BY: Senate Rules Committee

AMENDMENTS TO HOUSE BILL NO. 2
(Third Reading File Bill)

AMENDMENT NO. 1

On page 1, after line 1, insert:

"Maryland Medical Professional Liability Insurance Rate Stabilization Act of 2004

FOR the purpose of requiring certain alternative dispute resolution of certain health care malpractice actions under certain circumstances; authorizing the Court of Appeals to adopt rules relating to certain alternative dispute resolution; providing for certain alternative dispute resolution procedures and costs; authorizing an arbitration panel or court to make a certain finding as to whether a certain claim or action was brought or maintained in bad faith or without substantial justification; providing for certain procedures related to attorneys who bring a claim or action in bad faith or without substantial justification; providing for a certain limitation on noneconomic damages for personal injury and wrongful death actions concerning health care malpractice; limiting a certain limitation on noneconomic damages for personal injury and wrongful death actions concerning health care malpractice in which there are multiple claims, claimants, plaintiffs, or beneficiaries; providing that a certain limitation on noneconomic damages shall be increased by a certain amount on an annual basis; providing that in wrongful death actions in which there are two or more claimants or beneficiaries, the total amount of noneconomic damages may not exceed a certain percentage of the limitation on noneconomic damages; prohibiting a jury from being informed of certain limitations on noneconomic damages; requiring the court to reduce certain jury awards for noneconomic damages that exceed a certain limitation; requiring the court to take certain actions in wrongful death actions with two or more claimants or beneficiaries if a jury awards noneconomic damages in excess of a certain limitation; requiring the court to take certain actions in cases in which there is a personal injury and a wrongful death action if the jury

awards noneconomic damages in excess of a certain limitation; providing for immunity from suit for individuals who conduct alternative dispute resolution under certain circumstances; prohibiting the use of certain expressions of regret or apology as evidence of liability in certain actions and proceedings; providing that certain provisions relating to damages in personal injury and wrongful death actions do not apply to causes of action for medical injury arising on or after a certain date; requiring a hospital or related institution to report certain adverse events to the Department of Health and Mental Hygiene under certain circumstances; authorizing the imposition of a certain penalty for a violation of a certain reporting requirement; requiring the Secretary of Health and Mental Hygiene to adopt certain regulations; requiring a court to award certain costs and fees to certain prevailing parties in certain actions relating to decisions of certain medical review committees under certain circumstances; altering the standard of proof for certain findings by the State Board of Physicians; providing that formal rules of evidence shall be observed at certain hearings, including the cross-examination of witnesses; requiring the Maryland Insurance Administration to prepare annually a certain comparison guide of medical professional liability insurance premiums for health care providers that includes certain information; requiring insurers providing professional liability insurance to a health care provider in the State to submit certain information to the Maryland Insurance Commissioner on a certain form; requiring the Commissioner to submit a certain report on medical malpractice liability insurance to the Governor and the General Assembly on or before a certain date each year; requiring the Commissioner to adopt certain regulations relating to the submission of certain information on medical professional liability insurance; applying a certain tax to premiums of certain health maintenance organizations and managed care organizations under certain circumstances; requiring certain reporting of gross receipts by a managed care organization; prohibiting certain insurers from entering into certain exclusive appointment agreements with certain producers; prohibiting an insurer from including in a medical professional liability insurance policy coverage for the defense of an insured in disciplinary hearings; requiring insurers that issue or deliver medical professional liability insurance policies in the State to offer certain policies with certain deductibles; authorizing the insurer to cancel a policy for failure to pay a deductible in certain amounts; requiring an insurer to comply with certain notice provisions of law when canceling a policy due to nonpayment of certain deductibles; requiring the Legislative Auditor annually to conduct a fiscal and compliance audit of the accounts and transactions of the Medical Mutual Liability Insurance Society of Maryland; requiring the Society to pay the cost of a certain audit; providing that a medical professional

liability insurer that issues or delivers a new policy is not subject to a certain provision of law; providing that the Commissioner shall make a certain determination within 90 days of a request to review a cancellation or refusal to renew a policy for medical professional liability insurance; establishing a People's Insurance Counsel Division in the Office of the Attorney General; providing for the appointment, qualifications, and compensation of the People's Insurance Counsel; providing for certain procedures related to the People's Insurance Counsel Division; requiring the Attorney General's Office to provide money in its annual budget for the People's Insurance Counsel Division; requiring the Maryland Insurance Commissioner to collect a certain assessment from certain insurers and deposit the amounts collected into the People's Insurance Counsel Fund; establishing the People's Insurance Counsel Fund as a continuing, nonlapsing fund; providing for the purpose and administration of the Fund; providing for the powers and duties of the People's Insurance Counsel Division; requiring the People's Insurance Counsel Division to report on its activities to the Governor and the General Assembly on or before a certain date each year; prohibiting certain actions constituting false claims against a State health plan; providing certain penalties for making false claims against a State health plan; providing for certain procedures related to making a false claim against a State health plan; providing for certain remedies under a civil action for making a false claim against a State health plan; prohibiting an employer from taking retaliatory action against an employee under certain circumstances; providing certain remedies for retaliatory action; providing certain limitations on civil actions; establishing the Maryland Medical Professional Liability Insurance Rate Stabilization Program; establishing the purposes of the Program; establishing the Maryland Medical Professional Liability Insurance Rate Stabilization Board; providing for the membership of the Board; requiring the Board to make certain determinations; establishing the Maryland Medical Professional Liability Insurance Rate Stabilization Fund; establishing the purpose of the Fund; providing that the Fund is a special, nonlapsing fund; requiring the State Treasurer to hold the Fund and the Comptroller to account for the Fund; requiring the Insurance Commissioner to deposit the revenue from the premium tax on health maintenance organizations and managed care organizations into the Fund; requiring the Board to transfer a certain amount from the Fund to administer the Program; providing for certain disbursements in certain years from the Fund to the Rate Stabilization Account and the Medical Assistance Program Account; requiring a medical professional liability insurer to reduce medical professional liability insurance rates in the form of a rate reduction or rebate for certain health care providers; prohibiting a medical

professional liability insurer from reducing rates or providing a rebate on certain portions of a policy; requiring that a rate reduction or rebate be reduced by the value of a dividend; providing that disbursements from the Rate Stabilization Account may not exceed a certain amount; providing that the debts and obligations of the Fund are not debts and obligations of the State or a pledge of the full faith and credit of the State; providing that the Board is not required to use the balance of the Rate Stabilization Account when determining the amount of the rate reduction or rebate; requiring disbursements from the Medical Assistance Program Account be made to increase certain fee-for-service physician rates and to increase capitation payments to managed care organizations for certain procedures commonly performed by certain health care providers; providing that certain portions of the Medical Assistance Program Account shall be used to support the operations of the Maryland Medical Assistance Program; requiring a certain audit of the Fund and its accounts; requiring the Board to report certain information to the Legislative Policy Committee on or before a certain date each year; requiring the Governor to process a certain budget amendment on or before a certain date; defining certain terms; providing for the application of certain provisions of this Act; making this Act an emergency measure; providing for an alternate effective date under certain circumstances; and generally relating to the Maryland Medical Professional Liability Insurance Rate Stabilization Act of 2004.

