

1
2
3 Chairman Linda W. Cropp
4 at the request of the Mayor
5

6
7 A BILL
8
9

10
11 IN THE COUNCIL OF THE DISTRICT OF COLUMBIA
12
13

14
15 Chairman Linda W. Cropp, at the request of the Mayor, introduced the following bill, which was
16 referred to the Committee on _____.
17

18 To improve patient access to healthcare services and provide improved medical care by
19 amending existing law to broaden the immunity afforded healthcare professionals
20 providing volunteer medical services; reducing the incidences of preventable adverse
21 medical events in licensed health care facilities by authorizing the Department of Health
22 to develop a reporting system; authorizing the Department of Health to issue risk
23 management regulations for health care facilities; establishing a 60-day period for the
24 Insurance Commissioner to review a rate filing for a medical liability insurance increase
25 before allowing the rate to go into effect; requiring a certificate of merit in medical
26 liability actions; reducing the excessive burden the liability system places on the
27 healthcare delivery system; and establishing limits on compensation for non-economic
28 damages in medical liability claims.
29

30 BE IT ENACTED BY THE COUNCIL OF THE DISTRICT OF COLUMBIA That this
31 act may be cited as the “Health Care Reform Act of 2005”.

32 TITLE I. VOLUNTEER HEALTH CARE PROFESSIONAL IMMUNITY.

33 Sec. 101. Short title.

34 This title may be cited as the “Volunteer Health Care Professional Immunity Amendment
35 Act of 2005”.

1 Sec. 102. Section 2 of An Act To relieve physicians of liability for negligent medical
2 treatment at the scene of an accident in the District of Columbia, approved November 8, 1965
3 (79 Stat. 1302; D.C. Official Code § 7-402) is amended as follows:

4 (a) Subsection (a) is amended to read as follows:

5 “A licensed physician, registered nurse, or nurse-midwife who in good faith provides
6 health care or treatment lawfully in the District of Columbia without the expectation of receiving
7 or intending to receive compensation shall not be liable in civil damages for any act or omission
8 in the course of rendering the health care or treatment, unless the act or omission is an intentional
9 wrong or manifests a willful or wanton disregard for the health or safety of others.

10 (b) Subsection (b) is amended to read as follows:

11 “A licensed physician, registered nurse, or nurse-midwife providing medical care or
12 assistance in accordance with subsection (a) of this section shall provide and shall require his or
13 her prospective client to sign a written statement witnessed by 2 persons in which the parties
14 agree to the rendering of the health care or treatment.”.

15 TITLE II. PATIENT SAFETY INITIATIVES

16 Sec. 201. System for reducing preventable adverse medical events.

17 (a) The Department of Health shall develop a system for reducing the incidences of
18 preventable adverse medical events in licensed health care facilities, including a system for
19 reporting such incidences.

20 (b) In developing the system, the Department shall review:

21 (1) Federal reports and recommendations for identification of medical errors
22 including the most recent report of the Institute of Medicine of the National Academy of
23 Sciences;

1 (2) Recommendations of national accrediting and quality assurance
2 organizations, including the Joint Commission on the Accreditation of Health Care
3 Organizations;

4 (3) Recommendations of the National Quality Forum;

5 (4) Programs in other states designed to reduce adverse medical events; and,

6 (5) Best practices of hospitals and other health care facilities.

7 (c) The Department shall issue risk management regulations for health care facilities
8 to strengthen accountability, internal reporting and evaluation systems for certain events,
9 including, but not limited to:

10 (1) Defining adverse event, near-miss, root cause analysis and action plan;

11 (2) Encouraging identification and reporting of near-misses;

12 (3) Specifying type of response to serious adverse events and near-misses;

13 (4) Specifying reports to be submitted to the Department and confidentiality of
14 such reports;

15 (5) Requiring notification to a patient and, when appropriate, the patient's
16 family of an outcome of care that differs significantly from an anticipated outcome;

17 (6) Providing notice to patient and families that complaints can be filed with
18 the Department; and,

19 (7) Updating requirements to be consistent with national accrediting and
20 quality assurance organizations, including the Joint Commission on the Accreditation of Health
21 Care Organizations.

22 (d) All information collected pursuant to this act shall be treated as confidential, non-
23 discoverable and inadmissible as evidence in any civil or administrative disciplinary action.

