INTERIM REPORT

of the

SPECIAL COMMISSION

relative to

MEDICAL PROFESSIONAL LIABILITY

INSURANCE AND THE NATURE

AND CONSEQUENCES OF

MEDICAL MALPRACTICE


Mr. Robert E. MacQueen
Clerk, House of Representatives
State House, Room 145
Boston, MA 02133

Dear Mr. Clerk:

Enclosed please find the interim report of the Special Commission on Medical Malpractice submitted under the provisions of Section 12 of Chapter 362 of the Acts of 1975 and as amended by Section 39 of Chapter 351 of the Acts of 1986.

LINDA J. MELCONIAN  FRANCIS H. WOODWARD
Senate Chairman  House Chairman

We, the undersigned members of the special commission on medical malpractice accept the interim report of 1987.

Senator Linda J. Melconian  Rep. Francis H. Woodward
Senator Arthur J. Lewis, Jr.  Senator Edward L. Burke
Rep. Iris Holland  Commissioner Peter Hiam
Frederick Duncan, M.D.  James N. Esdaile, Esq.
MEMBERS OF THE SPECIAL

COMMISSION ON MEDICAL MALPRACTICE

PROFESSIONAL LIABILITY INSURANCE


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Pursuant to the Massachusetts Medical Professional Practice Act, as
made recom-
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In order to
appointed in
study sub-committee
findings to the study report. Part

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examined the
in Massachusetts
follows: — Massachusetts
M.D., repr:
Paula Gold,
Esq., represen-
Endaile, Esq.

Background

In response to medical

Pursuant to Section 12, of Chapter 362 of the Acts of 1975, the Massachusetts General Court established the Special Commission on Medical Professional Liability Insurance to investigate, study, and make recommendations to resolve the problems related to medical malpractice insurance. The scope of the Special Commission on Medical Professional Liability Insurance was expanded significantly by Section 39 of Chapter 351 of the Acts of 1986 to examine the feasibility of establishing a patient compensation fund and an early tender program in the Commonwealth; to study non-profit hospital service and medical service corporations; and to examine the medical service corporation's methods of reimbursement. Section 39 is attached as Affidavit A.

In order to fulfill this 1986 mandate, the Special Commission appointed in January, 1987, four study sub-committees. These four study sub-committees compiled available resources and reported their findings to the full Commission. The findings and recommendations of the study sub-committees are the subject of Part I of this interim report. Part II will report on preliminary observations of the impact of Chapter 351 of the Acts of 1986.

PART I: STUDY SUB-COMMITTEES FINDINGS AND RECOMMENDATIONS

PATIENT COMPENSATION FUND

The Special Commission established a study sub-committee which examined the feasibility of establishing a Patient Compensation Fund in Massachusetts. The members of this study sub-committee were as follows: — Mr. Patrick R. Carroll, Esq., representing the Massachusetts Hospital Association, Chair; Dr. Barbara Rockett, M.D., representing the Massachusetts Medical Association; Ms. Paula Gold, Secretary of Consumer Affairs; Mr. Joseph Hegarty, Esq., representing the Alliance of American Insurers; Mr. James N. Esdaile, Esq., representing the Massachusetts Bar Association.

Background

In response to the growing problem of availability of medical malpractice insurance and the medical profession's call for tort
reform, four states created Patient Compensation Funds, so called, which were designed to provide participating health care providers with excess liability coverage over a specific established limit. Financed by surcharges assessed to its participants, Patient Compensation Funds were intended to reduce indirectly the costs of medical malpractice insurance by reducing directly the size of awards and settlements to be paid by the individual health care provider. The sub-committee studied the experiences of three states (Florida, North Carolina and Indiana) which had legislated Patient Compensation Funds; information on the fourth, Pennsylvania, was not available at the time of the sub-committee’s study.

Florida

In 1975 the state of Florida passed the Medical Malpractice Reform Act which included a provision to establish a Patient Compensation Fund that would limit the liability of participants to $100,000 by paying the full excess over $100,000 of any judgment or settlement against a member. Through an insurer of self-insurance plan, the participant was required to show financial responsibility for the first $100,000 and to deposit an annual fee into the Fund. For the first few years, the Fund ran smoothly because fees were low ($1,000 for the first year and $500 per year thereafter for physicians and $300 per bed annually for hospitals) and claims against members were few. The fee system, however, was not actuarially sound, according to officials of Florida’s Hospital Association and Defense Lawyers Association. Because the fund operated on a pay-as-you-go basis, there was no way to estimate accurately the cost of maintaining the Fund. Substantial losses began to accumulate as claims against participants and total dollars paid from the Fund increased. To cover such losses, physician members could only be assessed up to 100 percent of their initial premium, but hospitals and other members faced unlimited assessments.

In the 1982 the Fund assessed its members for deficits relating to the 1978 and 1979 fiscal years totaling $17,046.190. Of this amount, $12,855,500 was assessed against Florida hospitals, even though the Fund’s records showed that almost $10 million of the nearly $13 million assessed against hospitals was attributable to claims against

Indiana

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physician members. According to a report from the Florida Insurance Commissioner, hospitals left the Fund due to the potential for large assessments; thus, they left the Fund without any means of paying large claims. By 1983 the Fund was insolvent.

Although the actuarial unsoundness of the fee system was the primary cause of the Fund’s failure, there were several other factors that contributed to the Fund’s downfall. The limit of $100,000 placed on the amount the Fund could pay in any one year to any one claimant proved to be unenforceable when confronted by large jury awards. Another factor responsible for the Fund’s failure was the statutory cap placed on the amount of premiums it could collect per year. Initially set at $15 million, the cap hindered the Fund’s ability to collect sufficient premiums to cover claims. The cap was later increased to $25 million, according to Florida Insurance Department officials, and subsequently deleted shortly before the Fund became bankrupt.

Indiana

Indiana’s Medical Malpractice Act of 1975 included a provision to establish a Patient Compensation Fund to be administered by the State Insurance Commissioner to pay claims over $100,000 up to the state’s $500,000 limit. Receiving no funding from tax dollars or the Legislature, the Fund was financed by participants’ surcharges. All of the administrative expenses were paid from the Fund, and the Department of Insurance had authority to use the Fund’s money to retain risk managers, defense counsel and financial advisors. The participating health care provider was required to purchase basic coverage ($100,000/$300,000 for physicians; $100,000/$2 million for hospitals under 100 beds and $100,000/$3 million for hospitals of 100 beds or more) or prove self-insurability.

Between 1980-1984 the number and amount of claims against the Fund significantly increased. Specifically, the Fund paid $3.9 million for 11 claims in 1980 versus $17.7 million for 57 claims in 1984, and then decreased to $11.7 million for 36 claims in 1985. The average amount paid for each claim closed against The Fund decreased from $354,545 in 1980 to $325,417 in 1985. The average paid claim by the Fund, however, had increased each year since 1981, from $281,786 to $325,417 in 1985 — a 15 percent increase.
Although the cost for Indiana physicians and hospitals is now among the lowest in the nation, the frequency of claims against physicians and the average paid claims for hospitals climbed significantly between 1980-1984. The large increase in the number of claims paid and the total dollars paid by the Patient Compensation Fund coupled with an attending rise in the Fund surcharge rate produced major concerns regarding the continued solvency of the Fund.

The Indiana Legislature, in response to growing concern over the Fund’s potential bankruptcy, enacted several changes to the 1975 Medical Malpractice Act which were designed to aid the Fund. Provisions were established that allowed the Fund to use periodic payments in lieu of lump sum payments in paying awards or settlements to the claimant; allowed the Fund to make payments to claimants twice a year (January 15 and July 15) instead of once a year; and raised that annual surcharge rate in April 1985 to 75 percent of the cost of needed medical malpractice insurance and to 100 percent in April 1986. Despite these recent legislative changes, however, state officials still foresee future problems for the Fund.

North Carolina

In 1976 North Carolina created the Health Care Excess Liability Fund to provide health care providers with excess liability coverage of $2 million per occurrence and $2 million annual aggregate. Participating health care providers were required to have primary malpractice coverage of at least $100,000 per occurrence and $100,000 annual aggregate. The Fund never became operational because a need for the Fund never developed after the Medical Mutual Insurance Company of North Carolina was established.

Sub-Committee Findings

In addition to a study of the Patient Compensation Funds in these states, the sub-committee examined and reviewed two Patient Compensation Fund proposals for Massachusetts. The first, a Patient Compensation Fund proposed by the Massachusetts Medical Society, was essentially identical to Patient Compensation Funds that were established in the three states examined by the sub-committee. The
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Commission's Recommendations

Since the Joint Underwriting Association projected a deficit of over $700 million dollars for 1986, the Commission believes that this is not the appropriate time to establish a possible duplicate system of paying medical malpractice claims. The Special Commission has agreed to retain the idea of alternative methods of claims payments on its agenda. Once the JUA's finances and rates have been stabilized, the Commission might wish to recommend a pilot program, carefully monitored, which would utilize an alternative method of claims payment.

EARLY COMPENSATION SYSTEM

The Special Commission appointed a study sub-committee to conduct a study relative to the viability of a system for early tender of compensation to victims of medical malpractice. The members of this committee were as follows: — Secretary Paula Gold, Chair; Mr. James N. Esdaile, Esq.; Dr. Barbara Rockett; Mr. Richard Moore, Ex Officio, representing the Joint Underwriting Association; Mr. Joseph Hegarty; Mr. Patrick R. Carroll, Esq.

Background

An early compensation system is one that would allow an injured person to make a claim and recover immediately economic damages such as medical expenses and loss of wages. Acceptance of this recovery precludes the right to pursue a legal cause of action against the health care provider for any economic or non-economic damages.

Proponents of such a system maintain that early tender would give the injured party a guarantee of payment for medical expenses,
rehabilitation expenses, lost wages, cost of replacement services and other economic losses along with attorneys' fees.

Opponents express real concern over injured persons losing their tort rights. Foremost among these would be no recovery for so-called pain and suffering and other non-economic damages.

Medical Malpractice may be defined for our purposes as the "improper treatment or culpable neglect of a patient by a provider of health care services." It is based on the notion that the provider of service does not live up to the standard of good and accepted care prevailing in the relevant medical community. In other words, the health care provider does something which the average provider should not do, or does not do something which the average provider should do.

Medical Malpractice has its principal impact on the provider and recipient of service. If the recipient suffers irreversible damage as a result of malpractice, the consequences can be serious, including wrongful death. As for the alleged culpable provider, malpractice has the potential effect of modifying or denying his professional status and exposing him to financial loss. In our legal system it is generally accepted that if one person causes harm to another in a manner which a jury finds to be negligent, the person causing the harm must bear the consequences of his act. If the injured person, or his legal representative, cannot show that the health care provider has committed a legal wrong, the burden of loss remains with the injured person and will not be shifted to the provider of service.

Significant questions have been raised by the medical community as to whether the theory is consistent with current practice. In theory our system of medical injury compensation is based on fault principles. Some argue, however, that our system of justice grants compensation to complaining patients irrespective of fault; that it shifts the burden of loss from the plaintiff to someone who the system believes is better able to bear it financially (usually an insurance company). Mr. Esdaile rejects this view and feels that there is no empirical evidence to support it.

It is of central importance to this Special Commission's study to determine whether courts and juries, and thus, our system of settling cases, have in fact abandoned that "fault" principle. In light of the suggestion by some that a "no-fault" system of patient compensation should replace inquiry has p that fault doe such comp damages. Th compensatory of a medical e more compen we had antici now paying tl this matter, tl C.

Sub-Committee

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should replace our present system based on fault, the outcome of this inquiry has particular significance. Those who oppose “no-fault” feel that fault does determine the entitlement to compensation, and that such compensation is then determined by the rules of compensatory damages. The compensatory event is therefore central. If that compensatory event were defined as merely an unsatisfactory result of a medical encounter, it is possible that we would incorporate many more compensatory events into our patient compensation system than we had anticipated, resulting in costs far in excess of anything we are now paying through our “fault”-based system. For further details on this matter, the report of the sub-committee is attached as Affidavit C.

Sub-Committee’s Findings

The sub-committee, over the objection of Mr. Esdaile, feels that an experimental program for early tender should be established in Massachusetts. Pursuant to a vote by the Special Commission, the sub-committee drafted legislation to establish this experimental program which would be limited to class 7 physicians for a trial period of approximately six years. The proposed legislation would include an “opt out” clause which would allow an injured party to avail himself of the present tort system under certain circumstances.

Commission’s Recommendations

The Commission with the objection of Mr. Esdaile recommends that the attached draft legislation, labeled Appendix A, be referred to the Joint Legislative Committee on Insurance for further review and recommendations.

NON-PROFIT MEDICAL/HOSPITAL CORPORATIONS

The Special Commission established a study sub-committee to investigate and study non-profit hospital service corporations and non-profit medical service corporations. The members of this sub-committee were as follows: — Mr. James N. Esdaile, Esq., Chair; Dr. Barbara Rockett; Secretary Paula Gold; Mr. Joseph Hegarty.
Background

Possibly the most complex portion of the Section 39, Chapter 351 mandate is the in depth investigation into the practices of Blue Cross/Blue Shield of Massachusetts. The sub-committee met weekly for two months and requested voluminous information from Blue Cross/Blue Shield. Although some of the material has been received and analyzed, much of the requested data on the details of Blue Cross/Blue Shield operations in the Commonwealth of Massachusetts is still being compiled.

Sub-Committee’s Findings

The sub-committee strongly believes that additional time is essential in order to complete a meaningful review and analysis of compiled information with which to base an appropriate recommendation. The sub-committee, therefore, requests a reasonable extension of time within which to complete this important work. A report of the sub-committee on medical/hospital corporations is attached as Affidavit D.

Commission’s Recommendations

The Special Commission, through the Joint Legislative Committee on Insurance, requests that the reporting date for this portion of the report required by Section 39 of Chapter 351 be extended to December 31, 1987.

MEDICAL/HOSPITAL SERVICE CORPORATIONS REIMBURSEMENT

The Special Commission appointed a sub-committee to conduct an investigation and study into the medical service corporation’s methods of reimbursement. The members of this study sub-committee were as follows: — Senator Linda J. Melconian, Chair; Representative Iris K. Holland; Representative Michael Walsh; Secretary Paula Gold; Mr. Joseph Hegarty; Dr. Barbara Rockett.

Background

In early 1987 a potential for a crisis in access to health care developed in Western Massachusetts. Many employer groups and an excess of 105 ph in Blue Shield of informational g: Technical Coml from consume reimbursement excessive delays arrogance on the Present statu reimbursing for services were pr The exceptions : participating pr participating ag Shield), while a participating ag The mass ex Massachusetts ( consumer access: are unable to se These citizens : paying a prem In many instanc only to recogniz no longer ac unacceptable fi Those of limited by paying all co
excess of 105 physicians had decided to withdraw from participation in Blue Shield of Massachusetts. The sub-committee held a six hour informational gathering public hearing in Springfield at Springfield Technical Community College on February 12, 1987. Complaints from consumers and health providers included inadequate reimbursement for providers, capricious disallowance of claims, excessive delays in payment, lack of communication and overall arrogance on the part of Blue Cross/Blue Shield of Massachusetts.

Present statute prohibits a medical service corporation from reimbursing for medical services either a provider or subscriber if the services were provided by a non-participating health care provider. The exceptions are in cases of emergency or out of state care. A non-participating provider is one who does not have a contractual participating agreement with the medical service corporation (Blue Shield), while a participating provider is one who has a contractual participating agreement with the medical service corporation.

The mass exodus by physicians from the largest insurer in Massachusetts (Blue Cross/Blue Shield) strikes a serious blow to consumer access to quality health care. Consequently, many citizens are unable to see the physician of their choice and be reimbursed. These citizens and/or their employer are financially burdened by paying a premium for medical insurance which they cannot utilize. In many instances a person pays for Blue Cross/Blue Shield coverage only to recognize that the provider from whom he is seeking treatment no longer accepts that insurer’s reimbursement. This creates an unacceptable financial burden on those of fixed and low incomes. Those of limited income can maintain continuity of medical care only by paying all costs out of pocket.