BY repealing and reenacting, with amendments,
Article - Courts and Judicial Proceedings
Section 3-2A-01, 3-2A-09, 5-615, and 11-108(c)
Annotated Code of Maryland
(2002 Replacement Volume and 2004 Supplement)

BY adding to
Article - Courts and Judicial Proceedings
Section 3-2A-06C, 3-2A-07A, 3-2A-09, 10-920, and 11-108(e)
Annotated Code of Maryland
(2002 Replacement Volume and 2004 Supplement)

BY adding to
Article - Health - General
Section 15-102.7 and 19-304

Annotated Code of Maryland
(2000 Replacement Volume and 2004 Supplement)

BY repealing and reenacting, with amendments
Article - Health - General
Section 19-727
Annotated Code of Maryland
(2000 Replacement Volume and 2004 Supplement)

BY repealing and reenacting, with amendments,
Article - Health Occupations
Section 1-401, 14-405, and 14-413
Annotated Code of Maryland
(2000 Replacement Volume and 2004 Supplement)

BY repealing and reenacting, with amendments,
Article - Insurance
Section 2-213, 4-401, 6-101, 6-102, 6-103, 6-104, 6-107, and 10-118(h) through (j)
Annotated Code of Maryland
(2003 Replacement Volume and 2004 Supplement)

BY adding to
Article - Insurance
Section 2-303.2 and 10-118(h)
Annotated Code of Maryland
(2003 Replacement Volume and 2004 Supplement)

BY repealing and reenacting, with amendments,
Article - Insurance
Section 19-104, 27-501(a) and (f), and 27-505
Annotated Code of Maryland
(2002 Replacement Volume and 2004 Supplement)

BY adding to
Article - Insurance
Section 19-104.1, 19-114, and 24-211
Annotated Code of Maryland
(2002 Replacement Volume and 2004 Supplement)
BY repealing and reenacting, without amendments,
Article - Insurance
Section 24-201(f)
Annotated Code of Maryland
(2002 Replacement Volume and 2004 Supplement)

BY adding to
Article - State Government
Section 6-301 through 6-308, inclusive, to be under the new subtitle "Subtitle 3. People's Insurance Counsel"; and 12-601 through 12-608, inclusive, to be under the new subtitle "Subtitle 6. Reporting of False Claims Against State Health Plans"
Annotated Code of Maryland
(2004 Replacement Volume)

BY repealing and reenacting, without amendments,
Article - Tax - General
Section 10-104
Annotated Code of Maryland
(2004 Replacement Volume)

SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND, That the Laws of Maryland read as follows:

Article - Courts and Judicial Proceedings

3-2A-01.

(a) In this subtitle the following terms have the meanings indicated unless the context of their use requires otherwise.

(b) "Arbitration panel" means the arbitrators selected to determine a health care malpractice claim in accordance with this subtitle.

(c) "Court" means a circuit court for a county.

(d) "Director" means the Director of the Health Claims Arbitration Office.

(E) "ECONOMIC DAMAGES" RETAINS ITS JUDICIALLY DETERMINED MEANING.

[(e)] (F) (1) "Health care provider" means a hospital, a related institution as defined in § 19-301 of the Health - General Article, A MEDICAL DAY CARE CENTER, A HOSPICE CARE PROGRAM, AN ASSISTED LIVING PROGRAM, A FREESTANDING AMBULATORY CARE FACILITY AS DEFINED IN § 19-3B-01 OF THE HEALTH - GENERAL ARTICLE, a physician, an osteopath, an optometrist, a chiropractor, a registered or licensed practical nurse, a dentist, a podiatrist, a psychologist, a licensed certified social worker-clinical, and a physical therapist, licensed or authorized to provide one or more health care services in Maryland.

(2) "Health care provider" does not [mean] INCLUDE any nursing institution conducted by and for those who rely upon treatment by spiritual means through prayer alone in accordance with the tenets and practices of a recognized church or religious denomination.

[(f)] (G) "Medical injury" means injury arising or resulting from the rendering or failure to render health care.

(H) "NONECONOMIC DAMAGES" MEANS:

(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 UNDER SUBTITLE 9 OF THIS TITLE.

3-2A-06C.

(A) (1) IN THIS SECTION THE FOLLOWING WORDS HAVE THE MEANINGS INDICATED.

(2) "MEDIATION" HAS THE MEANING STATED IN TITLE 17 OF THE MARYLAND RULES.

(3) "MEDIATOR" MEANS AN INDIVIDUAL WHO CONDUCTS MEDIATION.

(4) "NEUTRAL CASE EVALUATION" HAS THE MEANING STATED IN TITLE 17 OF THE MARYLAND RULES.

(5) "NEUTRAL FACT-FINDING" HAS THE MEANING STATED IN TITLE 17 OF THE MARYLAND RULES.

(6) "NEUTRAL PROVIDER" MEANS AN INDIVIDUAL WHO CONDUCTS NEUTRAL CASE EVALUATION OR NEUTRAL FACT-FINDING.

(B) THIS SECTION DOES NOT APPLY IF ALL PARTIES FILE WITH THE COURT AN AGREEMENT NOT TO ENGAGE IN ALTERNATIVE DISPUTE RESOLUTION AND:

(1) THE COURT FINDS THAT ALTERNATIVE DISPUTE RESOLUTION UNDER THIS SECTION WOULD NOT BE PRODUCTIVE; OR

(2) ALL PARTIES HAVE ALREADY ENGAGED IN ALTERNATIVE DISPUTE RESOLUTION.

(C) IN ADDITION TO THE QUALIFICATIONS AND REQUIREMENTS OF TITLE

17 OF THE MARYLAND RULES, THE COURT OF APPEALS MAY ADOPT RULES REQUIRING A MEDIATOR OR NEUTRAL PROVIDER TO HAVE EXPERIENCE WITH HEALTH CARE MALPRACTICE CLAIMS.

(D) WITHIN 30 DAYS OF THE LATER OF THE FILING OF THE DEFENDANT'S ANSWER TO THE COMPLAINT OR THE DEFENDANT'S CERTIFICATE OF A QUALIFIED EXPERT UNDER § 3-2A-04 OF THIS SUBTITLE, THE COURT SHALL ORDER THE PARTIES TO ENGAGE IN MEDIATION, NEUTRAL CASE EVALUATION, OR NEUTRAL FACT-FINDING AT THE EARLIEST PRACTICABLE DATE.

(E) (1) WITHIN 30 DAYS OF THE LATER OF THE FILING OF THE DEFENDANT'S ANSWER TO THE COMPLAINT OR THE DEFENDANT'S CERTIFICATE OF A QUALIFIED EXPERT UNDER § 3-2A-04 OF THIS SUBTITLE, THE PARTIES MAY CHOOSE A MEDIATOR OR NEUTRAL PROVIDER.

(2) IF THE PARTIES CHOOSE A MEDIATOR OR NEUTRAL PROVIDER, THE PARTIES SHALL NOTIFY THE COURT OF THE NAME OF THE MEDIATOR OR NEUTRAL PROVIDER.

(F) (1) IF THE PARTIES DO NOT PROVIDE TO THE COURT THE NOTICE DESCRIBED UNDER SUBSECTION (E) OF THIS SECTION, THE COURT SHALL ASSIGN WITHIN 30 DAYS A MEDIATOR OR NEUTRAL PROVIDER TO THE CASE.