1 TITLE III. MEDICAL LIABILITY INSURANCE ACCESS.

2 Sec. 301. Short title.

3 This title may be cited as the “Medical Liability Insurance Access Act of 2005”.

4 Sec. 302. Definitions.

5 For the purposes of this title the term:

6 (a) “Commissioner” means the Commissioner of the Department of Insurance, Securities,
7 and Banking.

8 (b) “Director” means the Director of the Department of Health.

9 (c) “District” means the District of Columbia.

10 (d) “Insurer” means an insurance, surety, or indemnity company, and shall be deemed to
11 include a corporation, partnership, association, individual, or aggregation of individuals engaging
12 in or proposing or attempting to engage in any kind of insurance, surety, or indemnity business,
13 including the exchanging of reciprocal or interinsurance contracts between individuals,
14 partnerships, and corporations; provided, however, that the term “insurer” shall not include
15 captive insurance companies or risk retention groups.

16 (e) “Medical liability insurance” means any insurance against liability of the assured for
17 the injury, disablement, or death of any person resulting from the provision of medical or
18 hospital care by the insured.

19 (f) “Noncompetitive market” means an insurance market condition in which one insurer
20 controls greater than a 40% share of the District of Columbia medical liability insurance market
21 as determined by gross premiums written in the District of Columbia.

22 Sec. 303. Applicability.

1 The provisions of this title shall apply only with respect to rates for medical liability insurance
2 made during a noncompetitive market.

3 Sec. 304. Notice of noncompetitive market.

4 Upon a determination that a noncompetitive market exists, the Commissioner shall, by notice
5 published in the D.C. Register, declare that the District of Columbia medical liability insurance
6 market is noncompetitive within the meaning of this title. Where the Commissioner determines
7 that a noncompetitive market no longer exists, he shall publish that determination in the D.C.
8 Register.

9 Sec. 305. Making of medical liability insurance rates.

10 (a) Every final rate or premium charge proposed to be used by any insurer shall first be
11 filed with the Commissioner and shall be adequate, not excessive, and not unfairly
12 discriminatory. A medical liability insurance rate may be held by the Commissioner to be
13 excessive if the rate is unreasonably high for the insurance provided and is not actuarially
14 justified based on the commonly accepted actuarial principles. In determining whether rates
15 comply with standards under this subsection, due consideration shall be given for past and
16 prospective loss experience within the District, a reasonable margin for underwriting profit and
17 contingencies, dividends, savings, or unabsorbed premium deposits allowed or returned by
18 insurers to their policyholders or members or subscribers, past and prospective expenses, both
19 countrywide and in the District, and investment income earned or realized by insurers both from
20 their unearned premiums and from their loss reserve funds.

21 (b) The Commissioner shall determine within 60 days after a rate has been filed whether
22 the rate is adequate, not excessive, and not unfairly discriminatory. Unless a rate has been

1 disapproved by the Commissioner, it shall be deemed approved at the expiration of the 60-day
2 period following the filing of the rate.

3 (c) (1) No later than 60 days after the effective date of this act, the Commissioner
4 shall calculate a presumed factor that reflects the impact that the changes contained in this act
5 will have on rates for medical liability insurance and shall issue a notice informing all insurers
6 writing medical liability insurance of such presumed factor. In determining the presumed factor,
7 the Commissioner shall use generally accepted actuarial techniques and standards provided in
8 this section in determining the expected impact on losses, expenses, and investment income of
9 the insurer. Upon request by the Commissioner, an insurer shall provide such actuarial
10 information as may assist the Commissioner in determining the presumed factor. Any actuarial
11 data provided to the Commissioner pursuant to this section shall be confidential and privileged,
12 shall not be subject to the Freedom of Information Act of 1976 (FOIA), as amended, effective
13 March 25, 1977 (D.C. Law 1-96; D.C. Official Code § 2-531 *et seq.*), shall not be subject to
14 subpoena, and shall not be subject to discovery or admissible in evidence in a private civil
15 action; provided, that the Commissioner may use such information in the furtherance of any
16 regulatory or legal action brought as a part of his or her official duties. To the extent that the
17 operation of a provision of this act is stayed pending a constitutional challenge, the impact of that
18 provision shall not be included in the calculation of a presumed factor under this subsection.

