

PLEASE NOTE: Legislative Information **cannot** perform research, provide legal advice, or interpret Maine law. For legal assistance, please contact a qualified attorney.

## **An Act To Establish the Patient Compensation System Act**

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

**Sec. 1. 5 MRSA §12004-G, sub-§21-C** is enacted to read:

**21-C.**

Insurance

Patient Compensation  
Board

Legislative Per Diem  
and Expenses Only

24 MRSA §2994

**Sec. 2. 24 MRSA c. 21, sub-c. 11** is enacted to read:

### **SUBCHAPTER 11**

### **PATIENT COMPENSATION SYSTEM ACT**

#### **§ 2991. Short title**

This subchapter may be known and cited as "the Patient Compensation System Act."

#### **§ 2992. Definitions**

As used in this subchapter, unless the context otherwise indicates, the following terms have the following meanings.

- 1. Applicant.** "Applicant" means a person who files an application.
- 2. Application.** "Application" means a request for investigation by the system of an alleged occurrence of a medical injury.
- 3. Board.** "Board" means the Patient Compensation Board established in section 2994.
- 4. Collateral source.** "Collateral source" means any payment made to an applicant or on the applicant's behalf by or pursuant to:
  - A.** The federal Social Security Act; any federal, state or local income disability act; or any other public program providing payment for medical expenses, disability payments or other similar benefits;
  - B.** Any health, sickness or income disability insurance; any automobile accident insurance that provides health benefits or income disability coverage; or any other similar insurance benefits, except life insurance benefits, available to the applicant, whether purchased by the applicant or provided by others;

C. Any contract or agreement of any group, organization, partnership or corporation to provide, pay for or reimburse the costs of hospital, medical, dental or other health care services; or

D. Any contractual or voluntary wage continuation plan provided by employers or any other program intended to provide wages during a period of disability.

**5. Compensation Committee.** "Compensation Committee" means the committee created pursuant to section 2995.

**6. Compensation schedule.** "Compensation schedule" means a schedule of damages for medical injuries.

**7. Department.** "Department" means the Department of Professional and Financial Regulation.

**8. Independent medical review panel.** "Independent medical review panel" or "panel" means a panel convened under section 2996.

**9. Medical injury.** "Medical injury" means a personal injury or wrongful death due to medical treatment, including a missed diagnosis, that reasonably could have been avoided in care provided by:

A. An individual participating provider under the supervision of an experienced specialist provider practicing in the same field of care under the same or similar circumstances or, for a general practitioner provider, under the supervision of an experienced general practitioner provider practicing under the same or similar circumstances; or

B. A participating provider in a system of care, if such care is rendered within an optimal system of care under the same or similar circumstances.

"Medical injury" includes consideration of an alternate course of treatment only if the personal injury or death could have been avoided through a different but equally effective manner of treatment for the underlying condition. "Medical injury" includes consideration only of information that would have been known to an experienced specialist or readily available to an optimal system of care at the time of the medical treatment.

"Medical injury" does not include a personal injury or wrongful death if the medical treatment conformed with national practice standards for the care and treatment of patients as determined by the independent medical review panel.

**10. Medical Review Committee.** "Medical Review Committee" means the committee created pursuant to section 2995.

**11. Office of Compensation.** "Office of Compensation" means the office established in section 2994, subsection 6, paragraph B.

**12. Office of Medical Review.** "Office of Medical Review" means the office established in section 2994, subsection 6, paragraph A.

**13. Office of Quality Improvement.** "Office of Quality Improvement" means the office established in section 2994, subsection 6, paragraph C.

**14. Participating provider.** "Participating provider" means a provider that, at the time of a medical injury, has paid the contribution required for participation in the system for the year in which the medical injury occurred.

**15. Provider.** "Provider" means a physician, hospital or person that is licensed or otherwise authorized in this State to provide health care services.

**16. System.** "System" means the Patient Compensation System established in section 2993.

### **§ 2993. Patient Compensation System**

The Patient Compensation System is established to provide a method for patients to be compensated for medical injuries. The system is administered by the department.

### **§ 2994. Patient Compensation Board**

The Patient Compensation Board is established to govern the system.