(2) THE COURT MAY CONSULT WITH THE PARTIES BEFORE MAKING AN ASSIGNMENT UNDER THIS SECTION.

(3) A MEDIATOR OR NEUTRAL PROVIDER MAY NOT:

(I) HAVE A PERSONAL OR ECONOMIC RELATIONSHIP WITH ANY PARTY OR AN ATTORNEY OF ANY PARTY; OR

(II) BE A PARTY IN ANY CASE BEFORE THE HEALTH CLAIMS ARBITRATION OFFICE OR A COURT THAT MAY FORM THE BASIS OF ANY

PARTIALITY ON THE INDIVIDUAL'S PART.

(4) A MEDIATOR OR NEUTRAL PROVIDER ASSIGNED UNDER THIS SUBSECTION SHALL BE COMPENSATED IN AN AMOUNT ORDERED BY THE COURT.

(G) THE MEDIATOR OR NEUTRAL PROVIDER SHALL SCHEDULE AN INITIAL SESSION FOR THE PARTIES AS SOON AS PRACTICABLE AND CONSISTENT WITH A COURT ORDER DESCRIBED UNDER SUBSECTION (D) OF THIS SECTION.

(H) IF THE MEDIATOR OR NEUTRAL PROVIDER FINDS AT THE INITIAL SESSION THAT ONE OR MORE PARTIES NEED TO ENGAGE IN DISCOVERY FOR A LIMITED PERIOD OF TIME IN ORDER TO FACILITATE THE MEDIATION, NEUTRAL CASE EVALUATION, OR NEUTRAL FACT-FINDING, THE MEDIATOR OR NEUTRAL PROVIDER MAY ADJOURN THE INITIAL SESSION AND RESCHEDULE IT FOR A LATER DATE.

(I) EXCEPT AS OTHERWISE EXPRESSLY PROVIDED IN THIS SECTION OR TITLE 17 OF THE MARYLAND RULES, ANY COMMUNICATIONS IN THE COURSE OF THE SESSION:

(1) ARE PRIVILEGED;

(2) ARE CONFIDENTIAL;

(3) MAY NOT BE DISCLOSED TO ANOTHER PARTY WITHOUT CONSENT;

(4) DO NOT CONSTITUTE AN ADMISSION; AND

(5) ARE NOT DISCOVERABLE.

(J) (1) EXCEPT AS PROVIDED IN PARAGRAPH (2) OF THIS SUBSECTION, EACH PARTY, THE PARTY'S COUNSEL, AND A PERSON WITH ACTUAL SETTLEMENT AUTHORITY SHALL ATTEND AND PARTICIPATE IN EACH SESSION HELD UNDER THIS

SECTION.

(2) WITH THE APPROVAL OF THE MEDIATOR OR NEUTRAL PROVIDER, THE PARTIES MAY AGREE TO WAIVE THE PARTY'S PRESENCE AT A SESSION.

(K) A PARTY WHO VIOLATES THIS SECTION OR WHO OTHERWISE FAILS TO PARTICIPATE IN GOOD FAITH IN A SESSION IS SUBJECT TO THE SANCTIONS SET FORTH IN MARYLAND RULE 2-433.

(L) IF A CASE IS SETTLED, THE PARTIES SHALL:

(1) IMMEDIATELY NOTIFY THE COURT THAT THE CASE HAS BEEN SETTLED; AND

(2) FILE A STIPULATION OF DISMISSAL AND COURT COSTS AND A COMPLETED SETTLEMENT ORDER WITH THE COURT.

(M) THE REQUIREMENTS OF THIS SECTION MAY BE MODIFIED BY:

(1) AGREEMENT OF THE PARTIES WITH THE APPROVAL OF THE MEDIATOR OR NEUTRAL PROVIDER; OR

(2) ORDER OF A COURT ON THE MOTION OF A PARTY.

(N) UNLESS OTHERWISE AGREED BY THE PARTIES, THE COSTS OF A MEDIATOR OR NEUTRAL PROVIDER SHALL BE DIVIDED EQUALLY BETWEEN THE PARTIES.

(O) A MEDIATOR OR NEUTRAL PROVIDER WHO CONDUCTS ALTERNATIVE DISPUTE RESOLUTION SHALL HAVE THE IMMUNITY FROM SUIT DESCRIBED UNDER § 5-615 OF THIS ARTICLE.

3-2A-07A.

(A) (1) AT THE CONCLUSION OF AN ARBITRATION PANEL OR TRIAL UNDER THIS SUBTITLE, THE PANEL OR COURT, ON MOTION OF A PARTY OR ON ITS OWN MOTION, MAY MAKE A FINDING AS TO WHETHER THE CLAIM OR ACTION WAS BROUGHT OR MAINTAINED IN BAD FAITH OR WITHOUT SUBSTANTIAL JUSTIFICATION.

(2) IF THE PANEL OR COURT FINDS THAT THE CLAIM OR ACTION WAS BROUGHT OR MAINTAINED IN BAD FAITH OR WITHOUT SUBSTANTIAL JUSTIFICATION, THE DIRECTOR OR COURT SHALL REPORT THE FINDING AND NAME OF THE ATTORNEY OR ATTORNEYS FOR THE CLAIMANT OR PLAINTIFF TO THE ADMINISTRATIVE OFFICE OF THE COURTS.

(B) THE ADMINISTRATIVE OFFICE OF THE COURTS SHALL:

(1) MAINTAIN A RECORD OF THE ATTORNEYS WHOSE NAMES HAVE BEEN REPORTED UNDER SUBSECTION (A) OF THIS SECTION; AND

(2) PUBLISH ON THE JUDICIARY WEBSITE A LIST CONTAINING THE NAME OF EACH ATTORNEY WHO HAS BEEN THE SUBJECT OF THREE OR MORE FINDINGS DESCRIBED IN SUBSECTION (A) OF THIS SECTION WITHIN 5 YEARS.

(C) (1) AN ATTORNEY WHO HAS BEEN THE SUBJECT OF THREE OR MORE FINDINGS DESCRIBED IN SUBSECTION (A) OF THIS SECTION WITHIN 5 YEARS MAY NOT BRING AN ACTION UNDER THIS SUBTITLE FOR 10 YEARS.

(2) AN ATTORNEY WHO WILFULLY VIOLATES PARAGRAPH (1) OF THIS SUBSECTION IS SUBJECT TO DISCIPLINARY PROCEEDINGS AS PROVIDED IN THE MARYLAND RULES.

(D) (1) WHEN A CLAIM OR ACTION IS FILED UNDER THIS SUBTITLE, THE DIRECTOR OR COURT SHALL CONSULT THE LIST UNDER SUBSECTION (B)(2) OF THIS SECTION.

(2) (I) IF THE NAME OF AN ATTORNEY WHO IS COUNSEL FOR THE CLAIMANT OR PLAINTIFF APPEARS ON THE LIST UNDER SUBSECTION (B)(2) OF THIS SECTION, THE DIRECTOR OR COURT SHALL STRIKE THE APPEARANCE OF THE ATTORNEY.

