SB2881

LRB093 19774 LCB 45515 b

93RD GENERAL ASSEMBLY

State of Illinois

2003 and 2004

Introduced 2/6/2004, by Denny Jacobs

SYNOPSIS AS INTRODUCED:

See Index

Amends the Illinois Insurance Code. Provides that a reasonable degree of competition does not exist in a county if a physician has less than 3 options for obtaining medical liability insurance from insurers that are not legally or corporately affiliated or otherwise related. Requires the Department to conduct and publish an impact analysis on: (i) the number of medical malpractice claims filed and amounts recovered for economic and non-economic damages per claim per year by county; (ii) the amount of attorneys' fees paid by medical malpractice plaintiffs and defendants per case per year by county; and (iii) the impact of the standards of the Act on the cost and availability of medical malpractice coverage for hospitals and physicians. Amends the Code of Civil Procedure. Provides that an affidavit from a reviewing health professional must contain the health professional's name, address, profession, and professional license number. Provides that, in order to qualify as a reviewing health professional for purposes of giving an affidavit for a petitioner in a pro se action, the reviewing health professional must meet the expert witness standards set out in the Code. Provides that any reviewing health professional that provides a frivolous or improper review of a case shall be liable to each of the parties for the reasonable costs and attorneys' fees the parties expended in resolving the case. Provides that a review shall be found frivolous if it is substantially lacking in factual support, is based upon a standard of care or practice that lacks substantial use in the relevant specialty or field of practice, or is made for an improper purpose, such as to harass or cause needless increase in the cost of litigation. Provides that in any individual action, fees for all plaintiffs' attorneys involved in the action representing the plaintiff or plaintiffs may not exceed $1,000,000 plus reasonable and documented expenses. Provides that any expression of grief, apology, remedial action, or explanation including, but not limited to a statement that the health care provider is sorry for the outcome, provided by a health care provider to a patient, the patient's family, or the patient's legal representative about an inadequate or unanticipated treatment outcome that is provided with 72 hours of when the provider knew or should have known of the outcome shall not be admissible as evidence, nor discoverable in any action of any kind in any court or before any tribunal, board, agency, or person. Provides that the disclosure of the information for the purpose of bringing a claim for damages against a provider is unlawful and any person convicted of violating any of the provisions of this Act is guilty of a Class A misdemeanor. Makes other changes. Effective January 1, 2005.

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CORRECTIONAL
BUDGET AND
IMPACT NOTE ACT
MAY APPLY

A BILL FOR

AN ACT in relation to health care delivery and civil actions, which may be referred to as the Health Care Access Improvement Amendments of 2004.

Be it enacted by the People of the State of Illinois, represented in the General Assembly:

Section 1. Legislative findings. The General Assembly finds that:

(1) Illinois is in the midst of a medical malpractice insurance crisis of unprecedented magnitude.

(2) Illinois is among the states with the highest medical malpractice insurance premiums in the nation.

(3) Medical malpractice insurance in Illinois is unavailable or unaffordable for many hospitals and physicians.

(4) The high and increasing cost of medical malpractice insurance in Illinois is causing health care providers to eliminate or reduce the provision of medical care throughout the State.

(5) The crisis is discouraging medical students from choosing Illinois as the place they will receive their medical education and practice medicine.

(6) The increase in medical malpractice liability insurance rates is forcing physicians to practice medicine without professional liability insurance, to leave Illinois, to not perform high-risk procedures, or to retire early from the practice of medicine.

(7) The high and increasing cost of medical malpractice insurance is due in large part to the inefficiency and unpredictability of adjudicating claims.

(8) Much of this inefficiency stems from the time and resources needlessly spent on valuing uncertain and unpredictable claims of medical negligence.

(9) Individuals bringing malpractice claims would benefit if the parties spent less time assessing the value of the

claimed injury.

(10) The public would benefit by making medical liability coverage for hospitals and physicians more affordable, which would make health care more available.