19 (2) No later than 60 days after the Commissioner issues his or her notice of the
20 presumed rate change factor under paragraph (c)(1) of this subsection, each insurer writing
21 medical liability coverage in the District shall submit to the office a rate filing for medical
22 liability insurance, which will take effect no later than 180 days after the effective date of this
23 act. Except as authorized under paragraph (c)(3), the filing shall reflect an overall rate reduction

1 at least as great as the presumed factor determined under paragraph (c)(1). All policies issued on
2 or after the effective date of this act and after the effective date of the rate filing required by this
3 subsection, shall charge no more than the rate that is approved.

4 (3) Any insurer or rating organization that contends that the rate provided for in
5 paragraph (c)(2) of this subsection is excessive, inadequate, or unfairly discriminatory shall
6 separately state in its filing the rate it contends is appropriate and shall state with specificity the
7 factors or data that it contends should be considered in order to produce such appropriate rate.
8 The insurer or rating organization shall be permitted to use all of the generally accepted actuarial
9 techniques provided in this section in making any filing pursuant to this subsection. The
10 Commissioner shall review each such exception and approve or disapprove it prior to use. It
11 shall be the insurer's burden to actuarially justify any deviations from the rates required to be
12 filed under paragraph (c)(2). The insurer making a filing under this paragraph shall include in the
13 filing the expected impact of the enactment of this act on losses, expenses, and rates.

14 (4) If any provision of this act is held invalid by a court of competent jurisdiction,
15 the Commissioner shall permit an adjustment of all medical liability rates filed under this section
16 to reflect the impact of such holding on such rates so as to ensure that the rates are not excessive,
17 inadequate, or unfairly discriminatory.

18 (5) The notice by the Commissioner of the presumed factor shall be given to
19 insurers pursuant to the provisions of section 6 of the District of Columbia Administrative
20 Procedure Act, as amended, approved October 21, 1968 (82 Stat. 1206; D.C. Official Code § 2-
21 505).

22 (d) Upon the filing of a proposed rate change by an insurer which filing would result in
23 an average District-wide increase of 15 percent or more, pursuant to standards determined by the

1 Commissioner, the insurer shall mail notice of such filing to each of its policyholders or
2 members. In reviewing the filing of the proposed rate, the Commissioner shall consider any
3 written comments received from the insurer's policyholders or members.

4 (e) All rate filings made pursuant to this section shall be sworn to by at least two
5 executive officers of the insurer.

6 (f) All information contained in a rate filing made pursuant to this section not otherwise
7 confidential or privileged as provided by law, shall be available for public inspection.

8 Sec. 306. Claims reporting requirement; confidential treatment.

9 (a) On or before June 1 of each year, each insurer placing medical liability insurance in
10 the District shall report to the Director and the Commissioner all claims or actions for damages
11 for personal injuries claimed to have been caused by error, omission, or negligence in the
12 performance of its insured's professional services or based on a claimed performance of
13 professional services without consent, if the claim resulted in the prior calendar year in:

14 (1) a final judgment in any amount;

15 (2) a settlement in any amount; or

16 (3) a final disposition of a medical liability claim resulting in no indemnity
17 payment on behalf of the insured.

18 (b) Documents, materials, or other information in the possession or control of the
19 Department of Insurance and Securities Regulation or the Department of Health or which are
20 obtained by or disclosed to the Commissioner or the Director or any other person pursuant to the
21 requirements of this section, shall be confidential and privileged, shall not be subject to the
22 Freedom of Information Act of 1976 (FOIA), as amended, effective March 25, 1977 (D.C. Law
23 1-96; D.C. Official Code § 2-531 *et seq.*), shall not be subject to subpoena, and shall not be

1 subject to discovery or admissible in evidence in a private civil action; provided, that the
2 Commissioner and the Director may use the documents, materials or other information in the
3 furtherance of any regulatory or legal action brought as a part of their official duties.

4 Sec. 307. Judicial review.

5 Any insurer aggrieved by any order, ruling, proceeding, or action of the Commissioner made or
6 taken pursuant to this title may contest the validity of such order, ruling, proceeding, or action,
7 by appeal to the District of Columbia Court of Appeals in accordance with Section 11 of the
8 District of Columbia Administrative Procedure Act, as amended, approved October 21, 1968 (82
9 Stat. 1209; D.C. Official Code § 2-510).

10 Sec. 308. Rulemaking authority.

11 The Commissioner, pursuant to section 6 of the District of Columbia Administrative Procedure
12 Act, as amended, approved October 21, 1968 (82 Stat. 1206; D.C. Official Code § 2-505), may
13 issue rules and regulations to implement the provisions of this title.