(II) WHEN THE APPEARANCE OF AN ATTORNEY IS STRICKEN UNDER SUBPARAGRAPH (I) OF THIS PARAGRAPH, AND THE CLAIMANT OR PLAINTIFF HAS NO ATTORNEY OF RECORD AND HAS NOT PROVIDED WRITTEN NOTIFICATION TO PROCEED IN PROPER PERSON, IF A NEW ATTORNEY HAS NOT ENTERED AN APPEARANCE WITHIN 60 DAYS AFTER THE DATE OF THE NOTICE, THE ABSENCE OF AN ATTORNEY IS NOT GROUNDS FOR A CONTINUANCE.

(III) THE DIRECTOR OR THE COURT SHALL SEND A NOTICE BY FIRST-CLASS MAIL TO THE CLAIMANT OR PLAINTIFF AT THE LAST KNOWN ADDRESS OF THE CLAIMANT OR PLAINTIFF STATING THAT:

1. IF A NEW ATTORNEY HAS NOT ENTERED AN APPEARANCE WITHIN 60 DAYS AFTER THE DATE OF THE NOTICE, THE ABSENCE OF AN ATTORNEY IS NOT GROUNDS FOR A CONTINUANCE; AND

2. THE CLAIMANT OR PLAINTIFF MAY RISK DISMISSAL OF THE CLAIM, JUDGMENT BY DEFAULT, AND ASSESSMENT OF COURT COSTS.

3-2A-09.

(A) THIS SECTION APPLIES TO AN AWARD UNDER § 3-2A-05 OF THIS SUBTITLE OR A VERDICT UNDER § 3-2A-06 OF THIS SUBTITLE FOR A CAUSE OF ACTION ARISING ON OR AFTER JANUARY 1, 2005.

(B) (1) (I) EXCEPT AS PROVIDED IN PARAGRAPH (2)(II) OF THIS SUBSECTION, AN AWARD OR VERDICT UNDER THIS SUBTITLE FOR NONECONOMIC DAMAGES FOR A CAUSE OF ACTION ARISING BETWEEN JANUARY 1, 2005, AND

DECEMBER 31, 2008, INCLUSIVE, MAY NOT EXCEED $650,000.

(II) THE LIMITATION ON NONECONOMIC DAMAGES PROVIDED UNDER SUBPARAGRAPH (I) OF THIS PARAGRAPH SHALL INCREASE BY $15,000 ON JANUARY 1 OF EACH YEAR BEGINNING JANUARY 1, 2009. THE INCREASED AMOUNT SHALL APPLY TO CAUSES OF ACTION ARISING BETWEEN JANUARY 1 AND DECEMBER 31 OF THAT YEAR, INCLUSIVE.

(2) (I) EXCEPT AS PROVIDED IN SUBPARAGRAPH (II) OF THIS PARAGRAPH, THE LIMITATION UNDER PARAGRAPH (1) OF THIS SUBSECTION SHALL APPLY 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, PLAINTIFFS, OR BENEFICIARIES.

(II) IF THERE IS A WRONGFUL DEATH ACTION IN WHICH THERE ARE TWO OR MORE CLAIMANTS OR BENEFICIARIES, WHETHER OR NOT THERE IS A PERSONAL INJURY ACTION ARISING FROM THE SAME MEDICAL INJURY, THE TOTAL AMOUNT AWARDED FOR NONECONOMIC DAMAGES FOR ALL ACTIONS MAY NOT EXCEED 150% OF THE LIMITATION ESTABLISHED UNDER PARAGRAPH (1) OF THIS SUBSECTION, REGARDLESS OF THE NUMBER OF CLAIMS, CLAIMANTS, PLAINTIFFS, OR BENEFICIARIES.

(C) (1) IN A JURY TRIAL, THE JURY MAY NOT BE INFORMED OF THE LIMITATION UNDER SUBSECTION (B) OF THIS SECTION.

(2) IF THE JURY AWARDS AN AMOUNT FOR NONECONOMIC DAMAGES THAT EXCEEDS THE LIMITATION ESTABLISHED UNDER SUBSECTION (B) OF THIS SECTION, THE COURT SHALL REDUCE THE AMOUNT TO CONFORM TO THE LIMITATION.

(3) IN A WRONGFUL DEATH ACTION IN WHICH THERE ARE TWO OR MORE CLAIMANTS OR BENEFICIARIES, IF THE JURY AWARDS AN AMOUNT FOR NONECONOMIC DAMAGES THAT EXCEEDS THE LIMITATION UNDER SUBSECTION (B) OF THIS SECTION OR A REDUCTION UNDER PARAGRAPH (4) OF THIS SUBSECTION,

THE COURT SHALL:

(I) IF THE AMOUNT OF NONECONOMIC DAMAGES FOR THE PRIMARY CLAIMANTS, AS DESCRIBED UNDER § 3-904(D) OF THIS TITLE, EQUALS OR EXCEEDS THE LIMITATION UNDER SUBSECTION (B) OF THIS SECTION OR A REDUCTION UNDER PARAGRAPH (4) OF THIS SUBSECTION:

1. REDUCE EACH INDIVIDUAL AWARD OF A PRIMARY CLAIMANT PROPORTIONATELY TO THE TOTAL AWARD OF ALL PRIMARY CLAIMANTS SO THAT THE TOTAL AWARD TO ALL CLAIMANTS OR BENEFICIARIES CONFORMS TO THE LIMITATION OR REDUCTION; AND

2. REDUCE EACH AWARD, IF ANY, TO A SECONDARY CLAIMANT AS DESCRIBED UNDER § 3-904(E) OF THIS TITLE TO ZERO DOLLARS; OR

(II) IF THE AMOUNT OF NONECONOMIC DAMAGES FOR THE PRIMARY CLAIMANTS DOES NOT EXCEED THE LIMITATION UNDER SUBSECTION (B) OF THIS SECTION OR A REDUCTION UNDER PARAGRAPH (4) OF THIS SUBSECTION OR IF THERE IS NO AWARD TO A PRIMARY CLAIMANT:

1. ENTER AN AWARD TO EACH PRIMARY CLAIMANT, IF ANY, AS DIRECTED BY THE VERDICT; AND

2. REDUCE EACH INDIVIDUAL AWARD OF A SECONDARY CLAIMANT PROPORTIONATELY TO THE TOTAL AWARD OF ALL OF THE SECONDARY CLAIMANTS SO THAT THE TOTAL AWARD TO ALL CLAIMANTS OR BENEFICIARIES CONFORMS TO THE LIMITATION OR REDUCTION.

(4) IN A CASE IN WHICH THERE IS A PERSONAL INJURY ACTION AND A WRONGFUL DEATH ACTION, IF THE TOTAL AMOUNT AWARDED BY THE JURY FOR NONECONOMIC DAMAGES FOR BOTH ACTIONS EXCEEDS THE LIMITATION UNDER SUBSECTION (B) OF THIS SECTION, THE COURT SHALL REDUCE THE AWARD IN EACH ACTION PROPORTIONATELY SO THAT THE TOTAL AWARD FOR

NONECONOMIC DAMAGES FOR BOTH ACTIONS CONFORMS TO THE LIMITATION.

[3-2A-09.] 3-2A-10.