Section 5. The Illinois Insurance Code is amended by changing Section 155.18 and by adding Section 155.20b as follows:

(215 ILCS 5/155.18) (from Ch. 73, par. 767.18)

Sec. 155.18. (a) This Section shall apply to insurance on risks based upon negligence by a physician, hospital or other health care provider, referred to herein as medical liability insurance. This Section shall not apply to contracts of reinsurance, nor to any farm, county, district or township mutual insurance company transacting business under an Act entitled "An Act relating to local mutual district, county and township insurance companies", approved March 13, 1936, as now or hereafter amended, nor to any such company operating under a special charter.

(b) The following standards shall apply to the making and use of rates pertaining to all classes of medical liability insurance:

(1) Rates shall not be excessive or inadequate, as herein defined, nor shall they be unfairly discriminatory. No rate shall be held to be excessive unless such rate is unreasonably high for the insurance provided, and a reasonable degree of competition does not exist in the area with respect to the classification to which such rate is applicable. A reasonable degree of competition does not exist in a county if a physician has less than 3 options for obtaining medical liability insurance from insurers that are not legally or corporately affiliated or otherwise related. The Department shall identify via its Website the current medical liability insurance options available to physicians in Illinois by county, specialty, annual premium rate, and other coverage terms and conditions

deemed appropriate by the Department. The Department shall also identify counties throughout Illinois where a reasonable degree of competition does not exist.

No rate shall be held inadequate unless it is unreasonably low for the insurance provided and continued use of it would endanger solvency of the company.

(2) Consideration shall be given, to the extent applicable, to past and prospective loss experience within and outside this State, to a reasonable margin for underwriting profit and contingencies, to past and prospective expenses both countrywide and those especially applicable to this State, and to all other factors, including judgment factors, deemed relevant within and outside this State.

Consideration may also be given in the making and use of rates to dividends, savings or unabsorbed premium deposits allowed or returned by companies to their policyholders, members or subscribers.

(3) The systems of expense provisions included in the rates for use by any company or group of companies may differ from those of other companies or groups of companies to reflect the operating methods of any such company or group with respect to any kind of insurance, or with respect to any subdivision or combination thereof.

(4) Risks may be grouped by classifications for the establishment of rates and minimum premiums. Classification rates may be modified to produce rates for individual risks in accordance with rating plans which establish standards for measuring variations in hazards or expense provisions, or both. Such standards may measure any difference among risks that have a probable effect upon losses or expenses. Such classifications or modifications of classifications of risks may be established based upon size, expense, management, individual experience, location or dispersion of hazard, or any other reasonable considerations and shall apply to all risks under the same or substantially the same circumstances or conditions. The rate for an established classification should be related generally

to the anticipated loss and expense factors of the class.

(c) Every company writing medical liability insurance shall file with the Director of Insurance the rates and rating schedules it uses for medical liability insurance.

(1) This filing shall occur at least annually and as often as the rates are changed or amended.

(2) For the purposes of this Section any change in premium to the company's insureds as a result of a change in the company's base rates or a change in its increased limits factors shall constitute a change in rates and shall require a filing with the Director.

(3) It shall be certified in such filing by an officer of the company and a qualified actuary that the company's rates are based on sound actuarial principles and are not inconsistent with the company's experience.

(d) If after a hearing the Director finds:

(1) that any rate, rating plan or rating system violates the provisions of this Section applicable to it, he may issue an order to the company which has been the subject of the hearing specifying in what respects such violation exists and stating when, within a reasonable period of time, the further use of such rate or rating system by such company in contracts of insurance made thereafter shall be prohibited;

(2) that the violation of any of the provisions of this Section applicable to it by any company which has been the subject of hearing was wilful, he may suspend or revoke, in whole or in part, the certificate of authority of such company with respect to the class of insurance which has been the subject of the hearing.

(Source: P.A. 79-1434.)

(215 ILCS 5/155.20b new)

Sec. 155.20b. Impact Analysis. The Department of Insurance shall conduct and publish an annual study of the impact of this amendatory Act of the 93rd General Assembly on the following:

(1) The number of medical malpractice claims filed and

amounts recovered for economic and non-economic damages per claim per year by county.

(2) The amount of attorneys' fees paid by medical malpractice plaintiffs and defendants per case per year by county.

(3) The impact of the standards of this Act on the cost and availability of medical malpractice coverage for hospitals and physicians.

