manner as the original appointment, and the term of the person appointed to fill the vacancy expires on the date of the original appointee's term.

(5) A member of the board may be removed from the board only for malfeasance, misfeasance, or nonfeasance, as determined by a three-fourths majority of the board or by a court of competent jurisdiction.

(6) (a) Except as provided in subsection (6)(b), each board member is compensated at the rate of $50 for each day of board business conducted by the member and approved by the board and is eligible to be reimbursed for expenses as provided in 2-18-501 through 2-18-503.

(b) A board member who is an employee of the state or any subdivision of the state may not be compensated under this section but is eligible to be reimbursed for expenses as provided in 2-18-501 through 2-18-503.

NEW SECTION. **Section 21. Fund administration and operation.** (1) Management of the fund is vested in the board.

(2) The commissioner shall, for the operation of the fund:

(a) provide all staff services as necessary, including hiring, retaining, and compensating personnel; or

(b) with the approval of the board, contract for all or part of the services.

(3) For the purposes of carrying out its functions and the purposes of [sections 1 through 31], the board may:

(a) sue and be sued;

(b) enter into contracts relating to the administration of the fund, including claims management, servicing, and payment;

(c) collect and disburse money received;

(d) adopt classifications and charge premiums for the classifications so that the fund is actuarially sound and will be self-supporting. The classifications and the initial premium rates for the classifications must be adopted pursuant to Title 2, chapter 4, parts 2 through 4. Subsequent to initially adopting the classifications and premiums, the board may change the classifications or premiums by using a method set forth in the rules. The

contested case rights and provisions of Title 2, chapter 4, do not apply to a health care provider's classification or premium rate. Except as provided in [sections 1 through 31], a person may not, without first obtaining the written permission of the health care provider, use, sell, or distribute the health care provider's specific loss information, including but not limited to experience modification factors.

(e) declare dividends if there is an excess of assets over liabilities. However, dividends may not be paid until adequate, actuarially determined reserves are set aside and until all money appropriated from the general fund to the fund for fiscal year 2006 has been repaid to the general fund.

(f) contract with licensed resident insurance producers;

(g) expend funds for scholarship, educational, or charitable purposes; and

(h) perform all functions and exercise all powers of a private insurance carrier that are necessary, appropriate, or convenient for the administration of the fund.

(4) The plan must include a provision in every policy of insurance issued pursuant to [sections 1 through 31] that incorporates the restrictions, provided in [section 18], on the use and transfer of money collected by the fund.

(5) Consistent with the provisions of Title 18, the commissioner shall adopt rules governing the procedures for creating and implementing a contract allowed under this section before entering into a contract. A contract executed under this section is subject to all nondiscrimination requirements applicable to public contracts under Title 18.

(6) If a contract is awarded under this section, the contractor shall report at least annually to the commissioner and the board all contract-related expenses incurred, including arrangements regarding the subcontracting of services.

(7) If the board approves, a contractor may hire legal counsel to provide staff services to administer the plan or fund.

NEW SECTION. **Section 22. Premiums for fund.** Each health care provider shall pay to the fund for the coverage provided under the plan an annual premium based on the following considerations:

(1) the past and prospective loss and expense experience in different types of practice;

(2) the past and prospective loss and expense experience of the fund;

(3) the loss and expense experience of the individual health care provider that resulted in the payment of money, from the fund or from other sources, for damages for medical negligence. An adjustment to a health

care provider's premiums may not be made under this subsection prior to the receipt of the recommendation of the council and the expiration of the time period provided under [section 29(4)] for the health care provider to comment or prior to the expiration of the time period under [section 29(1)].

(4) risk factors for an insured who is semiretired or a part-time professional;

(5) for a health care provider described in [section 4(1)(d), (1)(e), or (1)(f)], risk factors and past and prospective loss and expense experience attributable to employees of that health care provider other than an employee licensed as a physician or an advanced practice registered nurse; and

(6) other factors considered by the board to promote equity among the health care providers that pay premiums under this section.

NEW SECTION. **Section 23. Fund budget, accounting, and audit.** (1) The commissioner may expend money from the fund only after the board has approved a budget for the fund.

(2) All books, records, and audits of the fund, except confidential claims information, are open to the public for reasonable inspection.

(3) Each person authorized to receive deposits for, withdraw money from, or otherwise disburse any money from the fund shall post a bond in an amount reasonably sufficient to protect fund assets. The cost of the bond must be paid from the fund.

(4) After the close of each fiscal year, the board shall furnish a report on the financial condition of the fund to the commissioner. The report must be prepared in accordance with generally accepted accounting principles and must include the present value of all claims reserves, including reserves for claims incurred but not reported, and all other information as required by the commissioner. The board shall furnish an appropriate summary of the report to all fund participants.

(5) The board shall also prepare and submit to the state board of investments and the department of administration a quarterly report projecting the future cash flow needs of the fund.

NEW SECTION. **Section 24. Claims procedure.** (1) (a) A person may file a claim for damages for medical negligence arising out of the rendering of medical care or services within this state against a health care provider or an employee of a health care provider.