Sub-Committee’s Findings

As a result of the Springfield hearing and subsequent meetings, the sub-committee recommended drafting legislation which would alleviate those inequities which surfaced. Included in the recommended proposal were suggested provisions which would provide disincentives for physicians who withdrew from the participating agreement, such as a lower rate of reimbursement; direct reimbursement for services to the subscriber rather than to the
provider; a type of “informed consent” by a provider to a patient and protection for senior citizens against balance billing.

**Commission’s Recommendations**

The Special Commission adopted the sub-committee’s recommendations and reported them to the Joint Legislative Committee on Insurance. The Commission’s recommendations contained the following provisions and protections:

The offering of patients the freedom of choice of a physician regardless of whether or not the physician had a participating contract with a medical service corporation.

The reimbursement to a subscriber at a level of 85% of what it would have paid a participating physician.

A non-participating physician (prior to treating a patient) would be required to inform the patient that he/she might be charged for the difference in the amount reimbursed in addition to the physician’s usual charge.

A patient who chose a non-participating physician to render treatment would be paid directly by the medical service corporation and would then reimburse the physician.

A medical service corporation would be required to create a list of participating physicians available to subscribers, employers and other representatives of the group subscribers. A non-participating physician would be required to furnish patients with the names of participating physicians in a similar specialty in the immediate geographic area, thus ensuring the patient of his option of a participating or non-participating physician.

A guarantee of protection for the elderly covered under medicare. This provision would ensure that no out of pocket costs (balance billing) would be incurred by the elderly.

The Joint Legislative Committee on Insurance further amended the Commission’s recommendations by adding a section that would require an employer to offer, in a health care plan, coverage for either a participating physician or a non-participating physician. If a subscriber group is represented by a collective bargaining agreement, however, the collective bargaining agent would determine whether the non-participating option would be offered to employees. The final outcome became Senate bill number 1831, a copy of which is attached as Affadavit E.
PART II: PRELIMINARY IMPACT OF CHAPTER 351

JOINT UNDERWRITING ASSOCIATION

Chapter 351 temporarily froze at the 1983 rate all premiums of medical malpractice insurance from 1983 through 1986. Physicians insured through the JUA owed approximately $104 million in retroactive premiums which would be paid in an installment plan over five years to help minimize the impact of costs.

The JUA faced a deficit of $711 million by the end of 1986, an amount which was substantiated by the Office of the Massachusetts State Auditor in his report, number 86-2027-5 dated June 30, 1986. In addition, the JUA had also filed a request for a recoupment of $140 million which the JUA claimed was a deficit for the years 1975 through 1982. The Medical Malpractice Commission foresaw a possible lengthy lawsuit by the JUA if the Insurance Commissioner rejected the request for recoupment. Presently, the Massachusetts Medical Society and the JUA have suits pending before the Supreme Judicial Court challenging the methodology and factors utilized by the Commissioner in establishing the 1986-87 rates and the deferred 1983-85 due premiums. The Commission is concerned that another lawsuit regarding the recoupment of rates from 1975 through 1982 would seriously impair health delivery in Massachusetts. Most observers believe that once Chapter 351 has been fully implemented, premiums for medical malpractice insurance will be dramatically impacted. Premium increases for policy years 1986/1987 were 8.7% and for policy years 1987/1988 were 6.5%. Although the reforms mandated by Chapter 351 have been in place for a relatively short period of time, the Special Commission believes that premium increases for policy years 1988/1989 should be negligible.

The Commission, during its ongoing review of Chapter 351, noticed two inadequacies which required corrective changes. One would have allowed physicians who left the JUA and continued to practice medicine in Massachusetts to avoid paying their deferred premiums. This was not the legislative intent. Senate 1706, which is now Chapter 69 of the Acts of 1987, corrected this oversight. The other would have billed new physicians for retroactive premiums even though that new physician was not practicing in Massachusetts during the time that premiums were frozen. Senate 1705, which is now Chapter 169 of the
Acts of 1987, corrected this inadequacy. As a result those new physicians would be liable for premiums only in those years while they were practicing medicine in the Commonwealth.

The JUA has submitted a memorandum to members of the General Court outlining what it considers to be a crisis in its assets, a copy of which is attached and labeled Affidavit F.

**TORT CHANGES OF CHAPTER 351**

The Special Commission has been monitoring the tort changes of Chapter 351. Because many of these changes did not take effect until November 1, 1986, hard data is not readily available, and the financial impact ranges from marginal to imperceptible. There is some initial data available concerning Section 24, the itemized jury verdicts, which was designed to give accountability to jurors. The Commission had asked Attorney Frederick N. Halstrom, a plaintiff lawyer who has had several medical malpractice cases decided since November 1, 1986, for an opinion as to the effectiveness of this section. Attorney Halstrom has submitted an opinion which is attached as Affidavit G. Additionally, Mr. Halstrom submitted information on one case involving collateral source along with a memorandum prepared by Professor Peter A. Donovan of Boston College Law School. It seems that there is disagreement among insurance carriers and private payors as to the effect of Section 25 of Chapter 351. Should further cases reflect confusion similar to that in the “Harlow case,” it would seem appropriate for the Legislature to enact some clarifying legislation. The Commission wishes to thank Mr. Halstrom for his efforts and cooperation in this matter.

**BOARD OF REGISTRATION IN MEDICINE**

The failure to discipline physicians by restriction or revocation of licenses was often cited as a prime reason for the rising incidence of medical malpractice claims. The media criticized the Board for permitting physicians with extensive malpractice histories to continue to practice medicine.

The Board stated a lack of necessary disciplinary tools, compilation of data and insufficient staff impeded the Board from carrying out its function. Prior to Chapter 351, the Board’s functions were limited to licensing and discipline.
Chapter 351 expanded the powers of the Board which required new budget resource of $1.6 million. The new law mandated the reporting of physician behavior that was not previously available to the Board. In addition Chapter 351 gave to the Board subpoena power to compel evidence in its investigations of complaints.

The two major changes in the Board’s duties, under Chapter 351, were the establishment of a “Risk Management Unit” and a “Data Repository/Data Management Unit.”

The Risk Management Unit was designed to promote quality care in the work setting as an alternative to taking disciplinary action against physicians. The Board had adopted regulations implementing risk management effective July 1, 1987. The regulations coordinate medical staff quality with potential patient risks. The Commission, recognizing that provider compliance with the new regulations will take time, believes that in the long run risk management would be a prime factor in helping to reduce the number of incidents and frequency of medical malpractice.

The Data Repository/Data Management Unit is now fully operational. The confidential information being compiled includes: reports of disciplinary actions against physicians undertaken by hospitals, nursing homes, other providers and professional associations; reports of malpractice claims closed by the state’s four liability insurers; reports from the Trial Court and Malpractice Tribunals on all settlements and verdicts; reports from public agencies and agencies on physician conduct which might be subject to Board disciplinary action and major patient injury reports from health care providers. The Board will be able to utilize this data for both its disciplinary unit and its Risk Management Unit. In 1986, forty physicians were disciplined. This represents a 74% increase over 1985 and more than double the number issued in any recent individual year. The Special Commission believes that once fully operational, under Chapter 351, the Board of Registration in Medicine could be the most effective medical board in the nation.
1 SECTION 39. The special commission on medical malpractice
2 established in chapter three hundred and sixty-two of the acts of
3 nineteen hundred and seventy-five is hereby authorized and
4 directed to conduct an investigation and study of the legal, tax,
5 reimbursement, and regulatory status of nonprofit hospital service
6 corporations and nonprofit medical service corporations, as
7 established pursuant to chapters one hundred and seventy-six A
8 and one hundred and seventy-six B of the General Laws. Said
9 study shall also include a review of the standing of said
10 corporations in relationship to other health care insurers and
11 nonprofit medical service corporations within and without the
12 commonwealth, to government programs of health insurance and
13 to competing and alternative forms of health care financing.
14 Particular attention shall be paid to the corporations' rights to
15 contract with professional and other institutional providers of
16 health care services, the system of payments made by said
17 corporation, including the impact of the prohibition on the
18 practice of balance billing, so-called, the process by which the fees
19 paid by said corporations to participating physicians are set, the
20 extent to which said fees are reflective of the costs of providing
21 medical services, including but not limited to, the cost of medical
22 malpractice premiums, the adequacy and efficacy of existing
23 dispute resolution mechanisms available to said corporations and
24 professional providers, the financial and accounting procedures
25 of said corporations and their impact on the quality and cost of
26 health care services.
27 Said commission is further directed to conduct an investigation
28 and study into the feasibility of establishing a patient com-
29 pensation fund, so-called. Said study shall include a review of the
30 operation of such funds in other states, an analysis of various
31 funding mechanisms, and an estimate of the administrative cost
32 of such a fund and its potential impact on medical malpractice
33 premiums.
34 Said commission is further directed to conduct an investigation
35 and study relative to the viability of a system which would provide
36 for early tender of compensation to victims of medical
medical malpractice of the acts of authorized and of the legal, tax, hospital service corporations, and seventy-six A General Laws. Said standing of said re insurers and and without the th insurance and care financing. ations’ rights to al providers of made by said hibition on the by which the fees dians are set, the sts of providing cost of medical acy of existing orations and ting procedures ality and cost of an investigation a patient com- a review of the lysis of various ministrative cost cal malpractice an investigation would provide of medical malpractice, the economic ramifications of such a system upon such victims, the potential effect such a system might have upon premiums for medical malpractice insurance, the ability of the joint underwriting association to administer a system of early tender of compensation, a comparison of an early tender system of compensation to the existing medical malpractice procedure, the question of whether or not a system of early tender of compensation would have a negative effect on the ability of this commonwealth to effectively oversee and, where necessary, to discipline practicing physicians and such other matters as may help in determining whether the implementation of an early tender of compensation system to victims of medical malpractice is feasible.

The commissioner of insurance is hereby authorized to make an annual assessment against the insurance companies licensed to write health and accident insurance policies and personal injury liability insurance policies covering residents of Massachusetts and regulated under paragraph six of section forty-seven of chapter one hundred and seventy-five, fraternal benefit societies regulated under section thirteen A of chapter one hundred and seventy-six, hospital service corporations regulated under chapter one hundred and seventy-six A, medical service corporations regulated under chapter one hundred and seventy-six B, nonprofit medical service plans regulated under chapter one hundred and seventy-six C, dental service corporations regulated under chapter one hundred and seventy-six E, optometric service corporations regulated under chapter one hundred and seventy-six F, and health maintenance organizations regulated under chapter one hundred and seventy-six G an amount not to exceed four hundred thousand dollars. Said assessment shall be apportioned among such companies on a fair and reasonable basis. Said assessment shall be used, in addition to such other funds as may be appropriated, to defray the expenses of conducting the studies required by this section and may be expended for such expert, legal, investigative, clerical and other assistance as may be required.

The result of the studies together with any recommendations of the commission, shall be filed with the joint committee on
insurance and the house and senate committees on ways and means no later than July first, nineteen hundred and eighty-seven. The provisions of this section shall expire on December thirty-first, nineteen hundred and eighty-seven.

SPECIAL COM
Subcomm

DATE:
LOCATION:
ATTENDANCE:

ABSENT:

The committee revisited consideration by the Patient Compensation Medical Society and Industries of Massachusetts.

It was the consensus to retain the subject on the agenda, but it might require further refinement.

The Committee determined that the subject, as presented, was a viable one.

The authors of the议案, as submitted by the Massachusetts Medical Society.
The committee reviewed two plans which had been submitted for consideration by the Commission at earlier hearings. These included the Patient Compensation Fund as proposed by the Massachusetts Medical Society and the Special Claims Fund of the Associated Industries of Massachusetts (AIM).

It was the consensus of the subcommittee that the Commission should retain the subject of special claims or compensation funds on its agenda, but it might better direct its energy to the review analysis and further refinement of the enacted Ch. 351, Acts of 1986.

The Committee determined that neither compensation plan, at present, was a viable option.

The authors of the AIM proposal object to this conclusion and a copy of their statement is attached along with a summary of the Massachusetts Medical Society proposal.

Patrick R. Carroll, Esq.
Chairman
Associated Industries of Massachusetts
462 Boylston Street
Boston, Massachusetts 02116
March 9, 1987

Patrick Carroll, Esq., Chairman
Subcommittee on Patient Compensation Funds
Special Commission on Medical Malpractice
The State House
Boston, Massachusetts 02133

Dear Mr. Carroll:

It is my understanding that your Subcommittee has found that AIM’s Special Claims Fund (SCF) is not a viable option for addressing medical malpractice costs in Massachusetts. Although it is extremely unfortunate that AIM was not given the opportunity to appear before your Subcommittee, I appreciate your agreeing to include this letter outlining our position in the Special Commission’s Report.

AIM feels strongly that the SCF is the only viable solution to the medical malpractice cost problem because the present method of claim management and reserving practices by the Joint Underwriting Association (JUA) does not affect any insurance company’s bottom line, thereby removing any incentive to reserve and manage malpractice claims in an accurate and effective manner. The SCF plan is a workable plan for the following reasons:

- The SCF proposal makes physicians responsible for a reasonable, but manageable, share of malpractice costs and thus keeps them interested in underlying cost containment.
- The SCF plan directly assists physicians with malpractice claim costs through the Special Fund and does not rely on inequitable adjustments in physician fee schedules.
- The SCF exempts Medicare patients from any possible assessment surcharges, and does not financially penalize doctors providing services to such patients.
- The SCF stabilizes ratemaking for the JUA by limiting its responsibility to $350,000 per claim. Under the SCF plan, claim amounts abc Special Fund responsibilities result in actuarial projections, needed undue

In conclusion, A workable and responsible malpractice plan adheres to health care amendment is the underlying high...
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SCF plan, claim

amounts above $350,000 per claim are the responsibility of the Special Fund, but the public will not be asked to assume any responsibility for such claims amounts unless and until they result in actual claim payments. According to reliable actuarial projections, no assessment of health care consumers will be needed under the SCF plan for AT LEAST SEVEN YEARS.

• The SCF is given checks and balance powers like those a reinsurer would require in the voluntary market to monitor the claims reporting and claims management practices of its primary carrier — the JUA.

In conclusion, AIM believes that the SCF amendment is the only workable and responsible plan for assisting doctors with the costs of malpractice premiums, while avoiding unnecessary inequities to individual physicians and substantial, unnecessary, immediate costs to health care consumers and employers/employees. The SCF amendment is the only plan that addresses the root problems underlying higher malpractice rates.

Thank you for your cooperation and I hope that AIM will be consulted in future deliberations on the SCF issue.

Sincerely,

Walter P. Muther
President
SPECIAL COMMISSION ON MEDICAL MALPRACTICE
Report of the Subcommittee on Early Compensation System

The subcommittee has reviewed various forms of the Early Compensation System considered in connection with medical malpractice. It has discussed the limited data available to evaluate such a system and the problems which various commentators have with certain aspects of the Early Compensation proposals.

The Subcommittee determined that an Early Compensation System should be tried initially on an experimental basis in the medical malpractice area. Medical malpractice is particularly well suited to such an experiment because it is a relatively controlled insurance system, data on the results of early compensation would be easy to monitor, and if the experiment turned out to be unexpectedly costly, a mechanism could be created to spread any excess cost of the experiment to a group broader than the particular category of physician chosen for the experiment.

The feasibility and cost of an Early Compensation System depend in substantial part on the form the system takes. In this regard there are a number of options which are available.

I. The Basic Early Compensation Mechanism

The basic mechanism of the early compensation system is straightforward: An injured person could make a claim just as they presently do. The malpractice insurer would have six months to guarantee to pay 100 percent of the injured person's money damages, no matter what they turn out to be or how long they last. However, the insurer can limit the total amount of damages covered by the tender to the policy limits of all parties participating in the tender (at least $1 million). If the insurer does not make that commitment within six months, then the injured person simply proceeds with his or her tort suit.

