MISSISSIPPI LEGISLATURE REGULAR SESSION 2004

By: Senator(s) Robertson

To: Judiciary, Division A; Appropriations

SENATE BILL NO. 2870

AN ACT TO ESTABLISH A PATIENT'S COMPENSATION FUND FOR THE PURPOSE OF PROVIDING COMPENSATION TO PATIENTS SUFFERING LOSS, DAMAGES OR EXPENSE AS THE RESULT OF PROFESSIONAL MALPRACTICE BY HEALTH CARE PROVIDERS; TO DEFINE CERTAIN TERMS; TO PROVIDE LIMITATION OF RECOVERY AGAINST QUALIFIED HEALTH CARE PROVIDERS IN MEDICAL MALPRACTICE ACTIONS; TO PROVIDE FOR PAYMENTS FOR FUTURE MEDICAL CARE AND RELATED BENEFITS WITHOUT REGARD TO THE LIMITATION; TO CREATE THE PATIENT'S COMPENSATION FUND OVERSIGHT BOARD IN ORDER TO PROVIDE FOR THE ORGANIZATION, ADMINISTRATION AND DEFENSE OF THE FUND; TO AUTHORIZE A SURCHARGE PAID BY HEALTH CARE PROVIDERS TO FUND THE PATIENT'S COMPENSATION FUND; TO PROVIDE THAT THE AMOUNT OF THE SURCHARGE SHALL BE DETERMINED BY THE COMMISSIONER OF INSURANCE; TO PROVIDE THAT ALL MALPRACTICE CLAIMS SHALL BE REVIEWED BY A MEDICAL REVIEW PANEL; TO ESTABLISH THE MEMBERSHIP OF THE MEDICAL REVIEW PANEL; TO AMEND SECTION 11-1-60, MISSISSIPPI CODE OF 1972, IN CONFORMITY THERETO; TO LIMIT CONTINGENCY FEES CHARGED BY ATTORNEYS FOR REPRESENTING PERSONS SEEKING DAMAGES IN CONNECTION WITH ACTIONS FOR INJURY OR DAMAGE AGAINST HEALTH CARE PROVIDERS; TO REPEAL SECTIONS 83-48-1 THROUGH 83-48-7, MISSISSIPPI CODE OF 1972, WHICH CREATE THE MEDICAL MALPRACTICE INSURANCE AVAILABILITY ACT; AND FOR RELATED PURPOSES.

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

SECTION 1. Definitions.

(1) As used in this chapter, unless the context clearly requires otherwise:

(a) "Health care provider" means a person, partnership, limited liability partnership, limited liability company, corporation, facility, or institution licensed by this state to provide health care or professional services as a physician, hospital, institution for the aged or infirm, community blood center, tissue bank, dentist, registered or licensed practical nurse or certified nurse assistant, ambulance service, certified registered nurse anesthetist, nurse midwife, licensed midwife, pharmacist, optometrist, podiatrist, chiropractor, physical therapist, occupational therapist, psychologist, social worker, licensed professional counselor, or any nonprofit facility

considered tax-exempt under Section 501(c)(3), Internal Revenue Code, pursuant to 26 USC 501(c)(3), for the diagnosis and treatment of cancer or cancer-related diseases, whether or not such a facility is required to be licensed by this state, or any professional corporation a health care provider is authorized to form under the Mississippi Code of 1972, or any partnership, limited liability partnership, limited liability company, or corporation whose business is conducted principally by health care providers, or an officer, employee, partner, member, shareholder, or agent thereof acting in the course and scope of his employment.

(b) "Physician" means a person licensed to practice medicine in this state.

(c) "Patient" means a natural person who receives or should have received health care from a health care provider.

(d) "Hospital" means any hospital, institution for the aged or infirm, or any physician's or dentist's offices or clinics containing facilities for the examination, diagnosis, treatment or care of human illnesses.

(e) "Board" means the Patient's Compensation Fund Oversight Board created in Section 4 of this chapter.

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

(g) "Tort" means any breach of duty or any negligent act or omission proximately causing injury or damage to another. The standard of care required of every health care provider, except a hospital, in rendering professional services or health care to a patient, shall be to exercise that degree of skill ordinarily employed, under similar circumstances, by the members of his profession in good standing in the same community or locality, and to use reasonable care and diligence, along with his best judgment, in the application of his skill.

(h) "Malpractice" means any unintentional tort or any breach of contract based on health care or professional services

rendered, or which should have been rendered, by a health care provider, to a patient, including failure to render services timely and the handling of a patient, including loading and unloading of a patient, including failure to obtain a patient’s informed consent, and also includes all legal responsibility of a health care provider arising from acts or omissions in the training or supervision of health care providers, or from defects in blood, tissue, transplants, drugs and medicines, or from defects in or failures of prosthetic devices, implanted in or used on or in the person of a patient.

(i) "Health care" means any act, or treatment performed or furnished, or which should have been performed or furnished, by any health care provider for, to, or on behalf of a patient during the patient's medical care, treatment or confinement.

(j) "Insurer" means the authority or the entity chosen to manage the authority or an insurer writing policies of malpractice insurance.

(k) "Proof of financial responsibility" as provided for in this chapter shall be determined by the board.

(l) "Court" means a court of competent jurisdiction and proper venue over the parties.

(m) "Ambulance service" means an entity which operates either ground or air ambulances, using a minimum of two (2) persons on each ground ambulance, at least one of whom is trained and registered at the level of certified emergency medical technician-basic, or at the intermediate or paramedic levels, or one who is a registered nurse, and using a minimum on any air ambulance of one (1) person trained and registered at the paramedic level or a person who is a registered nurse, or any officer, employee or agent thereof acting in the course and scope of his employment.

(n) "Community blood center" means any independent nonprofit nonhospital based facility which collects blood and

blood products from donors primarily to supply blood and blood components to other health care facilities.

(o) "Tissue bank" means any independent nonprofit facility procuring and processing human organs or tissues for transplantation, medical education, research or therapy.

(p) "Executive director" means the executive director of the board, appointed and employed pursuant to Section 4(4)(b)(vi) of this chapter.

(q) "Claims manager" means the claims manager appointed and employed by the board pursuant to Section 4(4)(b)(vii) of this chapter.

(r) "Related benefits" with respect to future medical care are all reasonable and necessary medical, surgical, hospitalization, physical rehabilitation and custodial services, including drugs, prosthetic devices and other similar materials reasonably necessary in the provision of such services. The fund's obligation to provide these benefits or to reimburse the claimant for those benefits is limited to the lesser of the amount billed therefor or the maximum amount allowed under the reimbursement schedule.

(s) "Extended reporting endorsement" means tail coverage, or an endorsement which, when purchased by a provider at the end of his claims-made coverage period, provides coverage for a claim arising from an incident which occurred during the effective period of enrollment but was reported following the termination of active enrollment.

(2) A health care provider who fails to qualify under this chapter is not covered by the provisions of this chapter and is subject to liability under the law without regard to the provisions of this chapter. If a health care provider does not so qualify, the patient's remedy will not be affected by the terms and provisions of this chapter, except as hereinafter provided with respect to the suspension and the running of statute of

limitations against a health care provider who has not qualified under this chapter when a claim has been filed against the health care provider for review under this chapter.

(3) (a) Subject to Section 6 of this chapter, a person having a claim under this chapter for bodily injuries to or death of a patient on account of malpractice may file a complaint in any court of law having requisite jurisdiction.

(b) No dollar amount or figure shall be included in the demand in any malpractice complaint, but the prayer shall be for such damages as are reasonable in the premises.

(c) This section shall not prevent a person from alleging a requisite jurisdictional amount in a malpractice claim filed in a court requiring such an allegation.

(d) All claims and complaints submitted by a patient, claimant, or their representative, as a result of malpractice as defined in this section, shall, once the parties have certified to the court that discovery is complete, be given priority on the court's docket, to the extent practicable, over any other civil action before the court, provided that the provisions of this paragraph (d) shall not supersede the provisions of Mississippi Rules of Civil Procedure.

(4) Nothing in this chapter shall be construed to make the Patient's Compensation Fund liable for any sums except for those arising from medical malpractice. Notwithstanding any other law to the contrary, the provisions of this chapter shall not apply to medical malpractice actions against the state or any political subdivision thereof.

(5) The board shall appoint legal counsel for the Patient's Compensation Fund. It shall be the responsibility of the board to establish minimum qualifications and standards for lawyers who may be appointed to defend professional liability cases on behalf of the Patient's Compensation Fund. The minimum qualifications and the appointments procedure shall be published at least annually in

the Mississippi Bar Journal or such other publication as will reasonably assure dissemination to the membership of the Mississippi Bar Association. The primary insurer's counsel may be permitted by the board to continue the professional liability litigation on behalf of the Patient's Compensation Fund where no conflict of interest exists or where there is no potential conflict of interest.