[The] EXCEPT AS OTHERWISE PROVIDED IN § 3-2A-09 OF THIS SUBTITLE, THE provisions of this subtitle shall be deemed procedural in nature and [shall] MAY not be construed to create, enlarge, or diminish any cause of action not heretofore existing, except the defense of failure to comply with the procedures required under this subtitle.

5-615.

In the absence of an affirmative showing of malice or bad faith, each arbitrator, MEDIATOR, OR NEUTRAL PROVIDER in a health care malpractice claim under Title 3, Subtitle 2A of this article from the time of acceptance of appointment has immunity from suit for any act or decision made during tenure and within the scope of designated authority.

10-920.

(A) IN THIS SECTION, "HEALTH CARE PROVIDER" HAS THE MEANING STATED IN § 3-2A-01 OF THIS ARTICLE.

(B) (1) IN A PROCEEDING SUBJECT TO TITLE 3, SUBTITLE 2A OF THIS ARTICLE OR A CIVIL ACTION AGAINST A HEALTH CARE PROVIDER, AN EXPRESSION OF REGRET OR APOLOGY MADE BY OR ON BEHALF OF THE HEALTH CARE PROVIDER RELATING TO THE PAIN, SUFFERING, OR DEATH OF A PERSON DUE TO A MEDICAL INJURY AND MADE TO THAT PERSON OR TO THE FAMILY OF THAT PERSON, INCLUDING AN EXPRESSION OF REGRET OR APOLOGY MADE IN WRITING, ORALLY, OR BY CONDUCT, IS INADMISSIBLE AS AN ADMISSION OF LIABILITY FOR ANY PURPOSE.

(2) NOTWITHSTANDING PARAGRAPH (1) OF THIS SUBSECTION, A STATEMENT OF FAULT MADE BY OR ON BEHALF OF THE HEALTH CARE PROVIDER RELATING TO THE PAIN, SUFFERING, OR DEATH OF A PERSON DUE TO A MEDICAL INJURY AND MADE TO THAT PERSON OR TO THE FAMILY OF THAT PERSON, MADE

IN WRITING, ORALLY, OR BY CONDUCT, IS ADMISSIBLE AS AN ADMISSION OF LIABILITY.

11-108.

(c) An award by the health claims arbitration panel in accordance with [§ 3-2A-06] § 3-2A-05 of this article FOR DAMAGES IN WHICH THE CAUSE OF ACTION AROSE BEFORE JANUARY 1, 2005, shall be considered an award for purposes of this section.

(E) THE PROVISIONS OF THIS SECTION DO NOT APPLY TO A JUDGMENT UNDER TITLE 3, SUBTITLE 2A OF THIS ARTICLE FOR DAMAGES IN WHICH THE CAUSE OF ACTION ARISES ON OR AFTER JANUARY 1, 2005.

Article - Health - General

15-102.7.

THE PREMIUM TAX IMPOSED UNDER § 6-102 OF THE INSURANCE ARTICLE APPLIES TO MANAGED CARE ORGANIZATIONS.

19-304.

(A) A HOSPITAL OR RELATED INSTITUTION SHALL REPORT ADVERSE EVENTS TO THE DEPARTMENT IN ACCORDANCE WITH REGULATIONS ADOPTED BY THE SECRETARY RELATING TO HOSPITAL PATIENT SAFETY PROGRAMS.

(B) IF A HOSPITAL OR RELATED INSTITUTION FAILS TO COMPLY WITH SUBSECTION (A) OF THIS SECTION, THE SECRETARY MAY IMPOSE A FINE OF UP TO $10,000.

(C) THE SECRETARY SHALL ADOPT REGULATIONS TO IMPLEMENT THIS SECTION.

19-727.

[(a) Except as provided in subsection (b) of this section, a] A health maintenance organization is not exempted from any State, county, or local taxes solely because of this subtitle.

[(b) (1) Each health maintenance organization that is authorized to operate under this subtitle is exempted from paying the premium tax imposed under Title 6, Subtitle 1 of the Insurance Article.

(2) Premiums received by an insurer under policies that provide health maintenance organization benefits are not subject to the premium tax imposed under Title 6, Subtitle 1 of the Insurance Article to the extent:

(i) Of the amounts actually paid by the insurer to a nonprofit health maintenance organization that operates only as a health maintenance organization; or

(ii) The premiums have been paid by that nonprofit health maintenance organization.]

Article - Health Occupations

1-401.

(a) (1) In this section the following words have the meanings indicated.

(2) (i) "Alternative health care system" means a system of health care delivery other than a hospital or related institution.

(ii) "Alternative health care system" includes:

1. A health maintenance organization;

2. A preferred provider organization;

3. An independent practice association;

4. A community health center that is a nonprofit, freestanding ambulatory health care provider governed by a voluntary board of directors and that provides primary health care services to the medically indigent;

5. A freestanding ambulatory care facility as that term is defined in § 19-3B-01 of the Health - General Article; or

6. Any other health care delivery system that utilizes a medical review committee.

(3) "Medical review committee" means a committee or board that:

(i) Is within one of the categories described in subsection (b) of this section; and

(ii) Performs functions that include at least one of the functions listed in subsection (c) of this section.

(4) (i) "Provider of health care" means any person who is licensed by law to provide health care to individuals.

(ii) "Provider of health care" does not include any nursing institution that is conducted by and for those who rely on treatment by spiritual means through prayer alone in accordance with the tenets and practices of a recognized church or religious denomination.

(5) "The Maryland Institute for Emergency Medical Services Systems" means the State agency described in § 13-503 of the Education Article.

(b) For purposes of this section, a medical review committee is:

(1) A regulatory board or agency established by State or federal law to license,

certify, or discipline any provider of health care;

(2) A committee of the Faculty or any of its component societies or a committee of any other professional society or association composed of providers of health care;

(3) A committee appointed by or established in a local health department for review purposes;

(4) A committee appointed by or established in the Maryland Institute for Emergency Medical Services Systems;

(5) A committee of the medical staff or other committee, including any risk management, credentialing, or utilization review committee established in accordance with § 19-319 of the Health - General Article, of a hospital, related institution, or alternative health care system, if the governing board of the hospital, related institution, or alternative health care system forms and approves the committee or approves the written bylaws under which the committee operates;

(6) A committee or individual designated by the holder of a pharmacy permit, as defined in § 12-101 of this article, that performs the functions listed in subsection (c) of this section, as part of a pharmacy's ongoing quality assurance program;

(7) Any person, including a professional standard review organization, who contracts with an agency of this State or of the federal government to perform any of the functions listed in subsection (c) of this section;

(8) Any person who contracts with a provider of health care to perform any of those functions listed in subsection (c) of this section that are limited to the review of services provided by the provider of health care;

(9) An organization, established by the Maryland Hospital Association, Inc. and the Faculty, that contracts with a hospital, related institution, or alternative delivery system to:

(i) Assist in performing the functions listed in subsection (c) of this section; or

(ii) Assist a hospital in meeting the requirements of § 19-319(e) of the Health - General Article;

(10) A committee appointed by or established in an accredited health occupations school;

(11) An organization described under § 14-501 of this article that contracts with a hospital, related institution, or health maintenance organization to:

(i) Assist in performing the functions listed in subsection (c) of this section; or

(ii) Assist a health maintenance organization in meeting the requirements of Title 19, Subtitle 7 of the Health - General Article, the National Committee for Quality Assurance (NCQA), or any other applicable credentialing law or regulation;

(12) An accrediting organization as defined in § 14-501 of this article;

(13) A Mortality Review Committee established under § 5-801 of the Health - General Article; or

(14) A center designated by the Maryland Health Care Commission as the Maryland Patient Safety Center that performs the functions listed in subsection (c)(1) of this section.