If such a guarantee is offered, in most cases it would probably be accepted. However, under some versions of the system, the injured person may reject it and suffering.

The money data for the insurer to make rehabilitation expenses as those of a homemaker would also agree to a reasonable hourly rate to suffer any net economic loss for a low dollar amount and commit itself to pay if the costs or damage anticipated.

If an insurer and later refuses to settle, and strong reasons available to prevent

II. Options

A. The Approach

Early compensation in 1985 applied on a very high risk specialty basis; the other high risk specialty such as fetal injuries —

A test group enough potential claim and it must involve

1. Obstetricians: injured infants by expenses within six months is likely to be most objected to obstetricians type of medical spe
ALPRACTICE isation System

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would probably em, the injured person may reject the offer and sue for full damages, including pain and suffering.

The money damages that would have to be guaranteed, in order for the insurer to make a valid tender, would include all medical and rehabilitative expenses, lost wages, costs of replacement services (such as those of a homemaker), and other items of economic damages. The insurer would also have to pay the injured person’s attorneys fee, at a reasonable hourly rate, so that the injured person is guaranteed not to suffer any net economic injury. The insurer could not merely offer a low dollar amount to take advantage of this system — it has to commit itself to paying all the money damages as they occur, even if the costs or damages turn out to be more than either party anticipated.

If an insurer makes the commitment to pay economic damages and later refuses to pay a bill for damages, the victim can take it to court, and strong remedies, such as automatic double damages, are available to prevent any abuse by the insurance company.

II. Options

A. The Appropriate Test Group

Early compensation as originally proposed in the malpractice bill in 1985 applied on a test basis to injuries caused by obstetricians. It was later amended to apply only to orthopedic surgeons, and certain other high risk specialists. An alternative to defining a particular class of physician would be to define a particular type of injury — such as fetal injuries — for which early compensation would apply.

A test group must fit two principal criteria: It must contain enough potential claims to create statistically meaningful test results; and it must involve “high risk” medical specialties. The options are:

1. Obstetricians: Early compensation in this area could benefit injured infants by providing for payment of care and rehabilitation expenses within six months of the injury, when medical intervention is likely to be most successful. On the other hand, some legislators objected to obstetrics as the test category because it is a gender-linked type of medical specialty.
2. Orthopedic Surgeons: This group, while much smaller, would have claims across a wide spectrum of patients by age and gender.

3. “Class 7” Physicians: The highest risk group, including orthopedic surgeons, neurosurgeons and cardiovascular surgeons.

4. Fetal Injuries: Virginia and North Carolina have proposed early compensation for claimed fetal injuries. This would provide payment for early intervention in fetal injury cases, and does involve, potentially, enough claims to generate meaningful data.

The subcommittee recommends that the test group be composed of all “Class 7” physicians.

B. The “Triggering” Event for a Tender

Under any proposal, some specific event must be chosen, after which the insurer or defendant would have six months to make or not make a tender. The options are:

1. The date of treatment. This trigger date would require potential defendants to screen all their patient contacts to identify potential claims, evaluate them and make a tender, in many cases before a claim has been asserted. While this would possibly result in more active evaluation of results, under these circumstances tenders would be likely only in cases where the physician conduct and results were so egregious that it was immediately clear that a claim was likely.

2. The date a claim is asserted. This would have the injured party at least identify the claim and thus narrow the range of cases requiring evaluation. In most cases the injured person would have a lawyer by this point as well, which would be beneficial to an individual considering whether to accept a tender. Regulations could provide for the claim to be in writing, what form the assertion of the claim would have to have, and what information the injured person could be required to provide to permit proper evaluation of whether to make a tender.

3. The date a lawsuit is filed. This is a more certain date than the date a claim is asserted, but it is also later in the process than the first date a claim is asserted.

The subcommittee recommends that the “trigger” date be the date a claim is asserted in writing.
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group, including vascular surgeons.
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C. The Elements of a Tender

Substantively, the elements of damages covered by a tender should be described by statute as specifically as possible. In this regard, lost wages (with a presumptive wage for persons with no earnings history) would be preferable as one element of compensation, rather than “loss of earning capacity,” which would be guaranteed to generate disagreement and litigation. The attorney’s fee paid in a tender, moreover, would have to be at an hourly rate, perhaps set by regulation.

The form that a tender takes should be spelled out in regulations as well, so as to avoid any ambiguity as to whether a tender is valid and what it covers.

D. Opting Out from a Tender

As originally proposed, a plaintiff could reject a tender and sue in tort only in cases of willful misconduct, or if damages would exceed the amount of insurance available to satisfy the tender (at least $1 million). In response to concerns over plaintiffs losing their tort rights, various opt-out proposals were considered. However, a totally free option to reject a tender would not work because then there would be no incentive to make a tender, and we would be left with the current system.

Among the feasible options are:

1. Mandatory Acceptance with an opt-out only in cases of willful misconduct or for damages greater than the limit of the tender (at least $1 million).

2. Allowing rejection of a tender, but imposing a cost on the plaintiff for the rejection, for example a percentage reduction in the judgment if the plaintiff later wins.

3. Allowing rejection of a tender, but barring a plaintiff from recovering prejudgment interest for the period after the date of the tender.

Option 3 is as minor a detriment for rejecting a tender that could be imposed without eliminating, as a practical matter, any incentive for the defendant to make a tender.
The subcommittee recommends the first option, a mandatory acceptance except in cases of willful misconduct or if damages exceed the amount of a limited tender.

E. Joinder of Co-defendants

In the original proposal, co-defendants could be involuntarily joined in a tender, with any dispute among them resolved by arbitration. An alternative might be to allow a tendering party to sue nontendering parties for contribution, based on fault, just as defendants paying a judgment now have a right to sue joint tortfeasors. However, the subcommittee recommends that the original proposal on joinder be used, but that an expedited process be available for involuntarily joined parties to free themselves from liability if the claim on which joinder is based is frivolous or totally unsupported.

In any event, hospitals and other entities with limited liability could not make a tender without waiving their limited liability, and could not be joined in a tender beyond their limit without their consent.

F. Duration of the Test

The test period would have to be long enough for meaningful results. If the system only applied to injuries arising out of medical treatment after the effective date of the statute, the test would probably not begin to show results until 2 to 3 years later, since claims triggering a tender would not be asserted until long after the effective date of the statute. To obtain three years of valid experience, the test period would probably have to be at least 5 or 6 years long in those circumstances.

If the system applied to all claims asserted after the effective date of the statute, we would begin to see results within 6 months. In those circumstances, the test period could be as short as 3 to 4 years.

In order to avoid possible constitutional issues, the subcommittee recommends a 5 or 6 year test period, applicable only to injuries arising out of medical treatment after the effective date of the statute.

G. Miscellaneous Issues

There was some concern expressed that tenders would be considered in experience rating and that they would be reported to
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he subcommittee only to injuries ite of the statute.

Settlement of a claim by tender should be reported to the Board of Registration in Medicine just as any other resolution of a claim is reported (including dismissals, settlements and judgments).
AFFIDAVIT D

Esdaile, Barrett & Esdaile
Counselors at Law
Seventy-five Federal Street
Boston, Massachusetts 02110

Senator Linda Melconian, Chairperson
Special Legislative Commission on Medical Malpractice
State House, Room 504
Boston, MA 02133

Representative Frances Woodward, Chairperson
Special Legislative Commission on Medical Malpractice
State House, Room 254
Boston, MA 02133

Dear Co-Chairpersons:

The Blue Cross/Blue Shield Research Subcommittee of the Special Commission on Medical Malpractice met on a number of occasions during the last six months. As a result of these meetings, the group concluded that there is a need to obtain considerable additional information concerning the details of Blue Cross/Blue Shield operations here in the Commonwealth of Massachusetts.

Great credit must be given to the members of the subcommittee who gave many hours of their time in an effort to identify the types of information which would permit a responsible analysis of the Blue Cross/Blue Shield operation. Unfortunately, because the legislature in its wisdom has seen fit not to provide us with funds or with a full-time staff, the development of these questions has proven to be arduous and time consuming. I am informed that the most recent lengthy questionnaire was mailed to Blue Cross/Blue Shield only last week.

Indeed, to give you some idea of the complexity of the issues that we are dealing with, I am enclosing a new seven-page questionnaire for referral to the appropriate authorities of Blue Cross/Blue Shield. This new questionnaire picks up details which were not fully dealt with in the old questionnaire.
Under the circumstances, the committee feels strongly that we require more time to complete a meaningful gathering of information. We would, therefore, respectfully request through the Chairpersons of the Legislative Commission on Medical Malpractice an extension of time within which to complete this important work.

Respectfully submitted,

JAMES N. ESDAILE, JR.
Chairperson, Blue Cross/Blue Shield
Study Subcommittee
AFFIDAVIT E


The committee on Insurance, to whom was referred the petition (accompanied by bill, Senate, No. 490) of Linda J. Melconian, Frederick E. Berry, Martin T. Reilly, Walter J. Boverini, John P. Burke, William Q. MacLean, Jr., and Anna P. Buckley for legislation relative to increasing access to medical care for medical service corporation subscribers; the petition (accompanied by bill, Senate, No. 493) of Martin T. Reilly and Thomas M. Petrolati for legislation to require payments for certain medical services; the petition (accompanied by bill, Senate, No. 699) of Linda J. Melconian for legislation to allow freedom of choice for Medex subscribers; the petition (accompanied by bill, House, No. 1531) of Michael P. Walsh relative to clarifying the rights of subscribers to non-profit medical service plans; and the petition (accompanied by bill, House, No. 4958) of Michael P. Walsh and other members of the House relative to increasing access to medical care for medical service corporation subscribers, reports the accompanying bill (Senate, No. 1831).

For the committee,

LINDA J. MELCONIAN.

AN ACT RELATIVE TO INCREASE ACCESS TO MEDICAL CARE FOR MEDICAL SERVICE CORPORATION SUBSCRIBERS

Be it enacted by the Court assembled,

SECTION 1. As appearing in the then existing laws, "Non-Participating" provisions of insurance plans shall be hereby amended so as to strike out the following paragraph and to insert in its place the following paragraph:

A subscriber entitled to the services of a participating physician or the services of another person with a professional specialty entitled to the services of a participating chiropractor or participating medical or chiropractic provider under the terms and rules and regulations of the insurance plan participates in the practice of medicine, chiropractic or the like when outside the participating physician's regular practice area.

SECTION 2. As appearing in the then existing laws, adding the following paragraph:

A medical service corporation or other representative of a medical service corporation shall be considered to have participated in the practice of medicine, chiropractic or the like when outside the participating physician's regular practice area.

SECTION 3. As appearing in the then existing laws, striking out the following paragraph and inserting in its place the following paragraph:

A subscriber entitled to the services of a participating physician or the services of another person with a professional specialty entitled to the services of a participating chiropractor or participating medical or chiropractic provider under the terms and rules and regulations of the insurance plan participates in the practice of medicine, chiropractic or the like when outside the participating physician's regular practice area.
The Commonwealth of Massachusetts

In the Year One Thousand Nine Hundred and Eighty-Seven.

AN ACT RELATIVE TO INCREASING ACCESS TO MEDICAL CARE FOR MEDICAL SERVICE CORPORATIONS.

Be it enacted by the Senate and House of Representatives in General Court assembled, and by the authority of the same, as follows:

SECTION 1. Section 1 of Chapter 176B of the Geneal Laws is hereby amended by adding the following definition thereto:

"Non-Participating Physician", a physician registered under the provisions of chapter one hundred and twelve who does not agree in writing with a medical service corporation to perform medical service for subscribers and covered dependents.

SECTION 2. Section 7 of Chapter 176B of the General Laws, as appearing in the 1984 Official Edition, is hereby amended by striking out the sixth sentence as appearing in lines 37-44 thereof, and inserting in place thereof the following sentence:

A subscriber or a covered dependent, subject to the by-laws, rules and regulations of a medical service corporation and the terms and provisions of his subscription certificate, shall be entitled to the benefits of this chapter upon receiving medical or chiropractic service from any participating physician or participating chiropractor or from any non-participating physician or non-participating chiropractor, or upon receiving medical or chiropractic service from any physician or chiropractor when outside the commonwealth.

SECTION 3. Section 7 of Chapter 176B of the General Laws, as appearing in the 1984 Official Version, is hereby amended by adding the following paragraphs immediately after line 60 thereof:

A medical service corporation shall make available lists of participating physicians to subscribers or the employer, employees or other representatives of group subscribers. The words "usual
“fee” as used in this paragraph mean the fee usually charged by a non-participating physician for substantially similar services in other than emergencies to patients who are not subscribers or covered dependents of a medical service corporation. The words “direct pay covered services” as used in this paragraph mean covered medical services for which a medical service corporation customarily makes direct reimbursements to participating physicians. A non-participating physician, prior to establishing a physician-patient relationship between himself and such person (or for existing patients, prior to beginning a particular procedure or plan of treatment), shall inform such person that he is entitled to charge him, for direct pay covered services, an amount equal to his usual fee, that the medical service corporation will be obligated to reimburse such person eighty-five percent of what it would have paid a participating physician for such services and that such amount may be more than would be incurred by such person if he obtained the services of a participating physician. A non-participating physician shall be entitled to conclusively rely upon the most recently published list of such payments by a medical service corporation and approved by the Commissioner as to what such corporation customarily would have paid to participating physicians for a direct pay covered service. A non-participating physician shall furnish the patient with the names of participating physicians in a like specialty in the immediate geographic area so that the patient has the option of choosing a participating or non-participating physician. Should the patient choose the non-participating physician, such non-participating physician shall inform the patient that he or she may be responsible for the monetary difference between the amount allowed by the medical service corporation and the physicians usual fee. A subscriber or covered dependent shall be entitled to benefits for direct pay covered services rendered by a non-participating physician within the commonwealth at an amount equal to eighty-five percent of what a medical service corporation would have paid to a participating physician for such services. Where a direct pay covered service is rendered by a non-participating physician within the commonwealth such payment shall be made to the subscriber and not to the physician. The
the usually charged by the participating service corporation. The word "similiar services" are not subscribers of the applicable medical service corporation. The word "this" paragraph means that a patient has a right to participating or non-participating physician. Notwithstanding the provisions of this section, if any of the employees of an employer or organization required by this section to offer employees the option of selecting the services of a participating or non-participating physician are represented by a certified collective bargaining representative, the offer of the participating or non-participating option shall first be made to such collective bargaining representative. Said representative shall have the right not to accept such offer, thereby exempting the employer from the provisions of this section. If such offer is accepted by such representative, the offer of the option of selecting a participating or non-participating physician shall then be made to each employee.

Nothing in this section shall limit or derogate from the rights of beneficiaries of health insurance under Title XVIII of the federal Social Security Act to the benefits of Chapter 475 of the Acts of 1985.
AFFIDAVIT F
MEMORANDUM

TO: The Members of the Massachusetts General Court
FROM: Richard W. Moore, Executive Director
DATE: June 26, 1986

We at the JUA feel compelled to report on the state of medical malpractice insurance at this time. The reasons are two-fold: 1) we must bring to your attention a problem that threatens the operation of the JUA; and 2) we anticipate a strong reaction from your physician constituents to the measures we are required to take.

First a report on what this state’s physicians confront on and after July 1. They will receive malpractice insurance bills in three distinct areas:

1. Bills for insurance for their policy year 1987-1988;
2. Bills for a balance due on their insurance last year. Last year’s premiums were based on 1983 rates. Since 1986 rates have been approved, the difference is now collectible.
3. Bills for premiums deferred in the years 1983-85 when rates were frozen during litigation. The Medical Malpractice Reform Law of 1986 (c. 351) enables us to bill for premiums due us for that period. We will collect the approximately $104 million over a five-year period to minimize the impact of such costs.