SECTION 2. Limitation of Recovery.

(1) To be qualified under the provisions of this chapter, a health care provider shall:

(a) Cause to be filed with the board proof of financial responsibility as provided by subsection (5) of this section.

(b) Pay the surcharge assessed by this chapter on all health care providers according to Section 4 of this chapter.

(c) For self-insureds, qualification shall be effective upon acceptance of proof of financial responsibility by and payment of the surcharge to the board. Qualification shall be effective for all others at the time the malpractice insurer accepts payment of the surcharge.

(2) (a) Regardless of the number of health care providers against whom the claim or action is brought or the number of separate claims or actions brought with respect to the same injury, the total amount recoverable for all malpractice claims incurred for injuries to or death of a patient, exclusive of future medical care and related benefits as provided in Section 3 of this chapter, shall not exceed Five Hundred Thousand Dollars ($500,000.00) plus interest at the rate provided by law relating to judgments in circuit courts.

(b) A health care provider qualified under this chapter and any person or entity vicariously liable for the acts of that health care provider are not liable for an amount in excess of One Hundred Thousand Dollars ($100,000.00) plus interest thereon as provided by law relating to judgments in circuit courts accruing

after July 1, 2004, for all malpractice claims incurred because of injuries to or death of any one patient.

(c) (i) Any amount due from a judgment or settlement or from a final award in an arbitration proceeding which is in excess of the total liability of all liable health care providers, as provided in paragraph (b) of this subsection, shall be paid from the Patient's Compensation Fund pursuant to the provisions of Section 4(3) of this chapter.

(ii) The total amounts paid in accordance with paragraphs (b) and (c) of this subsection shall not exceed the limitation as provided in paragraph (a) of this subsection.

(3) Except as provided in Section 4(3), any advance payment made by the defendant health care provider or his insurer to or for the plaintiff, or any other person, may not be construed as an admission of liability for injuries or damages suffered by the plaintiff or anyone else in an action brought for medical malpractice.

(4) (a) Evidence of an advance payment is not admissible until there is a final judgment in favor of the plaintiff, in which event the court shall reduce the judgment to the plaintiff to the extent of the advance payment.

(b) The advance payment shall inure to the exclusive benefit of the defendant or his insurer making the payment.

(c) In the event the advance payment exceeds the liability of the defendant or the insurer making it, the court shall order any adjustment necessary to equalize the amount which each defendant is obligated to pay, exclusive of costs.

(d) In no case shall an advance payment in excess of an award be repayable by the person receiving it.

(e) In the event that a partial settlement is executed between the defendant and/or his insurer with a plaintiff for the sum of One Hundred Thousand Dollars ($100,000.00) or less, written notice of such settlement shall be sent to the board. Such

settlement shall not bar the continuation of the action against the Patient's Compensation Fund for excess sums in which event the court sha1l reduce any judgment to the plaintiff in the amount of malpractice liability insurance in force as provided for in subsection (2)(b) of this section. Prior to entering into any settlement which may bind the Patient's Compensation Fund, any insurer or self-insured health care provider must have participated in claim reserve consultations and must have provided notice to the fund that a settlement was being considered.

(5) (a) Financial responsibility of a health care provider under this section may be established only by filing with the board proof that the health care provider is insured by a policy of malpractice liability insurance in the amount of at least One Hundred Thousand Dollars ($100,000.00) per claim with qualification under this section taking effect and following the same form as the policy of malpractice liability insurance of the health care provider, or in the event the health care provider is self-insured, proof of financial responsibility by depositing with the board One Hundred Twenty-five Thousand Dollars ($125,000.00) in money or represented by irrevocable letters of credit, federally insured certificates of deposit, bonds, securities, cash values of insurance, or any other security approved by the board. In the event any portion of the amount is seized pursuant to the judicial process, the self-insured health care provider shall have five (5) days to deposit with the board the amounts so seized. The health care provider's failure to timely post the amounts with the board shall terminate his enrollment in the Patient's Compensation Fund.

SECTION 3. Future Medical Care and Related Benefits.

(1) (a) In all malpractice claims filed with the board which proceed to trial, the jury shall be given a special interrogatory asking if the patient is in need of future medical care and related benefits and the amount thereof.

(b) In actions upon malpractice claims tried by the court, the court's finding shall include a recitation that the patient is or is not in need of future medical care and related benefits and the amount thereof.

(c) If the total amount is for the maximum amount recoverable, exclusive of the value of future medical care and related benefits, the cost of all future medical care and related benefits shall be paid in accordance with this section.

(d) If the total amount is for the maximum amount recoverable, including the value of the future medical care and related benefits, the amount of future medical care and related benefits shall be deducted from the total amount and shall be paid from the Patient's Compensation Fund as incurred and presented for payment. The remaining portion of the judgment shall be paid in accordance with Section 4(1)(g) and Section 4(2)(b)(i), (ii) and (iii) of this chapter.

(e) In all cases where judgment is rendered for a total amount less than the maximum amount recoverable, including any amount awarded on future medical care and related benefits, payment shall be in accordance with Section 4(1)(g) and Section 4(2)(b)(i), (ii) and (iii) of this chapter.

(f) The provisions of this subsection shall be applicable to all malpractice claims.

(2) (a) "Future medical care and related benefits" for the purpose of this section means all reasonable and necessary medical, surgical, hospitalization, physical rehabilitation, and custodial services and includes drugs, prosthetic devices, and other similar materials reasonably necessary in the provision of such services, after the date of the injury and which are approved by the board.

(b) "Future medical care and benefits" as used in this section shall not be construed to mean nonessential specialty items or devices of convenience.

(3) Once a judgment is entered in favor of a patient who is found to be in need of future medical care and related benefits or a settlement is reached between a patient and the Patient's Compensation Fund in which the provision of medical care and related benefits is agreed upon and continuing as long as medical or surgical attention is reasonably necessary, the patient may make a claim to the Patient's Compensation Fund through the board for all future medical care and related benefits directly or indirectly made necessary by the health care provider's malpractice, subject to a semiprivate room limitation in the event of hospitalization, unless the patient refuses to allow them to be furnished.

(4) Payments for future and incurred medical care and related benefits shall be paid by the Patient's Compensation Fund without regard to the Five Hundred Thousand Dollar ($500,000.00) limitation imposed in Section 2 of this chapter.

(5) (a) The circuit court from which final judgment issues shall have continuing jurisdiction in cases where future medical care and related benefits are determined to be needed by the patient.

(b) The court shall award reasonable attorney fees to the claimant's attorney if the court finds that the Patient's Compensation Fund unreasonably fails to pay for medical care within thirty (30) days after submission of a claim for payment of such benefits.

(6) Nothing in this section shall be construed to prevent a patient and a health care provider and/or the Patient's Compensation Fund from entering into a court-approved settlement agreement whereby future medical care and related benefits shall be provided for a limited period of time only or to a limited degree.

(7) The provision of reasonable and necessary future medical care and services shall be governed by rule, except that all

nursing or sitter care shall be specifically prescribed or ordered by a patient's treating health care provider and such care shall be rendered by a licensed and/or qualified registered nurse or licensed practical nurse, or by a sitter, a member of the patient's family or household, or other person as specifically approved by the fund. All claims for nursing or sitter care must include a signed, detailed statement by the person rendering the care, setting forth the date, time and type of care rendered to and for the patient. Providers of nursing or sitter care shall be funded at the lesser of the billed amount or the maximum amount allowed under the reimbursement schedule, except that nursing or sitter care provided by members of the patient's family or household will be funded at an amount to be established and periodically reviewed by rule.

(8) The Patient's Compensation Fund shall be entitled to have a physical examination of the patient by a physician of the Patient's Compensation Fund's choice from time to time for the purpose of determining the patient's continued need of future medical care and related benefits, subject to the following requirements:

(a) (i) Notice in writing shall be delivered to or served upon the patient or the patient's counsel of record, specifying the time and place where it is intended to conduct the examination.

(ii) Such notice must be given at least ten (10) days before the time stated in the notice.

(iii) Delivery of the notice may be by certified mail.

(b) Such examination shall be by a licensed medical physician licensed under the laws of this state or of the state or county wherein the patient resides.

(c) (i) The place at which such examination is to be conducted shall not involve an unreasonable amount of travel for the patient considering all circumstances.

(ii) It shall not be necessary for a patient who resides outside this state to come into this state for such an examination unless so ordered by the court.

(d) Within thirty (30) days after the examination, the patient shall be compensated by the party requesting the examination for all necessary and reasonable expenses incidental to submitting to the examination including the reasonable costs of travel, meals, lodging, loss of pay, or other direct expenses.

(e) (i) Examinations may not be required more frequently than at six (6) months intervals except that, upon application to the court having jurisdiction of the claim and after reasonable cause shown therefor, examination within a shorter interval may be ordered.