14 TITLE IV. CERTIFICATE OF MERIT IN MEDICAL LIABILITY ACTIONS.

15 Sec. 401. Short title.

16 This title may be cited as the “Medical Liability Certificate of Merit Requirement Act of
17 2005”.

18 Sec. 402. Certificate of merit in medical liability actions.

19 (a) In any action for medical liability, the complaint shall be accompanied by a
20 certificate, executed by a physician, declaring that:

21 (1) the physician has reviewed the facts of the case;

22 (2) the physician is licensed to practice in the District, is board-certified in the
23 same specialty as the defendant, has at least ten (10) years of experience as a physician, spends at

1 least 75% of his or her professional time as a physician treating patients, and is knowledgeable in
2 the relevant issues involved in the particular action; and

3 (3) the physician has concluded on the basis of such review and consultation that
4 there is a reasonable basis for the commencement of such action.

5 (b) Where a certificate is required pursuant to this section, a single certificate shall be
6 filed for each defendant, even if more than one defendant has been named in the complaint or is
7 subsequently named.

8 (c) Where the attorney intends to rely solely on the doctrine of "res ipsa loquitur", the
9 requirements of this section shall be inapplicable. In such cases, the complaint shall be
10 accompanied by a certificate, executed by the attorney, declaring that the attorney is solely
11 relying on such doctrine and, for that reason, is not filing a certificate required by this section.

12 (d) If a request by the plaintiff for the records of the plaintiff's medical treatment by the
13 defendants has been made and such records have not been produced, the plaintiff shall not be
14 required to serve the certificate required by this section until ninety days after such records have
15 been produced.

16 TITLE V. MEDICAL INJURY COMPENSATION REFORM.

17 Sec. 501. Short title.

18 This title may be cited as the "Medical Injury Compensation Reform Act of 2005".

19 Sec. 502. Definitions.

20 For purposes of this title the term:

21 (a) "Alternative dispute resolution system" or "ADR" means a system that provides for
22 the resolution of healthcare lawsuits in a manner other than through a civil action brought in a
23 District or Federal court.

1 (b) “Claimant” means a person including a decedent’s estate seeking or who has sought
2 recovery of damages in a healthcare liability claim. All persons claiming to have sustained
3 damages as a result of a bodily injury or death of a single person are considered a single
4 claimant.

5 (c) “Collateral source benefits” means any amount paid or reasonably likely to be paid in
6 the future to or on behalf of the claimant, or any service, product or other benefit provided or
7 reasonably likely to be provided in the future to or on behalf of the claimant, as a result of the
8 injury or wrongful death, pursuant to:

9 (1) any District or Federal health, sickness, income-disability, accident, or
10 workers’ compensation law;

11 (2) any health, sickness, income-disability, or accident insurance that provides
12 health benefits or income-disability coverage;

13 (3) any contract or agreement of any group, organization, partnership, or
14 corporation to provide, pay for, or reimburse the cost of medical, hospital, dental, or income
15 disability benefits; and

16 (4) any other publicly or privately funded program.

17 (d) “Compensatory damages” means objectively verifiable monetary losses incurred as a
18 result of the provision of, use of, or payment for (or failure to provide, use, or pay for) healthcare
19 services or medical products, such as past and future medical expenses, loss of past and future
20 earnings, cost of obtaining domestic services, loss of employment, and loss of business or
21 employment opportunities, damages for physical and emotional pain, suffering, inconvenience,
22 physical impairment, mental anguish, disfigurement, loss of enjoyment of life, loss of society
23 and companionship, loss of consortium (other than loss of domestic service), hedonic damages,

1 injury to reputation, and all other nonpecuniary losses of any kind or nature. The term
2 “compensatory damages” includes economic damages and non-economic damages, as such
3 terms are defined in this section.

4 (e) “Contingent fee” includes all compensation to any person or persons which
5 is payable only if a recovery is effected on behalf of one or more claimants.

6 (f) “District” means the District of Columbia.

7 (g) “Economic damages or loss” means objectively verifiable monetary losses incurred as
8 a result of the provision of, use of, or payment for (or failure to provide, use, or pay for)
9 healthcare services or medical products, such as past and future medical expenses, loss of past
10 and future earnings, cost of obtaining domestic services, loss of employment, and loss of
11 business or employment opportunities.