(c) For purposes of this section, a medical review committee:

(1) Evaluates and seeks to improve the quality of health care provided by providers of health care;

(2) Evaluates the need for and the level of performance of health care provided by providers of health care;

(3) Evaluates the qualifications, competence, and performance of providers of health care; or

(4) Evaluates and acts on matters that relate to the discipline of any provider of health care.

(d) (1) Except as otherwise provided in this section, the proceedings, records, and files of a medical review committee are not discoverable and are not admissible in evidence in any civil action.

(2) The proceedings, records, and files of a medical review committee are confidential and are not discoverable and are not admissible in evidence in any civil action arising out of matters that are being reviewed and evaluated by the medical review committee if requested by the following:

(i) The Department of Health and Mental Hygiene to ensure compliance with the provisions of § 19-319 of the Health - General Article;

(ii) A health maintenance organization to ensure compliance with the provisions of Title 19, Subtitle 7 of the Health - General Article and applicable regulations;

(iii) A health maintenance organization to ensure compliance with the National Committee for Quality Assurance (NCQA) credentialing requirements; or

(iv) An accrediting organization to ensure compliance with accreditation requirements or the procedures and policies of the accrediting organization.

(3) If the proceedings, records, and files of a medical review committee are requested by any person from any of the entities in paragraph (2) of this subsection:

(i) The person shall give the medical review committee notice by certified mail of the nature of the request and the medical review committee shall be granted a protective order preventing the release of its proceedings, records, and files; and

(ii) The entities listed in paragraph (2) of this subsection may not release any of the proceedings, records, and files of the medical review committee.

(e) Subsection (d)(1) of this section does not apply to:

(1) A civil action brought by a party to the proceedings of the medical review committee who claims to be aggrieved by the decision of the medical review committee; or

(2) Any record or document that is considered by the medical review committee and that otherwise would be subject to discovery and introduction into evidence in a civil trial.

(f) (1) A person shall have the immunity from liability described under § 5-637 of the Courts and Judicial Proceedings Article for any action as a member of the medical review committee or for giving information to, participating in, or contributing to the function of the medical review committee.

(2) A contribution to the function of a medical review committee includes any statement by any person, regardless of whether it is a direct communication with the medical review committee, that is made within the context of the person's employment or is made to a person with a professional interest in the functions of a medical review committee and is intended to lead to redress of a matter within the scope of a medical review committee's functions.

(G) IN A CIVIL ACTION BROUGHT BY A PARTY TO THE PROCEEDINGS OF A MEDICAL REVIEW COMMITTEE DESCRIBED IN SUBSECTION (B)(5), (9), OR (11) OF THIS SECTION WHO CLAIMS TO BE AGGRIEVED BY THE DECISION OF THE MEDICAL REVIEW COMMITTEE, THE COURT MAY AWARD COURT COSTS AND REASONABLE ATTORNEY'S FEES TO THE PREVAILING PARTY IN THE CIVIL ACTION, INCLUDING A PERSON DESCRIBED IN SUBSECTION (F) OF THIS SECTION IF THE PERSON IS A PREVAILING PARTY IN THE CIVIL ACTION.

[(g)] (H) Notwithstanding this section, §§ 14-410 and 14-412 of this article apply to:

(1) The Board of Physicians; and

(2) Any other entity, to the extent that it is acting in an investigatory capacity for the Board of Physicians.

14-405.

(a) Except as otherwise provided in the Administrative Procedure Act, before the Board takes any action under § 14-404(a) of this subtitle or § 14-5A-17(a) of this title, it shall give the individual against whom the action is contemplated an opportunity for a hearing before a hearing officer.

(b) (1) The hearing officer shall give notice and hold the hearing in accordance with the Administrative Procedure Act.

(2) [Except as provided in paragraph (3) of this subsection, factual] FACTUAL findings shall be supported by a preponderance of the evidence.

[(3) Factual findings shall be supported by clear and convincing evidence if the charge of the Board is based on § 14-404(a)(22), § 14-5A-17(a)(18), or § 14-5B-14(a)(18) of this title.]

(c) The individual may be represented at the hearing by counsel.

(d) If after due notice the individual against whom the action is contemplated fails or refuses to appear, nevertheless the hearing officer may hear and refer the matter to the Board for disposition.

(e) After performing any necessary hearing under this section, the hearing officer shall refer proposed factual findings to the Board for the Board's disposition.

(f) The Board may adopt regulations to govern the taking of depositions and discovery in the hearing of charges.

(g) The hearing of charges may not be stayed or challenged by any procedural defects alleged to have occurred prior to the filing of charges.

14-413.

(a) (1) Every 6 months, each hospital and related institution shall file with the Board a report that:

(i) Contains the name of each licensed physician who, during the 6 months preceding the report:

1. Is employed by the hospital or related institution;

2. Has privileges with the hospital or related institution; and

3. Has applied for privileges with the hospital or related institution; and

(ii) States whether, as to each licensed physician, during the 6 months preceding the report:

1. The hospital or related institution denied the application of a physician for staff privileges or limited, reduced, otherwise changed, or terminated the staff privileges of a physician, or the physician resigned whether or not under formal accusation, if the denial, limitation, reduction, change, termination, or resignation is for reasons that might be grounds for disciplinary action under § 14-404 of this subtitle;

2. The hospital or related institution took any disciplinary action against a salaried, licensed physician without staff privileges, including termination of employment, suspension, or probation, for reasons that might be grounds for disciplinary action under § 14-404 of this subtitle;

3. The hospital or related institution took any disciplinary action against an individual in a postgraduate medical training program, including removal from the training program, suspension, or probation for reasons that might be grounds for disciplinary action under §

14-404 of this subtitle;

4. A licensed physician or an individual in a postgraduate training program voluntarily resigned from the staff, employ, or training program of the hospital or related institution for reasons that might be grounds for disciplinary action under § 14-404 of this subtitle; or

5. The hospital or related institution placed any other restrictions or conditions on any of the licensed physicians as listed in items 1 through 4 of this subparagraph for any reasons that might be grounds for disciplinary action under § 14-404 of this subtitle.

(2) The hospital or related institution shall:

(i) Submit the report within 10 days of any action described in paragraph (1)(ii) of this subsection; and

(ii) State in the report the reasons for its action or the nature of the formal accusation pending when the physician resigned.

(3) The Board may extend the reporting time under this subsection for good cause shown.

(4) The minutes or notes taken in the course of determining the denial, limitation, reduction, or termination of the staff privileges of any physician in a hospital or related institution are not subject to review or discovery by any person.

(b) (1) Each court shall report to the Board each conviction of or entry of a plea of guilty or nolo contendere by a physician for any crime involving moral turpitude.

(2) The court shall submit the report within 10 days of the conviction or entry of the plea.

(c) The Board may enforce this section by subpoena.

(d) Any person shall have the immunity from liability described under § 5-715(d) of the

Courts and Judicial Proceedings Article for giving any of the information required by this section.

