Department of Legislative Services

Maryland General Assembly
2004 Session

FISCAL AND POLICY NOTE

Senate Bill 193 (The President, *et al.*) (By Request – Administration)
Judicial Proceedings

Maryland Medical Injury Compensation Reform Act

This Administration bill alters the amount of damages that may be recovered from, and modifies procedures for, medical malpractice claims.

The bill takes effect June 1, 2004.

Fiscal Summary

State Effect: Although the bill would make changes in arbitration procedures, the Health Claims Arbitration Office would not be materially impacted. To the extent malpractice insurers reduce premium rates, there would be a minimal special fund revenue increase for the Maryland Insurance Administration (MIA) from the $125 rate and form filing fee in FY 2005.

Local Effect: None.

Small Business Effect: A small business impact statement was not provided by the Administration in time for inclusion in this fiscal note. A revised fiscal note will be issued when the Administration's assessment becomes available.

Analysis

Bill Summary:

Cap on Noneconomic Damages: For causes of action that arise on or after June 1, 2004, an award or verdict for noneconomic damages may not exceed $500,000. This cap applies in the aggregate to all claims for personal injury and wrongful death arising from

the same medical injury, regardless of the number of claims, claimants, or defendants. In a jury trial, the jury may not be informed of the cap. If the jury awards an amount that exceeds the cap, the court must reduce the amount to conform to the cap.

Limits on Economic Damages: An award or verdict for past medical expenses must exclude any amount not actually paid by or on behalf of the claimant to a health care provider. An award or verdict for past or future medical expenses must exclude any amount for goods or services that the claimant has received or is entitled to receive under the federal Individuals with Disabilities Education Act. An award or verdict for past or future loss of earnings must exclude any amount for federal, State, or local income taxes or payroll taxes, including Social Security and Medicare that the claimant would have paid on those earnings.

Determination of Medical Costs: An award or verdict for future medical expenses must be based solely on Medicare reimbursement rates in effect on the date of the award or verdict for the locality in which the care is to be provided. An award or verdict for future medical expenses for hospital services must be based solely on rates approved by the Health Services Cost Review Commission, if the federal Medicare waiver is still in effect. An award or verdict for future medical expenses for nursing facility services must be based solely on the statewide average payment rate for the Medicaid program in effect on the date of the award or verdict. An award or verdict for future medical expenses for which there is no specified rate must be based on actual cost on the date of the award or verdict. All awards or verdicts for future medical expenses are adjusted for inflation based on the average inflation rate for the five years immediately preceding the award or verdict.

Annuities: For a cause of action arising on or after June 1, 2004 for an award or verdict for noneconomic damages and future economic damages of $250,000 or less, a defendant must pay a lump sum with payments for past economic damages. For an award or verdict for noneconomic damages and future economic damages of more than $250,000, the court must: (1) order the defendant to pay $100,000 of the future economic damages and noneconomic damages as a lump sum with past economic damages; (2) order the defendant to pay future economic damages and noneconomic damages of more than $100,000 periodically to the claimant in the form of an annuity; and (3) enter as the amount of the award or verdict for future economic damages and noneconomic damages of more than $100,000, the purchase price of an annuity purchased by the defendant or the defendant's insurer.

To fully fund future economic damages and noneconomic damages in excess of $250,000, the defendant or insurer must purchase an annuity for the amount of the future economic damages and noneconomic damages less the $100,000 paid, which produces periodic payments sufficient to cover calculated future medical expenses, noneconomic

damages, and loss of wages. For a survivor or wrongful death action, noneconomic damages must be paid at the same time as past economic damages and future economic damages exceeding $250,000 are subject to the same annuity provisions.

The bill specifies certain financial requirements and calculations an annuity must meet to be approved.

Offer of Judgment by Defendant: The bill permits a defendant in a medical injury claim to make an offer to allow judgment to be taken against the defendant for a specified amount of money. When a defendant has been found liable but the amount or extent of the liability has yet to be determined, the defendant may make an offer of judgment not less than 45 days before the commencement of hearings to determine the amount or extent of liability. If the adverse party accepts the offer, either party may file the offer and notice of acceptance with the court, at which time the court must enter judgment. If the adverse party does not accept the offer within the specified timeframes, the offer is deemed withdrawn and evidence of the offer is generally not admissible. An unaccepted offer to allow judgment does not preclude a party from making a subsequent offer to allow judgment within the specified timeframes. If the final verdict is not more favorable than the offer, the adverse party who received the offer must pay the court costs and reasonable attorney's fees incurred after the offer was made of the party who made the offer.