**1. Membership.** The board is composed of 11 members who represent the medical, legal, patient and business communities from diverse geographic areas throughout the State. Members of the board are appointed by the Governor as follows:

- A. One member who is an allopathic or osteopathic physician who actively practices in this State;
- B. One member who is an executive in the business community who works in this State;
- C. One member who is a hospital administrator who works in this State;
- D. One member who is a certified public accountant who actively practices in this State;
- E. One member who is licensed to practice law in this State who actively practices in this State;
- F. Three members selected from a list of persons recommended by the President of the Senate, one of whom is an allopathic or osteopathic physician who actively practices in this State and one of whom is a patient advocate who resides in this State; and
- G. Three members selected from a list of persons recommended by the Speaker of the House of Representatives, one of whom is an allopathic or osteopathic physician who actively practices in this State and one of whom is a patient advocate who resides in this State.

The board shall annually elect from its membership one member to serve as chair of the board and one member to serve as vice-chair.

**2. Terms.** A member of the board is appointed for a 4-year term. If a vacancy occurs on the board before the expiration of a term, the Governor shall appoint a successor to serve the remainder of the term.

**3. Meetings.** The board shall meet at least quarterly upon the call of the chair. A majority of the board members constitutes a quorum. Meetings may be held by teleconference, Internet-based conference or other electronic means.

**4. Compensation.** Members of the board serve without compensation but are entitled to the legislative per diem and travel expenses under Title 3, section 2 for required attendance at board meetings.

**5. Powers and duties.** The board has the following powers and duties:

A. Ensuring the operation of the system in accordance with applicable federal and state laws, rules and regulations;

B. Entering into contracts as necessary to administer this subchapter;

C. Employing an executive director and other staff as necessary to perform the functions of the system, except that the Governor shall appoint the initial executive director;

D. Approving the hiring of a chief compensation officer and chief medical officer, as recommended by the executive director;

E. Approving a compensation schedule, as recommended by the Compensation Committee pursuant to section 2995, subsection 7, paragraph B;

F. Approving independent medical review panelists as recommended by the Medical Review Committee pursuant to section 2995, subsection 7, paragraph A;

G. Approving an annual budget; and

H. Annually approving participating provider fees under section 2999-C, subsection 1.

**6. Offices.** The following offices are established within the system.

A. The Office of Medical Review is established and shall evaluate and, as necessary, investigate all applications in accordance with this subchapter. For the purpose of an investigation of an application, the office has the power to administer oaths, take depositions, issue subpoenas, compel the attendance of witnesses and the production of papers, documents and other evidence and obtain patient records pursuant to the applicant's release of protected health information. The office staff must include individuals representing multidisciplinary clinical expertise to facilitate the review of applications.

B. The Office of Compensation is established and shall allocate compensation for each application in accordance with the compensation schedule as approved pursuant to subsection 5, paragraph E.

C. The Office of Quality Improvement is established and shall regularly review application data to conduct root cause analyses and develop and disseminate best practices based on the reviews. The office shall capture and record safety-related data obtained during an investigation conducted by the Office of Medical Review, including the cause of, the factors contributing to and any interventions that may have prevented the medical injury.

**7. Powers and duties of staff.** The executive director shall oversee the operation of the system in accordance with this subchapter. The following staff report directly to and serve at the pleasure of the executive director.

A. The advocacy director shall ensure that each applicant is provided high-quality individual assistance throughout the application process, from initial filing to disposition of the application. The advocacy director shall assist each applicant in determining whether to retain an attorney, including an explanation of possible fee arrangements and the advantages and disadvantages of retaining an attorney. If an applicant seeks to file an application without an attorney, the advocacy director shall assist the applicant in filing the application. The advocacy director shall regularly provide status reports to an applicant regarding an application.

B. The chief compensation officer shall manage the Office of Compensation. The chief compensation officer shall recommend to the Compensation Committee a compensation schedule for each type of medical injury. The chief compensation officer may not be a licensed physician or an attorney.

C. The chief financial officer is responsible for overseeing the financial operations of the system, including the development of an annual budget.

D. The chief legal officer shall represent the system in all contested applications, oversee the operation of the system to ensure compliance with established procedures and ensure adherence to all applicable federal and state laws, rules and regulations.

E. The chief medical officer must be a physician licensed under Title 32, chapter 36 or 48 and shall manage the Office of Medical Review. The chief medical officer shall prepare for the Medical Review Committee a list of qualified panelists from multiple disciplines for independent medical review panels. The chief medical officer shall convene independent medical review panels as necessary to review applications.