(ii) In considering such application, the court should exercise care to prevent harassment to the patient.

(f) (i) The patient shall be entitled to have a physician or an attorney of his own choice or both present at such examination.

(ii) The patient shall pay such physician or attorney himself.

(g) The patient shall be promptly furnished with a copy of the report of the examination made by the physician making the examination on behalf of the Patient's Compensation Fund.

(9) If a patient fails or refuses to submit to examination in accordance with a notice and if the requirements of subsection (8) of this section have been satisfied, then the patient shall not be entitled to attorney fees in any action to enforce rights pursuant to subsection (5) of this section.

(10) (a) Any physician selected by the Patient's Compensation Fund and paid by the Patient's Compensation Fund who

shall make or be present at an examination of the patient conducted in pursuance of this section may be required to testify as to the conduct thereof and the findings made.

(b) Communications made by the patient upon such examination by such physician or physicians shall not be considered privileged.

(11) The Patient's Compensation Fund shall pay all reasonable fees and costs of medical examinations and the costs and the fees of the medical expert witnesses in any proceeding in which the termination of medical care and related benefits is sought.

SECTION 4. Patient's Compensation Fund.

(1) (a) All funds collected pursuant to the provisions of this chapter shall be paid into the State Treasury and shall be credited to the special fund, which is hereby created in the State Treasury and designated as the "Patient's Compensation Fund." The state recognizes and acknowledges that the fund and any income from it are not public monies, but rather are private monies which shall be held in trust as a custodial fund by the state for the use, benefit and protection of medical malpractice claimants and the fund's private health care provider members, and all of such funds and income earned from investing the private monies comprising the corpus of this fund shall be subject to use and disposition only as provided by this section.

(b) (i) In order to provide monies for the fund, an annual surcharge shall be levied on all health care providers in Mississippi qualified under the provisions of this chapter.

(ii) The surcharge shall be determined by the Mississippi Department of Insurance based upon actuarial principles and in accordance with an application for rates or rate changes, or both, filed by the Patient's Compensation Fund Oversight Board, established and authorized pursuant to subsection (4) of this section.

(iii) The application for rate changes filed by the board shall be submitted to the Mississippi Department of Insurance at least annually on the basis of an annual actuarial study by an independent actuary of the Patient's Compensation Fund.

(iv) The surcharge shall be collected on the same basis as premiums by each insurer and surplus line agent.

(v) The board shall collect the surcharge from health care providers qualified as self-insureds.

(vi) The surcharge for self-insureds shall be the amount determined by the board in accordance with rules and regulations promulgated by the board and in accordance with the rate set by the Mississippi Department of Insurance to be the amount of surcharge which the health care provider would reasonably be required to pay were his qualification based upon filing a policy of malpractice liability insurance.

(c) (i) Such surcharge shall be due and payable to the Patient's Compensation Fund within forty-five (45) days after the premiums for malpractice liability insurance have been received by the agent of the insurer or surplus line agent from the health care provider in Mississippi.

(ii) It shall be the duty of the insurer or surplus line agent to remit the surcharge to the Patient's Compensation Fund within forty-five (45) days of the date of payment by the health care provider. Failure of the insurer or surplus line agent to remit payment within forty-five (45) days shall subject the insurer or surplus line agent to a penalty of twelve percent (12%) of the annual surcharge and all reasonable attorney's fees. Upon the failure of the insurer or surplus line agent to remit as provided herein, the board is authorized to institute legal proceedings to collect the surcharge, together with penalties, legal interest and attorney's fees.

(d) If the annual premium surcharge is not paid within the time required above, upon written notice of such nonpayment given by the board concurrently to the Commissioner of Insurance and the insurer or surplus line agent, the certificate of authority of the insurer and surplus line agent shall be suspended until the annual premium surcharge is paid.

(e) (i) All expenses of collecting, protecting and administering the fund shall be paid from the fund.

(ii) The functions of collecting, administering and protecting the fund, including all matters relating to establishing reserves, the evaluating and settlement of claims, and relating to the defense of the fund, shall be carried out by the board.

(iii) The function of selecting the list of attorney names from which the selection of the attorney chairman of the medical review panels is to be made shall be the responsibility of the board.

(iv) These expenses of the board shall be paid from the fund by the State Treasurer in accordance with the law.

(v) The board shall budget and appropriate from the fund sufficient monies for carrying out the duties, functions and responsibilities imposed in this section and shall also appropriate all remaining monies in the fund for use by the board to pay approved claims based upon final judgments, court-approved settlements, final arbitration awards, and judgments awarding medical care and related benefits rendered pursuant to Section 3 of this chapter and vouchers drawn by the board pursuant to a judgment reciting that a patient is in need of future medical and related benefits under the provisions of Section 3 of this chapter in accordance with paragraph (g) of this subsection and in accordance with subsection (2) of this section.

(vi) Any purchases from the fund of furniture, fixtures, equipment or other property shall be specifically

designated, by such method of identification as is reasonable and practical for each item, as the property of the fund.

(f) (i) The Mississippi Department of Insurance in accordance with a rate filing request made by the board may reduce the surcharge provided in this subsection; however, at all times the fund shall be maintained so as to provide an actuarially sound percentage of the annual surcharge premiums, reserves established for individual claims, reserves established for incurred but not reported claims, and expenses.

(ii) No reduction in the surcharge shall be made unless sufficient surplus is available in the fund.

(g) (i) Claims from the Patient's Compensation Fund exclusive of those provided for in Section 3 of this chapter shall be computed at the time the claim becomes final.

(ii) A final claim shall be paid within forty-five (45) days of the board's receipt of a certified copy of the settlement, judgment, or arbitration award, unless the fund is exhausted and the proration provision contained in subparagraph (g)(iii) applies.

(iii) If the fund would be exhausted by payment in full of all final claims then the amount paid to each claimant shall be prorated.

(iv) Any amounts due and unpaid shall be prorated.

(v) Any amounts due and unpaid shall be paid in the following semiannual periods.

(2) (a) The board shall request the State Treasurer to issue payment in the amount of each claim submitted to and approved by the board, or prorated payment as the case may be, against the fund within thirty (30) days of receipt of a certified copy of the settlement, judgment, or arbitration award except that payment for claims made pursuant to subparagraph (b)(iv) or (v) of this subsection, or both, shall be made upon receipt of such certified copy.

(b) The only claim against the fund shall be a voucher or other appropriate request by the board after it receives at least one (1) of the following:

(i) A certified copy of a final judgment in excess of One Hundred Thousand Dollars ($100,000.00) against a health care provider.

(ii) A certified copy of a court approved settlement in excess of One Hundred Thousand Dollars ($100,000.00) against a health care provider.

(iii) A certified copy of a final award in excess of One Hundred Thousand Dollars ($100,000.00) in an arbitration proceeding against a health care provider.

(iv) A certified copy of a judgment awarding medical care and related benefits rendered pursuant to Section 3 of this chapter.

(v) A voucher drawn by the board through the Patient's Compensation Fund defense counsel pursuant to a judgment reciting that a patient is in need of future medical care and related benefits under the provisions of Section 3 of this chapter.

(3) If the insurer of a health care provider or a self-insured health care provider has agreed to settle its liability on a claim against its insured and claimant is demanding an amount in excess thereof from the Patient's Compensation Fund for a complete and final release, then the following procedure must be followed:

(a) A petition shall be filed by the claimant with the court in which the action is pending against the health care provider, if none is pending in the county where the alleged malpractice occurred, seeking (i) approval of an agreed settlement, if any, and/or (ii) demanding payment of damages from the Patient's Compensation Fund.

(b) A copy of the petition shall be served on the board, the health care provider and his insurer at least ten (10) days before filing and shall contain sufficient information to inform the other parties about the nature of the claim and the additional amount demanded.

(c) The board and the insurer of the health care provider or the self-insured health care provider may agree to a settlement with the claimant from the Patient's Compensation Fund, or the board and the insurer of the health care provider or the self-insured health care provider may file written objections to the payment of the amount demanded. The agreement or objections to the payment demanded shall be filed within twenty (20) days after the petition is filed.

(d) As soon as practicable after the petition is filed in the court, the judge shall fix the date on which the petition seeking approval of the agreed settlement and/or demanding payment of damages from the fund shall be heard, and shall notify the claimant, the insurer of the health care provider or the self-insured health care provider and the board thereof as provided by law.