(b) A person who files a claim under subsection (1)(a) may recover from the fund only if:

(i) the health care provider or the employee of the health care provider has coverage under the plan;

(ii) the plan is named as a party in the action; and

(iii) the action against the plan is commenced within the same time limitation within which a civil action against the health care provider or employee of the health care provider must be commenced.

(2) (a) A person may file an action for damages for medical negligence arising out of the rendering of medical care or services outside this state against a health care provider or an employee of a health care provider.

(b) A person who files an action under subsection (2)(a) may recover from the fund only if:

(i) the health care provider or the employee of the health care provider that is named in the action is covered under the plan;

(ii) the plan is named as a party in the action; and

(iii) the action against the plan is commenced within the same time limitation within which a civil action against the health care provider or employee of the health care provider must be commenced.

(c) If the law or rules of procedure of the jurisdiction in which the action is brought under subsection (2)(a) do not permit naming the plan as a party, the person filing the action may recover from the fund only if:

(i) the health care provider or the employee of the health care provider that is named in the action is covered under the fund; and

(ii) except as provided in subsection (2)(d), the person filing the action notifies the commissioner, as the representative of the fund, of the action within 60 days of service of process on the health care provider or the employee of the health care provider that is named in the action.

(d) The board may extend the 60-day time limit if it finds that enforcing the time limit would be prejudicial to the purposes of the fund and would not benefit either the insured or the claimant.

(3) If, after reviewing the facts upon which the claim or action is based, it appears reasonably probable that damages to be paid will exceed $1 million or the maximum liability limit for which the health care provider is insured, whichever is greater, the board may:

(a) appear and actively defend itself whenever the board, the plan, or the fund is named as a party in an action against a health care provider or an employee of a health care provider that has coverage under the plan;

(b) retain legal counsel; or

(c) pay out of the fund attorney fees and expenses, including court costs incurred and awarded in defending the insured, the plan, or the fund.

(4) If legal counsel is retained under subsection (3)(b), the attorney or law firm retained may not be retained or employed by the board to perform legal services for the board other than those services directly connected with defending the insured, the plan, or the fund.

(5) A judgment affecting the fund may be appealed as provided by law. The board is not required to file any undertaking in any judicial action, proceeding, or appeal.

(6) An insurer or a self-insurer that provides, respectively, insurance or self-insurance for a health care provider shall provide an adequate defense of the plan or fund on any claim filed that may potentially affect the fund with respect to the insurance contract or self-insurance contract. The insurer or self-insurer shall act in good faith and in a fiduciary relationship with respect to any claim affecting or potentially affecting the fund. A settlement offer that exceeds an amount that could require payment from the fund may not be agreed to unless approved by the board.

(7) A health care provider with a cash or surety bond in effect to insure the health care provider against medical negligence shall:

(a) provide an adequate defense of the plan or fund on any medical negligence claim filed that may affect the fund; and

(b) act in good faith and in a fiduciary relationship with respect to any claim affecting the fund.

(8) A person who has recovered a final settlement approved by the board, a final arbitration award, or a final judgment against a health care provider or an employee of a health care provider may file a claim with the board to recover the amount of the settlement, arbitration award, or judgment that is not payable by the health care provider or the health care provider's liability insurer, other than the fund.

(9) (a) If the fund incurs liability for future payments that exceed $1 million to any person under a single claim as the result of a settlement, arbitration award, or judgment that is entered into or rendered under [sections 1 through 31] for medical negligence that occurred on or after [the applicability date of this section], the board shall pay from the fund, after deducting the reasonable costs of collection attributable to the remaining liability, including attorney fees reduced to present value, all relevant medical expenses each year, plus an amount, not to exceed $500,000 a year, that will pay the remaining liability over the person's anticipated lifetime or until the liability is paid in full.

(b) If the remaining liability is not paid in full before the person dies, the board may pay from the fund the remaining liability in a lump sum.

(10) Payments must be made from money collected and paid into the fund under [section 22] and from

interest and other income earned on the fund.

(11) (a) Except as provided in [section 11] or subsection (9)(b) of this section, for a claim subject to a periodic payment made under this section, payments must be made until the claim has been paid in full. Periodic payments made under this section include direct or indirect payment or a commitment of money to or on behalf of any person under a single claim by any funding mechanism.

(b) Except as provided in subsection (11)(c), interest on a claim is not paid by the fund.

(c) If there is an offer of settlement by a claimant under this section that is not accepted and the claimant recovers a judgment that is greater than or equal to the amount specified in the offer of settlement, the claimant is entitled to interest at the annual rate of 12% on the full amount recovered. Interest accrues from the date of the offer of settlement until the amount of the settlement, plus the accrued interest, is paid in full.

(12) (a) Each claim that is payable from the fund must be paid in the order that the claim was received, relative to other claims, within 90 days after filing, unless the board denies the claim or files an action against the claim.

(b) If the amount of money in the fund is insufficient to pay all of the payable claims, payable claims received after the amount in the fund is exhausted are payable immediately in the following year in the order in which the payable claims were received.