F. The chief quality officer shall manage the Office of Quality Improvement.

## **§ 2995. Committees**

The board shall create a Medical Review Committee and a Compensation Committee. The board may create additional committees as necessary to assist in the performance of its duties and responsibilities. Each committee is composed of 3 board members chosen by a majority vote of the board.

**1. Medical Review Committee.** The Medical Review Committee is composed of 2 physicians who are licensed in this State and a board member who is not an attorney and who resides in this State. The board shall designate a physician committee member as chair of the committee.

**2. Compensation Committee.** The Compensation Committee is composed of a certified public accountant who practices in this State and 2 board members who are not physicians or attorneys and who reside in this State. The certified public accountant shall serve as chair of the committee.

**3. Terms of appointment.** Members of each committee serve 2-year terms concurrent with their respective terms as board members. If a vacancy occurs on a committee, the board shall appoint a successor to serve the remainder of the term. A committee member who is removed or resigns from the board must be removed from the committee.

**4. Vice-chair.** The board annually shall designate a vice-chair of each committee.

**5. Meetings.** Each committee shall meet at least quarterly or at the specific direction of the board. Meetings may be held by teleconference, Internet-based conference or other electronic means.

**6. Compensation.** Members of the committees serve without compensation but are entitled to the legislative per diem and travel expenses under Title 3, section 2 for required attendance at committee meetings.

**7. Committee powers and duties.** The committees have the following powers and duties.

**A.** The Medical Review Committee, in consultation with the chief medical officer pursuant to section 2994, subsection 7, paragraph E, shall prepare for the board a comprehensive list of qualified panelists from multiple disciplines to serve on independent medical review panels as needed.

**B.** The Compensation Committee, in consultation with the chief compensation officer pursuant to section 2994, subsection 7, paragraph B, shall recommend to the board:

(1) A compensation schedule, formulated so that the aggregate cost of medical malpractice and the aggregate of participating provider fees are equal to or less than the prior fiscal year's aggregate cost of medical malpractice. Compensation awards for each injury must be no less than the average indemnity payment reported by the Physician Insurers Association of America or a successor organization for similar medical injuries with similar severity. The committee shall annually review the compensation schedule and, if necessary, recommend a revised schedule so that a projected increase in the upcoming fiscal year's aggregate cost of medical malpractice does not exceed the percentage change from the prior year in the medical care component of the Consumer Price Index for All Urban Consumers as compiled by the Bureau of Labor Statistics, United States Department of Labor;

(2) Guidelines for the payment of compensation awards through periodic payments; and

(3) Guidelines for the apportionment of the cost of compensation among multiple providers, which must be based on the historical apportionment among multiple providers for similar injuries with similar severity.

### **§ 2996. Independent medical review panels**

The chief medical officer of the system shall convene an independent medical review panel to evaluate each application to determine whether a medical injury occurred. Each panel must be composed of an odd number of at least 3 panelists chosen from a list of panelists that represent the same or a similar specialty as the provider and convenes, either in person or by teleconference, at the call of the chief medical officer. Each panelist must be paid a stipend as determined by the board for service on the panel. In order to expedite the review of applications, the chief medical officer may, whenever practicable, group related applications together for consideration by a single panel.

### **§ 2997. Conflict of interest**

A board member, panelist of an independent medical review panel or employee of the system may not engage in any conduct that constitutes a conflict of interest. For purposes of this section, "conflict of interest" means a situation in which the private interest of a board member, panelist or employee could influence that person's judgment in the performance of that person's duties under this subchapter. A board member, panelist or employee shall immediately disclose in writing the presence of a conflict of interest when the board member, panelist or employee knows or reasonably should have known that the factual circumstances surrounding a particular application constitute or constituted a conflict of interest. A board member, panelist or employee who violates this section is subject to disciplinary action as determined by the board. "Conflict of interest" includes, but is not limited to:

**1. Bias.** Conduct that would lead a reasonable person having knowledge of all of the circumstances to conclude that a board member, panelist or employee is biased against or in favor of an applicant; and

**2. Financial interest.** Participation in an application in which the board member, panelist or employee or the parent, spouse or child of a board member, panelist or employee has a financial interest.