(e) At the hearing the board, the claimant and the insurer of the health care provider or the self-insured health care provider may introduce relevant evidence to enable the court to determine whether or not the petition should be approved if it is submitted on agreement without objections. If the board, the insurer of the health care provider, or the self-insured health care provider and the claimant cannot agree on the amount, if any, to be paid out of the Patient's Compensation Fund, then the trier of fact shall determine at a subsequent trial which shall take place only after the board shall have been given an adequate opportunity to conduct discovery, identify and retain expert witnesses, and prepare a defense, the amount of claimant's damages, if any, in excess of the amount already paid by the

insurer of the health care provider or self-insured health care provider. The trier of fact shall determine the amount for which the fund is liable and render a finding and judgment accordingly. The board shall have a right to request trial by jury whether or not a jury trial has been requested by the claimant or by any health care provider.

(f) The board shall not be entitled to file a suit or otherwise assert a claim against any qualified health provider as defined in this chapter on the basis that the qualified health care provider failed to comply with the appropriate standard of care in treating or failing to treat any patient.

(g) The board may apply the provisions of Section 11-7-15, Mississippi Code of 1972, or Section 85-5-7, Mississippi Code of 1972, or both, to assert a credit or offset for the allocated percentage of negligence or fault of a qualified health care provider provided at least one (1) of the following conditions is met:

(i) A payment has been made to the claimant by, in the name of, or on behalf of the qualified health care provider whose percentage of fault the board seeks to allocate.

(ii) A payment has been made to the claimant by, in the name of, or on behalf of another qualified health care provider in order to obtain a dismissal or release of liability of the qualified health care provider whose percentage of fault the board seeks to allocate, provided that there shall be no separate credit or offset for the fault of an employer or other vicariously liable entity who was not independently negligent or otherwise at fault and who makes a payment in order to obtain a dismissal or release of liability of a single qualified health care provider for whom the payor is vicariously liable.

(iii) All or a portion of a payment made by another qualified health care provider, by the insurer of another qualified health care provider, or by the employer of another

qualified health care provider has been attributed to or allocated to the qualified health care provider whose percentage of fault the board seeks to allocate, provided that there shall be no separate credit or offset for the fault of an employer or other vicariously liable entity who has not independently negligent or otherwise at fault and who makes a payment in order to obtain a dismissal or release of liability of a single qualified health care provider for whom the payor is vicariously liable.

(iv) A medical review panel has determined that the qualified health care provider whose percentage of fault the board seeks to allocate failed to comply with the appropriate standard of care and that the failure was a cause of the damage or injury suffered by the patient, or a medical review panel has determined that there is a material issue of fact, not requiring expert opinion, bearing on liability of the qualified health care provider whose percentage of fault the board seeks to allocate for consideration by the trier of fact.

(v) The qualified health care provider does not object within thirty (30) days after notice of the board's intention to allocate the health care provider's percentage of fault is delivered via certified mail to the plaintiff, the qualified health care provider, and the qualified health care providers' professional liability insurer or to their attorneys.

(vi) The trier of fact determines, after a hearing in which the qualified health care provider whose percentage of fault the board seeks to allocate shall be given an opportunity to appear and participate, that there has been collusion or other improper conduct between the defendant health care providers to the detriment of the interests of the fund.

(vii) Except where the sum of One Hundred Thousand Dollars ($100,000.00) has been paid by, in the name of, or on behalf of the qualified health care provider whose percentage of fault the board seeks to allocate, in any case in which the board

is entitled pursuant to the provisions of Section 11-7-15, Mississippi Code of 1972, or Section 85-5-7, Mississippi Code of 1972, or both, to assert a credit or offset for the allocated percentage of negligence or fault of a qualified health care provider, the board shall have the burden of proving the negligence or fault of the qualified health care provider whose percentage of fault the board seeks to allocate.

(viii) In approving a settlement or determining the amount, if any, to be paid from the Patient's Compensation Fund, the trier of fact shall consider the liability of the health care provider as admitted and established where the insurer has paid its policy limits of One Hundred Thousand Dollars ($100,000.00) or where the self-insured health care provider has paid One Hundred Thousand Dollars ($100,000.00).

(ix) In each instance in which a claimant seeks to recover any sum from the board, each qualified health care provider or insurer or employer of a qualified health care provider who has made or has agreed to make any payment, including any reimbursement of court costs, medical expenses, or other expenses, to the claimant, the claimant's attorney, or any other person or entity shall be required, not later than ten (10) days after the filing of the petition for approval of the settlement, to file and serve upon the board an answer to the petition for approval of the settlement which sets forth a complete explanation of each such payment, to include the identity of each payee, the identity of each entity by or on whose behalf each payment has been or is to be made, each amount paid or to be paid directly or indirectly by, on behalf of, or which has been or is to be attributed or allocated to any qualified health care provider, the purpose of each such payment, and the precise nature of any collateral agreement which has been made or is to be made in connection with the proposed settlement.

(f) Any settlement approved by the court shall not be appealed. Any judgment of the court fixing damages recoverable in any such contested proceeding shall be appealable pursuant to the rules governing appeals in any other civil court case tried by the court.

(g) For the benefit of both the insured and the Patient's Compensation Fund, the insurer of the health provider shall exercise good faith and reasonable care both in evaluating the plaintiff's claim and in considering and acting upon settlement thereof. A self-insured health care provider shall, for the benefit of the Patient's Compensation Fund, also exercise good faith and reasonable care both in evaluating the plaintiff's claim and in considering and acting upon settlement thereof.

(h) The parties may agree that any amounts due from the Patient's Compensation Fund pursuant to Section 4(2) of this chapter be paid by annuity contract purchased by the Patient's Compensation Fund for and on behalf of the claimant.

(i) Notwithstanding any other provision of this chapter, any self-insured health care provider who has agreed to settle its liability on a claim and has been released by the claimant for such claim or any other claim arising from the same cause of action shall be removed as a party to the petition, and his name shall be removed from any judgment that is rendered in the proceeding. Such release shall be filed with the clerk of court in the county in which the petition is filed upon the filing of a properly executed, sworn release and settlement of claim.

(4) (a) (i) The Patient's Compensation Fund Oversight Board is hereby created and established in the Office of the Governor. The board shall be comprised of nine (9) members, appointed by the Governor subject to Senate confirmation.

(ii) Nine (9) members of the board shall be a representative of and for one or more classes of health care providers enrolled in the fund, and the board's membership shall

be apportioned according to the distribution of aggregate surcharges paid to the fund among the several classes of health care providers enrolled with the fund, as follows:

1. Four (4) members of the board shall be representatives of the class of health care providers contributing the greatest percentage of the fund's aggregate surcharges.

2. Two (2) members of the board shall be representatives of the class of health care providers contributing the second greatest percentage of the fund's aggregate surcharges.

3. One (1) member of the board shall be a representative of the class of health care providers contributing the third greatest percentage of the fund's aggregate surcharges.

4. One (1) member of the board shall be appointed to represent all other classes of health care providers enrolled with the fund.

(iii) The ninth member of the board shall be appointed from nominees provided by the Commissioner of Insurance, and this member must be an executive of a property and casualty insurance company that is licensed in this state which does not sell medical professional liability insurance.

(iv) Appointments of members representing a single class of health care providers shall be made from nominations solicited from the respective principal professional organizations of such health care providers in the state. The member of the board representing all other classes of health care providers shall be nominated by concurrence of the respective principal professional organizations of such health care providers in the state. In the absence of such concurrence each such professional organization shall name a representative to an ad hoc committee which shall, from among its number, nominate a representative to the board.

(v) For the purpose of apportioning representation on the board, the percentage surcharge contribution of each

distinct class of health care providers listed in Section 1 of this chapter to the aggregate surcharges paid to the fund shall be calculated for each fiscal year of the fund, and apportionment with respect to an initial or subsequent appointment to the board shall be based on such percentage contributions for the fund fiscal year preceding any such appointment.

(vi) Two (2) of the initial members of the board appointed pursuant to paragraph (a)(ii)1. of this subsection, one (1) of the initial members appointed pursuant to paragraph (a)(ii)2., and the member appointed pursuant to paragraph (a)(ii)3. shall serve for terms of three (3) years. One (1) of the members of the initial board appointed pursuant to paragraph (a)(ii)1. of this subsection and one (1) of the initial members appointed pursuant to paragraph (a)(ii)2. shall serve for terms of two (2) years. The remaining members of the initial board shall serve for terms of one (1) year. Thereafter, each member of the board shall serve for a term of three (3) years, with any vacancy occurring in any such position being filled for the unexpired term of such position in the manner of the original appointment, in accordance with the apportionment of representation provided for by this subsection.

(vi) The board shall annually elect a chairman and secretary from among its members and shall meet not less frequently than quarterly during the calendar year on the call of the chairman at such times and places as he may designate.

(viii) The members of the board shall receive Seventy-five Dollars ($75.00) per day while engaged in board business and for attendance at all meetings of the board. Reasonable expenses incurred by board members in their travel to and attendance at meetings of the board shall be reimbursed by the fund in accordance with applicable laws and administrative regulations. The members of the board shall not be reimbursed for any expenses incurred for board meetings outside of the state.