NEW SECTION. **Section 25. Reports -- reinsurance.** (1) On or before December 31 of each year, the board shall submit a report on the financial and operational status of the fund to the legislature as provided in 5-11-210(2)(a) through (2)(e).

(2) Subject to approval by the commissioner, the board may cede reinsurance to an insurer authorized to do business in this state or pursue other loss-funding management to preserve the solvency and integrity of the fund. The commissioner may prescribe controls over or other conditions on the use of reinsurance or other loss-funding management mechanisms.

NEW SECTION. **Section 26. Actions against insurers, self-insurers, or health care providers.** The board may bring an action against an insurer, self-insurer, or health care provider for failure to act in good faith or breach of fiduciary responsibility under [section 24(6) or (7)].

NEW SECTION. **Section 27. Injured patients and families compensation fund peer review council**

-- members -- meetings -- assessments -- compensation -- report. (1) There is an injured patients and families compensation fund peer review council.

(2) (a) The board shall appoint five individuals to serve as the council.

(b) No more than three of the appointees may be physicians who are actively engaged in the practice of medicine in this state.

(c) The board shall annually designate:

(i) the presiding officer of the council who:

(A) must be a physician; and

(B) serves as an ex officio, nonvoting member of the board of medical examiners; and

(ii) the vice presiding officer of the council and the secretary of the council.

(3) A majority of the members of the council constitutes a quorum for the purpose of conducting business.

(4) Council members serve staggered 3-year terms. A council member may not serve for more than two consecutive terms.

(5) The council shall meet at the call of the presiding officer of the council or the presiding officer of the board or by an affirmative vote of at least three members of the council. The council shall meet in Helena or at an alternate location determined by the presiding officer or the members who call the meeting.

(6) Assessments sufficient to cover the council's costs, including costs of administration, must be imposed and collected as provided in [section 28].

(7) (a) Members of the council must be paid at a rate established by the board by rule and are eligible to be reimbursed for expenses as provided in 2-18-501 through 2-18-503. The rate of pay must be the same for all members.

(b) A person acting as a consultant to the council must be paid at a rate established by the commissioner by rule.

(8) (a) Except as provided in subsection (8)(b), the council shall submit annually to the presiding officer of the board a report on the operation of the council.

(b) The board or the commissioner may at any time direct the council to submit a report on the operation of the council. A report directed under this subsection (8)(b) must be submitted within 60 days following the direction to submit the report.

NEW SECTION. **Section 28. Assessments for council.** (1) The plan and each private health care liability insurer, including health care liability self-insurers, shall pay to the fund an annual assessment in support of the council. The total amount of the assessments must be sufficient to cover the costs of the council, including costs of administration, for reviewing claims paid under the plan by the fund and by insurers pursuant to [section 29].

(2) The commissioner, after approval by the board, shall set by rule the amount of the assessments imposed under subsection (1).

(3) (a) Except as provided in subsection (3)(b), the assessments must be paid quarterly in the manner established by the commissioner.

(b) An assessment for a period of time less than one calendar or fiscal quarter must be prorated by the commissioner.

(4) Except as provided in subsection (5), the rules may not provide for more than four assessment classifications for physicians, and each classification may be based only on:

(a) the amount of surgery performed; and

(b) the risk of diagnostic and therapeutic services provided or procedures performed.

(5) In addition to the assessment classifications, the commissioner, after approval by the board, may establish by rule a separate assessment classification for physicians satisfying [section 4(1)(b)] and a separate assessment for advanced practice registered nurses satisfying [section 4(1)(b)] that take into account the loss experience of health care providers for whom an adjacent state is a principal place of practice.

(6) (a) Except as provided in subsection (6)(b), rules adopted pursuant to this section must provide that any assessment is subject to an increase if the loss and expense experience of the fund and other sources, with respect to the health care providers or employees of the health care providers insured by each private insurer, including health care liability insurers, exceeds a threshold number of claims paid or a threshold dollar volume of claims paid as either threshold is established in the rules. The rules must also specify applicable amounts of increase corresponding to the number of claims paid and the dollar volume of claims paid in excess of the respective thresholds for the number of claims paid or the dollar volume of claims paid.

(b) The rules must provide that the increase does not apply if the board determines that the performance of the council in making recommendations under [section 29] adequately addresses the consideration set forth in subsection (5).

(7) The rules setting assessments for a particular fiscal year must ensure that the total amount of

assessments does not exceed the greatest of the following:

(a) the estimated total dollar amount to be expended on the costs of the council during the particular fiscal year;

(b) the total amount assessed on all health care providers for the fiscal year preceding the particular fiscal year, adjusted by the commissioner to reflect changes in the consumer price index for all urban consumers, U.S. city average, for the medical care group, as determined by the U.S. department of labor, and changes in the number of health care providers covered by the plan; or

(c) 200% of the total dollar amount expended on the costs of the council during the calendar year preceding the particular fiscal year.

(8) (a) If the rules establishing assessments under subsection (2) do not take effect on July 1 of any fiscal year, the commissioner may collect assessments at the rates established for the previous fiscal year.