12 (h) “Healthcare lawsuit” means any healthcare liability claim concerning the provision of
13 healthcare goods or services affecting interstate commerce, or any healthcare liability action
14 concerning the provision of healthcare goods or services affecting interstate commerce, brought
15 in a District or Federal court or pursuant to an alternative dispute resolution system, against a
16 healthcare provider, a healthcare organization, or the manufacturer, distributor, supplier,
17 marketer, promoter, or seller of a medical product, regardless of the theory of liability on which
18 the claim is based, or the number of claimants, plaintiffs, defendants, or other parties, or the
19 number of claims or causes of action, in which the claimant alleges a healthcare liability claim.

20 (i) “Healthcare liability action” means a civil action brought in a District or Federal court
21 or pursuant to an alternative dispute resolution system, against a healthcare provider, a healthcare
22 organization, or the manufacturer, distributor, supplier, marketer, promoter, or seller of a medical
23 product, regardless of the theory of liability on which the claim is based, or the number of

1 plaintiffs, defendants, or other parties, or the number of causes of action, in which the claimant
2 alleges a healthcare liability claim.

3 (j) “Healthcare liability claim” means a demand by any person, whether or not pursuant
4 to ADR, against a healthcare provider, healthcare organization, or the manufacturer, distributor,
5 supplier, marketer, promoter, or seller of a medical product, including, but not limited to, third-
6 party claims, cross-claims, counter-claims, or contribution claims, which are based upon the
7 provision of, use of, or payment for (or the failure to provide, use, or pay for) healthcare services
8 or medical products, regardless of the theory of liability on which the claim is based, or the
9 number of plaintiffs, defendants, or other parties, or the number of causes of action.

10 (k) “Healthcare organization” means any person or entity which is obligated to provide or
11 pay for health benefits under any health plan, including any person or entity acting under a
12 contract or arrangement with a healthcare organization to provide or administer any health
13 benefit.

14 (l) “Healthcare provider” means any person or entity required by District or Federal laws
15 or regulations to be licensed, registered, or certified to provide healthcare services, and being
16 either so licensed, registered, or certified, or exempted from such requirement by other statute or
17 regulation.

18 (m) “Healthcare goods or services” means any goods or services provided by a healthcare
19 organization, provider, or by any individual working under the supervision of a healthcare
20 provider, that relates to the diagnosis, prevention, or treatment of any human disease or
21 impairment, or the assessment of the health of human beings.

22 (n) “Malicious intent to injure” means intentionally causing or attempting to cause
23 physical injury other than providing healthcare goods or services.

1 (o) “Medical product” means a drug or device intended for humans, and the terms “drug”
2 and “device” have the meanings given such terms in sections 201(g)(1) and 201(h) of the Federal
3 Food, Drug and Cosmetic Act (21 U.S.C. 321), respectively, including any component or raw
4 material used therein, but excluding healthcare services.

5 (p) “Non-economic damages” means damages for physical and emotional pain, suffering,
6 inconvenience, physical impairment, mental anguish, disfigurement, loss of enjoyment of life,
7 loss of society and companionship, loss of consortium (other than loss of domestic service),
8 hedonic damages, injury to reputation, and all other nonpecuniary losses of any kind or nature.

9 (q) “Punitive damages” means damages awarded, for the purpose of punishment or
10 deterrence, and not solely for compensatory purposes, against a healthcare provider, healthcare
11 organization, or a manufacturer, distributor, or supplier of a medical product. Punitive damages
12 are neither economic nor noneconomic damages.

13 (r) “Recovery” means the net sum recovered after deducting any disbursements or costs
14 incurred in connection with prosecution or settlement of the claim, including all costs paid or
15 advanced by any person. Costs of healthcare incurred by the plaintiff and the attorneys’ office
16 overhead costs or charges for legal services are not deductible disbursements or costs for such
17 purpose.

18 Sec. 503. Resolution of claims.

19 A healthcare lawsuit may be commenced no later than 3 years after the date of
20 injury or 1 year after the claimant discovers, or through the use of reasonable diligence should
21 have discovered, the injury, whichever occurs first. In no event shall the time for
22 commencement of a healthcare lawsuit exceed 3 years, except that in the case of an alleged
23 injury sustained by a minor before the age of 6, a healthcare lawsuit may be commenced by or on

1 behalf of the minor until the later of 3 years from the date of injury, or the date on which the
2 minor attains the age of 8.

3 Sec. 504. Compensating patient injury.

4 (a) In any healthcare lawsuit, the full amount of a claimant’s economic loss may be fully
5 recovered without limitation.