(b) The board shall be responsible, and have full authority under law, for the management, administration, operation and defense of the fund in accordance with the provisions of this chapter.

(c) In addition to such other powers and authority elsewhere expressly or impliedly conferred on the board by this chapter, the board shall have the authority, to the extent not inconsistent with the provisions of this chapter, to:

(i) Collect all surcharges and other monies due the fund.

(ii) Establish and define the standards and forms of financial responsibility required of self-insured health care providers, and the standards and forms of malpractice liability insurance policies issued by admitted insurance companies and the standards, forms, acceptable ratings and other criteria for medical malpractice liability insurance policies issued by nonadmitted insurance companies which are acceptable as proof of financial responsibility pursuant to Section 2 of this chapter, as a condition to initial and continuing enrollment with the fund.

(iii) Collect, accumulate, and maintain claims experience data from enrolled health care providers and insurance companies providing professional liability insurance coverage to health care providers in this state in such form as may be necessary or appropriate to permit the fund to develop appropriate surcharge rates for the fund.

(iv) Employ, or retain the services of a qualified competent independent actuary to perform the annual actuarial study of the fund required by this section and to advise the board on all aspects of the fund's administration, operation and defense which require application of the actuarial science.

(v) Contract for any services necessary or advisable to implement the authority and discharge the

responsibilities conferred and imposed on the board by this chapter.

(vi) Employ an appropriately qualified executive director and delegate to such executive director all or any portion of the authority for administration and operation of the fund vested in the board, subject to the superseding authority of the board.

(vii) Employ an appropriately qualified claims manager and delegate to such claims manager all or any portion of the authority for the protection and defense of the fund vested in the board, subject to the superseding authority of the board.

(viii) Employ, or contract with, legal counsel to advise and represent the board and represent the fund in proceedings pursuant to this chapter. Such counsel shall be licensed to practice law in the State of Mississippi.

(ix) Employ such clerical personnel as may be necessary or appropriate to carry out the responsibilities of the board under this chapter.

(x) Defend the fund from all claims due wholly or in part to the negligence or liability of anyone other than a qualified health care provider regardless of whether a qualified health care provider has settled and paid its statutory maximum, or has been adjudged liable or negligent.

(xi) Defend the fund from all claims arising under subparagraph (x) of this paragraph (c), and obtain indemnity and reimbursement to the fund of all amounts for which anyone other than a qualified health care provider may be held liable. The right of indemnity and reimbursement to the fund shall be limited to that amount that the fund may be cast in judgment.

(xii) The right to apply the provisions of Section 11-7-15, Mississippi Code of 1972, and Section 85-5-7, Mississippi Code of 1972, or both, to assert a credit or offset

for the allocated percentage of negligence or fault of a qualified health care provider governed by the provisions of those sections.

(xiii) Intervene as a matter of right, at its discretion, in any civil action or proceeding in which the constitutionality of this chapter and/or any other Mississippi law related to medical malpractice as defined in this chapter is challenged.

(d) The board shall have authority to adopt and promulgate such rules, regulations and standards as it may deem necessary or advisable to implement the authority and discharge the responsibilities conferred and imposed on the board by this chapter.

(e) All communications made and all documents and records developed by, between or among the Attorney General, claims manager, the oversight board, any person or entity contracted to provide services to or on behalf of the fund under this chapter, and enrolled health care providers and their insurers, relative to or in anticipation of defense of the fund or enrolled health care providers against, establishment of reserves with respect to, or prospective settlement of, individual malpractice claims shall be confidential and privileged against disclosure to any third party, pursuant to request, subpoena, or otherwise.

(5) The executive director shall annually project revenue and expense budgets for the fund for the succeeding fiscal year. Such budget shall reflect all revenues projected to be collected or received by or accruing to the fund during such fiscal year, together with the projected expenses of the administration, operation, and defense of the fund and satisfaction of its liabilities and obligations. Such budgets shall be submitted to the board for approval, and as approved by the board, submitted to the Governor, joint legislative budget office and the State Treasurer.

(6) The executive director shall annually prepare an appropriate request based on the annual budget prepared pursuant to subsection (5) of this section for approval by the board.

(7) The executive director shall prepare or cause to be prepared, statements of the financial condition of the fund at the end of each calendar quarter. Such statement may be prepared, at the election of the executive director, in accordance with the statutory accounting principles applicable to liability insurance companies authorized to do business in this state or in accordance with generally accepted accounting principles relating to accounting for governmental funds.

(8) On or before July 1 of each year, the executive director shall cause to be prepared an annual statement of the financial condition of the fund at December 31 of the preceding year, which statement shall be substantially in the form of the annual report required to be filed by liability insurance companies authorized to do business in this state, and which statement shall have been audited or reviewed by an independent certified public accountant. Such statement shall be submitted to the Governor, the board and the Legislature on or before July 1 of each year and shall be a public record.

SECTION 5. Malpractice Coverage.

(1) (a) Only while malpractice liability insurance remains in force, or in the case of a self-insured health care provider, only while the security required by regulations of the board remains undiminished, are the health care provider and his insurer liable to a patient, or his representative, for malpractice to the extent and in the manner specified in this chapter.

(b) When, and during the period that each shareholder, partner, member, agent, officer, or employee of a corporation, partnership, limited liability partnership, or limited liability company, who is eligible for qualification as a health care provider under this chapter, and who is providing health care on

behalf of such corporation, partnership, or limited liability company, is qualified as a health care provider under the provisions of Section 2(1) of this chapter, such corporation, partnership, limited liability partnership, or limited liability company shall, without the payment of an additional surcharge, be deemed concurrently qualified and enrolled as a health care provider under this chapter.

(2) The filing of proof of financial responsibility with the board shall constitute, on the part of the insurer, a conclusive and unqualified acceptance of the provisions of this chapter.

(3) Any provision in a policy attempting to limit or modify the liability of the insurer contrary to the provisions of this chapter is void, except that a provision in a malpractice liability insurance policy approved by the board which limits the aggregate sum for which the insurer may be liable during the policy period shall be valid.

(4) Every policy issued under this chapter is deemed to include the following provisions, and any change which may be occasioned by legislation adopted by the Legislature of the State of Mississippi as fully as if it were written therein:

(a) The insurer assumes all obligations to pay an award imposed against its insured under the provisions of this chapter; and

(b) Any termination of this policy by cancellation is not effective as to patients claiming against the insured covered hereby, unless at least thirty (30) days before the taking effect of the cancellation, a written notice giving the date upon which termination becomes effective has been received by the insured and the board at their offices. In no event shall the cancellation affect in any manner any claim which was first reported to the insurer during the term of the policy; except that the insurer may deny defense and indemnification to an insured by reason of

exclusions set forth in the policy or the insurer's failure to comply with any provision of the policy.

(5) If an insurer fails or refuses to pay a final judgment, except during the pendency of an appeal, or fails or refuses to comply with any provisions of this chapter, in addition to any other legal remedy, the board may also revoke the approval of its policy form until the insurer pays the award or judgment or has complied with the violated provisions of this chapter and has resubmitted its policy form and received the approval of the board.

SECTION 6. Medical Review Panel.

(1) (a) All malpractice claims against health care providers covered by this chapter, other than claims validly agreed for submission to a lawfully binding arbitration procedure, shall be reviewed by a medical review panel established as hereinafter provided for in this section.

(b) A request for review of a malpractice claim or malpractice complaint shall contain, at a minimum, all of the following:

(i) A request for the formation of a medical review panel;

(ii) The name of the patient;

(iii) The names of the claimants;

(iv) The names of the defendant health care providers;

(v) The dates of the alleged malpractice;

(vi) A brief description of the alleged malpractice as to each named defendant health care provider; and

(vii) A brief description of the alleged injuries.

(c) A claimant shall have forty-five (45) days from the mailing date of the confirmation of receipt of the request for review in accordance with this section to pay to the board a

filing fee in the amount of One Hundred Dollars ($100.00) per named defendant qualified under this chapter.

(d) Such filing fee may be waived only upon receipt by the board of one (1) of the following:

(i) An affidavit of a physician holding a valid license to practice his or her specialty in the state of his or her residence certifying the adequate medical records have been obtained and reviewed and that the allegations of malpractice against each defendant state health care provider named in the claim constitute a claim of a breach of the applicable standard of care as to each named defendant state health care provider.

(ii) A pauper's affidavit prepared and submitted in accordance with Sections 11-53-17 and 11-53-19, Mississippi Code of 1972, in a circuit court in a venue in which the malpractice claim could properly be brought upon the conclusion of the medical review process.

(e) Failure to comply with the provisions of this section within the specified time frame shall render the request for review of a malpractice claim invalid and without effect. Such an invalid request for review of a malpractice claim shall not suspend the time within which suit must be instituted in paragraph (g) of this subsection.