(b) Subject to subsection (8)(c), if the commissioner collects assessments pursuant to subsection (8)(a) and the rules promulgated under subsection (2) become effective after July 1, the assessments must be adjusted to reflect the assessments established pursuant to subsection (2).

(c) The commissioner may refund, adjust for, or not collect minimal amounts of assessments, pursuant to rules adopted by the commissioner.

NEW SECTION. **Section 29. Claims review by council -- recommendations.** (1) For damages arising out of medical negligence for the rendering of medical care by a health care provider or an employee of a health care provider, the council shall review, within 1 year of the date of first payment from the fund of the damages, each claim that is paid by:

(a) the plan, through the fund;

(b) a private health care liability insurer; or

(c) a health care provider that self-insures.

(2) The council:

(a) shall make recommendations to:

(i) the commissioner and the board regarding any adjustments to be made, under [section 28(5)], to the assessment against the health care liability insurer, based on paid claims; and

(ii) the commissioner and the board regarding any adjustments to be made, under [section 22(3)], to premiums assessed against a health care provider under the plan based on the paid claims; and

(b) may make recommendations to a private health care liability insurer, if requested by the private insurer, regarding adjustments to premiums assessed against a health care provider that is covered by private insurance or that self-insures, based on paid claims.

(3) In developing recommendations under subsection (2), the council may consult with any person and shall consult with the following:

(a) if a claim was paid for damages arising out of the rendering of care by a physician, with at least one physician from the area of medical specialty of the physician who rendered the care and with at least one physician from the area of medical specialty of the medical procedure involved, if the specialty area of the procedure is different from the specialty area of the physician who rendered the care; or

(b) if a claim was paid for damages arising out of the rendering of care by an advanced practice registered nurse, with at least one advanced practice registered nurse.

(4) The council shall notify, in writing, the affected health care provider of the council's recommendations to the commissioner, the board, or a private insurer made under subsection (2). The notice must inform the health care provider that the health care provider may submit written comments on the council's recommendations to the commissioner, the board, or the private insurer within a reasonable period of time as specified in the notice.

(5) A person consulting with the council under subsection (3) must be paid at a rate established by the commissioner by rule.

NEW SECTION. **Section 30. Council review of patient records.** (1) Subject to the limitations on disclosure imposed under 42 U.S.C. 1320d, et seq., the council may obtain any information that is in the possession of the commissioner or the board that relates to any claim that the council is required to review under [section 29].

(2) The council shall keep patient health care information confidential, and all patient health care information is exempt from the provisions of Title 2, chapter 6.

NEW SECTION. **Section 31. Council immunity.** Members of the council and any person consulting with the council under [section 29(3)] are immune from civil liability for acts or omissions while performing their duties under [sections 27 through 30].

NEW SECTION. **Section 32. Appropriation.** There is appropriated $10 million from the general fund to the injured patients and families compensation fund established in [section 18] for fiscal year 2006. The appropriation and all other money in the fund may be used only for the purposes described in [section 18], including establishing and administering the health care liability insurance plan for health care providers provided for under [section 3].

Section 33. Section 2-15-1731, MCA, is amended to read:

"2-15-1731. Board of medical examiners. (1) There is a Montana state board of medical examiners.

(2) (a) The board consists of:

(i) 11 members appointed by the governor with the consent of the senate; and

(ii) the presiding officer of the injured patients and families compensation fund peer review council established in [section 27], who serves as a nonvoting member of the board.

(b) Appointments made by the governor when the legislature is not in session may be confirmed at the next session of the legislature.

(3) The members appointed by the governor are:

(a) five members having the degree of doctor of medicine;

(b) one member having the degree of doctor of osteopathy;

(c) one member who is a licensed podiatrist;

(d) one member who is a licensed nutritionist;

(e) one member who is a licensed physician assistant-certified; and

(f) two members of the general public who are not medical practitioners.

(4) ~~The~~ No two members listed in subsection (3)(a) having the degree of doctor of medicine may ~~not~~ be from the same county. Each member appointed by the governor must be a citizen of the United States. Each member appointed by the governor, except for public members, must have been licensed and must have practiced medicine or dietetics-nutrition in this state for at least 5 years and must have been a resident of this state for at least 5 years.

(5) Members appointed by the governor shall serve staggered 4-year terms. A term commences on September 1 of each year of appointment. A member appointed by the governor may, upon notice and hearing, be removed by the governor for neglect of duty, incompetence, or unprofessional or dishonorable conduct.

(6) The board is allocated to the department for administrative purposes only as prescribed in 2-15-121."

Section 34. Section 17-6-201, MCA, is amended to read:

"17-6-201. Unified investment program -- general provisions. (1) The unified investment program directed by Article VIII, section 13, of the Montana constitution to be provided for public funds must be administered by the board of investments in accordance with the prudent expert principle, which requires an investment manager to:

(a) discharge the duties with the care, skill, prudence, and diligence, under the circumstances then prevailing, that a prudent person acting in a like capacity with the same resources and familiar with like matters exercises in the conduct of an enterprise of a like character with like aims;

(b) diversify the holdings of each fund within the unified investment program to minimize the risk of loss and to maximize the rate of return unless, under the circumstances, it is clearly prudent not to do so; and

(c) discharge the duties solely in the interest of and for the benefit of the funds forming the unified investment program.