Every 2 years, the Department of Insurance shall make recommendations to the Governor, the Speaker of the House, and the President of the Senate on whether any portion of this amendatory Act of the 93rd General Assembly should be supplemented, amended, or repealed.

Section 10. The Code of Civil Procedure is amended by changing Sections 2-622, 2-1114, 8-1901, and 8-2501 and by adding Sections 2-624.5 and 2-1707.5 as follows:

(735 ILCS 5/2-622) (from Ch. 110, par. 2-622)

(Text of Section WITHOUT the changes made by P.A. 89-7, which has been held unconstitutional)

Sec. 2-622. Healing art malpractice.

(a) In any action, whether in tort, contract or otherwise, in which the plaintiff seeks damages for injuries or death by reason of medical, hospital, or other healing art malpractice, the plaintiff's attorney or the plaintiff, if the plaintiff is proceeding pro se, shall file an affidavit, attached to the original and all copies of the complaint, declaring one of the following:

1. That the affiant has consulted and reviewed the facts of the case with a health professional who the affiant reasonably believes: (i) is knowledgeable in the relevant issues involved in the particular action; (ii) practices or has practiced within the last 6 years or teaches or has taught within the last 6 years in the same area of health care or medicine that is at issue in the

particular action; and (iii) is qualified by experience or demonstrated competence in the subject of the case; that the reviewing health professional has determined in a written report, after a review of the medical record and other relevant material involved in the particular action that there is a reasonable and meritorious cause for the filing of such action; and that the affiant has concluded on the basis of the reviewing health professional's review and consultation that there is a reasonable and meritorious cause for filing of such action. If the affidavit is filed as to a defendant who is a physician licensed to treat human ailments without the use of drugs or medicines and without operative surgery, a dentist, a podiatrist, a psychologist, or a naprapath, the written report must be from a health professional licensed in the same profession, with the same class of license, as the defendant. For affidavits filed as to all other defendants, the written report must be from a physician licensed to practice medicine in all its branches. In either event, the affidavit must identify the ~~profession of the~~ reviewing health professional's name, address, profession, and professional license number. Any reviewing health professional under this Section must satisfy the expert witness standards of Section 8-2501 of this Code ~~professional~~. A copy of the written report, clearly identifying the plaintiff and the reasons for the reviewing health professional's determination that a reasonable and meritorious cause for the filing of the action exists, must be attached to the affidavit, including ~~but~~ information which would identify the reviewing health professional and the reasons this health professional satisfies the expert witness conditions of Section 8-2501 of this Code ~~may be deleted from the copy so attached~~. Any reviewing health professional that provides a frivolous or improper review of a case shall be liable to each of the parties for the reasonable costs and attorneys' fees the parties expended

in resolving the case. A review shall be found frivolous if it is substantially lacking in factual support, is based upon a standard of care or practice that lacks substantial use in the relevant specialty or field of practice, or is made for an improper purpose such as to harass or cause needless increase in the cost of litigation.

2. That the affiant was unable to obtain a consultation required by paragraph 1 because a statute of limitations would impair the action and the consultation required could not be obtained before the expiration of the statute of limitations. If an affidavit is executed pursuant to this paragraph, the certificate and written report required by paragraph 1 shall be filed within 90 days after the filing of the complaint. The defendant shall be excused from answering or otherwise pleading until 30 days after being served with a certificate required by paragraph 1.

3. That a request has been made by the plaintiff or his attorney for examination and copying of records pursuant to Part 20 of Article VIII of this Code and the party required to comply under those Sections has failed to produce such records within 60 days of the receipt of the request. If an affidavit is executed pursuant to this paragraph, the certificate and written report required by paragraph 1 shall be filed within 90 days following receipt of the requested records. All defendants except those whose failure to comply with Part 20 of Article VIII of this Code is the basis for an affidavit under this paragraph shall be excused from answering or otherwise pleading until 30 days after being served with the certificate required by paragraph 1.

(b) Where a certificate and written report are required pursuant to this Section a separate certificate and written report shall be filed as to each defendant who has been named in the complaint and shall be filed as to each defendant named at a later time.

