HB 1299

Department of Legislative Services

Maryland General Assembly
2004 Session

FISCAL AND POLICY NOTE
Revised

House Bill 1299 (Delegate Vallario, *et al.*)
Economic Matters and Judiciary Judicial Proceedings

Medical Malpractice Reforms and Task Force

This bill requires that in situations where arbitration of a malpractice claim has been waived, the claim is subject to mediation. It also makes several other changes to medical malpractice arbitration and establishes a task force to study medical malpractice insurance costs.

Fiscal Summary

State Effect: The Health Claims Arbitration Office (HCAO) could handle any increase in cases with existing budgeted resources. The Maryland Insurance Administration (MIA) could handle reporting requirements with existing budgeted resources. The Department of Legislative Services (DLS) could handle task force staffing costs with existing budgeted resources. No effect on revenues.

Local Effect: None.

Small Business Effect: Potential meaningful. To the extent small business health care providers who have been subject to litigation in malpractice claims are able to resolve the claim in mediation, legal costs could decrease significantly.

Analysis

Bill Summary:

Mediation: Any claim that is filed with HCAO but for which arbitration is waived is subject to mediation. The bill specifies mediation procedures and establishes requirements for individuals who serve as mediators. The Maryland Court of Appeals

must adopt an application process for qualified individuals to be on a roster of mediators for a health care malpractice case. Mediators are immune from suit for any act or decision made during mediation and within the scope of authority. The court may impose sanctions, including contempt or removal of the case from the trial docket, against a party or counsel who fails to participate in one or more mediation sessions.

If a case is settled as a result of mediation, the parties must notify HCAO and file a stipulation of dismissal and court costs and a completed settlement with the court. If the parties fail to agree to a settlement, the mediator must notify HCAO and the court that mediation has not been effective. A party may file a motion with the court objecting to mediation on the ground that mediation is not appropriate. The court may accept the case from mediation if warranted.

Collateral Source Rule: The bill modifies the Collateral Source Rule by requiring reduction of an award or verdict for past medical expenses to the extent those expenses are paid, reimbursed, or indemnified by a collateral source, less the costs to obtain the payment, reimbursement, or indemnification. This reduction does not apply in circumstances where a right of recovery or subrogation is expressly provided by federal law or from a criminal injuries compensation act.

The bill defines "noneconomic damages" as: (1) in a claim for personal injury, pain, suffering, inconvenience, physical impairment, disfigurement, loss of consortium, or other nonpecuniary injury; or (2) in a claim for wrongful death, mental anguish, emotional pain and suffering, loss of society, companionship, comfort, protection, care, marital care, parental care, filial care, attention advice, counsel, training, guidance, or education, or other noneconomic damages authorized by law.

Certificate of Qualified Expert: If a claim or action requires the filing of a certificate of qualified expert, a claimant or plaintiff must file, within 15 days after discovery is completed, a supplemental certificate of a qualified expert that contains specific allegations, such as the specific injury, standard of care, the basis for alleging that standard of care, and the expert's qualifications to testify. Copies of the certificate must be filed with all parties.

Venue for Action Against Insurer for Excess Judgment: In an action to recover damages against an insurer based on the insurer's failure to settle a health care malpractice action brought against a health care provider insured by the insurer, the only venue permitted is the county in which the health care malpractice action was brought against the provider.

Health Care Provider: For the purpose of health care malpractice claims, the bill expands the definition of "health care provider" to include a medical day care center, hospice care program, assisted living program, and freestanding ambulatory care facility.

Itemization of Damages: An arbitration panel or circuit court must itemize any damages awarded to reflect the monetary amount for: (1) past medical expenses; (2) future medical expenses; (3) past loss of earnings; (4) future loss of earnings; (5) noneconomic damages; (6) in a wrongful death action, the pecuniary loss or benefit; and (7) other damages.

Reporting Requirements for Medical Malpractice Insurers: Each insurer providing professional liability insurance to a health care provider in the State must submit to the Maryland Insurance Commissioner information on claims experience, costs, settlements, reserves, and any other information relating to malpractice claims as prescribed by the Insurance Commissioner in regulations. On September 1 of each year, the Insurance Commissioner must report on the availability of health care malpractice and other liability insurance in the State to the House Economic Matters, House Judiciary, Senate Finance, and Senate Judicial Proceedings committees.

Task Force: The bill creates a Task Force on Medical Malpractice, consisting of six members of the Senate and six members of the House of Delegates. The task force must: (1) assess the extent to which the cost of medical malpractice liability coverage for health care providers increased in recent years; (2) determine the causes of the cost increases; (3) study any aspect of the health care, insurance, or legal systems related to malpractice liability; and (4) make recommendations to address the increased costs of malpractice liability coverage. The task force must report its findings and recommendations to the Governor and the General Assembly by December 15, 2004.

The bill's certificate of qualified expert and venue provisions may only be construed to apply prospectively and may not be applied to any cause of action arising before the bill's effective date.

The bill's reporting requirements take effect June 1, 2004 and terminate May 31, 2009. The task force provisions take effect June 1, 2004 and terminate December 31, 2004. The bill's other provisions take effect June 1, 2004.

Current Law:

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 HCAO. HCAO must appoint an arbitration panel, which determines the issue of liability. If the health care provider is liable, the panel must then consider, itemize, assess, and apportion appropriate damages against one or more of the health care providers that it has found liable.

Collateral Source Rule: Evidence of the claimant's receipt of payments from collateral sources may not be admitted to reduce 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).

Certificate of Qualified Expert: A claimant must file a certificate of qualified expert with HCAO attesting to departure from standards of care, and that the departure from standards of care is the proximate cause of the alleged injury, within 90 days from the date of the complaint.

Venue in Excess Judgment Action: A civil action may be filed in a county where the defendant conducts regular business or maintains its principal offices.

Health Care Provider: For the purpose of health care malpractice claims, a health care provider includes a hospital, nursing home, physician, osteopath, optometrist, chiropractor, nurse, dentist, podiatrist, psychologist, social worker, and physical therapist.

Itemization of Damages: An arbitration award must be itemized by category and amount any damages assessed for incurred medical expenses, rehabilitation costs, and loss of earnings. Damages assessed for any future expenses, costs, and losses must be itemized separately.

Background: Arbitration is a process of dispute resolution in which a neutral third party, the arbitrator, renders a decision after a hearing at which both parties have an opportunity to be heard. It is intended to avoid the formalities, delay, and expense of ordinary litigation. Generally, an arbitration award is binding on both parties, although it may be subject to review in the courts.

Mediation is an informal dispute resolution process in which a neutral third person, the mediator, helps disputing parties to reach an agreement. The mediator has no power to impose a decision on the parties.

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.

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.

In response to soaring rates, other states have been considering a variety of measures to alleviate the problems in the medical community created by the medical malpractice insurance crisis. These initiatives include tort reform measures such as caps on noneconomic and punitive damages; limits on medical care provider liability; reforms to states 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 the medical malpractice insurance crisis 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.

While a variety of health care providers obtain malpractice insurance, the vast majority of insureds are physicians. Private practice physicians purchase their own liability insurance, while many physicians who work for hospitals, nursing homes, practice groups, or other institutions often receive some type of insurance subsidy from the institution. Larger entities, such as large hospitals, may self-insure their malpractice liability.

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.

Additional Information

Prior Introductions: None.

Cross File: None.

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