(2) (a) Retirement funds may be invested in common stocks of any corporation.

(b) Other public funds may not be invested in private corporate capital stock. "Private corporate capital stock" means only the common stock of a corporation.

(3) (a) This section does not prevent investment in any business activity in Montana, including activities that continue existing jobs or create new jobs in Montana.

(b) The board is urged under the prudent expert principle to invest up to 3% of retirement funds in venture capital companies. Whenever possible, preference should be given to investments in those venture capital companies that demonstrate an interest in making investments in Montana.

(c) In discharging its duties, the board shall consider the preservation of purchasing power of capital during periods of high monetary inflation.

(d) The board may not make a direct loan to an individual borrower. The purchase of a loan or a portion of a loan originated by a financial institution is not considered a direct loan.

(4) The board has the primary authority to invest state funds. Another agency may not invest state funds unless otherwise provided by law. The board shall direct the investment of state funds in accordance with the laws and constitution of this state. The board has the power to veto investments made under its general supervision.

(5) The board shall:

(a) assist agencies with public money to determine if, when, and how much surplus cash is available for investment;

(b) determine the amount of surplus treasury cash to be invested;

(c) determine the type of investment to be made;

(d) prepare the claim to pay for the investment; ~~and~~

(e) keep an account of the total of each investment fund and of all the investments belonging to the fund and a record of the participation of each treasury fund account in each investment fund; and

(f) invest the money held in the injured patients and families compensation fund in investments with maturities and liquidity that are appropriate and necessary to meet the needs of the fund, including cash flow needs, as reported under [section 23].

(6) The board may:

(a) execute deeds of conveyance transferring real property obtained through investments. Prior to the transfer of real property directly purchased and held as an investment, the board shall obtain an appraisal by a qualified appraiser.

(b) direct the withdrawal of funds deposited by or for the state treasurer pursuant to 17-6-101 and 17-6-105;

(c) direct the sale of securities in the program at their full and true value when found necessary to raise money for payments due from the treasury funds for which the securities have been purchased.

(7) The cost of administering and accounting for each investment fund must be deducted from the income from each fund."

Section 35. Section 17-6-203, MCA, is amended to read:

"17-6-203. Separate investment funds. Separate investment funds must be maintained as follows:

(1) the permanent funds, including all public school funds and funds of the Montana university system and other state institutions of learning referred to in Article X, sections 2 and 10, of the Montana constitution. The principal and any part of the principal of each fund constituting the Montana permanent fund type are subject to deposit at any time when due under the statutory provisions applicable to the fund and according to the provisions of the gift, donation, grant, legacy, bequest, or devise through or from which the particular fund arises.

(2) a separate investment fund, which may not be held jointly with other funds, for money pertaining to each retirement or insurance system maintained by the state, including:

(a) the highway patrol officers' retirement system described in Title 19, chapter 6;

(b) the public employees' retirement system described in Title 19, chapter 3;

(c) the game wardens' and peace officers' retirement system described in Title 19, chapter 8;

(d) the teachers' retirement system described in Title 19, chapter 20; ~~and~~

(e) the workers' compensation program described in Title 39, chapter 71, part 23; and

(f) the injured patients and families compensation fund, established in [section 18];

(3) a pooled investment fund, including all other accounts within the treasury fund structure established by 17-2-102;

(4) the fish and wildlife mitigation trust fund established by 87-1-611;

(5) a fund consisting of gifts, donations, grants, legacies, bequests, devises, and other contributions made or given for a specific purpose or under conditions expressed in the gift, donation, grant, legacy, bequest, devise, or contribution to be observed by the state of Montana. If a gift, donation, grant, legacy, bequest, devise, or contribution permits investment and is not otherwise restricted by its terms, it may be treated jointly with other gifts, donations, grants, legacies, bequests, devises, or contributions.

(6) a fund consisting of coal severance taxes allocated to the coal severance tax trust fund under Article IX, section 5, of the Montana constitution. The principal of the coal severance tax trust fund is permanent. If the legislature appropriates any part of the principal of the coal severance tax trust fund by a vote of three-fourths of the members of each house, the appropriation or investment may create a gain or loss in the principal.

(7) a Montana tobacco settlement trust fund established in accordance with Article XII, section 4, of the Montana constitution and Title 17, chapter 6, part 6; and

(8) additional investment funds that are expressly required by law or that the board of investments determines are necessary to fulfill fiduciary responsibilities of the state with respect to funds from a particular source."

Section 36. Section 25-9-402, MCA, is amended to read:

"25-9-402. Findings by trier of fact -- civil actions. ~~In~~ Except as provided in [section 11], in any action for personal injury, property damage, or wrongful death where liability is found after trial and in which $100,000 or more in future damages is awarded to the claimant, the trier of fact shall make a separate finding as to the amount of any future damages so awarded and state whether the amount of future damages has been reduced to present value."