6 (b) In an action on a health care liability claim where final judgment is rendered against
7 a physician or health care provider other than a health care institution, the limit of civil liability
8 for noneconomic damages of the physician or health care provider other than a health care
9 institution, inclusive of all persons and entities for which vicarious liability theories may apply,
10 shall be limited to an amount not to exceed \$250,000 for each claimant, regardless of the number
11 of defendant physicians or health care providers other than a health care institution against whom
12 the claim is asserted or the number of separate causes of action on which the claim is based.

13 (c) In an action on a health care liability claim where final judgment is rendered against a
14 single health care institution, the limit of civil liability for noneconomic damages inclusive of all
15 persons and entities for which vicarious liability theories may apply, shall be limited to an
16 amount not to exceed \$500,000 for each claimant.

17 (d) In an action on a health care liability claim where final judgment is rendered against
18 more than one health care institution, the limit of civil liability for noneconomic damages
19 for each health care institution, inclusive of all persons and entities for which vicarious liability
20 theories may apply, shall be limited to an amount not to exceed \$500,000 for each claimant and
21 the limit of civil liability for noneconomic damages for all health care institutions, inclusive of
22 all persons and entities for which vicarious liability theories may apply, shall be limited to an
23 amount not to exceed \$1,000,000 for each claimant.

1 (e) In any healthcare lawsuit, each party shall be liable for that party's several share of
2 any damages only and not for the share of any other person. Each party shall be liable only for
3 the amount of damages allocated to such party in direct proportion to such party's percentage of
4 responsibility. A separate judgment shall be rendered against each such party for the amount
5 allocated to such party. For purposes of this section, the trier of fact shall determine the
6 proportion of responsibility of each party for the claimant's harm.

7 Sec. 505. Maximizing patient recovery.

8 (a) In any healthcare lawsuit, the court shall supervise the arrangements for payment of
9 damages to protect against conflicts of interest that may have the effect of reducing the amount
10 of damages awarded that are actually paid to claimants. In particular, in any healthcare lawsuit
11 in which the attorney for a party claims a financial stake in the outcome by virtue of a contingent
12 fee, the court shall have the power to restrict the payment of a claimant's damage recovery to
13 such attorney, and to redirect such damages to the claimant based upon the interests of justice
14 and principles of equity. In no event shall the total of all contingent fees for representing all
15 claimants in a healthcare lawsuit exceed the following limits:

16 (1) 40 percent of the first \$50,000 recovered by the claimant(s).

17 (2) 33.33 percent of the next \$50,000 recovered by the claimant(s).

18 (3) 25 percent of the next \$500,000 recovered by the claimant(s).

19 (4) 15 percent of any amount by which the recovery by the claimant(s) is in
20 excess of \$600,000.

21 (b) The limitations in this section shall apply whether the recovery is by judgment,
22 settlement, mediation, arbitration, or any other form of alternative dispute resolution. In a
23 healthcare lawsuit involving a minor or incompetent person, a court retains the authority to

1 authorize or approve a fee that is less than the maximum permitted under this section.

2 Sec. 506. Additional health benefits.

3 In any healthcare lawsuit, any party may introduce evidence of collateral source benefits.

4 If a party elects to introduce such evidence, any opposing party may introduce evidence of any
5 amount paid or contributed or reasonably likely to be paid or contributed in the future by or on
6 behalf of the opposing party to secure the right to such collateral source benefits. No provider of
7 collateral source benefits shall recover any amount against the claimant or receive any lien or
8 credit against the claimant's recovery or be equitably or legally subrogated to the right of the
9 claimant in a healthcare lawsuit. This section shall apply to any healthcare lawsuit that is settled
10 as well as a healthcare lawsuit that is resolved by a fact finder.