(f) All funds generated by such filing fees shall be private monies and shall be applied to the costs of the Patient's Compensation Fund Oversight Board incurred in the administration of claims.

(g) The filing of the request for a review of a claim shall suspend the time within which suit must be instituted, in accordance with this chapter, until ninety (90) days following notification, by certified mail, as provided in subsection (10) of this section, to the claimant or his attorney of the issuance of the opinion by the medical review panel, in the case of those health care providers covered by this chapter, or in the case of a

health care provider against whom a claim has been filed under the provisions of this chapter, but who has not qualified under this chapter, until sixty (60) days following notification by certified mail to the claimant or his attorney by the board that the health care provider is not covered by this chapter. The filing of a request for review of a claim shall suspend the running of the statute of limitations against all joint and several obligors, and all joint tort-feasors, including, but not limited to, health care providers, both qualified and not qualified, to the same extent that the statute of limitations is suspended against the party or parties that are the subject of the request for review. Filing a request for review of a malpractice claim as required by this section with any agency or entity other than the board shall not suspend or interrupt the statute of limitations.

(h) The request for review of a malpractice claim under this section shall be deemed filed on the date of receipt of the request stamped and certified by the board or on the date of mailing of the request if mailed to the board by certified or registered mail only upon timely compliance with the provisions of Section (5) of this chapter.

(i) It shall be the duty of the board within fifteen (15) days of the receipt of the claim by the board to:

(i) Confirm to the claimant that the filing has been officially received and whether or not the named defendant or defendants have qualified under this chapter.

(ii) In the confirmation to the claimant pursuant to subparagraph (i), notify the claimant of the amount of the filing fee due and the time frame within which such fee is due to the board, and that upon failure to comply with the provisions of subsection (1)(c) and/or (d) the request for review of a malpractice claim is invalid and without effect and that the request shall not suspend the time within which suit must be instituted in paragraph (g) of this subsection.

(iii) Notify all named defendants, whether or not qualified under the provisions of this section that a filing has been made against them and request made for the formation of a medical review panel, and forward a copy of the proposed complaint to each named defendant at his or her last and usual place of residence or his or her office.

(j) The board shall notify the claimant and all named defendants of the following information:

(i) The date of the receipt of the filing fee.

(ii) That no filing was due because the claimant timely provided the affidavit set forth in subsection (1)(d)(i).

(iii) That the claimant has timely complied with the provisions of this section.

(iv) That the required filing fee was not timely paid pursuant to subsection (1)(c).

(k) An attorney chairman for the state medical review panel shall be appointed within six (6) months from the date the request for review of the claim was filed. Upon appointment of the attorney chairman, the parties shall notify the board of the name and address of the attorney chairman. If the board has not received notice of the appointment of an attorney chairman within four (4) months from the date the request for review of the claim was filed, then the board shall send notice to the parties by certified or registered mail that the claim will be dismissed in sixty (60) days unless an attorney chairman is appointed within six (6) months from the date the request for review of the claim was filed. If the board has not received notice of the appointment of an attorney chairman within six (6) months from the date the request for review of the claim was filed, then the board shall promptly send notice to the parties by certified or registered mail that the claim has been dismissed for failure to appoint an attorney chairman and the parties shall be deemed to have waived the use of the state medical review panel. The filing

of a request for a medical review panel shall suspend the time within which suit must be filed until ninety (90) days after the claim has been dismissed in accordance with this section.

(2) (a) (i) No action against a health care provider covered by this chapter, or his insurer, may be commenced in any court before the claimant's proposed complaint has been presented to a medical review panel established pursuant to this section.

(ii) A certificate of enrollment issued by the board shall be admitted in evidence.

(iii) However, with respect to an act of malpractice which occurs after July 1, 2004, if an opinion is not rendered by the panel within twelve (12) months after the date of notification of the selection of the attorney chairman by the executive director to the selected attorney and all other parties pursuant to paragraph (a) of subsection (3) of this section, suit may be instituted against a health care provider covered by this chapter. However, either party may petition a court of competent jurisdiction for an order extending the twelve-month period provided in this subsection for good cause shown. After the twelve-month period provided for in this subsection or any court-ordered extension thereof, the medical review panel established to review the claimant's complaint shall be dissolved without the necessity of obtaining a court order of dissolution.

(iv) By agreement of both parties, the use of the medical review panel may be waived.

(b) (i) A health care provider, against whom a claim has been filed under the provisions of this chapter, may raise any exception or defenses available pursuant to Mississippi law in a court of competent jurisdiction and proper venue at any time without need for completion of the review process by the medical review panel.

(ii) If the court finds that the statute of limitations for the claim has expired or otherwise was preempted

before being filed, the panel, if established, shall be dissolved.

(c) Ninety (90) days after the notification to all parties by certified mail by the attorney chairman of the board of the dissolution of the medical review panel or ninety (90) days after the expiration of any court-ordered extension as authorized by paragraph (a) of this subsection, the suspension of the running of statute of limitations with respect to a qualified health care provider shall cease.

(3) The medical review panel shall consist of three (3) health care providers who hold unrestricted licenses to practice their profession in Mississippi and one (1) attorney. The parties may agree on the attorney member of the medical review panel or if no agreement can be reached, then the attorney member of the medical review panel shall be selected in the following manner:

(a) (i) Upon receipt of notification, the board shall draw five (5) names at random from the list of attorneys maintained by the board who reside or maintain an office in the county which would be proper venue for the action in a court of law. The names of judges, magistrates, district attorneys and assistant district attorneys shall be excluded if drawn and new names drawn in their place. After selection of the attorney names, the Office of the Clerk of the Supreme Court shall notify the board of the names so selected. It shall be the duty of the board to notify the parties of the attorney names from which the parties may choose the attorney member of the panel within five (5) days. If no agreement can be reached within five (5) days, the parties shall immediately initiate a procedure of selecting the attorney by each striking two (2) names alternately, with the claimant striking first and so advising the health care provider of the name of the attorney so stricken; thereafter, the health care provider and the claimant shall alternately strike until both sides have stricken two (2) names and the remaining name shall be the attorney member of the panel. If either the plaintiff or

defendant fails to strike, the clerk of the Mississippi Supreme Court shall strike for that party within five (5) additional days.

(ii) After the striking, the office of the board shall notify the attorney and all other parties of the name of the selected attorney.

(b) The attorney shall act as chairman of the panel and in an advisory capacity but shall have no vote. It is the duty of the chairman to expedite the selection of the other panel members, to convene the panel, and expedite the panel's review of the proposed complaint. The chairman shall establish a reasonable schedule for submission of evidence to the medical review panel but must allow sufficient time for the parties to make full and adequate presentation of related facts and authorities within ninety (90) days following selection of the panel.

(c) (i) The plaintiff shall notify the attorney chairman and the named defendants of his choice of a health care provider member of the medical review panel within thirty (30) days of the date of certification of his filing by the board.

(ii) The named defendant shall then have fifteen (15) days after notification by the plaintiff of the plaintiff's choice of his health care provider panelist to name the defendant's health care provider panelist.

(iii) If either the plaintiff or defendant fails to make a selection of health care provider panelist within the time provided, the attorney chairman shall notify by certified mail the failing party to make such selection within five (5) days of the receipt of the notice.

(iv) If no selection is made within the five-day period, then the chairman shall make the selection on behalf of the failing party. The two (2) health care provider panel members selected by the parties or on their behalf shall be notified by the chairman to select the third health care provider panel member within fifteen (15) days of their receipt of such notice.

(v) If the two (2) health care provider panel members fail to make such selection within the fifteen-day period allowed, the chairman shall then make the selection of the third panel member and thereby complete the panel.

(vi) The qualification and selection of physician members of the medical review panel shall be as follows:

1. All physicians who hold an unrestricted license to practice medicine in the State of Mississippi and who are engaged in the active practice of medicine in this state, whether in the teaching profession or otherwise, shall be available for selection.

2. Each party to the action shall have the right to select one (1) physician and upon selection the physician shall be required to serve.

3. When there are multiple plaintiffs or defendants, there shall be only one (1) physician selected per side. The plaintiff, whether single or multiple, shall have the right to select one (1) physician, and the defendant, whether single or multiple, shall have the right to select one (1) physician.

4. A panelist so selected and the attorney member selected in accordance with this subsection shall serve unless for good cause shown may be excused. To show good cause for relief from serving, the panelist shall present an affidavit to a judge of a court of competent jurisdiction and proper venue which shall set out the facts showing that service would constitute an unreasonable burden or undue hardship. A health care provider panelist may also be excused from serving by the attorney chairman if during the previous twelve-month period he has been appointed to four (4) other medical review panels. In either such event, a replacement panelist shall be selected within fifteen (15) days in the same manner as the excused panelist.