Section 37. Section 25-9-403, MCA, is amended to read:

"25-9-403. Request for periodic payment of future damages -- nonmalpractice claims. (1) Except as provided in 25-9-412 and [section 11], a party to an action for personal injury, property damage, or wrongful death in which $100,000 or more of future damages is awarded may, prior to the entry of judgment, request the court to enter a judgment ordering future damages to be paid in whole or in part by periodic payments rather than by a lump-sum payment. Upon a request, the court may enter an order for periodic payment of future damages if the court finds that periodic payment is in the best interests of the claimant. The total dollar amount of the ordered periodic payments must equal the total dollar amount of the future damages without a reduction to present value.

(2) A court ordering the payment of future damages by periodic payments shall make specific findings as to the dollar amount of periodic payments needed to compensate the judgment creditor for future damages and as to whether an order for periodic payment of future damages is in the best interests of the claimant.

(3) The judgment order must specify the recipient or recipients of periodic payments, the dollar amount of the payments, the interval between payments, and the number of payments or the period of time over which payments must be made.

(4) A court ordering periodic payment of future damages shall order that the payments be made, during the life of the judgment creditor or during the continuance of the compensable injury or disability of the judgment creditor, through the purchase of an inflation-indexed annuity approved by the court. The annuity must be in the form of an inflation-indexed annuity contract purchased from a qualified insurer that, in the most recent edition of A.M. Best, has an "A" (excellent) or higher rating and is in a class 7 or higher classification. The annuity also serves as any required supersedeas bond. Upon purchase of a court-approved annuity, the court may order that the judgment is satisfied and that the judgment debtor is discharged. If the judgment creditor dies before all periodic payments have been made, the remaining payments become the property of the creditor's estate."

Section 38. Section 25-9-412, MCA, is amended to read:

"25-9-412. Periodic payment of future damages in medical malpractice cases. (1) (a) ~~A~~ With respect to an act of malpractice that occurred prior to [the effective date of this section], a party to an action for a malpractice claim, as defined in 25-9-411, in which $50,000 or more of future damages is awarded may, prior to the entry of judgment, request the court to enter a judgment ordering future damages to be paid in whole or

in part by periodic payments rather than by a lump-sum payment. Upon a request, the court shall enter an order for periodic payment of future damages. The total dollar amount of the ordered periodic payments must equal the total dollar amount of the future damages without a reduction to present value.

(b) With respect to an act of malpractice that would be subject to a malpractice claim, as defined in 25-9-411, or medical negligence, as defined in [section 2], that occurred on or after [the effective date of this section], the provisions of [section 11] apply.

(2) A court ordering the payment of future damages by periodic payments shall make specific findings as to the dollar amount of periodic payments needed to compensate the judgment creditor for future damages.

(3) The judgment order must specify the recipient or recipients of periodic payments, the dollar amount of the payments, the interval between payments, and the number of payments or the period of time over which payments must be made.

(4) The court shall order that periodic payment of future damages be made, during the life of the judgment creditor or during the continuance of the compensable injury or disability of the judgment creditor, through the purchase of an inflation-indexed annuity approved by the court. The annuity must be in the form of an inflation-indexed annuity contract purchased from a qualified insurer that, in the most recent edition of A.M. Best, has an "A" (excellent) or higher rating and is in a class 7 or higher classification. The annuity also serves as any required supersedeas bond. Upon purchase of a court-approved annuity, the court shall order that the judgment is satisfied and that the judgment debtor is discharged. If the judgment creditor dies before all periodic payments have been made, the remaining payments become the property of the creditor's estate."

Section 39. Section 27-6-103, MCA, is amended to read:

"27-6-103. Definitions. As used in this chapter, the following definitions apply:

(1) "Advanced practice registered nurse" has the meaning provided in [section 2] and includes:

(a) an advanced practice registered nurse who has liability coverage under the Montana health care liability insurance plan established pursuant to [section 3]; and

(b) a person who at the time of the occurrence of the incident giving rise to the claim:

(i) was an individual who had as the principal residence or place of practice the state of Montana and was not employed full-time by any federal governmental agency or entity; or

(ii) was a professional service corporation, partnership, or other business entity organized under the laws of any state to render services of advanced practice registered nurses and whose shareholders, partners, or

owners were individual advanced practice registered nurses licensed to practice under the provisions of Title 37, chapter 8.

~~(1)~~(2) "Dentist" means:

(a) for purposes of the assessment of the annual surcharge, an individual licensed to practice dentistry under the provisions of Title 37, chapter 4, who at the time of the assessment:

(i) has as the individual's principal residence or place of dental practice the state of Montana;

(ii) is not employed full-time by any federal governmental agency or entity; and

(iii) is not fully retired from the practice of dentistry; or

(b) for all other purposes, a person licensed to practice dentistry under the provisions of Title 37, chapter 4, who at the time of the occurrence of the incident giving rise to the claim:

(i) was an individual who had as the principal residence or place of dental practice the state of Montana and was not employed full-time by any federal governmental agency or entity; or

(ii) was a professional service corporation, partnership, or other business entity organized under the laws of any state to render dental services and whose shareholders, partners, or owners were individual dentists licensed to practice dentistry under the provisions of Title 37, chapter 4.