(c) Where the plaintiff intends to rely on the doctrine of

"res ipsa loquitur", as defined by Section 2-1113 of this Code, the certificate and written report must state that, in the opinion of the reviewing health professional, negligence has occurred in the course of medical treatment. The affiant shall certify upon filing of the complaint that he is relying on the doctrine of "res ipsa loquitur".

(d) When the attorney intends to rely on the doctrine of failure to inform of the consequences of the procedure, the attorney shall certify upon the filing of the complaint that the reviewing health professional has, after reviewing the medical record and other relevant materials involved in the particular action, concluded that a reasonable health professional would have informed the patient of the consequences of the procedure.

(e) Allegations and denials in the affidavit, made without reasonable cause and found to be untrue, shall subject the party pleading them or his attorney, or both, to the payment of reasonable expenses, actually incurred by the other party by reason of the untrue pleading, together with reasonable attorneys' fees to be summarily taxed by the court upon motion made within 30 days of the judgment or dismissal. In no event shall the award for attorneys' fees and expenses exceed those actually paid by the moving party, including the insurer, if any. In proceedings under this paragraph (e), the moving party shall have the right to depose and examine any and all reviewing health professionals who prepared reports used in conjunction with an affidavit required by this Section.

(f) A reviewing health professional who in good faith prepares a report used in conjunction with an affidavit required by this Section shall have civil immunity from liability which otherwise might result from the preparation of such report.

(g) The failure to file a certificate required by this Section shall be grounds for dismissal under Section 2-619.

(h) This Section does not apply to or affect any actions pending at the time of its effective date, but applies to cases

filed on or after its effective date.

(i) This amendatory Act of 1997 does not apply to or affect any actions pending at the time of its effective date, but applies to cases filed on or after its effective date.

(j) This amendatory Act of the 93rd General Assembly does not apply to or affect any actions pending at the time of its effective date, but does apply to cases filed on or after its effective date.

(Source: P.A. 86-646; 90-579, eff. 5-1-98.)

(735 ILCS 5/2-624.5 new)

Sec. 2-624.5. Health care claims based upon apparent or ostensible agency. In any action against a hospital or hospital affiliate arising out of the provision of health care, in which the plaintiff seeks damages for any loss, bodily injury, or death, in order to state a claim based upon apparent or ostensible agency, a party must allege with specific facts and prove the following:

(1) that the alleged principal through its own action or conduct created the reasonable inference by the plaintiff that the alleged agent was authorized to act on behalf of the alleged principal;

(2) that the plaintiff reasonably relied upon the alleged principal's action or conduct suggesting that the alleged agent was the alleged principal's actual agent; and

(3) that a reasonable person would not have sought goods or services from the alleged principal if that person knew that the alleged agent was not the alleged principal's actual agent.

A plaintiff basing a claim upon apparent or ostensible agency must prove these elements by a preponderance of the evidence.

This amendatory Act of the 93rd General Assembly applies to causes of action accruing on or after its effective date.

(735 ILCS 5/2-1114) (from Ch. 110, par. 2-1114)

Sec. 2-1114. Contingent fees for attorneys in medical

malpractice actions. (a) In all medical malpractice actions the total contingent fee for plaintiff's attorney or attorneys shall not exceed the following amounts:

33 1/3% of the first $150,000 of the sum recovered;

25% of the next $850,000 of the sum recovered; and

20% of any amount recovered over $1,000,000 of the sum recovered.

(b) For purposes of determining any lump sum contingent fee, any future damages recoverable by the plaintiff in periodic installments shall be reduced to a lump sum value.

(c) The court may review contingent fee agreements for fairness. In special circumstances, where an attorney performs extraordinary services involving more than usual participation in time and effort the attorney may apply to the court for approval of additional compensation.

(d) As used in this Section, "contingent fee basis" includes any fee arrangement under which the compensation is to be determined in whole or in part on the result obtained.

(e) In any individual action, fees for all plaintiffs' attorneys involved in the action representing the plaintiff or plaintiffs may not exceed $1,000,000 plus reasonable and documented expenses. The non-prevailing defendants shall pay such fees in addition to any award for economic and noneconomic damages in the case.

(Source: P.A. 84-7.)

