

## Article - Insurance

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§4-405.

(a) (1) Each insurer providing professional liability insurance to a health care provider in the State shall submit to the Commissioner information on:

- (i) the nature and cost of reinsurance;
  - (ii) the claims experience, by category, of health care providers;
  - (iii) the amount of claim settlements and claim awards;
  - (iv) the amount of reserves for claims incurred and incurred but unreported claims;
  - (v) the number of structured settlements used in payment of claims;
- and
- (vi) any other information relating to health care malpractice claims prescribed by the Commissioner in regulation.

(2) (i) An insurer subject to the reporting requirement under paragraph (1) of this subsection shall notify the Commissioner of any information that the insurer considers proprietary.

(ii) In accordance with § 4-335 of the General Provisions Article, the Commissioner shall deny inspection of any part of a report submitted under paragraph (1) of this subsection that the Commissioner determines contains confidential commercial information or confidential financial information.

(b) In addition to the information required under subsection (a) of this section, for each claim filed with the Director of the Health Care Alternative Dispute Resolution Office under § 3-2A-04 of the Courts Article, each insurer providing professional liability insurance to a health care provider in the State shall submit to the Commissioner the following information:

- (1) (i) name of insurer;
- (ii) name of insurer group;
- (iii) claim file identification;
- (iv) name of person completing form;
- (v) telephone number (area code); and

- (vi) date form completed;
- (2) (i) date of injury;
- (ii) date injury reported to insurer; and
- (iii) date claim closed;
- (3) age and gender of insured person at time of injury;
- (4) (i) type of injury;
- (ii) description of injury; and
- (iii) if the claim is against a health care provider covered under a policy issued or delivered by the insurer completing this form, the name of the health facility where the injury occurred;
- (5) (i) type of medical professional liability policy;
- (ii) if known, whether the patient was:
  - 1. an inpatient;
  - 2. an emergency room outpatient; or
  - 3. other outpatient;
- (iii) physician ISO classification, or equivalent classification;
- (iv) health care provider name and license number; and
- (v) policy limits for:
  - 1. each claim or medical incident; and
  - 2. annual aggregate;
- (6) (i) if known, the facility, office, or county where injury occurred; and
- (ii) the case number and the name and location of the court where the suit was filed and the case was tried;
- (7) (i) whether settlement was reached or award was made at one of the following stages:
  - 1. arbitration;
  - 2. mediation;

3. before suit was filed;
4. after suit was filed, but before trial;
5. during trial, but before court verdict;
6. court verdict;
7. after verdict; or
8. after appeal was filed;

(ii) if settlement was reached or award was made by court verdict, whether the result was:

1. directed verdict for plaintiff;
2. directed verdict for defendant;
3. judgment notwithstanding the verdict for the plaintiff;
4. judgment notwithstanding the verdict for the defendant;
5. judgment for the plaintiff;
6. judgment for the defendant;
7. for plaintiff, after appeal;
8. for defendant, after appeal; or
9. any other;

(iii) if there was no final judgment or settlement, the date and reason for the final disposition; and

(iv) if the case did go to trial, whether the case was tried by a jury;

(8) with respect to the total amount paid to the claimant:

(i) the amount paid by the insurer;

(ii) the amount paid by the insured due to retention or deductible;

(iii) if known, the amount paid by an excess carrier;

(iv) if known, the amount paid by the insured due to settlement or award in excess of policy limits;

(v) if known, the amount paid by other defendants or contributors;

and

(vi) the total amount of settlement or award;

(9) a summary of the occurrence from which the claim or action arose, including:

(i) a description of the misdiagnosis or alleged misdiagnosis made, if any, of the patient's actual condition;

(ii) a description of the procedure giving rise to the claim; and

(iii) a description of the principal injury giving rise to the claim;

(10) (i) whether a structured settlement or periodic payment was used in closing this claim; and

(ii) if a structured settlement or periodic payment was used:

1. the amount of immediate payment;

2. the present value of the projected total future payout (price of annuity if purchased); and

3. the projected total future payout;

(11) if a neutral expert witness is employed under § 3-2A-09(d)(2) of the Courts Article, the findings of a neutral expert witness as to a plaintiff's future medical expenses or future loss of earnings;

(12) if the case was tried to verdict, the amount of noneconomic damages; and

(13) (i) the total allocated loss adjustment expense by fees and expenses paid to defense counsel; and

(ii) the total allocated loss adjustment expense.

(c) The Commissioner:

(1) shall adopt regulations on the submission of information described in this section; and

(2) may adopt regulations that require insurers of other lines of liability insurance to submit reports containing information that is substantially similar to the information described in subsection (a) of this section.

(d) Failure to report in accordance with this section may result in the imposition by the Commissioner of a civil penalty of up to \$5,000.

(e) The Commissioner shall report, in accordance with § 2-1246 of the State Government Article, the Commissioner's findings as to the impact of Chapter 5 of the Acts of the 2004 Special Session of the General Assembly and Chapter 477 of the Acts of the General Assembly of 1994 on the availability of health care malpractice and other liability insurance in the State to the Legislative Policy Committee on or before September 1 of each year.

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