~~(2)~~(3) (a) "Health care facility" means a facility, other than a governmental infirmary but including a university or college infirmary, licensed as a health care facility under Title 50, chapter 5.

(b) For the purposes of this chapter, a health care facility does not include an end-stage renal dialysis facility, a home infusion therapy agency, or a residential care facility if the alleged malpractice occurred prior to [the effective date of this section].

~~(3)~~(4) "Health care provider" means a physician, an advanced practice registered nurse, a dentist, a podiatrist, or a health care facility.

~~(4)~~(5) "Hospital" means a hospital as defined in 50-5-101.

~~(5)~~(6) "Malpractice claim" means a claim or potential claim of a claimant against a health care provider for medical or dental treatment, lack of medical or dental treatment, or other alleged departure from accepted standards of health care that proximately results in damage to the claimant, whether the claimant's claim or potential claim sounds in tort or contract, and includes but is not limited to:

(a) allegations of battery or wrongful death; and

(b) medical negligence, as defined in [section 2].

~~(6)~~(7) "Panel" means the Montana medical legal panel provided for in 27-6-104.

~~(7)~~(8) "Physician" means:

(a) for purposes of the assessment of the annual surcharge, an individual licensed to practice medicine under the provisions of Title 37, chapter 3, who at the time of the assessment:

(i) (A) has as the individual's principal residence or place of medical practice the state of Montana;

~~(ii)~~(B) is not employed full-time by any federal governmental agency or entity; and

~~(iii)~~(C) is not fully retired from the practice of medicine; or

(ii) is a physician, as defined in [section 2], who has liability coverage under the Montana health care liability insurance plan established pursuant to [section 3]; or

(b) for all other purposes, a person licensed to practice medicine under the provisions of Title 37, chapter 3, who at the time of the occurrence of the incident giving rise to the claim:

(i) was an individual who had as the principal residence or place of medical practice the state of Montana and was not employed full-time by any federal governmental agency or entity; or

(ii) was a professional service corporation, partnership, or other business entity organized under the laws of any state to render medical services and whose shareholders, partners, or owners were individual physicians licensed to practice medicine under the provisions of Title 37, chapter 3.

~~(8)~~(9) "Podiatrist" means:

(a) for purposes of the assessment of the annual surcharge, an individual licensed to practice podiatry under the provisions of Title 37, chapter 6, who at the time of the assessment:

(i) (A) has as the individual's principal residence or place of podiatric practice the state of Montana;

~~(ii)~~(B) is not employed full-time by any federal governmental agency or entity; and

~~(iii)~~(C) is not fully retired from the practice of podiatry; or

(ii) has liability coverage under the Montana health care liability insurance plan established pursuant to [section 3]; or

(b) for all other purposes, a person licensed to practice podiatry under the provisions of Title 37, chapter 6, who at the time of the occurrence of the incident giving rise to the claim:

(i) was an individual who had as the principal residence or place of podiatric practice the state of Montana and was not employed full-time by any federal governmental agency or entity; or

(ii) was a professional service corporation, partnership, or other business entity organized under the laws of any state to render podiatric services and whose shareholders, partners, or owners were individual podiatrists licensed to practice podiatry under the provisions of Title 37, chapter 6."

Section 40. 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:

(1) filed before [the effective date of this section] against ~~health care providers covered by this chapter except those claims subject to a valid arbitration agreement allowed by law or upon which suit has been filed prior to April 19, 1977~~ a physician, a dentist, a podiatrist, or a health care facility if those claims were not subject to a valid arbitration agreement allowed by law; and

(2) filed on or after [the effective date of this section] against a health care provider, as defined in [section 2]."

Section 41. Section 27-6-606, MCA, is amended to read:

"27-6-606. Decision not binding -- settlement agreements -- nonbinding mediation. (1) The panel's decision is without administrative or judicial authority and is not binding upon any party.

(2) The panel may recommend an award, approve settlement agreements, and discuss the settlement agreements, all in a manner consistent with this part. All approved settlement agreements are binding on the parties.

(3) If the panel decides both questions required by 27-6-602 in the affirmative and a complaint is filed in district court, the court in which the complaint is filed shall, at the request of a party, require the parties to participate in court-supervised, nonbinding mediation prior to proceeding."

Section 42. Section 27-6-703, MCA, is amended to read:

"27-6-703. Records of proceedings -- confidentiality. The director shall maintain records of all proceedings before the panel~~, which~~. The records must include the nature of the act or omissions complained of, a brief summary of the evidence expressed, the decision of the panel, and any majority or dissenting opinions filed. Any records ~~which~~ that may identify any party to the proceedings may not be made public and are not subject to subpoena but are to be used solely for the purpose of compiling statistical data, setting premiums and assessments pursuant to [section 13], and facilitating ongoing studies of medical malpractice in Montana."