Attachment #1 and #1A reports the cost of the 1987-1988 rates to physicians by rate class, breaks down by category the billings that will commence on July 1, and details the deferred premium liability. Clearly, the distress of the state’s medical community is not unjustified, though Attachment #2 presents evidence that the burden here compares favorably with other states. Chapter 351 also requires Blue Shield to increase its physician reimbursements beginning July 1 to reflect increased malpractice insurance costs.

What is critical is that you, as a present member of the General Court, which created the JUA in 1975, understand all that is involved in this matter — and all that is at stake. That requires a review of how, in 1975, faced with a crisis in the cost and availability of malpractice insurance, the General Court created this non-profit Joint Underwriting Association and delivered to it this mandate:
The purpose of the association shall be to provide medical malpractice insurance on a self-supporting basis.

Every year since its inception, the JUA has found it harder to do the job it was mandated to do. The essential problem has been the establishing of insurance rates that are inadequate to meet the genuine needs of the system. Steadily, over the twelve years of our existence, we have been forced into a position that is untenable — and that must become a matter of concern for the General Court.

Simply put, our job is to take in enough money to pay out claims to victims of malpractice. The money we take in comes from premiums paid by those we insure; the money we pay out goes to those persons who suffer malpractice. The fundamental problem is that we will be paying out hundreds of million more than we have taken in. We have almost a billion dollars in liabilities, but only $362 million in the bank, leaving a deficit of $711 million at the end of 1986. In fact, we have less money available now to pay claims than we had at the end of 1986.

We are taking steps to reduce that deficit. The five year rebilling which the General Court approved last year will bring in $104 million over the next five years. We have filed with the Insurance Division a plan for the recoupment of the $140 million deficit for the first seven years of our operation, 1975-1982, which, if approved, will be assessed against all doctors in the state.

But the fundamental question remains. Why are we paying out more than we're taking in? Because claim payments have exceeded predictions by the Division of Insurance. The rates the Division set have proved inadequate because the increase in the number of claims and the amount of each claim were greatly underestimated.

The result is that we are using money that should be set aside and invested for the future to pay the claims of the present — which, of course, means that when future claims must be paid, we will have to pay them by borrowing even more from the future: a kind of pyramidizing Ponzi scheme, an ever growing deficit well on its way to the billion dollar mark. One observer has declared: “If you were a private insurance company, the Insurance Division would put you into receivership.”

(See Attachment #3)
The Growing Deficit of the JUA

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<tr>
<th>Year</th>
<th>Deficit</th>
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<tbody>
<tr>
<td>1983</td>
<td>$309m</td>
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<tr>
<td>1984</td>
<td>$470m</td>
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<tr>
<td>1985</td>
<td>$600m</td>
</tr>
<tr>
<td>1986</td>
<td>$711m</td>
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Deficit = Income less Losses
Income (earned premiums + investment income) less Losses (paid losses + incurred claims)

The Growing Deficit is Attributable to Inadequate Rates
The Rates are Inadequate because . . . .
The Increase in both Claims Severity and Claims Frequency were Underestimated

* These calculations of the deficit are not discounted for future investment income because of the uncertainty of future investable assets and income.
Instead and ironically, the Division of Insurance, which has denied us the rates we need to do our job, believes it is acting in the best interest of "the consumer", in this case the state's doctors, in holding down premium costs and thus lessening the burden on physicians. In fact, the Division is only postponing a day of reckoning that will impact the next generation of doctors even more severely than physicians practicing now.

We urge special legislative attention to this situation. It is time for the General Court that created the JUA to review its function and to appreciate the reality of its continuing operation on a deficit basis. Like the state's unfunded pension liability, the JUA's rising deficit and its increasing inability to meet the mandate of the legislature must be confronted now before a dangerous situation becomes a full-blown crisis. My staff and I stand ready to aid and assist in whatever way possible such inquiry as the legislature may decide to make. We thank you for your consideration of this request.

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assets and income.
Medical Malpractice JUA
Premium Billing by JUA, beginning July 1, 1987
by Physician Rate Class
1987-1988 Policy Year

<table>
<thead>
<tr>
<th>RATE CLASS/ number of doctors in rate class</th>
<th>'87-'88 premium</th>
<th>Balance '86 policy year</th>
<th>One-fifth deferred premium liability</th>
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<tbody>
<tr>
<td>1A Psychiatry/668</td>
<td>$2359</td>
<td>$366</td>
<td>$329</td>
</tr>
<tr>
<td>1 General Practice (GP), Gynecology/5500</td>
<td>$4719</td>
<td>$2576</td>
<td>$914</td>
</tr>
<tr>
<td>2 GP-minor surgery, Emergency Medicine, Ophthalmology/1720</td>
<td>$7078</td>
<td>$3681</td>
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<tr>
<td>3 GP-surgery, Emergency Medicine — no major surgery/963</td>
<td>$12,134</td>
<td>$6692</td>
<td>$2361</td>
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<tr>
<td>4 Urology, Otolaryngology (ENT)/266</td>
<td>$16,987</td>
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<tr>
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<tr>
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<tr>
<td>7 Neurosurgery, Orthopedics, Thoracic Surgery/616</td>
<td>$38,828</td>
<td>$21,789</td>
<td>$7051</td>
</tr>
</tbody>
</table>

Premium amount is based on the purchase of an “occurrence policy” at limits of $1 million coverage per claim and $3 million maximum coverage for all claims arising from the policy year. Two-thirds of all JUA insured physicians purchase occurrence policies and 80 to 85% purchase $1 million/$3 million policy limits.
**Medical Malpractice JUA**

**Rate Decision, March 4, 1987**
by Mark Leymaster, Division of Insurance

- 1985 rates up 23.6% from 1984-5 rates
- 1986 rates up 8.7% from new 85-86 rates
- 1987 rates up 6.5% from new 86-87 rates

**Deferred Premium Liability — The Five Year Rebilling**

The deferred premium liability is the amount doctors owe the JUA for past policy years (83-84, 84-85, 85-86) when rates were the subject of litigation and the Legislature prohibited the collection of premium increases until July 1987. Chapter 351, the Medical Malpractice Reform Law of 1986, allows doctors to repay the deferred premium liability over the next 5 years at 11% interest.

The approximate total due for the three policy years is $104 million.

Beginning July 1, Blue Shield is required to increase physician reimbursements to reflect the new malpractice rates as well as the deferred premium liability.

The dollar amount any doctor will pay for his one-fifth deferred premium liability is, on an average, 19.55% of his or her 1987 premium. The calculation will depend on who remains in the JUA pool (has not died, become disabled, retired at age 65, or interns or residents who leave the state.) Senate bill 1705 would also take out doctors who were not insured by the JUA for all or part of the policy years 1983-1987.

**Three Part Premium Billing for Doctors beginning July 1, 1987**

1. New 1987 premium
2. Balance due on the 1986-1987 policy year
3. One fifth of the deferred premium liability

Attachment 1 details the cost of the 3 part premium billing by physician rate class.
This letter is in response to the experience of at least three malpractice changes in the Commonwealth of Massachusetts. The enactment of which took effect through November 1986. The industry has undertaken a few notable steps. With a few notable exceptions. The “Lawsuit Crisis” article in the June 3, 1986 issue of Insurance Information Institute has undertaken an analysis. Marcotte reported that a copy enclosed as Exhibit A, Executive Vice President. The “Lawsuit Crisis” article in the June 3, 1986 issue of Insurance Information Institute has undertaken an analysis. Marcotte reported that a copy enclosed as Exhibit A, Executive Vice President. The “Lawsuit Crisis” article in the June 3, 1986 issue of Insurance Information Institute has undertaken an analysis.

<table>
<thead>
<tr>
<th></th>
<th>General Practice</th>
<th>Obstetrics</th>
<th>Neurosurgery</th>
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<tbody>
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<td>$4,719</td>
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<td>$38,820</td>
</tr>
<tr>
<td>Florida</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Dade/Broward</td>
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<td>76,441</td>
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<td>$4,704</td>
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</tbody>
</table>

Premium comparisons are based on occurrence policies at $1 million/ $3 million coverage limits. Non-Massachusetts rates are those in effect as of February 1987. Several states noted that rate increases are pending or planned.

Sources: Mass Office of Consumer Affairs and Business Regulation and Mass Medical Malpractice JUA
June 30, 1987

Senator Linda J. Melconian
State House
Room 504
Boston, Massachusetts 02133

RE: Medical Malpractice; Chapter 351 of The Acts of 1986

Dear Senator Melconian:

This letter is in response to an inquiry from your office relative to the experience of at least one member of the Bar with the medical malpractice changes which were enacted last year, Chapter 351 of the Acts of 1986 entitled, “An Act Relative To Medical Malpractice”, the enactment of which received the governor’s approval on July 23, 1986.

With a few notable exceptions discussed below, juries in the Commonwealth of Massachusetts have, for the most part, been returning verdicts for defendants in meritorious medical malpractice cases. Through November 3, 1986, twenty-one (21) of twenty-two (22) medical malpractice verdicts taken in Suffolk Superior Court have been returned for the defendant. Similar statistics were available in the Middlesex Superior Court and continue to today. The insurance industry has undertaken a media blitz which primarily occurred in 1986. The industry affectively reached “90% of the American population”. The “lawsuit crisis” promotion promulgated by the Insurance Information Institute has proved to be very effective. In the June 3, 1986 issue of the American Bar Association Journal, Paul Marcotte reported the magnitude and effectiveness of the media blitz (a copy enclosed as Exhibit “A”). Mr. Marcotte quoted Charles Clark, Executive Vice President of the Insurance Information Institute, that “The Lawsuit Crisis” ads “...are expected to reach 90% of the American population”. As you are aware, Senator, lawyers in this state have an extremely limited right to jury voir dire. Accordingly, I believe that this media blitz has been extremely effective. Also, the advertising on television, radio and in print by the Massachusetts Medical Society has proven to be very effective.
In the June 27, 1987 issue of Massachusetts Lawyers Weekly, there appeared a story regarding the Claim Evaluation Project commissioned in December, 1986 by the Insurance Services Office, the insurance industry's rate-making arm. This study was recently released by the National Insurance Consumer Organization (NICO), a nation wide insurance consumer coalition. That study, after surveying 1,200 insurance adjusters, concluded that the financial impact of the recently enacted "tort" changes generally ranged from "marginal" to "imperceptable" (see Exhibit "A1").

With regard to the one year experience under Chapter 351 of the Acts of 1986, some of these provisions have not had any perceptible impact at all since they only relate to actions commenced on or after November 1, 1986 — Section 20 regarding the admissibility of Tribunal findings and proceedings for counsel fees in frivolous cases; Section 21, change in the plaintiff's bond requirement following an adverse finding by the Medical Malpractice Tribunal; Sections 23, 29, and 30, changes in the statute of limitations; and Section 27, limitations on plaintiff's attorney's fees. Section 24 regarding itemized verdicts and Section 25 regarding the collateral source offset became effective on any judgment, findings or other dispositions entered on or after November 1, 1986 (which in 1986 was a Saturday). This firm probably received the first itemized verdict under Section 24 on November 3, 1986 in the case of William J. Harlow, Jr. Vs. Massachusetts General Hospital, et al., Suffolk docket number 59041. That particular case was sent to the jury on Thursday, October 31, 1986 with a non-itemized verdict slip. The law changed during jury deliberations and they were then provided with an itemized verdict. A copy of that itemized verdict is attached as Exhibit "B1".

In my opinion, itemized verdicts are working quite well. They do allow the Court to review what elements the jury considered when it entered an award. I will discuss three (3) itemized verdicts below.

**Harlow Vs. Massachusetts General Hospital, et al.**

William Harlow, at the time of the verdict, was a forty-one (41) year old unmarried male who was rendered quadriplegic in February/March, 1982 as a result of negligent non-treatment at the Chelsea Unit of the Massachusetts General Hospital. The defendant, Dr. Chin, was a salaried employee of Massachusetts General Hospital. The hospital...
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Pursuant to Section 24 of Chapter 351 of the Acts of 1986, the jury

At trial, before District Court Judge Ernest S. Hayeck, sitting by designation on the Superior Court, the plaintiff offered into evidence, through Professor Harold Goldstein, a Medical Economist from Northeastern University, figures regarding past and future loss of earning capacity and future medical expenses. Furthermore, evidence was introduced regarding work-life expectancy (22 years) and life expectancy (31.5 years). Professor Goldstein is a reputable expert who has testified in numerous cases in Massachusetts and throughout the country in his field of Medical Economics. When the case was argued to the jury on Thursday, October 30, 1986, the plaintiff was not allowed to use a blackboard or any charts whatsoever to bring the actual special (economic) figures, once again, to the attention of the jury. Also, when the case was argued, there was no itemized verdict slip pursuant to Section 24 of Chapter 351 of the Acts of 1986 since as of that date, the law was not effective.

Monday morning, November 3, 1986, the jury was brought back in and instructed by the Court on how to fill out the new supplementary verdict slip (2 pages as questions 7(a) through (g)), and without the benefit of further argument, retired to reach its results.

Five (5) hours later, the jury's total award of special (economic) damages of Three Million Six Hundred and Fifty-Six Thousand Dollars ($3,656,00.00) was 99.9% of the figure that the plaintiff introduced (in subsections), even though the jury did not have the benefit of the breakdown of the figures during final argument, four (4) days earlier. On the itemized verdict slip with regard to past medical bills, the evidence introduced by the plaintiff (but not agreed to by the defendant) was that the medical bills to time of trial totalled One Hundred and Sixty-Eight Thousand One Hundred and Ninety-One Dollars and Forty-Three Cents ($168,191.43). The jury awarded
Five Hundred and Fifty-Five Thousand Dollars ($555,000.00) on question 7a for past medicals.

With regard to future medical expenses, the evidence introduced by Professor Goldstein, over defendants' objection, totalled Three Million Twenty-Three Thousand Six Hundred and Thirty-Five Dollars ($3,023,635.00) and that this amount was to last Mr. Harlow for 31.5 years. Dr. Goldstein testified that “quadriplegia is the most severe disabling, financially disabling type of medical problem one can have and still be alive.” The jury, in response to question 7(b), awarded Two Million Six Hundred Thousand Dollars ($2,600,000.00) in future medical expenses and in question 7(g)(b) gave that award for 31.5 years.

With regard to lost earning capacity, through Professor Goldstein, the plaintiff introduced past loss of earning capacity in the sum of Sixty-Six Thousand Nine Hundred and Eighty-Nine Dollars ($66,989.00). That sum had been reduced back to present value to the date of the injury (March 5, 1982) even though the law only requires that said sum be reduced back to the date of the suit, in Harlow's case, December 28, 1986. The jury, in question 7c, awarded Seventy-Seven Thousand Dollars ($77,000.00) in past loss of earning capacity.

With regard to future loss of earning capacity, Professor Goldstein introduced the sum (reduced to present value at time of trial) of Four Hundred Thousand Two Hundred and Forty-Four Dollars and Twenty Cents ($400,244.20) assuming working for twenty-two (22) future years (to age sixty-three (63) only). The jury awarded future loss of earning capacity in response to 7(d) in the amount of Four Hundred Twenty-Four Thousand Dollars ($424,000.00) and in response to 7(g)(d) awarded that sum for twenty-two (22) years, the work-life expectancy testified to by Professor Goldstein.

With regard to past pain and suffering, the jury awarded One Million Four Hundred Thousand Dollars ($1,400,000.00) in response to 7(e), and with regard to future pain and suffering, the jury awarded, in response to 7(f), Two Million Six Hundred Thousand Dollars ($2,600,000.00) which future sum for pain and suffering (non-economic) was to compensate the plaintiff for 31.5 years (answer 7(g)(f)). Even though quadriplegic, Bill Harlow, experiences constant pain in his upper legs.
At post-trial motions, the discrepancy between the evidence on past medical bills and the jury's award on past medical bills as well as Professor Goldstein's testimony on future medical expenses as opposed to the jury's award of future medical expenses were discussed. Basically, the jury appeared to have awarded too much money for past medical bills, approximately Five Hundred Fifty-Five Thousand Dollars ($555,000.00) when only One Hundred Sixty-Eight Thousand Dollars ($168,000.00) of bills were introduced and shortchanged the plaintiff on future medical bills since Professor Goldstein testified that such bills would exceed Three Million Dollars ($3,000,000.00) and yet the award was only $2.6 Million Dollars ($2,600,000.00). Of course, adding past and future medical bills as awarded by the jury together and adding Professor Goldstein's testimony regarding future medical bills and the evidence of past medical bills introduced are approximately equal to each other.