11 Sec. 507. Punitive damages.

12 (a) Punitive damages may, if otherwise permitted by applicable District or federal law, be
13 awarded against any person in a healthcare lawsuit only if it is proven by clear and convincing
14 evidence that such person acted with malicious intent to injure the claimant, or that such person
15 deliberately failed to avoid unnecessary injury that such person knew the claimant was
16 substantially certain to suffer. In any healthcare lawsuit where no judgment for compensatory
17 damages is rendered against such person, no punitive damages may be awarded with respect to
18 the claim in such lawsuit. No demand for punitive damages shall be included in a healthcare
19 lawsuit as initially filed. A court may allow a claimant to file an amended pleading for punitive
20 damages only upon a motion by the claimant and after a finding by the court, upon review of
21 supporting and opposing affidavits or after a hearing, after weighing the evidence, that the
22 claimant has established by a substantial probability that the claimant will prevail on the claim

1 for punitive damages. At the request of any party in a healthcare lawsuit, the trier of fact shall
2 consider in a separate proceeding:

3 (1) whether punitive damages are to be awarded and the amount of such award;
4 and

5 (2) the amount of punitive damages following a determination of punitive
6 liability. If a separate proceeding is requested, evidence relevant only to the claim for punitive
7 damages, as determined by applicable District law, shall be inadmissible in any proceeding to
8 determine whether compensatory damages are to be awarded.

9 (b) In determining the amount of punitive damages, the trier of fact shall consider only
10 the following:

11 (1) the severity of the harm caused by the conduct of such party;

12 (2) the duration of the conduct or any concealment of it by such party;

13 (3) the profitability of the conduct to such party;

14 (4) the number of products sold or medical procedures rendered for compensation,
15 as the case may be, by such party, of the kind causing the harm complained of by the claimant;

16 (5) any criminal penalties imposed on such party, as a result of the conduct
17 complained of by the claimant; and

18 (6) the amount of any civil fines assessed against such party as a result of the
19 conduct complained of by the claimant.

20 (c) The amount of punitive damages awarded in a healthcare lawsuit may be up to
21 as much as two times the amount of economic damages awarded or \$500,000, whichever is
22 greater. The jury shall not be informed of this limitation.

23 (d) No punitive damages may be awarded against the manufacturer or distributor of a

1 medical product based on a claim that such product caused the claimant's harm where:

2 (1) (A) such medical product was subject to premarket approval or clearance
3 by the federal Food and Drug Administration with respect to the safety of the formulation or
4 performance of the aspect of such medical product which caused the claimant's harm or the
5 adequacy of the packaging or labeling of such medical product; and

6 (B) such medical product was so approved or cleared; or

7 (2) such medical product is generally recognized among qualified experts as safe
8 and effective pursuant to conditions established by the federal Food and Drug Administration
9 and applicable Food and Drug Administration regulations, including without limitation those
10 related to packaging and labeling.

11 (e) A healthcare provider who prescribes a drug or device, including blood products
12 approved by the Food and Drug Administration, shall not be named as a party to a product
13 liability lawsuit involving such drug or device and shall not be liable to a claimant in a class
14 action lawsuit against the manufacturer, distributor, or product seller of such drug or device.

15 (f) In a healthcare lawsuit for harm which is alleged to relate to the adequacy of the
16 packaging or labeling of a drug which is required to have tamper-resistant packaging under
17 regulations of the Secretary of Health and Human Services, including labeling regulations related
18 to such packaging, the manufacturer or product seller of the drug shall not be held liable for
19 punitive damages unless such packaging or labeling is found by the trier of fact by clear and
20 convincing evidence to be substantially out of compliance with such regulations.

21 (1) Paragraph (d) shall not apply in any healthcare lawsuit in which:

22 (A) a person, before or after premarket approval or clearance of such
23 medical product, knowingly misrepresented to or withheld from the Food and Drug

1 Administration information that is required to be submitted under the Federal Food, Drug, and
2 Cosmetic Act (21 U.S.C. 301 et seq.) or section 351 of the Public Health Service Act (42 U.S.C.
3 262) that is material and is causally related to the harm which the claimant allegedly suffered; or

4 (B) a person made an illegal payment to an official of the Food and Drug
5 Administration for the purpose of either securing or maintaining approval or clearance of such
6 medical product.

7 Sec. 508. Authorization of payment of future damages to claimants in health care law-
8 suits.

9 (a) In any healthcare lawsuit, if an award of future damages, without reduction to present
10 value, equaling or exceeding \$50,000 is made against a party with sufficient insurance or other
11 assets to fund a periodic payment of such a judgment, the court shall, at the request of any party,
12 enter a judgment ordering that the future damages be paid by periodic payments in accordance
13 with section 509 of this Act.

14 (b) This section applies to all actions which have not been first set for trial or retrial
15 before the effective date of this title.