### **§ 2998. Rulemaking**

The board shall adopt routine technical rules pursuant to Title 5, chapter 375, subchapter 2-A to implement and administer this subchapter, including rules addressing:

**1. Applications.** The application process, including forms necessary to collect relevant information from applicants;

**2. Disciplinary procedures.** Disciplinary procedures for a board member, panelist of an independent medical review panel or employee of the system who violates the conflict of interest provisions of section 2997;

**3. Stipends.** Stipends paid pursuant to section 2996 to panelists, which may be adjusted in accordance with the relative scarcity of the panelist's specialty, if applicable;

**4. Compensation.** Payment of compensation awards through periodic payments and the apportionment of the cost of compensation among multiple providers, as recommended by the Compensation Committee; and

**5. Opt-out process.** The opt-out process for providers under section 2999-C, subsection 5.

## **§ 2999. Filing of applications**

**1. Content.** In order to obtain compensation for a medical injury, an applicant or the applicant's legal representative must file an application with the system. The application must include the following:

A. The name and address of the applicant and the applicant's legal representative and the basis of the representation;

B. The name and address of any participating provider who provided medical treatment allegedly resulting in the medical injury;

C. A brief statement of the facts and circumstances surrounding the medical injury;

D. An authorization for release to the Office of Medical Review of all protected health information that is potentially relevant to the application;

E. Any other information that the applicant believes will be beneficial to the investigatory process, including the names of potential witnesses; and

F. Documentation of any applicable collateral source relative to the medical injury.

**2. Incomplete applications.** If an application is not complete, the system shall, within 30 days after the receipt of the initial application, notify the applicant in writing of any errors or omissions. An applicant has 30 days after receipt of the notice in which to correct the errors or omissions in the initial application.

**3. Time limit on applications.** An application must be filed within the time period specified in section 2902 for professional negligence actions.

**4. Supplemental information.** After the filing of an application, the applicant may supplement the initial application with additional information that the applicant believes may be beneficial in the resolution of the application.

**5. Legal counsel.** This section does not prohibit an applicant or participating provider from retaining an attorney to represent the applicant or participating provider in the review and resolution of an application.

## **§ 2999-A. Disposition of applications**

**1. Initial medical review.** The Office of Medical Review shall, within 10 days after the receipt of a completed application, determine whether the application, prima facie, constitutes a medical injury.

A. If the Office of Medical Review determines that the application, prima facie, constitutes a medical injury, the office shall immediately notify by registered or certified mail each participating provider named in the application and, for participating providers that are not self-insured, the insurer that provides coverage for the participating provider. The notification must inform the participating provider that the participating provider may support the application to expedite the processing of the application. A participating provider has 15 days after the receipt of notification of an application to support the application. If the participating provider supports the application, the office shall review the application in accordance with subsection 2.

B. If the Office of Medical Review determines that the application does not, prima facie, constitute a medical injury, the office shall send a rejection letter to the applicant by registered or certified mail informing the applicant of the right to appeal the determination of the office. The applicant has 15 days after the receipt of the letter in which to appeal the determination of the office pursuant to section 2999-B.

**2. Expedited medical review.** An application that is supported by a participating provider in accordance with subsection 1 must be reviewed by the Office of Medical Review within 30 days after notification of the participating provider's support of the application to determine the validity of the application. If the Office of Medical Review finds that the application is valid, the Office of Compensation shall determine a compensation award in accordance with subsection 4. If the Office of Medical Review finds that the application is not valid, the office shall immediately notify the applicant by registered or certified mail of the rejection of the application and the right to appeal the determination of the office. In the case of suspected fraud, the Office of Medical Review shall immediately notify relevant law enforcement authorities.

**3. Formal medical review.** If the Office of Medical Review determines that the application, prima facie, constitutes a medical injury and the participating provider does not elect to support the application, the office shall complete a thorough investigation of the application within 60 days after the determination by the office. The investigation must include a thorough investigation of all available documentation, witnesses and other information. Within 15 days after the completion of the investigation, the chief medical officer shall allow the applicant and the participating provider to access records, statements and other information obtained in the course of the investigation, in accordance with relevant state and federal laws, rules and regulations.

Within 30 days after the completion of the investigation under this subsection, the chief medical officer shall convene an independent medical review panel to determine whether the application constitutes a medical injury. The independent medical review panel must have access to all information, with names redacted, obtained by the office in the course of the investigation of the application and shall make a written determination, which must be immediately provided to the applicant and the participating provider.