5. If there is only one (1) party defendant which is not a hospital, community blood center, tissue bank or ambulance service, all panelists except the attorney shall be from the same class and specialty of practice of health care provider as the defendant. If there is only one (1) party defendant which is a hospital, community blood center, tissue bank or ambulance service, all panelists except the attorney shall be physicians. If there are claims against multiple defendants, one or more of whom are health care providers other than a hospital, community blood center, tissue bank, or ambulance service, the panelists selected in accordance with this subsection may also be selected from health care providers who are from the same class and specialty of practice of health care providers as are any of the defendants other than a hospital, community blood center, tissue bank, or ambulance service.

(d) When the medical review panel is formed, the chairman shall within five (5) days notify the board and the parties by registered or certified mail of the names and addresses of the panel members and the date on which the last member was selected.

(e) Before entering upon their duties, each voting panelist shall subscribe before a notary public the following oath: "I, (name) do solemnly swear/affirm that I will faithfully perform the duties of a medical review panel member to the best of my ability and without partiality or favoritism of any kind. I acknowledge that I represent neither side and that it is my lawful duty to serve with complete impartiality and to render a decision in accordance with law and the evidence." The attorney panel member shall subscribe to the same oath except that in lieu of the last sentence thereof the attorney's oath shall state: "I acknowledge that I represent neither side and that it is my lawful duty to advise the panel members concerning matters of law and

procedure and to serve as chairman." The original of each oath shall be attached to the opinion rendered by the panel.

(f) The party aggrieved by the alleged failure or refusal of another to perform according to the provisions of this section may petition any circuit court of proper venue over the parties for an order directing that the parties comply with the medical review panel provisions of this chapter.

(g) A panelist or a representative or attorney for any interested party shall not discuss with other members of a medical review panel on which he serves a claim which is to be reviewed by the panel until all evidence to be considered by the panel has been submitted. A panelist or a representative or attorney for any interested party shall not discuss the pending claim with the claimant or his attorney asserting the claim or with a health care provider or his attorney against whom a claim has been asserted under this section. A panelist or the attorney chairman shall disclose in writing to the parties prior to the hearing any employment relationship or financial relationship with the claimant, the health care provider against whom a claim is asserted, or the attorneys representing the claimant or health care provider, or any other relationship that might give rise to a conflict of interest for the panelists.

(4) (a) The evidence to be considered by the medical review panel shall be promptly submitted by the respective parties in written form only.

(b) The evidence may consist of medical charts, x-rays, lab tests, excerpts of treatises, depositions of witnesses including parties, affidavits, interrogatories, and reports of medical experts, and any other form of evidence allowable by the medical review panel.

(c) If expert testimony is utilized in any claim against a physician for injury to or death of a patient, a person may qualify as an expert witness on the issue of whether the

physician departed from accepted standards of medical care and whether the actions of the physician caused the injury to or the death of the patient only if the person is a physician who meets all of the following criteria:

(i) He is practicing medicine at the same time such testimony is given or was practicing medicine at the time the claim arose.

(ii) He has knowledge of accepted standards of medical care for the diagnosis, care, or treatment of the illness, injury or condition involved in the claim.

(iii) He is qualified on the basis of training or experience to offer an expert opinion regarding those accepted standards of care.

(iv) He is licensed to practice medicine by the Mississippi State Board of Medical Licensure, is licensed to practice medicine by any other jurisdiction in the United States, or is a graduate of a medical school accredited by the American Medical Association's Liaison Committee on Medical Education or the American Osteopathic Association.

(v) For purposes of this subsection "practicing medicine or "medical practice" includes, but is not limited to, training residents or students at an accredited school of medicine or osteopathy or serving as a consulting physician to other physicians who provide direct patient care, upon the request of such other physician.

(d) In determining whether a witness is qualified on the basis of training or experience, the court shall consider whether, at the time the claim arose or at the time the testimony is given, the witness is board certified or has other substantial training or experience in an area of medical practice relevant to the claim and is actively practicing in that area.

(e) The court shall apply the criteria specified in paragraph (c)(i), (ii), (iii) and (iv) of this subsection in

determining whether a person is qualified to offer expert testimony on the issue of whether the physician departed from accepted standards of medical care.

(f) Nothing herein shall be construed to prohibit a physician from qualifying as an expert solely because he is a defendant in a medical malpractice claim.

(g) Depositions of the parties and witnesses may be taken prior to the convening of the panel.

(h) Upon request of any party, or upon request of any two (2) panel members, the clerk of any district court shall issue subpoenas and subpoenas duces tecum in aid of the taking of depositions and the production of documentary evidence for inspection and/or copying.

(i) The chairman of the panel shall advise the panel relative to any legal question involved in the review proceeding and shall prepare the opinion of the panel as provided in subsection (7).

(j) A copy of the evidence shall be sent to each member of the panel.

(5) Either party, after submission of all evidence and upon ten (10) days' notice to the other side, shall have the right to convene the panel at a time and place agreeable to the members of the panel. Either party may question the panel concerning any matters relevant to issues to be decided by the panel before the issuance of their report. The chairman of the panel shall preside at all meetings. Meetings shall be informal.

(6) The panel shall have the right and duty to request and procure all necessary information. The panel may consult with medical authorities, provided the names of such authorities are submitted to the parties with a synopsis of their opinions and provided further that the parties may then obtain their testimony by deposition. The panel may examine reports of such other health care providers necessary to fully inform itself regarding the

issue to be decided. Both parties shall have full access to any material submitted to the panel.

(7) The panel shall have the sole duty to express its expert opinion as to whether or not the evidence supports the conclusion that the defendant or defendants acted or failed to act within the appropriate standards of care. After reviewing all evidence and after any examination of the panel by counsel representing either party, the panel shall, within thirty (30) days but in all events within one hundred eighty (180) days after the selection of the last panel member, render one or more of the following expert opinions, which shall be in writing and signed by the panelists, together with written reasons for their conclusions:

(a) The evidence supports the conclusion that the defendant or defendants failed to comply with the appropriate standard of care as charged in the complaint.

(b) The evidence does not support the conclusion that the defendant or defendants failed to meet the applicable standard of care as charged in the complaint.

(c) That there is a material issue of fact, not requiring expert opinion, bearing on liability for consideration by the court.

(d) Where paragraph (a) above is answered in the affirmative, that the conduct complained of was or was not a factor of the resultant damages. If such conduct was a factor, whether the plaintiff suffered:

(i) any disability and the extent and duration of the disability; and

(ii) any permanent impairment and the percentage of the impairment.

(8) Any report of the expert opinion reached by the medical review panel shall be admissible as evidence in any action subsequently brought by the claimant in a court of law, but such expert opinion shall not be conclusive and either party shall have

the right to call, at his cost, any member of the medical review panel as a witness. If called, the witness shall be required to appear and testify. A panelist shall have absolute immunity from civil liability for all communications, findings, opinions and conclusions made in the course and scope of duties prescribed by this chapter.

(9) (a) (i) Each physician member of the medical review panel shall be paid at the rate of One Hundred Dollars ($100.00) per diem, not to exceed a total of One Thousand Dollars ($1,000.00) for all work performed as a member of the panel exclusive of time involved if called as a witness to testify in a court of law regarding the communications, findings, and conclusions made in the course and scope of duties as a member of the medical review panel, and in addition thereto, reasonable travel expenses.

(ii) The attorney chairman of the medical review panel shall be paid at the rate of One Hundred Dollars ($100.00) per diem, not to exceed a total of Fifteen Hundred Dollars ($1500.00) for all work performed as a member of the panel exclusive of time involved if called as a witness to testify in a court of law regarding the communications, findings and conclusions made in the course and scope of duties as a member of the medical review panel, and in addition thereto, reasonable travel expenses. Additionally, the attorney chairman shall be reimbursed for all reasonable out-of-pocket expenses incurred in performing his duties for each medical review panel. The attorney chairman shall submit the amount due him for all work performed as a member of the panel by affidavit, which shall attest that he has performed in the capacity of chairman of the medical review panel and that he was personally present at all the panel's meetings or deliberations.

(b) The costs of the medical review panel shall be paid by the party or side which the opinion of the review panel does

not favor, or the nonprevailing party. However, if the medical review panel's opinion is unfavorable to the claimant and the claimant is unable to pay, the claimant shall submit to the attorney chairman prior to the convening of the medical review panel an in forma pauperis ruling issued in accordance with Sections 11-53-17 and 11-53-19, Mississippi Code of 1972, by a circuit court in a venue in which the malpractice claim could properly be brought upon the conclusion of the medical review process. Upon timely receipt of the in forma pauperis ruling, the costs of the medical review panel shall be paid by the health care provider, with the proviso that if the claimant subsequently receives a settlement or receives a judgment, the advance payment of the medical review panel costs will be offset.