In January, 1987, Judge Hayeck remitted the past medical bill award of Five Hundred Fifty-Five Thousand Dollars ($555,000.00) to One Hundred Sixty-Eight Thousand One Hundred and Ninety-One Dollars and Forty-Three Cents ($168,191.43) but denied the plaintiff's motion to add Four Hundred Thousand Dollars ($400,000.00) to the award of future medical bills.

Other than the remittitur referred to above on past medical bills, the Court affirmed the verdict in January, 1987 and the defendants have claimed an appeal. The plaintiff has filed a cross-appeal on the grounds that the jury had no basis for finding 13% contributory negligence.

Parissi Vs. Johnson, et al.

In June, 1987, before Judge Mel Greenberg, at the Worcester Superior Court, a jury returned a verdict for the plaintiff in Parissi Vs. Russell Johnson, et al., Worcester docket number 84-27302, in a total amount of Five Million Fifteen Thousand Dollars ($5,015,000.00). A copy of one of those verdict slips is enclosed as Exhibit “Cl”. This case involved a baby who was quadriplegic and was rendered so during the birth process. This case was tried by Attorney Drew Meyer of Lubin & Meyer of Boston, Massachusetts. At that trial, Professor Harold Goldstein testified that the special damages (medical-economic) for the future for this victim was Four
Million Five Hundred Fifty-Three Thousand Four Hundred and Seventy-Four Dollars ($4,553,474.00). The jury awarded future medical expenses of Four Million Six Hundred Thousand Dollars ($4,600,000.00) and awarded future earning capacity for this five (5) year old baby in the amount of One Hundred and Sixty Thousand Dollars ($160,000.00). I do not know the other amounts awarded which netted a total verdict of Five Million Fifteen Thousand Dollars ($5,015,000.00), which amount was to last her for her life. This case is awaiting post-trial motions to be heard by the trial judge.

Wheble Vs. Rampone

On June 19, 1987, Attorney Camille Sarrouf, President of the Massachusetts Academy of Trial Attorneys, received a plaintiff’s verdict in a malpractice case in the Hampshire Superior Court sitting at Northampton, Wheble Vs. Rampone, Hampshire docket number 84-350. A copy of the jury questionnaire and judgment are enclosed as Exhibits “D1”. Wherein the figures are typed, those were agreed upon by the parties, and wherein they are hand-written, those were amounts entered by the jury. For example, question number 4 is the amount of Three Hundred Seventy-Two Thousand Dollars ($372,000.00) for future pain and suffering, and that amount was arrived at by the jury, whereas past loss of earning capacity, question number 5, was agreed to in the amount of Four Hundred Dollars ($400.00). I am unfamiliar with the facts of the Wheble case. The economic damages appear to be Eight Thousand One Hundred Eighty-Eight Dollars and Sixty-One Cents ($8,188.61) and the remainder of the verdict is for pain and suffering (non-economic) damages. Again, post-trial motions are pending in this case.

A $7 Million Dollar Verdict in Non-Medical Malpractice Case

With regard to jury verdicts (non-itemized), the case of Wu Vs. Freezing Equipment Sales, Inc., Suffolk docket number 66690, is worthy of discussion. In this case, the plaintiff, age 34 and married at the time of trial, suffered severe burns, blindness in one eye, and other injuries as a result of the defendant’s negligence. The case was tried to a jury in Boston, Massachusetts before Judge Cortland A. Mathers. Judge Mathers formerly was an insurance defense lawyer in Brockton, Massachusetts. Special (economic) damages introduced into the case through an economist, Richard Siegal, totalled as
Itemized Non-Massachusetts Verdicts

I wish to bring two (2) other cases to your attention since they involve disastrous injuries and itemized verdicts.

On October 31, 1986, a former attorney in Chicago, Illinois who was disastrously injured due to medical negligence received a jury verdict which totalled, without interest, $15.8 Million Dollars. $9.7 Million Dollars of that verdict were for non-economic damages. A copy of the Chicago Daily Law Bulletin report of the case as well as a copy of the actual jury verdict slip are attached as Exhibit “F1” for your review. Post trial motions for remittitur were denied and the case is currently awaiting appeal.

Also in the Ohio case of Hawkins Vs. Bedford Municipal Hospital, a little boy in a medical malpractice case was awarded $8.5 Million Dollars in damages this past fall. (see enclosed copy of National Law Journal issue of Monday, January 19, 1987 as Exhibit “G”). According to the National Law Journal, the jury awarded Two Million Dollars for pain and suffering (non-economic) damages, $4.6 Million Dollars for future medical expenses, Seven Hundred Thousand Dollars ($700,000.00) for his lifetime loss of earnings, and awarded his parents $1.2 Million Dollars for their care of this little boy and their loss of his services.

In conclusion on the itemized verdict change, Section 24 of Chapter 351 of the Acts of 1986, I believe that this is an admirable change and probably would be useful in all tort cases, not just those involving medical malpractice.
Collateral Sources

With regard to Section 25 of Chapter 351 of the Acts of 1986, namely collateral sources, the only case that I am aware of to date which goes into that matter in detail, is again, my case of William J. Harlow, Jr. Vs. Massachusetts General Hospital, et al. I enclose a copy of plaintiff's Memorandum of Law (see Exhibit "H") on that issue which was prepared by this office in association with Professor Peter A. Donovan of Boston College Law School arguing that since all the sources of collateral help available to Mr. Harlow were based on state or federal law, no collateral source reduction was appropriate. I also enclose a copy of the first fifteen (15) pages of the transcript of the post-trial hearings before Judge Hayeck on January 16, 1987. The Court agreed with the position set forth in our Memorandum of Law. Interestingly, Attorney Jean Farrington for the Welfare Department of the Commonwealth of Massachusetts, appeared and explained to the Court the sources of payment. Furthermore, she agreed with Mr. Harlow that there should be no reduction since the funds provided to Mr. Harlow were jointly funded by the state and federal governments. (See Exhibit "H2", pages 3, 4 and 5). The Court agreed with our position on collateral sources and refused to reduce the remitted award of One Hundred Sixty-Eight Thousand One Hundred Ninety-One Dollars and Forty-Three Cents ($168,191.43) for past medicals.

One development with regard to the so-called collateral source rule, Section 25 of Chapter 351 of the Acts of 1986 has been that the Joint Underwriting Association and Risk Management Foundation have taken the position that they need not, in settlement as opposed to verdicts or judgments, repay collateral sources. The statute says that it only applies to verdicts ("if the jury returns a verdict..."). Accordingly, some private (not state or federal government payors) have taken the position that they are in fact entitled to their money back since Section 24 only applies to verdicts. This results in an untenable scenario since the malpractice insurance carriers are refusing to compensate the victims for these sums, yet the private payors demand repayment. Some clarifying legislation in this matter would be appropriate and helpful.
the Acts of 1986, aware of to date y case of William, et al. I enclose hibit “H”) on that on with Professor arguing that since Larlow were based n was appropriate. of the transcript January 16, 1987. our Memorandum 1 for the Welfare etts, appeared and Furthermore, she eduction since the d by the state and and 5). The Court refused to reduce it Thousand One ents ($168,191.43)
lateral source rule, seen that the Joint Foundation have ent as opposed to e statute says that ns a verdict...”). gernment pays) ed to their money This results in an ance carriers are us, yet the private tion in this matter

**Caps on General Damages**

With regard to the cap on general (non-economic) damages set forth in Section 26 of Chapter 351 of the Acts of 1986, this Section only affects injuries on or after November 1, 1986. In the aforementioned cases of Harlow, (Exhibit “B1”), Parissi, (Exhibit “C1”), Wheble (Exhibit “D1”), and Wu (Exhibit “E1”), all four of these cases, with the possible exception of Wheble (because I do not know what the injuries were), would have and did merit awards for general (non-economic) damages in excess of Five Hundred Thousand Dollars ($500,000.00). Harlow and Parissi are quadriplegics and Wu has disastrous injuries including loss of sight, second and third degree burns, etc. Accordingly, I believe that Section 25 of Chapter 351 of the Acts of 1986 as enacted is appropriate.

In conclusion, I enclose (as Exhibit “I”) a copy of the decision of the Florida Supreme Court of April, 1987 wherein the Florida Supreme Court finds unconstitutional under the Constitution of Florida a medical malpractice cap on general damages of $450,000.00.

In closing, I wish to thank you very much for allowing me to share with you my experiences of the past year under the new malpractice statutes and to bring to your learned attention the enclosed materials.

Respectfully,

Frederic N. Halstrom

FNH:bkc
Enclosures

cc: William J. Harlow, Jr.
    Camille Sarrouf, President MATA
    Alice Richmond, President MBA
    Ben Fierro, Legislative Counsel, MBA
    Edward W. Smith, Legislative Counsel, MATA
    Michael E. Mone, Esquire, Past President MATA
    Thomas E. Connelly, Esquire, Treasurer MATA
    Leo V. Boyle, Esquire, Chair, MBA Tort Action Committee
    James F. Meehan, Esquire, Past President MATA
    Paul R. Sugarman, Esquire, Chair, MBA Medical Malpractice Action Committee
I. The New Medical Malpractice Statute Requires Deduction Only Of Those Items Of Cost Or Expense Included In The Jury Award Which Have Been Paid By Collateral Sources Which The Plaintiff Does Not Have To Repay

The legislative purpose behind Chapter 351 of the Acts of 1986 is clear. In enacting the statute, the Legislature decided that the amount of a jury award of damages to a medical malpractice victim should be reduced by an amount equal to the benefits received by the plaintiff from sources other than the defendants, that is, from so-called “collateral sources”. The obvious intention of the Legislature was to avoid a duplicative recovery by the plaintiff. To the extent that the plaintiff had already received benefits to compensate him for a loss and to the further extent that he was not obligated to repay the benefits so received, the Legislature concluded that there was no need to compensate him again for the same loss or expense. Accordingly, the new medical malpractice statute provides that the jury award is to be reduced by the amount of such non-repayable collateral source benefits.
However, while the Legislature intended to avoid a double recovery, it did not intend that there be any deduction from the jury award for any benefit received which the plaintiff would have to repay. Reduction of the award by the amount of benefits which the plaintiff would have to repay would not serve to avoid a double recovery. Instead, it would operate to punish the innocent victim of malpractice by depriving him of compensation needed to make him whole. The new statute did not intend this result. It operates as follows.

Under new G.L. c. 231, Section 60G(a), as inserted by St. 1986, c. 351, sec. 25, the court is directed to hear “evidence of any amount of...damages incurred prior to the judgment which the defendant or defendants claim was replaced, compensated or indemnified pursuant to the United States Social Security Act, any state or federal income disability...act...or any other source of collateral benefits whatsoever...”. To the extent that such item of damages are in fact “replaced, compensated or indemnified from any collateral source”, subsection (b) provides that the court “shall reduce the amount of the award by such finding”. The key language is that such items of damage must truly be “replaced, compensated or indemnified” by collateral source benefits. Obviously, such items are not “replaced” by collateral source benefits if the victim is obligated to repay the collateral source. Nor is the victim “compensated” if he must reimburse the collateral source for any cost or expense temporarily paid by that source. Obviously, the victim has not been “indemnified” if he, in turn, must reimburse the collateral source temporarily paid by that source. Where reimbursement occurs, it is the victim that truly indemnifies the collateral source. The plain meaning of the words utilized by the Legislature, “replaced, compensated or indemnified”, clearly state an intention to deduct only those collateral source benefits that do not have to be repaid. Where the victim remains legally obligated to reimburse the collateral source payer, the items of cost or expense included in the jury award are truly not “replaced, compensated or indemnified” within the language or intent of the statute.

A. There Can Be No Deduction For Collateral Source Benefits Which Must Be Repaid Under Federal Law
This position is clearly recognized by the proviso to subsection (c) of Section 25 of Stat. 1986, c. 351 (inserting G. L. c. 231, sec. 60G(c)) which covers collateral sources in federal law and which states, in pertinent part:

provided that, if the plaintiff has received compensation or indemnification from any collateral source whose right of subrogation is based in any federal law, the court shall not reduce the award by the amounts received prior to judgment from such collateral source and such amounts may be recovered in accordance with such federal law.

B. Collateral Source Benefits Covered By Massachusetts Law Are Deductable Only To The Extent Covered By G. L. c. 111, Sec. 70A

This same principle that the plaintiff’s award should be not reduced by the amounts of collateral source benefits he must repay under state law is also recognized in new sec. 24(c) of c. 231 (inserted by Statute 1986, c. 351, sec. 60G(c)) which provides that:

Notwithstanding the provisions of [G.L. c. 111, sec. 70A], no entity which is the source of the collateral benefits by which the court has reduced the award to the plaintiff hereunder shall recover any amount against the plaintiff, nor shall it be subrogated to the rights of the plaintiff against the defendant, nor shall it have a lien against the plaintiff’s judgment, on account of its payment of the benefits by which the court has reduced the amount of the plaintiff’s damage.

It is observed that this last provision of new sec. 24(c) applied “notwithstanding the provisions of section seventy A of chapter one hundred and eleven [i.e., c. 111 sec. 70A] of the General Laws”. However, the new statute does not affect any recovery or subrogation rights of, nor any liens protecting, collateral source payers existing under other provision of Massachusetts law. Therefore, the medicaid liens existing under G. L. c. 18 sec. 5G have not been extinguished by the new medical malpractice statute and remain in full force and effect.

C. The Burden Is Upon The Defendants To Establish For Each Deduction Claimed That The Item Was Included Within The Jury Award And Is Not Subject To Reimbursement By The Plaintiff
The burden of proof is upon the defendants to establish the right to each and every collateral source deduction it claims. To this end, the judicial hearing authorized by the new medical malpractice statute (G. L. c. 231, sec. 60G(a), inserted by Statute 1986, c. 351, sec. 25) is limited to “evidence of any amount of such damages” included in a jury verdict which were “incurred prior to judgment which the defendant or defendants claim was replaced, compensated or indemnified.” Under new sec. 60G(b), deduction is to be made only “[i]f the court finds that any such cost or expense was replaced, compensated or indemnified.” Therefore, it is incumbent upon the defense to prove two things for each item of cost or expense for which it claims a deduction. First, the defendant must prove that the specific cost or expense is included within the jury award, otherwise there would be no need of a reduction to avoid a double recovery. Second, the defendant must sustain the burden of proving that the specific cost or expense has been “replaced, compensated or indemnified” within the meaning of the statute, that is, the defendant to repay the specific costs or expenses involved.

II. No Deductions For Collateral Source Benefits Are Appropriate In This Case

In this case, the plaintiff has received collateral source benefits from five sources, two federal and three state. The source of the federal benefits are the Social Security Administration (SSA) and the Housing and Urban Development Agency (HUD). On the state level, medicaid benefits have been received from two agencies, the Department of Public Welfare and the Boston Center for Independent Living, Inc., with the latter agency administering a medicaid funded program for personal care attendant service.

A. No Deductions Are Appropriate For Benefits Received From The Social Security Administration

Pursuant to the United States Social Security Act, 42 U.S.C. sec. 401 et seq., the plaintiff has, and is receiving, both disability (SSD) and supplemental income (SSI) benefits as well as medical assistance in the form of medicare benefits. All of these benefits are interrelated and subject to the same recovery provisions. The medicare benefits to which the plaintiff is entitled include SSD payments because the plaintiff qualifies as a disabled worker. (20 C.F.R. 404 1505). He is
also receiving SSI benefits because he is disabled. (42 U.S.C. sec. 1381, et. seq., 20 C.F.R. sec. 416 et seq.) These programs integrate state and federal funding and disbursement activities.