A. If the independent medical review panel determines that:

(1) The medical treatment conformed to national practice standards for the care and treatment of patients, then the application must be dismissed and the participating provider is not held responsible for the applicant's medical injury; or

(2) All of the following criteria exist by a preponderance of the evidence, then the panel shall report that the application constitutes a medical injury:

(a) The participating provider performed a medical treatment on the applicant;

(b) The applicant suffered a personal injury or wrongful death;

(c) The medical treatment was the proximate cause of the personal injury or wrongful death; and

(d) One or more of the following has occurred:

(i) An accepted medical treatment was not used;

(ii) An accepted medical treatment was used but was executed in a substandard fashion; and

(iii) An accepted medical treatment was used, but, as determined by a prospective analysis, personal injury or wrongful death could have been avoided by using a less hazardous but equally effective medical treatment.

B. If the independent medical review panel determines that the application constitutes a medical injury, the Office of Medical Review shall immediately notify the participating provider by registered or certified mail of the right to appeal the determination of the panel. The participating provider has 15 days after the receipt of the letter in which to appeal the determination of the panel pursuant to section 2999-B.

C. If the independent medical review panel determines that the application does not constitute a medical injury, the Office of Medical Review shall immediately notify the applicant by registered or certified mail of the right to appeal the determination of the panel. The applicant has 15 days from the receipt of the letter to appeal the determination of the panel pursuant to section 2999-B.

**4. Compensation review.** If the Office of Medical Review finds that an application under expedited medical review under subsection 2 is valid, or if an independent medical review panel finds that an application constitutes a medical injury under subsection 3 and all appeals of that finding have been exhausted by the participating provider pursuant to section 2999-B, the Office of Compensation shall, within 30 days after the finding or the exhaustion of all appeals of that finding, whichever occurs later, make a written determination of a compensation award in accordance with the compensation schedule and the finding. The office shall notify the applicant and the participating provider by registered or certified mail of the amount of the compensation award and shall also explain to the applicant the process to appeal the determination of the office. The applicant has 15 days from the receipt of the letter to appeal the determination of the office pursuant to section 2999-B.

**5. Limitation on compensation.** Compensation for each application must be offset by any past and future collateral source payments. Compensation may be paid by periodic payments as determined by the Office of Compensation in accordance with rules adopted by the board under section 2998.

**6. Payment of compensation.** Within 14 days after the acceptance of a compensation award by the applicant or the conclusion of all appeals pursuant to section 2999-B, whichever occurs later, the participating provider, or the insurer for a participating provider who has insurance coverage, shall remit the compensation award to the system, which shall immediately provide compensation to the applicant. Beginning 45 days after the acceptance of a compensation award by the applicant or the conclusion of all appeals pursuant to section 2999-B, whichever occurs later, an unpaid award begins to accrue interest at the rate of 18% per year.

**7. Professional board notice.** The system shall provide the department with electronic access to applications for which a medical injury was determined to exist related to a participating provider licensed under Title 32, chapter 36 or 48 when the participating provider represents an imminent risk of harm to the public. The department shall review such applications to determine whether any of the incidents that resulted in the application potentially involved conduct by the licensee that is subject to disciplinary action, in which case chapter 36 or 48 applies as appropriate.

## **§ 2999-B. Review by Superior Court; appellate review; extensions of time**

**1. Review by Superior Court.** The Superior Court shall hear and determine appeals filed under this subchapter. The Superior Court is limited to determining whether the Office of Medical Review, the independent medical review panel or the Office of Compensation, as appropriate, has faithfully followed the requirements of this subchapter and rules adopted under this subchapter in reviewing applications. If the Superior Court determines that such requirements were not followed in reviewing an application, the court shall require the office to perform another initial medical review or shall require the chief medical officer to either reconvene the original independent medical review panel or convene a new independent medical review panel or shall require the Office of Compensation to redetermine the compensation amount, in accordance with the determination of the court.

**2. Appellate review.** A determination by the Superior Court under subsection 1 regarding the award or denial of compensation under this subchapter is conclusive and binding as to all questions of fact and must be provided to the applicant and the participating provider. An applicant may appeal the compensation award or the denial of compensation to the Supreme Judicial Court. Appeals must be filed in accordance with rules of procedure adopted by the Supreme Judicial Court.

**3. Extensions of time.** Upon a written petition by either the applicant or the participating provider, the Superior Court may grant, for good cause, an extension of any of the time periods specified in this subchapter. The relevant time period is tolled from the date of the written petition until the date the Superior Court issues a determination.

### **§ 2999-C. Expenses of administration; opt out**

**1. Fees.** The board annually shall determine a fee that must be paid by each provider, unless the provider opts out of participation in the system pursuant to subsection 5. The fee amount must be determined by July 1st of each year and must be based on the anticipated expenses of the administration of this subchapter for the next fiscal year.