The provisions of the bill are severable.

Current Law:

Cap on Noneconomic Damages: Noneconomic damages, which include pain, suffering, and disfigurement, are subject to the current cap of $635,000, which increases by $15,000 annually every October 1.

Economic Damages: Economic damages include loss of earnings and medical expenses. There is no cap on awards for these damages.

Arbitration: Unless at least one party waives arbitration, a person who has a claim against a health care provider for damage due to a medical injury in which the amount in controversy exceeds $25,000 must attempt to settle the claim by arbitration by filing the claim with the Health Claims Arbitration Office (HCAO).

Periodic Payments of Future Damages: HCAO or the court may order that future damages be paid in the form of periodic payments, subject to adequate security. Upon the death of a claimant receiving periodic payments, the unpaid balance for future medical expenses reverts to the defendant.

Collateral Source Rule: If the court finds that the damages awarded are excessive, it may grant a new trial as to such damages or may deny a new trial if the claimant agrees to a remittitur of the excess. Evidence of the claimant's receipt of payments from collateral sources may not be admitted to reduce his damages. *Schreiber v. Cherry Hill Construction Co.*, 105 Md. App. 462, 660 A.2d 970 (Ct. Spec. App.), cert. denied, 340 Md. 500, 667 A.2d 341 (1995).

Statute of Repose: An action for damages for an injury arising out of a rendering of or failure to render professional services by a health care provider must be filed the earlier of: (1) five years from the time the injury was committed; or (2) three years of the date the injury was discovered. If the claimant was a minor, the statute does not begin to run until the claimant has reached the age of 11, and if the action involves a foreign object left in the body or an injury to the reproductive system, the statute does not begin to run until the claimant is 16.

Background: Recently, national attention has focused on what some are calling a medical malpractice insurance crisis. There is evidence in at least some parts of the country to support the claim that medical malpractice insurance is becoming dangerously unaffordable and/or unavailable, especially for individuals practicing in certain high-risk specialties such as obstetrics, neurosurgery, and orthopedic surgery. Certain areas have seen steep premium increases, the withdrawal of major insurance companies from the medical malpractice market, insurer-instituted moratoriums on the issuance of new policies, the closure of trauma centers and hospital maternity wards, the elimination of obstetrics from OB/GYN practices, an exodus of physicians, and increases in early retirements.

In 2003, the federal General Accounting Office (GAO) published a report that studied the extent of increases in medical malpractice insurance rates, analyzed the factors contributing to these increases, and identified any market changes that might make this period of rising insurance premiums different from previous such periods. GAO found that the largest contributor to increased premium rates was insurer losses on medical malpractice claims. Other contributing factors include decreased investment income, artificially low premium rates adopted while insurers competed for market share during boom years, and higher overall costs due largely to increased reinsurance rates for medical malpractice insurers.

States have adopted a variety of tort reforms in an effort to stop the rapid increase in malpractice insurance rates. According to the GAO report, direct tort reform, such as placing caps on damage awards, have a direct impact on malpractice insurance costs, while indirect tort reforms, such as permitting annuity payments and limiting attorneys'

fees, have less impact. The report also noted that indirect reforms helped lower malpractice costs when coupled with caps on damages.

Until recently, the medical malpractice insurance industry in Maryland had not experienced the steep rate increases that had occurred in other states. In June 2003, the Medical Mutual Liability Insurance Society of Maryland, the insurance provider to most of the State's private practice physicians, requested a 28% rate increase in medical malpractice insurance premiums. On August 15, 2003, the Maryland Insurance Commissioner approved the rate increase. The new rates became effective January 1, 2004. Opponents of the rate increase argued that a 3.7% rate increase was sufficient and that Medical Mutual was seeking to set aside more money than it would likely need for malpractice claims.