(735 ILCS 5/2-1707.5 new)

Sec. 2-1707.5. Preservation of emergency medical care.

(a) The General Assembly acknowledges that many hospitals and physicians provide great benefits to the citizens of Illinois by operating emergency departments and trauma centers and providing services to individuals in need of emergency care throughout the State, without regard to their ability to pay for the care and often without payment for services. The General Assembly also acknowledges that many hospitals and physicians are discontinuing their status as trauma centers or

reducing the scope of their emergency care due to the fear of lawsuits based on claims of medical negligence. The public and society in general will suffer if these trauma centers cease operations or hospital emergency department reduce their level of emergency care.

(b) Any physician licensed under the Medical Practice Act of 1987, any licensed hospital and any of the hospital's employees, agents, apparent agents, and independent contractors who, in good faith provide emergency care or services to a person who is in need of emergency medical treatment and has presented to a hospital for emergency medical care, shall not be liable for civil damages as a result of his, her, or its acts or omissions, except for willful or wanton misconduct on the part of the physician, the hospital, or any of the hospital's employees, independent contractors, agents, or apparent agents, in providing the care.

(735 ILCS 5/8-1901) (from Ch. 110, par. 8-1901)

Sec. 8-1901. Admission of liability - Effect.

(a) The providing of, or payment for, medical, surgical, hospital, or rehabilitation services, facilities, or equipment by or on behalf of any person, or the offer to provide, or pay for, any one or more of the foregoing, shall not be construed as an admission of any liability by such person or persons. Testimony, writings, records, reports or information with respect to the foregoing shall not be admissible in evidence as an admission of any liability in any action of any kind in any court or before any commission, administrative agency, or other tribunal in this State, except at the instance of the person or persons so making any such provision, payment or offer.

(b) Any expression of grief, apology, remedial action, or explanation, including but not limited to a statement that the health care provider is sorry for the outcome, provided by a health care provider to a patient, the patient's family, or the patient's legal representative about an inadequate or unanticipated treatment outcome that is provided with 72 hours

of when the provider knew or should have known of the outcome shall not be admissible as evidence, nor discoverable in any action of any kind in any court or before any tribunal, board, agency, or person. The disclosure of any such information, whether proper or improper, shall not waive or have any effect upon its confidentiality, nondiscoverability, or inadmissibility. The disclosure of the information for the purpose of bringing a claim for damages against a provider is unlawful, and any person convicted of violating any of the provisions of this Act is guilty of a Class A misdemeanor. As used in this Act a "health care provider" is any hospital, any hospital employee or agent, a physician, or other licensed health care professional.

(Source: P.A. 82-280.)

(735 ILCS 5/8-2501) (from Ch. 110, par. 8-2501)

(Text of Section WITHOUT the changes made by P.A. 89-7, which has been held unconstitutional)

Sec. 8-2501. Expert Witness Standards. In any case in which the standard of care given by a medical profession is at issue, the court shall apply the following standards to determine if a witness qualifies as an expert witness and can testify on the issue of the appropriate standard of care.

(a) Whether the witness is board certified or board eligible in the same medical specialties as the defendant and is familiar with ~~Relationship of the medical specialties of the witness to~~ the medical problem or problems and the type of treatment administered in the case;

(b) Whether the witness has devoted 75% ~~a substantial portion~~ of his or her working hours ~~time~~ to the practice of medicine, teaching or University based research in relation to the medical care and type of treatment at issue which gave rise to the medical problem of which the plaintiff complains;

(c) whether the witness is licensed by any state or the District of Columbia in the same profession as the defendant; and

(d) whether, in the case against a nonspecialist, the witness can demonstrate a sufficient familiarity with the standard of care practiced in this State.

An expert shall provide proof of active practice, teaching, or engaging in university-based research. If retired, an expert must provide proof of attendance and completion of continuing education courses for 3 years previous to giving testimony. An expert who has not actively practiced, taught, or been engaged in university-based research for 10 years may not be qualified as an expert witness.

This amendatory Act of the 93rd General Assembly applies to causes of action accruing on or after its effective date.

(Source: P.A. 84-7.)

Section 99. Effective date. This Act takes effect January 1, 2005.

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Statutes amended in order of appearance