(e) A report made under this section is not subject to subpoena or discovery in any civil action other than a proceeding arising out of a hearing and decision of the Board under this title.

(f) (1) [Failure to report pursuant to this section shall result in imposition of] THE BOARD MAY IMPOSE a civil penalty of up to $5,000 [by a circuit court of this State] FOR FAILURE TO REPORT UNDER THIS SECTION.

(2) THE BOARD SHALL REMIT ANY PENALTY COLLECTED UNDER THIS SUBSECTION INTO THE GENERAL FUND OF THE STATE.

Article - Insurance

2-213.

(A) "DIVISION" MEANS THE PEOPLE'S INSURANCE COUNSEL DIVISION ESTABLISHED UNDER TITLE 6, SUBTITLE 3 OF THE STATE GOVERNMENT ARTICLE.

[(a)] (B) (1) Except as otherwise provided in this subsection, all hearings shall be open to the public in accordance with Article 41, § 1-205 of the Code.

(2) A hearing held by the Commissioner that relates to a filing under Title 11 of this article is not required to be open to the public.

(3) A hearing held by the Commissioner to determine whether an insurer is being operated in a hazardous manner that could result in its impairment is not required to be open to the public if:

(i) the insurer requests that the hearing not be a public hearing; and

(ii) the Commissioner determines that it is not in the interest of the public to hold a public hearing.

(4) A hearing held by the Commissioner to evaluate the financial condition of an insurer under the risk based capital standards set out in Title 4, Subtitle 3 of this article is not required to be open to the public.

[(b)] (C) (1) The Commissioner shall allow any party to a hearing to:

(i) appear in person;

(ii) be represented:

1. by counsel; or

2. in the case of an insurer, by a designee of the insurer who:

A. is employed by the insurer in claims, underwriting, or as otherwise provided by the Commissioner; and

B. has been given the authority by the insurer to resolve all issues involved in the hearing;

(iii) be present while evidence is given;

(iv) have a reasonable opportunity to inspect all documentary evidence and to examine witnesses; and

(v) present evidence.

(2) On request of a party, the Commissioner shall issue subpoenas to compel attendance of witnesses or production of evidence on behalf of the party.

[(c)] (D) The Commissioner shall allow any person that was not an original party to a hearing to become a party by intervention if:

(1) the intervention is timely; and

(2) the financial interests of the person will be directly and immediately affected by an order of the Commissioner resulting from the hearing.

[(d)] (E) (1) Formal rules of pleading or evidence need not be observed at a hearing.

(2) IN A HEARING IN WHICH THE DIVISION APPEARS, THE RIGHT TO CROSS EXAMINE WITNESSES MAY BE EXERCISED BY:

(I) THE DIVISION; OR

(II) THE INSURER WHOSE RATE INCREASE IS THE SUBJECT OF THE HEARING.

[(e)] (F) (1) On timely written request by a party to a hearing, the Commissioner shall have a full stenographic record of the proceedings made by a competent reporter at the expense of that party.

(2) If the stenographic record is transcribed, a copy shall be given on request to any other party to the hearing at the expense of that party.

(3) If the stenographic record is not made or transcribed, the Commissioner shall prepare an adequate record of the evidence and proceedings.

2-303.2.

(A) THE ADMINISTRATION SHALL PREPARE ANNUALLY A COMPARISON GUIDE OF MEDICAL PROFESSIONAL LIABILITY INSURANCE PREMIUMS.

(B) THE COMPARISON GUIDE SHALL:

(1) LIST EACH INSURER AUTHORIZED TO PROVIDE MEDICAL PROFESSIONAL LIABILITY INSURANCE IN THE STATE;

(2) INCLUDE, FOR EACH SPECIALTY AND TERRITORY, THE BASE PREMIUM CHARGED BY AN INSURER FOR PHYSICIANS WITH POLICY LIMITS OF $1,000,000 AND $3,000,000; AND

(3) INCLUDE THE BASE PREMIUM CHARGED BY AN INSURER FOR A:

(I) HOSPITAL;

(II) MEDICAL DAY CARE CENTER;

(III) HOSPICE CARE PROGRAM;

(IV) ASSISTED LIVING PROGRAM; AND

(V) FREESTANDING AMBULATORY CARE FACILITY AS DEFINED IN § 19-3B-01 OF THE HEALTH - GENERAL ARTICLE.

(C) THE ADMINISTRATION SHALL PUBLISH THE COMPARISON GUIDE REQUIRED UNDER SUBSECTION (A) OF THIS SECTION ON ITS WEBSITE AND IN PRINTED FORM.

4-401.

(a) This section applies to:

(1) each insurer that provides MEDICAL professional liability insurance to A:

(i) [a] physician, nurse, dentist, podiatrist, optometrist, or chiropractor licensed under the Health Occupations Article; [or]

(ii) [a] hospital licensed under the Health - General Article; [and]

(III) MEDICAL DAY CARE CENTER;

(IV) HOSPICE PROGRAM;

(V) ASSISTED LIVING PROGRAM; OR

(VI) FREESTANDING AMBULATORY CARE FACILITY AS DEFINED IN § 19-3B-01 OF THE HEALTH - GENERAL ARTICLE;

(2) each self-insured:

(I) hospital;

(II) MEDICAL DAY CARE CENTER;

(III) HOSPICE PROGRAM;

(IV) ASSISTED LIVING PROGRAM; OR

(V) FREESTANDING AMBULATORY CARE FACILITY AS DEFINED IN § 19-3B-01 OF THE HEALTH - GENERAL ARTICLE;

(3) EACH RISK RETENTION GROUP AS DEFINED UNDER § 25-101 OF THIS ARTICLE; AND

(4) EACH PHYSICIAN, NURSE, DENTIST, PODIATRIST, OPTOMETRIST, OR CHIROPRACTOR LICENSED UNDER THE HEALTH OCCUPATIONS ARTICLE OR A HOSPITAL, MEDICAL DAY CARE CENTER, HOSPICE PROGRAM, ASSISTED LIVING PROGRAM, OR FREESTANDING AMBULATORY CARE FACILITY AS DEFINED IN § 19-3B-01 OF THE HEALTH - GENERAL ARTICLE THAT OBTAINS MEDICAL PROFESSIONAL LIABILITY INSURANCE FROM A SOURCE OTHER THAN THOSE LISTED IN ITEMS (1) THROUGH (3) OF THIS SUBSECTION.

(b) An entity subject to this section shall report quarterly any claim or action for damages for personal injury if the claim or action:

(1) is claimed to have been caused by an error, omission, or negligence in the performance of the insured's professional services or is based on a claimed performance of the insured's professional services without consent; and

(2) resulted in:

(i) a final judgment in any amount;

(ii) a settlement in any amount; or

(iii) a final disposition that does not result in payment on behalf of the insured.

(c) A report required under this section shall contain THE FOLLOWING INFORMATION AND BE IN THE FOLLOWING FORM:

[(1) the name and address of the insured;
(2) the policy number of the insured;

(3) the date of the occurrence from which the claim or action arose;

(4) the date of filing suit, if any;

(5) the date and amount of final judgment or settlement, if any;

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

(7) a summary of the occurrence from which the claim or action arose; and

(8) any other information as may be required.]