The federal statutes and the regulations require reimbursement by the recipient and/or provider of these funds. The medicare statute on recoveries provides that payment “may not be made” if the item or service has been covered, or can reasonably be expected to be promptly covered, by liability insurance. 42 U.S.C. sec. 1395y(b)(1). Liability insurance is defined to include “medical malpractice insurance.” 20 C.F.R. sec. 405.322(b). Where such insurance is in effect, the statute provides that payments “shall be conditioned on reimbursement” and that “[t]he United States shall be subrogated (to the extent of payment made...) to any right of an individual...to payment...under such...insurance.” 42 U.S.C. sec. 1395y(b)(1). The regulations provide that “[m]edicare payment may not be made for any services to the extent that payment...can reasonably be expected to be made under...any liability insurance policy or plan”. “If payment was erroneously made” by [the Health Care Finance Administration] HCFA the regulations provided both that “the payment is subject to recovery” (20 C.F.R. sec. 405.322(c)(2)) and “will be recovered from the provider, supplier, or beneficiary who received the Medicare payment” 20 C.F.R. sec. 405.322(d)(1). Finally, the regulations provide that “the amount to be recovered from the beneficiary is the amount Medicare paid, less a proportionate share of the costs of procuring the judgment or settlement.” 20 C.F.R. sec. 405.324(b)(1).

Similar provisions exist for recovery from a third party obligor of federal funds disbursed through a participating state agency. Under 42 U.S.C. sec. 1396a(a)(25), “[a] State plan for medical assistance must —

(25) provide (A) that the State or local agency administering such plan will take all reasonable measures to ascertain the legal liability of third parties to pay for care and services (available under the plan) arising out of injury, disease, or disability, (B) that where the State or local agency knows that a third party has such a legal liability such agency will treat such legal liability as a resource of the individual on whose behalf the care and services are made available for purposes of paragraph (17)(B), and (C) that in any case where such a

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legal liability is found to exist after medical assistance has been made available on behalf of the individual and where the amount of reimbursement the State can reasonably expect to recover exceeds the costs of such recovery, the State or local agency will seek reimbursement for such assistance to the extent of such legal liability.

Since all of the medicare benefits are thus subject to reimbursement, there can be no reduction in the amount of the jury award for any of such payments.

B. No Deduction For Benefits Received From HUD, SSI Or SSD Are Appropriate Since None Of These Benefits Were Included Within The Jury Award

With respect to the housing benefits from HUD and the benefits from SSI and SSD received by the plaintiff, there is no basis for any collateral source reduction for the simple reason that the jury did not include any of these benefits in its verdict. There was no evidence before the jury as to the amount of the differential between the rental payments made by the plaintiff and any supplement by HUD nor was there any evidence before the jury as to the amount of SSI or SSD benefits received. In fact there was no evidence with respect to any amounts received from these sources at all. Consequently, the jury could not have included the HUD, SSI and/or SSD benefits in its award. There is no basis, therefore, for any reduction for these collateral source payments.

C. No Deductions Are Appropriate For Medicaid Benefits Received From State Sources Since These Are Subject To Reimbursement Pursuant to G. L. c. 18, sec. 5G

The remainder of the collateral source benefits have been received by the plaintiff as medicaid benefits under state law. For all of these benefits, the Department of Public Welfare for the Commonwealth of Massachusetts, has perfected its lien under G. L. c.18, sec. 5G. Since new sec. 60G(c) of G. L. C. 231 (as inserted by Statute 1986, c. 351, sec. 24(c)) has repealed only the liens existing under c. 111, sec. 70A, and has no effect upon any other liens, the plaintiff is obligated to repay to the state the full amount of the liens claimed under c. 18 sec. 5G. Accordingly, there can
be no deduction from the jury verdict for any amounts paid by the state recoverable under c. 18, sec. 5G.

In the abundance of caution, plaintiff points out that the personal care attendance service he has received from the Boston Center For Independent Living are medicaid benefits covered by the lien assented by the state under c. 18, sec. 56. To the extent that the full amount of these services have not been paid by the Boston Center For Independent Living, therefore, plaintiff remains liable for their payment. Therefore, no deduction for personal care attendant services are appropriate.

Conclusion

Since all of the benefits which the plaintiff has received from the collateral sources which have been included within the jury award must be repaid by the plaintiff under either federal and/or state law, the defendants are not entitled to any deductions from the jury verdict. Accordingly, the motion of defendants for collateral source benefit deductions must be denied.

Respectfully submitted,

Frederic N. Halstrom
HALSTROM LAW OFFICES, P.C.
132 Boylston Street
Boston, Massachusetts 02116
(617) 262-1060

CERTIFICATE OF SERVICE

I, FREDERIC N. HALSTROM do hereby certify that on this 14th day of January, 1987, I served a copy of the aforementioned " Plaintiff's Memorandum Regarding The Hearing Under Massachusetts General Law Chapter 231, Section 60G Relative to Collateral Source Benefits Received by A Medical Malpractice Victim" by hand-delivering a copy thereof to the Defendant's counsel of record: Richard Melick, Esquire and George Wakeman, Esquire, Melick & Porter, 11 Arlington Street, Boston, Massachusetts 02116.

FREDERIC N. HALSTROM
COMMONWEALTH OF MASSACHUSETTS

SUFFOLK, ss.

SUPERIOR COURT
No. 59041

**************************

WILLIAM HARLOW, *
Plaintiff,

* VS.

* DANNY CHIN AND
* MASSACHUSETTS
* GENERAL HOSPITAL,
* Defendants.

*

**************************

Before: Hayeck, J.

HEARING ON MOTIONS

Appearances:

FREDERICK HALSTROM, ESQ., 132 Boylston Street, Boston, MA 02116, on behalf of the Plaintiff.

RICHARD P. MELICK, ESQ., Melick & Porter, 11 Arlington Street, Boston, MA 02116, on behalf of the Defendants.

Also present:

Maureen Griffin, Esq.
George Wakeman, Jr., Esq.

Friday, January 16, 1987

JULIET BAIRD ALEXANDER
CERTIFIED COURT REPORTER

THE COURT: Okay. The case is the case of Harlow against Doctor Danny Chin of the Massachusetts General Hospital. The attorneys are all here: Frederick Halstrom and Maureen Griffin for the plaintiffs, Attorney Richard Melick and George Wakeman, Jr. is with him for the defendants.
We are here, first of all, to address this morning, the motion of the defendants for an order to compel further answers to interrogatories by the plaintiff. That's the one, isn't it?

MR. MELICK: Yes, your Honor.

THE COURT: Okay. All right. Now, your position is — I heard from you a moment ago before we went on the record, is that Mr. Halstrom, you have furnished everything you have got, is that your position?

MR. HALSTROM: Correct, your Honor. We have inquired of Social Security, we have inquired of every source of income or funding that Mr. Harlow has received.

THE COURT: Now, will you tell us, on the record, what you say the sources of Mr. Harlow's income are that we would be interested under this motion.

MR. HALSTROM: Mr. Harlow, since he was injured on February 11th, 1982, has received no benefits from any private insurer of any kind. At the time of the incident, he had no private insurer of any kind. At the time of the incident, he had no private health insurance; he had no private disability insurance. He never received workman's compensation benefits. He received nothing. He has never, personally, paid a bill in his life for anything that has happened as a result of these injuries.

THE COURT: Did he make any other recovery from anybody else, any kind of a tort claim or a negligence claim, contract claim, workman's comp claim, any kind of claim?

MR. HALSTROM: None. Nothing. No compensation, no collateral source benefits at all. The people that have been paying his medical bills and the people that have been paying his housing bills have been the state and federal governments. He has been collecting some from Social Security Disability, Social Security Supplemental Income. He has been receiving reduced housing benefits from H.U.D., or whatever the federal agency is now. And, his medical bills and personal care attendant bills —

THE COURT: Is that that Center for —

MR. HALSTROM: They are either being paid by medicare or Medicaid; one's a federal program and one's a state program. The state program, as I understand it, is being reimbursed by federal funds from the federal government.
THE COURT: Which state program? Are you talking about the welfare payments he has been receiving?

MR. HALSTROM: I think, in part, your Honor, yes. Not a hundred percent.

THE COURT: Let the record show that Attorney Farrington is here from the Welfare Department of the Commonwealth of Massachusetts, right, Attorney Farrington?

MS. FARRINGTON: Yes, your Honor.

THE COURT: Your first name, please, for the record?

MS. FARRINGTON: Jean.

THE COURT: Spelled?

MS. FARRINGTON: J-E-A-N.

MR. HALSTROM: She might be the one who knows how the payments are made.

THE COURT: Well, let me ask Attorney Jean Farrington, what her records from that department show that Mr. Harlow has been paid or what he has received and where it came from.

MS. FARRINGTON: Our records, your Honor, are in the form of a print-out which is maintained in a computer-based system, which orders these payments for each individual who receives medicaid.

THE COURT: What is the source of the payment? Medicaid, Medicare, public welfare — what’s it called, so that we can put it on the record.

MS. FARRINGTON: Your Honor, it is the Medicaid program, which is administered by the Department of Public Welfare. This is a program which is jointly funded by the state and federal governments.

The way it operates is that the state expends funds and we are reimbursed for approximately fifty percent of the payments which are actually made on behalf of Medicare recipient by the federal government.

THE COURT: All right.

MS. FARRINGTON: Medicare is a separate program of medical assistance which is — the state does not administer; it is administered entirely by the Social Security Administration.

THE COURT: Okay. Thank you very much. Is there anything that you want to add?
MS. FARRINGTON: I would, simply, I don't know how much argument you wish to hear on the —

THE COURT: I run a friendly delicatessen. There is no jury here before me on a Motion for Further Answers so you tell me anything you want.

MS. FARRINGTON: Well, I would simply point out, your Honor, that the Department of Public Welfare agrees with the position taken by the plaintiffs in this proceeding.

THE COURT: Woops. I guess we have gone too far. Now you are telling me what the law is and you will have to leave that to me. In a little while, when I need some help, I will ask you about that. All right. And, by the way, I can use all of the help I can get in this case, since it is a matter of first impression. I have a statute in my hand; it is right before me and I am looking at section 25, I believe it is 25 C, all right and I have got it right in front of me, and, incidentally, I have had it right along.

Okay, now what else is there besides those things that you have ticked off for us already, Mr. Halstrom?

MR. HALSTROM: I would ask Ms. Griffin.

THE COURT: Maureen.

MS. GRIFFIN: Your Honor, that, in total, are all of the sources of collateral benefits which Mr. Harlow has received.

THE COURT: Maureen, is it your understanding, as Fred has just said that all of these collateral sources have their basis in state and/or federal funds?

MS. GRIFFIN: Yes, your Honor.

THE COURT: Indeed, did he receive anything that the federal government didn't at least contribute to partially?

MS. GRIFFIN: No. All of the medical payments, which Mr. Harlow received and the subsidies for his housing and all of his income since the accident, in fact, has been derived from both state and federal sources. He has had no independent collateral source benefits, whatsoever.

THE COURT: Okay. All right. Now, the next question we have to press is whether or not there was a sufficient disclosure to Mr. Melick of the information that he requested in the interrogatories and I want to hear from Mr. Melick on that. Okay, Mr. Melick.
MR. MELICK: I would start from the beginning, if your Honor please, because this is the first time that I have spoken on the record and I want to, again, state to the Court that prior to the trial of this case, plaintiff counsel addressed the issue of a trial date with Judge Connolly in Suffolk Superior Court and argued that this statute would be effective November 1, because it was prejudicial to his client; his client would lose substantial sums of money if the new statute became effective prior to the verdict, as a result of the collateral source issue.

I am, now, therefore surprised to find both he and Ms. Griffin, agreeing to the Court that the collateral source aspect of this statute does not apply to this case because that was not his previous position.

Insofar as the duty of one of the parties under the statute, I agree that it is the defendant's duty, but I would remind the Court, respectfully, that there are two matters here that address that.

One is, there was an understanding between your Honor, plaintiff counsel and me, as defense counsel, that this information would be supplied. Although it is the burden of the defendant to do so, by a cooperation between plaintiff counsel and defense counsel, by virtue of the defendant filing interrogatories and the plaintiff filing answers thereto. I do not find that the agreement has been adhered to.

That brings me to my second comment.

THE COURT: I'm not trying to cut you off, Dick, I want to find out what was filed. (Court and Clerk confer.)

Go ahead, Dick.

MR. MELICK: The answers were not complete and therefore we sought to compel further answers. We obtained further answers and when your Honor reviews them you will find that the further answers are not complete, either.

Now, if, in fact, the Court wishes, then I would be happy to have us suspend this matter today, set it down for evidentiary hearing and the defendant will summons in each of these departments to get their records. I did not think that would be necessary in light of the foregoing comments that I have made to the Court. I thought that the plaintiff, who had these records, not within his control, but, at least, within his opportunity to determine the figures of the agencies involved, would get the information.

We have pursued the matter, both by interrogatories and Motion to Compel Further Answers and I suggest that the defendant has met
his burden as of the moment. However, we do not have the figures. The lady from the Welfare Department is incorrect when she says that she assumes that or she says, apparently her records and the print-out form have been furnished to Mr. Melick. That’s not true. Mr. Halstrom held them up and waved them a while ago. It is the first knowledge I had of the print-out. We have never gotten the print-out records. I don’t know that they are material. They may not be because the answers to interrogatories have indicated to us that Welfare Medicaid costs, expenses to November 9 of ’86 are in the amount of one hundred fifty-nine thousand, two hundred and twenty-five dollars and thirty-five cents. The verdict was after that day, if my memory is correct.

THE COURT: I think the verdict was the 3rd, wasn’t it?

MR. MELICK: Of November?

THE COURT: Yes.

MR. MELICK: Then, this number would go beyond it, that’s true, your Honor.

The second element is the Boston Center for Independent Living. It is our understanding to October and this is from the answer to interrogatories there is an expense of fifty thousand, five hundred and forty-seven dollars and ten cents.

The Social Security Disability is the third element and we understand that that was paid in the amount of four hundred and six dollars a month. Again, from the answers to interrogatories, but we don’t have any idea of how many months.

The fourth element is supplemental security income paid in the amount of sixty-seven dollars a month, and, again, I don’t know what the period of time is.

The fifth element is H.U.D., and we have no numbers from H.U.D. at all.

THE COURT: For the sake of the record, that is the United States Department of Housing and Urban Development, right?

MR. MELICK: Yes, your Honor. And, they have made payments for rent and they have also made payments for, I believe, an assistant. And, that may or may not be true.

The sixth element would be inconsistent with what Ms. Griffin has said to you, that there is no other pending actions. There is pending —
THE COURT: Hold it. Hold it. I want you two to listen, will you please. He is saying something important. Go ahead.

MR. MELICK: There is pending a workman's compensation action by the plaintiff against his employer for failure to have workman's compensation insurance.

MR. HALSTROM: That's correct.

MR. MELICK: When the statement was made to the Court that there are no other sources, nor have there been, nor will there be, that isn't correct because there is that suit pending unless within the last week or two the suit has been dismissed or waived. The last I know a couple of weeks ago the suit was pending and there was counsel, other than present plaintiff counsel; representing the plaintiff in that suit. I guess that is all I have to say to the Court.

THE COURT: At this time. You will get plenty of opportunity to say anything else that you want.

MR. MELICK: If Mr. Halstrom drafted this statute — and that's what he said: I testified and then we drafted the statute, were his words — I'm sorry he didn't have more influence because I think he realizes, as do all of us, that this is not a well drafted statute. And, your Honor is stuck with the horrendous problem of interpreting it. I don't relish your Honor's job at all.

THE COURT: Maureen, let me hear from you.