(c) If the claimant receives an unfavorable opinion from the medical review panel and files suit which results in a verdict in favor of the defendant health care provider the defendant health care provider is entitled to recover all reasonable expenses, including attorneys' fees, incurred by him in defending the suit.

(d) If the medical review panel decides that there is a material issue of fact bearing on liability for consideration by the court, the claimant and the health care provider shall split the costs of the medical review panel. However, in those instances in which the claimant is unable to pay his share of the costs of the medical review panel, the claimant shall submit to the attorney chairman prior to convening of the medical review panel an in forma pauperis ruling issued in accordance with this section by a circuit court in a venue in which the malpractice claim could properly be brought upon the conclusion of the medical review panel process. Upon timely receipt of the in forma pauperis ruling, the costs of the medical review panel shall be paid by the health care provider with the proviso that if the claimant subsequently receives a settlement or receives a

judgment, the advance payment of the claimant's share of the costs of the medical review panel will be offset.

(e) Upon the rendering of the written panel decision, if any one of the panelists finds that the evidence supports the conclusion that a defendant health care provider failed to comply with the appropriate standard of care and such failure caused injury to or the death of the claimant as charged in the complaint, each defendant health care provider as to whom such a determination was made shall reimburse to the claimant that portion of the filing fee applicable to the claim against such defendant health care provider or if any one (1) of the panelists finds that the evidence supports the conclusion that there is a material issue of fact, not requiring expert opinion, bearing on liability of such defendant health care provider for consideration by the court, each such defendant health care provider as to whom such a determination was made shall reimburse to the claimant fifty percent (50%) of that portion of the filing fee applicable to the claim against such defendant health care provider.

(10) The chairman shall submit a copy of the panel's report to the board and all parties and attorneys by registered or certified mail within five (5) days after the panel renders its opinion.

(11) In the event the medical review panel after a good faith effort has been unable to carry out its duties by the end of the one hundred-eighty-day period, as provided in subsection (7), either party or the board, after exhausting all remedies available to them under this section, may petition the appropriate court of competent jurisdiction for an order to show cause why the panel should not be dissolved and the panelists relieved of their duties. The suspension of the running of the statute of limitations shall cease sixty (60) days after the receipt by the claimant or his attorney of the final order dissolving the medical

review panel, which order shall be mailed to the claimant or his attorney by certified mail.

(12) Where the medical review panel issues its opinion after the one hundred eighty (180) days required by this section, the suspension of the running of the statute of limitations shall not cease until ninety (90) days following notification by certified mail to the claimant or his attorney of the issuance of the opinion as required by subsection (10) of this section.

(4) All reports made to the licensing board pursuant to this section shall be and remain confidential and not subject to view or discovery by any person or party.

SECTION 7. Reporting of Claims.

(1) For the purpose of providing the various licensing boards of Mississippi health care providers, as defined by Section (1)(a) of this chapter, with information on malpractice claims paid by insurers or self insurers on behalf of health care providers in this state, each insurer of such health care provider, and each health care provider in Mississippi who is self-insured shall, within thirty (30) days of the date of payment, provide a written report to the licensing board of this state having licensing authority over the health care provider on whose behalf payment was made, and each such report shall contain:

(a) The name and address of the health care provider.

(b) A brief description of the acts of omission or commission which gave rise or allegedly gave rise to the claim, and the date thereof.

(c) The name of the patient and the injury which resulted or allegedly resulted therefrom.

(d) The amount paid in settlement or discharge of the claim, whether paid by compromise, by payment of judgment, by payment of arbitration award, or otherwise; and

(e) Where any judicial opinion has been rendered with regard to a claim, a copy of all such opinions shall be attached to the report.

Provided, however, no report shall be required for compromise settlements of claims where the amount paid is One Thousand Dollars ($1,000.00) or less, except where such payments were made in satisfaction or compromise of judgment of court or of award of arbitrators.

(2) The provisions of this section shall apply to all health care providers in Mississippi, whether or not such health care provider has qualified under the provisions of this chapter.

(3) There shall be no liability on the part of any insurer or person acting for said insurer, for any statements made in good faith in the reports required by this section.

SECTION 8. Section 11-1-60, Mississippi Code of 1972, is amended as follows:

11-1-60. (1) For the purposes of this section, the following words and phrases shall have the meanings ascribed herein unless the context clearly requires otherwise:

(a) "Noneconomic damages" means subjective, nonpecuniary damages arising from death, pain, suffering, inconvenience, mental anguish, worry, emotional distress, loss of society and companionship, loss of consortium, bystander injury, physical impairment, injury to reputation, humiliation, embarrassment, loss of the enjoyment of life, hedonic damages, other nonpecuniary damages, and any other theory of damages such as fear of loss, illness or injury. The term "noneconomic damages" shall not include damages for disfigurement, nor does it include punitive or exemplary damages.

(b) "Actual economic damages" means objectively verifiable pecuniary damages arising from medical expenses and medical care, rehabilitation services, custodial care, disabilities, loss of earnings and earning capacity, loss of

income, burial costs, loss of use of property, costs of repair or replacement of property, costs of obtaining substitute domestic services, loss of employment, loss of business or employment opportunities, and other objectively verifiable monetary losses.

(c) "Provider of health care" means a licensed physician, psychologist, osteopath, dentist, nurse, nurse practitioner, physician assistant, pharmacist, podiatrist, optometrist, chiropractor, institution for the aged or infirm, hospital, licensed pharmacy or any legal entity which may be liable for their acts or omissions.

(2) (a) In any action for injury based on malpractice or breach of standard of care against a provider of health care, including institutions for the aged or infirm, in the event the trier of fact finds the defendant liable, they shall not award the plaintiff more than the following for noneconomic damages:

(i) For claims for causes of action filed on or after January 1, 2003, but before July 1, 2011, the sum of Five Hundred Thousand Dollars ($500,000.00);

(ii) For claims for causes of action filed on or after July 1, 2011, but before July 1, 2017, the sum of Seven Hundred Fifty Thousand Dollars ($750,000.00);

(iii) For claims for causes of action filed on or after July 1, 2017, the sum of One Million Dollars ($1,000,000.00).

It is the intent of this section to limit all noneconomic damages to the above.

(b) The trier of fact shall not be advised of the limitations imposed by this subsection (2) and the judge shall appropriately reduce any award of noneconomic damages that exceeds the applicable limitation.

(3) The limitation on noneconomic damages set forth in subsection (2) shall not apply in cases where the judge determines that a jury may impose punitive damages.

(4) Nothing in this section shall be construed to impose a limitation on damages for disfigurement or actual economic damages.

(5) The provisions of this section shall not apply to health care providers qualified under Sections 1 through 7 of Senate Bill No. ____, 2004 Regular Session, whose liability is governed by those sections.

SECTION 9. (1) An attorney shall not contract for or collect a contingency fee for representing any person seeking damages in connection with an action for injury or damage against a health care provider based upon such person's alleged professional negligence in excess of the following limits:

(a) Thirty-three and one-third percent (33-1/3%) of the first One Hundred Thousand Dollars ($100,000.00) recovered.

(b) Twenty-five percent (25%) of the next Four Hundred Thousand Dollars ($400,000.00) recovered.

The limitations shall apply regardless of whether the recovery is by settlement, arbitration, or judgment, or whether the person for whom the recovery is made is a responsible adult, an infant, or a person of unsound mind.

(2) If periodic payments are awarded to the plaintiff, or an annuity purchased, the court shall place a total value on these payments based upon the projected life expectancy of the plaintiff and include this amount in computing the total award from which attorney's fees are calculated under this section.

(3) For purposes of this section:

(a) "Recovered" means the net sum recovered after deducting any disbursements or costs incurred in connection with prosecution or settlement of the claim. Costs of medical care incurred by the plaintiff and the attorney's office-overhead costs or charges are not deductible disbursements or costs for such purpose.

(b) "Health care provider" means any person as defined in Section 1(1)(a) of this act. "Health care provider" includes the legal representatives of a health care provider.

(c) "Professional negligence" is a negligent act or omission to act by a health care provider in the rendering of professional services, which act or omission is the proximate cause of a personal injury or wrongful death, provided that the services are within the scope of services for which the provider is licensed and which are not within any restriction imposed by the licensing agency or licensed hospital.

SECTION 10. Sections 83-48-1, 83-48-3, 83-48-5 and 83-48-7, Mississippi Code of 1972, which create the Medical Malpractice Insurance Availability Plan, are hereby repealed. On July 1, 2004, all assets and liabilities of the Medical Malpractice Insurance Availability Plan shall be transferred to the Patient's Compensation Fund.

SECTION 11. The provisions of Sections 1 through 7 of this act shall be codified as a separate chapter within the Mississippi Code of 1972.

SECTION 12. This act shall take effect and be in force from and after July 1, 2004, and shall apply only to acts of malpractice that occur on or after this date.