Other states have been considering a variety of measures to alleviate the problems in the medical community created by soaring medical malpractice insurance rates. These initiatives include tort reform measures such as caps on noneconomic and punitive damages; limits on medical care provider liability; reforms to statutes of limitations, collateral source rules, and good faith hearings. Other measures include changes to physician discipline statutes and increased regulation of insurers.

The U.S. Congress has considered medical malpractice insurance issues several times. The most recent bill would have capped noneconomic damages at $250,000, limited the availability of punitive damages, required lawsuits to be brought within three years of the date of injury or one year of discovery, and preempted state law unless it imposes greater protections for health care providers and organizations from liability, loss, or damages.

In calendar 2003, there were 15,019 medical doctors and 302 osteopaths actively practicing in Maryland. Medical Mutual Liability Insurance Society of Maryland's direct written premiums for calendar 2004 are projected to be $113.7 million to provide malpractice insurance to 6,200 physicians. Annual premiums range from about $10,000 for a general practitioner to over $100,000 for certain specialists such as obstetricians. Medical Mutual covers approximately 80% of private practice physicians. Many other physicians who are associated with or employed by hospitals or professional practice groups receive partial or full malpractice insurance subsidies from the hospitals or practice groups.

According to a *Public Citizen* report, about 3% of Maryland physicians have been responsible for 51% of malpractice payouts to patients since 1990. Conversely, 89.4% of Maryland physicians have never made a malpractice payout. Only 21% (37 of 180) of physicians who made three or more malpractice payouts since 1990 were disciplined by the State Board of Physicians.

Small Business Effect: To the extent a lower noneconomic damages cap helps to stabilize medical malpractice premiums, small business health care providers could be positively impacted. A cap on damages could encourage additional malpractice insurers to enter the State, creating price competition that would stabilize rates or even reduce them.

Nationally, high malpractice premium rates have been burdensome on some health care providers, particularly specialists such as obstetricians and trauma physicians. As a result, many physicians have discontinued practice, or portions of their practices, or moved to other states where malpractice issues are not as onerous. Maryland has not yet experienced this problem to any significant degree. Two contiguous states, West Virginia and Pennsylvania, have seen an exodus of health care providers, many of whom have relocated to Maryland. However, malpractice insurance rates recently increased by 28%, and could continue to do so in the next several years, potentially jeopardizing the availability of specialty care if health care providers are financially forced out of certain practice areas. Stabilizing malpractice insurance rates could encourage specialists to continue practicing in Maryland, and could encourage other health care providers to enter specialty practices.

Additional Comments: Individuals who are awarded medical costs could be adversely impacted by the bill's specified reimbursement rates for future medical costs. An award or verdict for future medical expenses must be based solely on Medicare reimbursement rates in effect on the date of the award or verdict for the locality in which the care is to be provided.

Historically, Medicare has reimbursed outpatient medical services at rates much lower than those paid by private payors such as health insurers. In 2002, Medicare reimbursement rates to physicians were about 83% of private insurance rates nationally. These rates were much lower for certain specialties, such as anesthesiology, for which Medicare rates averaged 39% of commercial rates.

Additional Information

Prior Introductions: None.

Cross File: HB 287 (The Speaker and The Minority Leader, *et al.*) (By Request – Administration) – Judiciary.

Information Source(s): *January 15, 2004 Press Release*, *Public Citizen*; American Medical Association; *Maryland Nursing Home Occupancy Rates and Nursing Home Utilization by Payment Source* (2003); Maryland Health Care Commission; Judiciary

(Administrative Office of the Courts); *Medical Malpractice: Tort Reform* (2003) Health Policy Tracking Service; *Medical Malpractice – Implications of Rising Premiums on Access to Health Care (August 2003);* U.S. General Accounting Office; *More Medicare Cuts in Reimbursements* (December 2002), Patricia A. Daily, M.D.; Maryland Health Claims Arbitration Office; Department of Health and Mental Hygiene (Medicaid, Community Health Administration, Family Health Administration, Developmental Disabilities Administration, Maryland Health Care Commission, Board of Physicians, Boards and Commissions); Maryland Insurance Administration; Office of the Attorney General; Department of Legislative Services

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Analysis by: Susan D. John

Direct Inquiries to:
(410) 946-5510
(301) 970-5510