16 Sec. 509. Periodic payment of future damages in a health care lawsuit.

17 (a) Definitions. In this section:

18 (1) "Future damages" means damages that are incurred after the date of judgment
19 for:

20 (A) medical, health care, or custodial care services;

21 (B) physical pain and mental anguish, disfigurement, or physical
22 impairment;

23 (C) loss of consortium, companionship, or society; or

1 (D) loss of earnings.

2 (2) "Future loss of earnings" means the following losses incurred after the date of
3 the judgment:

4 (A) loss of income, wages, or earning capacity and other pecuniary losses;

5 and

6 (B) loss of inheritance.

7 (3) "Periodic payments" means the payment of money or its equivalent to the
8 recipient of future damages at defined intervals.

9 (b) The court shall make a specific finding of the dollar amount of periodic payments that
10 will compensate the claimant for the future damages.

11 (c) The court shall specify in its judgment ordering the payment of future damages by
12 periodic payments, the:

13 (1) recipient of the payments;

14 (2) dollar amount of the payments;

15 (3) interval between payments; and

16 (4) number of payments or the period of time over which payments must be made.

17 (d) The entry of an order for the payment of future damages by periodic payments
18 constitutes a release of the health care liability claim filed by the claimant.

19 (e) As a condition to authorizing periodic payments of future damages, the court shall
20 require a defendant who is not adequately insured to provide evidence of financial responsibility
21 in an amount adequate to assure full payment of damages awarded by the judgment.

22 (f) The judgment must provide for payments to be funded by:

23 (1) An annuity contract issued by a company licensed to do business as an

1 insurance company, including an assignment within the meaning of Section 130, Internal
2 Revenue Code of 1986, as amended;

3 (2) an obligation of the United States;

4 (3) applicable and collectible liability insurance from one or more qualified
5 insurers; or

6 (4) any other satisfactory form of funding approved by the court.

7 (g) On termination of periodic payments of future damages, the court shall order the
8 return of the security, or as much as remains, to the defendant.

9 (h) Periodic payments for loss of future earnings shall terminate upon the death of the
10 recipient. Any other periodic payments shall continue, without reduction, to the estate of the
11 deceased recipient, except that the Court may modify the judgment to award and apportion the
12 unpaid future earnings payments to interested parties as appropriate under law.

13 (i) Following the satisfaction or termination of any obligations specified in the judgment
14 for periodic payments, any obligation of the defendant physician or health care provider to make
15 further payments shall end and any security given shall revert to the defendant.

16 (j) For purposes of computing the award of attorney's fees when the claimant is awarded
17 a recovery that will be paid in periodic payments, the court shall:

18 (1) Place a total value on the payments based on the claimant's projected life
19 expectancy; and

20 (2) Reduce the amount in subsection (j)(1) of this section to present value.

21 Sec. 510. Effect on other laws.

22 (a) To the extent that title XXI of the Public Health Service Act (42 U.S.C. § 262)
23 establishes a federal rule of law applicable to a civil action brought for a vaccine-related injury or

1 death:

2 (1) this title does not affect the application of the rule of law to such an action;

3 and

4 (2) any rule of law prescribed by this title in conflict with a rule of law of such
5 title XXI of the Public Health Service Act (42 U.S.C. § 262) shall not apply to such action.

6 (b) If there is an aspect of a civil action brought for a vaccine-related injury or death to
7 which a federal rule of law under title XXI of the Public Health Service Act (42 U.S.C. § 262)
8 does not apply, then this title, or otherwise applicable law as determined by this title, will apply
9 to such action.

10 (c) Except as provided in this section, nothing in this title shall be deemed to affect any
11 defense available to a defendant in a healthcare lawsuit or action under any other provision of
12 federal law.

13 TITLE VI. FISCAL IMPACT STATEMENT.

14 Sec. 601. Fiscal impact statement.

15 The Council adopts the fiscal impact statement in the committee report as the fiscal
16 impact statement required by section 602(c)(3) of the District of Columbia Home Rule Act,
17 approved December 24, 1973 (87 Stat. 813; D.C. Official Code § 2-206.02 (c)(3)).

18 TITLE VII. EFFECTIVE DATE.

19 Sec. 701. Effective date.

20 This act shall take effect following approval by the Mayor (or in the event of veto by the
21 Mayor, action by the Council to override the veto), a 30-day period of Congressional review as
22 provided in section 602(c)(1) of the District of Columbia Home Rule Act, approved December
23 24, 1973 (87 Stat. 813; D.C. Official Code § 1-206.02(c)(1)), and publication in the District of

1 Columbia Register.