MS. GRIFFIN: Your Honor, there, in fact, is a workman's compensation suit pending in Suffolk Superior Court. We do not represent Mr. Harlow in that action and I made no such representation to this Court that there was no workman's comp claim. What I stated earlier was that Mr. Harlow, since his injury on February 11th, 1982, has been subsidized by state and federal programs and those are the only sources of income or subsidy which he has received. He does, in fact, have a workman's compensation claim that is outstanding and that case is still presently pending in Suffolk Superior Court.

THE COURT: I understand that there is no workman's compensation insurance and that he is suing his employer for failure to have the coverage, right?

MS. GRIFFIN: Correct.
THE COURT: Do you see, Mr. Halstrom, I do listen. Anything else, Maureen?

MS. GRIFFIN: Your Honor, we have, in good faith, contacted all of the agencies, the Social Security Administration, H.U.D., and both Medicare and Medicaid, in an attempt to respond as fully as we could to the interrogatories of the defendants. In fact, we have done so.

THE COURT: All right, Okay. Anything else you want to say, Mr. Melick? On this motion, at this time.

MR. HALSTROM: The computer records, your Honor, were hand-delivered over, at least a week ago, if not before, the very day we got them by Ms. O'Connor, the law clerk in the office. She physically delivered them to Mr. Melick's office.


MR. MELICK: I believe, if your Honor please —

MR. HALSTROM: We got them after we got the cover letter from Jean Farrington with the computer print-out and I have the letter.

MR. MELICK: I believe Mr. Halstrom has asked his law clerk to provide me with a cover letter to the documents that he has now represented to the Court the same way he has represented to the jury, that I am a liar. Which I really don't enjoy. I don't have a cover letter. This young lady has been very good about delivering documents but when I say to the Court that we didn't receive those documents, I mean just that. We didn't receive them. We have never received them.

I am not sure that they are despositive of anything. My guess is that they total the amount of dollars that you have already been told. I am only saying that we don't have them and the only thing of substance that I can add to what I have said, your Honor, is that the statute talks about deducting various items. The statute says: replaced compensated or indemnified pursuant to the United States Social Security Act. Now, I don't know how plain that statute can be. It specifically refers to the Social Security Act and it specifically refers to —

THE COURT: What are you quoting from, Dick?

MR. MELICK: It will take just a moment.

THE COURT: I have the statute in my hand as it originally came down.

MR. MELICK: If your Honor please, in House Bill 5700, it's page 24, Sir, Section 25, Section 60G, small "A", and it is approximately half-way down —
THE COURT: I have got my hand in it, sure, All right.

MR. MELICK: All I am saying to the Court that the argument that this statute was never intended to include social security payments is a difficult argument to make in face of the fact that the statute specifically refers to them. If the statute were general in nature and talked about disability payments in general, that would be one thing. But this particular statute is specific and identifies it.

THE COURT: But, would you flip over to the next page, Dick, you are in Section “A”, 60Ga, and take a look at “C” on the next page.

MR. MELICK: I appreciate that, if your Honor please, and that is the inconsistency that I have referred to when I said a little while ago that I am glad I am not in the position that your Honor is in determining what the statute means.

THE COURT: All right. I'm not going to spend — Please strike that. I'm not going to say that I will take the matter under advisement and read everything that is before me and consider all of the arguments because I have read all of the material and I have looked at it and I know what the problems are that I find in this statute. I don't think I am going to reach the question of specific amounts that he received if I come out with a ruling to the effect that — to the extent that the plaintiff has received compensation or indemnification from any collateral sources, right of subrogation that’s based in any federal law, the Court shall not reduce the award by the amounts received prior to judgement from such collateral source and such amounts may be recovered in accordance with such federal law.

In effect, I have just quoted from what was House Bill 5700, Section 60 — Section 25 under Section 60Gc. It is abundantly clear from everything I have heard that the man has received compensation from collateral sources where the right of subrogation is based on federal law. So, to that extent, I guess, the Court is not to reduce the judgement.

Now, what those sources are — I suppose we get from that Ms. Farrington has told us and what Ms. Griffin has told us and what Mr. Halstrom has told us this morning, and also from the information from the answers to interrogatories and the further answers to interrogatories. It would seem to me that the statute does not intend to slam the door shut or attempt to slam the door shut in the face
of the federal government recovering whatever it is entitled to recover for the money that it has expended on behalf of Mr. Harlow, either by paying him directly or by reimbursement of some state program.

I have further heard what to me indicates that everything Mr. Harlow has received has been infused, at least, with some federal funds. And, I am going to find, and let the Appeals Court or the Supreme Judicial Court make up its own mind, that this statute does not require and the legislative history of the statute indicates that the statute does not require the reduction of the verdict by the amount that Mr. Harlow has received from the state and federal governments — the amounts that he has received from the state and federal governments.

So that as far as the motion of the defendants for or to compel further answers to interrogatories by the plaintiff is concerned, I will deny that motion at this time. We can go on to the other motions that we have and you have got your basis for an appeal already laid.

MR. MELICK: Will your Honor note the defendants’ objection?
MR. MELICK: Thank you.
THE COURT: Okay. What is the next one we should take up, Mr. Melick?
MR. MELICK: I leave that entirely up to your Honor.
THE COURT: Well, I have got a Motion for a New Trial, a motion for Judgement N.O.V., from the defendants, of course, and a Motion for a Remittitur from the defendants.
APPENDIX A

SECTION 1. Chapter 231 of the General Laws is amended to add section 60K, as follows:

A. Early Tender of Compensation Benefits. In the case of a health care provider (as defined in paragraph F(4)), who or which is potentially liable for a personal injury (as defined in paragraph F(1)) to an injured individual, if the provider provides the individual not later than the date specified in paragraph B with a written tender to pay compensation benefits with respect to such injury in accordance with this section, the individual and any other entity shall (except as provided in paragraph E(1) or E(2)) be foreclosed from bringing or prosecuting any civil action described in paragraph D against such provider or other entity joined under subsection G based on such personal injury. Said tender shall be in a form and in a manner as prescribed by the commissioner of insurance by regulations. Such a tender may be limited to cover compensation benefits up to a present value equivalent to the total amount of liability insurance available to satisfy the asserted claim.

A health care provider may, upon the filing of a claim, freely communicate with his/her or its medical malpractice professional liability insurer for the purposes of evaluating such claim and of determining whether to provide a written tender to pay compensation benefits pursuant to this section. No rule of physician-patient confidentiality shall apply so as to prevent such communication.

B. Date of Tender. The date referred to in paragraph A is 180 days after the date of the filing of a written claim against the provider, except that such date may be extended for up to an additional 60 days for purposes of paragraph A if the provider and the patient agree in writing to such extension.

C. Statute of Limitations. Nothing in this section shall be construed as changing any applicable statute of limitations.

D.(1) Civil Actions Covered. Except as provided in sub-paragraph D(2) hereof, civil actions referred to in paragraph A include any civil action (whether brought in a federal or state court) which could have been brought against a compensation
37 obligor (as defined in paragraph F(5)) for recovery of damages relating to personal injury, whether based on (a) negligence or gross negligence, (b) strict or absolute liability in tort, (c) breach of express or implied warranty or contract, (d) failure to discharge a duty to warn or instruct or to obtain consent, or (e) any other theory that is (or may be) a basis for an award of damages for personal injury.

(2) Civil actions referred to in paragraph A do not include: —

(a) any action to recover for compensation benefits tendered under this subpart, or

(b) any action in the nature of a wrongful death action, but only in the case of such an action for losses accruing to survivors after the death of an injured individual and resulting from the death of the individual.

E.(1) Rejection of Tender. In no event shall a civil action be foreclosed under paragraph A against any entity which intentionally caused or intended to cause injury, except that this paragraph shall not apply with respect to a personal injury, unless the injured individual provides the provider making a tender with a written notice of rejection not later than 90 days after the date the tender of compensation benefits was made. If no written notice of rejection is given to the provider within said 90-day period, the tender will be deemed accepted.

(2) If a tender is limited to cover compensation benefits up to a present value equivalent to the total amount of liability insurance available to satisfy the asserted claim, the injured individual will not be foreclosed under paragraph A from bringing or maintaining an action against any party for compensation benefits in excess of the tender, if the injured individual gives the provider making the tender notice of election not later than 90 days after the date the tender of compensation benefits was made. If the injured individual does not prevail in an action after making such an election, or if the total compensation benefits awarded in such action do not exceed the limits of the tendering defendant’s or defendants’ liability insurance coverage, the plaintiff will be liable to the tendering defendant or defendants for attorney’s fees, except for attorney’s fees.
expenses and all costs of defense in the said civil action incurred after the date the tender was made. Said fees, expenses and costs of defense may be deducted from the judgment, from future compensation benefits to be paid to the plaintiff or may be collected by any other lawful means.

(3) An injured individual who provides a timely notice of rejection under paragraph E(1) shall not be allowed to introduce evidence of the tender in any action against the party making the tender, except for an action for payment of unpaid compensation benefits pursuant to paragraph L hereof.

(4) An attorney representing a plaintiff who has received a tender of compensation benefits hereunder must fully and fairly inform the plaintiff of the legal consequences and potential legal and economic of acceptance or rejection of the tender. The Supreme Judicial Court may by rule specify the manner, form and content by which an attorney must so inform his client.

(5) The provider making a tender of compensation benefits may offer, as a part of such tender, to pay, at the injured individual’s option, a reasonable attorney’s fee to secure for the injured individual an independent legal opinion as to whether the tender should be accepted or not. Such offer may be for a limited dollar amount, but it shall not restrict in any way the injured individual’s choice of such independent counsel other than to except from such choice the attorney then appearing on behalf of the injured individual and any partner or associate of the said attorney or any member of his firm. The attorney rendering such independent opinion shall represent the injured individual and not the provider in performing such legal services, but may not thereafter represent the injured individual, the provider, or any other party, in any civil action based on the personal injury claimed by the injured individual for which the tender of compensation benefits was made.

(6) A provider which has made a valid and timely tender hereunder, upon receipt of a valid acceptance of that tender or after the expiration of 90 days from the date the tender of compensation benefits was made, without written notice of rejection having been given, may move that any civil action
foreclosed hereunder be dismissed. Said motion shall be allowed
unless the court finds that no valid and timely tender was made,
acceptance of the tender was not valid, or written notice of
rejection of the tender was given within said 90-day period.

F. Definitions. As used in this section:

(1) The terms “injury” and “personal injury” mean sickness
or disease or bodily harm arising in the course of the provision
of health care services.

(2) The term “injured individual” means an individual
suffering injury in the course of health care provided by an
individual or entity.

(3) An entity intentionally causes or attempts to cause a
personal injury when the entity acts or fails to act for the purpose
of causing injury or with knowledge that injury is substantially
certain to follow; but an entity does not intentionally cause or
attempt to cause injury merely because the individual’s act or
failure to act is intentional or is done with the individual’s
realization only that it creates a grave risk of causing injury
without the purpose of causing injury or if the act or omission
is for the purpose of averting bodily harm to the individual or
another entity.

(4) The term “health care provider” means a physician
licensed in the Commonwealth of Massachusetts who practices
cardiovascular surgery, neurosurgery, orthopedic surgery,
thoracic surgery, traumatic surgery, or vascular surgery, either full
or part time, and any person or entity which may be jointly liable
for any action of said physician, except that the term “health care
provider” does not include the manufacturer of a product which
may have caused or contributed to the injured individual’s injury.

(5) The term “compensation obligor” —
(a) means, with respect to a personal injury, the health
care provider that has obligated itself to pay compensation
benefits under paragraph A with respect to that injury, and
(b) includes —
(i) any entity that has been joined under paragraph
G with respect to that injury, and
(ii) any other entity (including an insurance
company) which is contractually responsible for payment of the
obligations of a compensation obligor under this section.
The term “initiating compensation obligor” means, with respect to a personal injury, the compensation obligor which (a) first tenders compensation benefits to the injured individual, or (b) agrees to serve as an initiating compensation obligor and has been designated as such by a majority of the compensation obligors for that injury for purposes of this section.

G.(1) Joinder of Other Defendants. A health care provider which has tendered (or deemed to have tendered) compensation benefits under paragraph A may, by written notice to the entity, join in the foreclosure provided under paragraph A any entity which is potentially liable, in whole or in part, for the personal injury and who may benefit from foreclosure of action against the entity under paragraph A. Joinder under this paragraph may only be by written notice to the entity to be joined, and such notice shall not be effective if provider later than the date the provider makes the tender under paragraph A. The manufacturer of a product which may have caused or contributed to the injured individual’s injury may not be joined hereunder.

(2) Any entity which would benefit from foreclosure of action against the entity under paragraph A with respect to a personal injury shall be joined in any tender made under paragraph A with respect to that injury, if the entity requests such joinder by written notice to the provider making the tender under paragraph A not later than the date the tender under paragraph A is made. The manufacturer of a product which may have caused or contributed to the injured individual’s injury may not be joined hereunder.

(3) By joinder under this subsection, an entity is deemed to have agreed to pay a share of (a) such compensation benefits and (b) the reasonable costs incurred by the provider in preparing and making such tender and paying compensation benefits. Any disagreement between such entities involved as to any entity’s share of the benefits and costs or the amount of such costs shall be submitted to binding arbitration for determination and each entity’s share shall be based on the comparative fault of the entities (other than the injured individual) involved. An entity which is involuntarily joined in a tender and which claims to have had no
possible connection with the treatment, care or transaction
allegedly causing the injury, shall be entitled to a prompt
determination, by arbitration, of its claim of no connection. Such
arbitration shall be governed by the provisions of Massachusetts
General Laws, chapter 251 to the extent apt.

4 Notwithstanding the provisions thereof, any entity has
a statutory limit on its liability for damages in tort for personal
injuries, which limit is less than $1,000,000 shall not be joined in
a tender without its consent and shall not make a tender without
waiving the limits of its liability.

H.(1) Subrogation. Any entity which has tendered com-
penation benefits with respect to an individual under paragraph
A or been joined in the tender under paragraph G shall be
subrogated to any rights of the individual against another entity
(other than another entity joined under paragraph G
arising from or contributing to the personal injury and shall have
a cause of action separate from that of the individual to the extent
that (a) elements of damage compensated for by compensation
benefits are recoverable, and (b) the entity has paid or becomes
obligated to pay accrued or future compensation benefits.

2 In the case that a foreclosure from liability is effected
under paragraph A, no right of subrogation, contribution, or
indemnity shall exist against a compensation obligor other than
the right of contribution among compensation obligors under
paragraph G, nor shall any provision of any contract be enforced
that has the effect of limiting or excluding payment under that
contract because of the existence or payment of compensation
benefits under this section.

I. Compensation Benefits. The amount of compensation
benefits payable with respect to a personal injury is equal to the
net economic loss (as defined in subparagraph (1) hereof) resulting
from such injury, plus attorney’s fees (as provided under
subparagraph 5 hereof).

1. For purposes of this section:

(a) The term “net economic loss” means —

(i) economic detriment, consisting only of —

(aa) allowable expense (as defined in sub-
paragraph (2) (a)),

(b) a

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(bb) work loss (as defined in subparagraph (2) (b)), and

(cc) replacement services loss (as defined in subparagraph (2) (C)), whether caused by pain and suffering or physical impairment, but not including noneconomic loss (as defined in subparagraph (3)), less collateral benefits (as defined in subparagraph (4)).

(2) (a) The term "allowable expense" means reasonable expenses incurred for products, services, and accommodations reasonably needed for medical care, training, and other remedial treatment and care of an injured individual, but includes expenses for rehabilitation treatment and occupational training only in accordance with subparagraph (6) (a).

(b) The term "work loss" means 100 percent of the loss of income from work the injured individual would have performed if the individual had not been injured, reduced by any income from substitute work actually performed by the individual or by income the individual would have earned in available appropriate substitute work the individual was capable of performing but unreasonably failed to undertake. An injured individual over age 18 and under age 65 shall be presumed, in the absence of evidence to the contrary, to have been able to earn income from work which he would have performed if he had not been injured in the amount of two-thirds of the average weekly wage in the Commonwealth.