**2. Schedule.** The fee determined under this section must be payable by each provider upon notice delivered by July 1st each year. Each provider shall pay the fee within 30 days after the date the notice is delivered to the provider. If a provider fails to pay the fee determined under this section within 30 days after notice, the board shall notify the provider by certified or registered mail that the provider's license is subject to revocation if the fee is not paid within 60 days from the date of the original notice.

**3. Licensure revocation.** A provider that has not opted out of participation in the system pursuant to subsection 5 that fails to pay the fee determined under this section within 60 days after receipt of the original notice is subject to a licensure revocation action by the department.

**4. Account.** All fees collected under this section must be paid into the Patient Compensation System Fund established in section 2999-F.

**5. Opt out.** A provider may elect to opt out of participation in the system. The election to opt out must be made in writing no later than 15 days before the due date of the fee required under this section. A provider that opts out may subsequently elect to participate by paying the appropriate fee for the current year.

### **§ 2999-D. Notice to patients of participation in the system**

**1. Notice.** Each participating provider shall provide notice to the participating provider's patients that the participating provider is participating in the system. The notice must be provided on a form furnished by the system and include a concise explanation of a patient's rights and benefits under the system.

**2. Exceptions.** Notice under subsection 1 is not required to be given to a patient when the patient has a medical emergency, as defined in Title 32, section 1525-A, subsection 2, or when notice is not practicable.

### **§ 2999-E. Annual report**

The board annually, beginning on October 1, 2016, shall submit to the Department of Professional and Financial Regulation, the Governor and the joint standing committee of the Legislature having jurisdiction over insurance matters a report that describes the filing and disposition of applications in the preceding fiscal year. The report must include, in the aggregate, the number of applications, the disposition of the applications and the compensation awarded.

### **§ 2999-F. Patient Compensation System Fund**

The Patient Compensation System Fund, referred to in this section as "the fund," is established within the department as a nonlapsing fund for the purposes specified in this subchapter. The fund is funded from the fees collected under section 2999-C and from other funds accepted by the department or allocated or appropriated by the Legislature. Allocations from the fund must be made for expenses of the administration of this subchapter, including the costs the board may incur for staff, administrative support services, legal representation and contracted services.

### **§ 2999-G. Exclusive remedy**

The rights and remedies granted by this subchapter due to a personal injury or wrongful death exclude all other rights and remedies of the applicant and the applicant's personal representative, parents, dependents and next of kin against any participating provider directly involved in providing the medical treatment resulting in the injury or death, arising out of or related to a professional negligence claim, whether in tort or in contract, with respect to the injury or death. Notwithstanding any other law, this subchapter applies exclusively to applications submitted under this subchapter.

### **§ 2999-H. Early offer**

This subchapter does not prohibit a self-insured provider or an insurer from providing an early offer of settlement or apology in satisfaction of a medical injury. A person who accepts a settlement or apology offer under this section may not file an application under this subchapter for the same medical injury. If an application has been filed before the offer of settlement or apology, the acceptance of the settlement or apology offer by the applicant results in the withdrawal of the application.

### **§ 2999-I. Wrongful death**

Compensation may not be provided under this subchapter for an application that requests an investigation of an alleged wrongful death due to medical treatment if that application is filed by an adult child on behalf of the adult child's parent or by a parent on behalf of the parent's adult child.

**Sec. 3. Staggered terms.** Notwithstanding the Maine Revised Statutes, Title 24, section 2994, subsection 2, of the initial appointments to the Patient Compensation Board, the 5 members appointed by the Governor under Title 24, section 2994, subsection 1, paragraphs A to E are appointed to 2-year terms, and the remaining 6 members are appointed to 3-year terms.

**Sec. 4. Application.** This Act applies to medical incidents for which a notice of intent to initiate litigation has not been mailed before July 1, 2016.

## SUMMARY

This bill establishes within the Department of Professional and Financial Regulation the Patient Compensation System, which allows a person who has suffered a medical injury to receive compensation outside of the court system. The Patient Compensation System is governed by a board of medical, legal, patient and business representatives. The bill establishes 3 offices within the system to provide medical review of claims, compensation allocations and quality review, as well as 2 committees to provide guidance in the selection of medical review panelists and the design of compensation schedules. The bill also creates the Patient Compensation System Fund, which is funded by fees paid by physicians participating in the system.