Section 43. Section 33-1-311, MCA, is amended to read:

"33-1-311. General powers and duties. (1) The commissioner shall enforce the applicable provisions of the laws of this state and shall execute the duties imposed on the commissioner by the laws of this state.

(2) The commissioner has the powers and authority expressly conferred upon the commissioner by or reasonably implied from the provisions of the laws of this state.

(3) The commissioner shall administer the department to ensure that the interests of insurance consumers are protected.

(4) The commissioner may conduct examinations and investigations of insurance matters, in addition to examinations and investigations expressly authorized, as the commissioner considers proper, to determine whether any person has violated any provision of the laws of this state or to secure information useful in the lawful administration of any provision. The cost of additional examinations and investigations must be borne by the state.

(5) The commissioner shall maintain as confidential any information or document received from:

(a) the national association of insurance commissioners; or

(b) an insurance department from another state or federal agency that treats the same information or document as confidential. The commissioner may provide information or documents, including information or documents that are confidential, to the national association of insurance commissioners, a state or federal law enforcement agency, a federal agency, or an insurance department in another state, if the recipient agrees to maintain the confidentiality of the information or documents.

(6) The commissioner shall establish a plan of health care liability coverage for health care providers as required under [section 3].

~~(6)~~(7) The department is a criminal justice agency as defined in 44-5-103."

NEW SECTION. **Section 44. Two-thirds vote required -- contingent voidness.** Because [section 3(5)] and [section 31] limit governmental liability, Article II, section 18, of the Montana constitution requires a vote of two-thirds of the members of each house of the legislature for [section 3(5)] and [section 31] to become effective. If [this act] is not approved by at least two-thirds of the members of each house of the legislature, then [section 3(5)] and [section 31] are void.

NEW SECTION. **Section 45. Codification instruction.** [Sections 1 through 31] are intended to be codified as an integral part of Title 33, and the provisions of Title 33 apply to [sections 1 through 31].

NEW SECTION. **Section 46. Saving clause.** [This act] does not affect rights and duties that matured, penalties that were incurred, or proceedings that were begun before [the effective date of this act].

NEW SECTION. **Section 47. Transition -- implementation.** (1) Under [section 14], an insurer may not enter into or issue any health care liability insurance policy until the insurer's policy form has been submitted to and approved by the commissioner of insurance as provided in Title 33, chapter 1, part 5. However, a health care liability insurance policy legally issued or entered into prior to January 1, 2006, is valid unless voided by the commissioner and is, after December 31, 2005, subject to the provisions of [this act]. Every health care liability insurance policy in effect on January 1, 2006, is subject to the provisions of [this act].

(2) [Section 20] requires the appointment of members to the health care liability insurance plan board of governors. All the appointments must be made by August 1, 2005. Upon expiration of the initial term of appointment under this subsection (2), all subsequent terms of appointment are for 3 years. For the purposes of transition:

(a) the person appointed by the state bar of Montana shall serve until January 1, 2007;

(b) the person appointed by the Montana trial lawyers association shall serve until January 1, 2008;

(c) one person appointed by the Montana medical association shall serve until January 1, 2007, and the second person appointed by the Montana medical association shall serve until January 1, 2008;

(d) the person appointed by the Montana hospital association shall serve until January 1, 2008; and

(e) the governor shall make two of the required appointments for terms that expire on January 1, 2007, one of the appointments to expire on January 1, 2008, and one of the appointments to expire on January 1, 2009.

(3) [Section 22] requires each health care provider to pay to the fund an annual premium for the purposes of the Health Care Liability and Injured Patients Compensation Act. The commissioner and the board of governors of the health care liability insurance plan shall as soon as practicable but no later than December 31, 2005, establish and collect the premiums necessary to establish and administer the injured patients and families compensation fund. The premiums established pursuant to [section 22] and this section are effective upon approval by the board of governors and are effective until new premiums are set as provided in [section 22].

(4) [Section 27] requires the board of governors of the health care liability insurance plan to appoint five

individuals as the injured patients and families compensation fund peer review council. For the initial appointments, the board shall appoint one individual to serve until January 1, 2007, two individuals to serve until January 1, 2008, and two individuals to serve until January 1, 2009.

(5) [Section 33] revises the composition of the board of medical examiners to include the presiding officer of the injured patients and families compensation fund peer review council provided for in [section 27]. All legal actions of the board of medical examiners are effective regardless of whether or not the presiding officer of the council has been appointed under [section 27] and, by the appointment, is a member of the board of medical examiners under [section 27].

(6) Beginning [the applicability date of this section], every patient, every patient's representative, every insurer who offers liability coverage to indemnify health care providers against medical negligence, as those terms are defined in [section 2], and every health care provider is subject to and bound by [sections 1 through 31].

NEW SECTION. **Section 48. Effective dates.** (1) Except as provided in subsection (2), [this act] is effective July 1, 2005.

(2) [Sections 36 through 41] are effective January 1, 2006.

NEW SECTION. **Section 49. Applicability.** [Sections 4 through 9, 11, 12, 15, 16, 19, 24, 26, and 47(6)] apply January 1, 2006.

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