(c) The term "replacement services loss" means reasonable expenses incurred in obtaining ordinary and necessary services in lieu of those the injured individual would have performed, not for income, but for the benefit of the individual or the individual's family, if the individual had not been injured.

(3) The term "noneconomic detriment" means pain, suffering, inconvenience, physical impairment, mental anguish, emotional pain and suffering, punitive or exemplary damages, and all other general (as opposed to special) damages, including loss of earning capacity and loss of any of the following which would have been provided by an injured individual to another: consortium, society, companionship, comfort, protection, marital care, attention, advice, counsel, training, guidance, and education. Such term does not include pecuniary loss caused by pain and suffering or by physical impairment.
(4) The term "collateral benefits" means all benefits and advantages received or entitled to be received (regardless of any right any other entity has or is entitled to assert for recoupment through subrogation, trust agreement, lien, or otherwise) by an injured individual or other entity as reimbursement of loss because of personal injury, payable or required to be paid, under —

(a) the laws of any state or the federal government (other than through a claim for breach of an obligation or duty), or

(b) any health or accident insurance, wage or salary continuation plan, or disability income insurance.

(5) (a) Compensation benefits shall include reasonable expenses incurred by the injured individual in collecting such benefits, including his attorney's fee, which shall be based on a reasonable hourly rate of compensation. Such expenses may be offset from the amount of compensation benefits otherwise provided, if any significant part of a claim for compensation benefits is fraudulent or so excessive as to have no reasonable foundation.

(b) A compensation obligor defending a claim for compensation benefits shall be allowed a reasonable attorney's fee, in addition to other reasonable expenses incurred, in defending such a claim or part thereof that is fraudulent or so excessive as to have no reasonable foundation. The fee or expenses may be treated as an offset to any compensation benefits due. The compensation obligor may recover from the claimant any part of the fee or expenses not so offset or otherwise paid.

(6) (a) Allowable expenses under subparagraph (2) (a) include expenses for a procedure or treatment for rehabilitation and rehabilitative occupational training if the procedure, treatment, or training is reasonable and appropriate for the particular case, the expenses are reasonable in relation to the probable rehabilitative effects and the compensation benefits otherwise payable, and it is likely to contribute substantially to rehabilitation, even though it will not enhance the injured individual's earning capacity.

(b) Allowable expenses shall not include expenses described in paragraph (a) with respect to a procedure or treatment for rehabilitation or a course of rehabilitative
302 occupational training which exceed $2,000 in any 30-day period, unless the injured individual has provided the initiating compensation obligor with notice of such procedure, treatment, or course of training before expenses totaling $2,000 with respect to such procedure, treatment, or course of training during such period have been incurred.

308 J.(1) (a) Payment of Compensation Benefits. Compensation benefits shall be paid not later than 30 days after the date there is submitted to the initiating compensation obligor reasonable proof of the fact and amount of net economic loss incurred, except that payment may be made, for expenses incurred over periods not exceeding 31 days, within 15 days after the end of the period. If reasonable proof is supplied as to only a portion of net economic loss, and the portion totals $100 or more, the compensation benefits with respect to that portion shall be paid without regard to the remainder of the net economic loss. An injured individual to whom a tender of compensation benefits has been made under paragraph A shall be entitled to interest, at the annual rate of interest applied to judgments on such benefits not paid on a timely basis.

(b) If there elapses a period of five years after a claim for payment of net economic loss incurred is last made with respect to a personal injury, the injured individual is no longer entitled to receive compensation benefits with respect to that injury.

311 (2) A compensation obligor who rejects in whole or in part a claim for compensation benefits shall give to the claimant prompt written notice of the rejection and the reasons therefor.

312 (3) Compensation benefits with respect to allowable expenses may be paid either to the injured individual or to the entity supplying the products, services, or accommodations to the individual.

313 (4) In lieu of payment therefor as a part of allowable expenses and with the consent of the injured individual, a health care provider may provide medical or rehabilitative services needed by the injured individual.

314 (5) (a) Except as otherwise provided in this paragraph, paragraph E or paragraph I, compensation benefits shall be paid without deduction or set off.
(b) An assignment or an agreement to assign any right to compensation benefits under this subpart for net economic loss accruing in the future is unenforceable except as to benefits for —

(i) work loss to secure payment of alimony, maintenance, or child support; or

(ii) allowable expenses to the extent are for the cost of products, services, or accommodations provided or to be provided by the assignee.

(c) (i) Compensation benefits for allowable expense are exempt from garnishment, attachment, execution, and any other process or claim, except upon a claim of a creditor who has provided products, services, or accommodations to the extent benefits are for allowable expense for those products, services or accommodation.

(ii) Compensation benefits other than those for allowable expense are exempt from garnishment, attachment, execution and any other process or claim to the extent that wages or earnings are exempt under any applicable law exempting wages or earnings from process or claims.

(d) (i) Except as provided in clause (iii), a claim for compensation benefits shall be paid without deduction or offset for collateral benefits, if the collateral benefits have not been paid to the injured individual before the incurring of expenses included in net economic loss.

(ii) The compensation obligor is entitled to reimbursement from the entity obligated to make the payments or from the entity which actually receives the payments.

(iii) A compensation obligor may offset amounts it is entitled to recover under clause (ii) against any compensation benefits otherwise due to the entity which actually receives the payments.

(e) (i) An entity making payment of compensation benefits under this paragraph may bring an action against an entity to recover compensation benefits paid because of an intentional misrepresentation of a material fact by the payee upon which the payor relied, except that such an action may not be brought against the injured individual unless the injured individual made or had knowledge of the making of the misrepresentation.
(e) (ii) If such payor entity secures judgment in an action under clause (i), that entity may offset amounts it is entitled to recover under such judgment against any compensation benefits otherwise due.

K.1 (a) Disclosures. Upon request of an injured individual or compensation obligor, information relevant to payment of compensation benefits shall be disclosed as follows:

(i) The injured individual shall furnish evidence of the individual's earnings, if self-employed.

(ii) An employer of the individual shall furnish a statement of the work record and earnings of an injured individual who is or was an employee of the employer, for the period specified by the injured individual or obligor making the request, which may include a reasonable period before, and the entire period after, the injury.

(iii) The injured individual shall deliver to the compensation obligor upon request a copy of every written report, not otherwise available to the compensation obligor, previously or thereafter made, available to the individual, concerning any medical treatment or examination of the injured individual and the names and addresses of hospitals, physicians and other entities, examining, diagnosing, treating or providing accommodations to the individual in regard to the injury or to a relevant past injury, and the injured individual shall authorize the compensation obligor to inspect and copy all relevant records made by such entities.

(iv) A hospital, physician or other entity examining, diagnosing, testing or providing accommodations to an injured individual in connection with a condition alleged to be connected with an injury upon which a claim for compensation benefits is based, upon authorization of the injured individual, shall furnish a written report of the history, condition, diagnosis, medical tests, treatment and dates and cost of treatment of the injured individual in connection with that condition or any previous or other condition which may be relevant to assessing such condition and permit inspection and copying of all records and reports as to the history, condition, treatment and dates and cost of treatment.

Any entity (other than the injured individual or a compensation obligor) providing information under this
paragraph may charge the entity requesting the information for
the reasonable cost of providing it.

(b) In case of dispute as to the right of an injured
individual or compensation obligor to discover information
required to be disclosed under this paragraph, the individual or
obligor may file a complaint in the superior court having
jurisdiction over the injured individual for an order for discovery,
including the right to take written or oral depositions. Upon notice
to all entities having an interest, the order may be made for good
cause shown. It shall specify the time, place, manner, conditions
and scope of the discovery. To protect against oppression, the
court may enter an order refusing discovery or specifying
conditions of discovery and directing payment of costs and
expenses of the proceeding, including reasonable attorney's fees.

(2) (a) If the mental or physical condition of an injured
individual is material and relevant to compensation benefits, a
compensation obligor may file a complaint in the superior court
having jurisdiction over the injured individual for an order
directing the individual to submit to a mental or physical
examination by a physician. Upon notice to the individual to be
examined and all entities having an interest, the court may make
the order for good cause shown. The order shall specify the time,
place, manner, conditions, scope of the examination and the
physician by whom it is to be made.

(b) If requested by the individual examined, a com-
pensation obligor causing a mental or physical examination to be
made shall deliver to the individual examined a copy of the written
report of the examining physician and reports of earlier
examinations of the same condition. By requesting and obtaining
a report of the examination ordered or by taking the deposition
of the physician, the individual examined waives any privilege the
individual may have, in relation to the claim for compensation
benefits, regarding the testimony of every other person who has
examined or may thereafter examine the individual respecting the
same condition. This paragraph does not preclude discovery of
a report of an examining physician, taking a deposition of the
physician or other discovery procedures in accordance with any
rule of court or other provision of law. This paragraph applies
to examinations made by agreement of the individual examined and a compensation obligor unless the agreement provides otherwise.

(c) If any individual refuses to comply with an order entered under this subparagraph, the court may make any just order as to the refusal, but may not find an individual in contempt for failure to submit to a mental or physical examination.

(3) If a health care provider tenders compensation benefits with respect to an injured individual under this section, and there is a dispute between the initiating compensation obligor and the injured individual respecting the determination of the amount of the compensation benefits owing, except as otherwise provided under this section, the initiating compensation obligor or the individual may file a complaint in the superior court having jurisdiction for a declaration as to the amount of the compensation benefits owed.

L.(1) Actions for Compensation Benefits. An obligation to pay compensation benefits may be discharged initially or at any time thereafter by a settlement or lump sum payment by mutual agreement of the parties. A settlement agreement may also provide that the compensation obligor shall pay the reasonable cost of appropriate medical treatment or procedures, with reference to a specified condition, to be performed in the future.

(2) (a) In an action for payment of unpaid compensation benefits, a judgment may be entered for compensation benefits, other than allowable expense, that would accrue after the date of the award. The court may enter a judgment declaring that the compensation obligor is liable for the reasonable cost of appropriate medical treatment or procedures, with reference to a specified condition, to be performed in the future if it is ascertainable or foreseeable that treatment will be required as a result of the injury for which the claim is made. If the court finds that compensation benefits should have been paid by the compensation obligor, but were not paid prior to the filing of the complaint for compensation benefits, it shall enter a judgment for the injured individual in the amount of two times the amount of said unpaid compensation benefits, and it shall award the injured individual his costs and a reasonable attorney's fee based on a reasonable hourly rate of compensation.
(b) A judgment for compensation benefits, other than
with respect to allowable expenses, that will accrue thereafter may
be entered only for a period as to which the court can reasonably
determine future net economic loss.

(c) If the injured individual notifies the initiating
compensation obligor of a proposed specified procedure or
treatment for rehabilitation or specified course of rehabilitation
occupational training the expenses of which are an allowable
expense and the compensation obligor does not promptly agree
to such characterization, the injured individual may move the
court in an action to adjudicate the individual’s claim, or, if no
action is pending, bring an action in the superior court having
jurisdiction over the matter for a determination respecting
whether or not such expenses are allowable expenses for which
compensation benefits are payable. The initiating compensation
obligor may move the court in an action to adjudicate the injured
individual’s claim, or, if no action is pending, bring an action in
a court having jurisdiction over the matter for such a
determination as to whether or not expenses for such a procedure,
treatment or course of training which an injured individual has
undertaken or proposes to undertake are allowable expenses for
which compensation benefits are payable. This subsection does
not preclude an action by the initiating compensation obligor or
the injured individual for declaratory relief under any other
applicable law, nor an action by the injured individual to recover
compensation benefits.

(d) If an injured individual unreasonably fails, either
directly or through one legally empowered to act on the
individual’s behalf, to obtain medical care, rehabilitation,
rehabilitative occupational training, or other medical treatment
which is reasonable and appropriate, the initiating compensation
obligor may move the court in an action to adjudicate the injured
individual’s claim, or, if no action is pending, may bring an action
in a court having jurisdiction over the matter for a determination
that future benefits will be reduced or terminated so that they
equal the benefits that in reasonable probability would have been
due if the injured individual had submitted to the procedure,
treatment or training, and for other reasonable orders.
determining whether an injured individual has reasonable ground for refusal to undertake the procedure, treatment or training, the court shall consider all relevant factors, including the risks to the injured individual, the extent of the probable benefit, the place where the procedure, treatment or training is offered, the extent to which the procedure, treatment or training is recognized as standard and customary and whether the restriction of this paragraph because of the individual's refusal would abridge the individual's right to the free exercise of religion.

(3) (a) A judgment under this paragraph may be modified as to amounts to be paid in the future upon a finding that a material and substantial change of circumstances has occurred after the date the judgment was made, or that there is newly-discovered evidence concerning the injured individual's physical condition, loss or rehabilitation, which would not have been known previously or discovered in the exercise of reasonable diligence prior to such judgment.

(b) The court may make appropriate orders concerning the safeguarding and disposing of the proceeds of or funds collected under judgments under this paragraph.

M. Required Insurance. A health care provider described in paragraph A may not participate in the Early Compensation System under this section unless the provider has insurance against professional malpractice (or has a suitable bond or other indemnity against liability for professional malpractice) at least in the amount of $1,000,000.

N. Insurance Costs. In fixing and establishing the premium charges as provided in section 5A of chapter 175A of the General Laws for medical malpractice insurance to be effective during the period from July 1, 1988 through December 31, 1993, and written by the association established pursuant to chapter 362 of the Acts of 1975 or by any other person authorized to write such insurance, the commissioner of insurance shall determine the rates for medical malpractice insurance policies issued for the risk classification or classifications of health care providers based on evidence of the actual and projected loss experience realized under the early compensation system; provided that, in no event, shall medical malpractice insurance rates charged to the risk
classification or classifications of health care providers during the aforesaid period exceed the rates then fixed and established for the highest classification of risk; and provided, further, if the premium charges for the risk classification or classifications of health care providers as so determined would not be self-supporting, then the commissioner shall further determine the amount of the additional premium charges needed to make up the deficit and provide self-supporting rates for such risk classification or classifications of health care providers. The full amount of such deficit shall be assessed against and paid by all insurers authorized to write and engaged in writing personal injury liability insurance within the Commonwealth, pursuant to chapters 90 and 175, of the General Laws, said assessment to be apportioned to the accident and health insurers in the proportion that the net direct premiums of each such insurer bears to the aggregate net direct premiums written in the Commonwealth by all such insurers, said amounts to be paid in the manner and in accordance with a plan to be established by the commissioner. The payment of such assessments when due shall be a condition of the authority of accident and health insurers to continue to transact such kind of insurance of the Commonwealth, but the commissioner shall allow such insurers a premium increase on accident and health policies effective subsequent to the date of such payment, which premium increase shall be sufficient to permit the insurers to recover the full amount of such assessment over a period of not more than twelve months from the effective date of such premium increase. The commissioner shall file a report of his finding and actions under this paragraph within 15 days after he renders his decision.

No tender of compensation benefits hereunder shall be considered an adverse judgment or settlement for purposes of any experience rating or surcharge plan used by the said association.

O. Regulations. The commissioner of insurance shall make rules and regulations interpreting the provisions of this section. Violation of any such rule or regulation shall constitute a violation of this section and chapter 93A of the General Laws.
SECTION ___. General Laws, chapter 231, section 60B is amended by adding at the end of the first sentence of the fifth paragraph thereof the following:

but in no event shall such action be heard by said tribunal prior to 180 days after the action is commenced. However, any action in which a valid and timely tender of compensation benefits is made pursuant to section 60K of this chapter 231 shall not be heard by said tribunal, and no bond shall be required of the plaintiff in any such action to pursue the claim through the usual judicial process as provided herein, regardless of whether the tender is rejected.

SECTION ___. General Laws, chapter 231, section 59A, is amended by adding at the end thereof the following:

In any action in which an injured individual has received a tender of compensation benefits under section 60K of this chapter 231 and has given valid and timely notice of rejection thereof, the court shall, upon motion by the plaintiff who rejected the tender, advance such action for speedy trial.