MARYLAND COMMERCIAL LIABILITY INSURANCE

CLOSED CLAIMS SURVEY
MEDICAL PROFESSIONAL LIABILITY

1. (A) NAME OF INSURER _____

(B) NAME OF INSURER GROUP _____

(C) CLAIM FILE IDENTIFICATION _____

(D) NAME OF PERSON COMPLETING FORM _____

(E) TELEPHONE NUMBER (AREA CODE) _____

(F) DATE FORM COMPLETED _____

2. (A) DATE OF INJURY (MO) _____ (DAY) _____ (YR) _____

(B) DATE INJURY REPORTED TO INSURER (MO) _____ (DAY) _____ (YR) _____

(C) DATE CLAIM CLOSED (MO) _____ (DAY) _____ (YR) _____

3. AGE OF INSURED PERSON AT TIME OF INJURY _____

4. WAS INJURED PERSON EMPLOYED AT TIME OF INJURY? YES _____ NO _____

5. (A) TYPE OF INJURY

_____ WRONGFUL DEATH

_____ PERMANENT TOTAL DISABILITY

_____ OTHER BODILY INJURY

(Over)

(B) DESCRIPTION OF INJURY _____

6. (A) TYPE OF MEDICAL PROFESSIONAL LIABILITY

_____ OCCURRENCE

_____ CLAIMS MADE - BASIC

_____ CLAIMS MADE - TAIL

(B) HOSPITAL OR RELATED INSTITUTION CLASSIFICATION EXPOSURE BY NUMBER OF BEDS

_____ FOR PROFIT

_____ NOT FOR PROFIT

_____ GOVERNMENT

_____ OSTEOPATHIC

_____ MENTAL FOR PROFIT

_____ MENTAL NOT FOR PROFIT

_____ MENTAL GOVERNMENT

_____ COMPOSITE RATED

(C) HOSPITAL OR RELATED INSTITUTION CLASSIFICATION EXPOSURE BY NUMBER OF OUTPATIENTS

_____ FOR PROFIT

_____ NOT FOR PROFIT

_____ GOVERNMENT

_____ OSTEOPATHIC

_____ MENTAL FOR PROFIT

_____ MENTAL NOT FOR PROFIT

_____ MENTAL GOVERNMENT

(D) PATIENT STATUS

_____ INPATIENT

_____ OUTPATIENT (EMERGENCY ROOM)

_____ OUTPATIENT (OTHER)

(E) PHYSICIAN ISO CLASSIFICATION _____

(F) OTHER HEALTH CARE PROVIDER INCLUDING DENTAL ISO CLASSIFICATION

_____

(G) HEALTH CARE PROVIDER NAME AND LICENSE NUMBER

_____

(H) POLICY LIMITS:

EACH CLAIM OR MEDICAL INCIDENT

$_____

ANNUAL AGGREGATE

$_____

7. (A) STATE WHERE INJURY OCCURRED

_____ MARYLAND _____ OTHER (NAME STATE)

(B) IF MARYLAND, ENTER COUNTY WHERE INJURY OCCURRED

_____

(C) DATE OF FILING SUIT, IF ANY

_____

(D) IF MARYLAND, ENTER COUNTY WHERE SUIT WAS FILED

_____

(E) IF MARYLAND, ENTER COUNTY WHERE CASE WAS TRIED

_____

8. (A) WAS THE PLAINTIFF REPRESENTED BY AN ATTORNEY?

_____ YES _____ NO

(B) WAS THE INSURED REPRESENTED BY AN ATTORNEY?

_____ YES, AT INSURER'S EXPENSE

_____ YES, AT INSURED'S OWN EXPENSE

_____ NO

(C) WAS THE INSURER REPRESENTED BY A SEPARATE ATTORNEY?

_____ YES _____ NO

9. (A) STATE OF LEGAL SYSTEM AT WHICH SETTLEMENT WAS REACHED OR AWARD WAS MADE:

_____ ARBITRATION

_____ MEDIATION

_____ NO SUIT FILED

_____ SUIT FILED BUT SETTLEMENT REACHED BEFORE TRIAL

_____ DURING TRIAL, BUT BEFORE COURT VERDICT

_____ COURT VERDICT

_____ SETTLEMENT REACHED AFTER VERDICT

_____ SETTLEMENT REACHED AFTER APPEAL WAS FILED

(B) IF A COURT VERDICT IS INDICATED IN 9(A), ABOVE, INDICATE RESULT:

_____ DIRECTED VERDICT FOR PLAINTIFF

_____ DIRECTED VERDICT FOR DEFENDANT

_____ JUDGMENT NOTWITHSTANDING THE VERDICT FOR THE PLAINTIFF

_____ JUDGMENT NOTWITHSTANDING THE VERDICT FOR THE DEFENDANT

_____ JUDGMENT FOR THE PLAINTIFF

_____ JUDGMENT FOR THE DEFENDANT

_____ FOR PLAINTIFF, AFTER APPEAL

_____ FOR DEFENDANT, AFTER APPEAL

_____ ALL OTHERS

(C) IF THERE IS NO FINAL JUDGMENT OR SETTLEMENT, THE DATE AND REASON FOR THE FINAL DISPOSITION

_____

(D) IF CASE DID GO TO TRIAL, WAS THE CASE TRIED BY A JURY?

_____ YES (BY JUDGE AND JURY)

_____ NO (BY JUDGE ALONE)

10. (A) WERE THERE DEFENDANTS OTHER THAN YOUR INSURED(S) INCLUDED IN THE ORIGINAL CLAIM OR AN AMENDED VERSION OF THE CLAIM?

_____ YES _____ NO

(B) IF 10(A) IS YES, HOW MANY OTHER DEFENDANTS?

_____

(C) IF 10(A) IS YES, INDICATE THE TYPE OF OTHER DEFENDANTS (CHOOSE ALL THAT APPLY)

_____

PHYSICIANS AND SURGEONS, INCLUDING NAME AND LICENSE NUMBER

_____

_____

HOSPITALS AND OTHER HEALTH CARE PROVIDERS, INCLUDING NAME AND LICENSE NUMBER

_____

_____

ALL OTHERS, INCLUDING NAME

_____

_____

11. (A) IF CASE WAS TRIED TO VERDICT, WHAT PERCENTAGE OF FAULT WAS ASSIGNED TO YOUR INSURED:

_____%

(B) IF CLAIM WAS SETTLED, ESTIMATE THE PERCENTAGE OF FAULT FOR

YOUR INSURED:

_____%

(C) WHAT PERCENTAGE OF THE FINAL AWARD OR SETTLEMENT WAS PAID BY YOU?

_____%

12. PLEASE INDICATE THE FOLLOWING WITH RESPECT TO THE TOTAL AMOUNT PAID TO CLAIMANT

(A) AMOUNT PAID BY YOU, THE INSURER

$_____

(B) AMOUNT PAID BY INSURED, DUE TO RETENTION OR DEDUCTIBLE

$_____

(C) AMOUNT PAID BY EXCESS CARRIER

$_____

(D) AMOUNT PAID BY INSURED DUE TO SETTLEMENT OR AWARD IN EXCESS OF POLICY LIMITS

$_____

(E) AMOUNT PAID BY OTHER DEFENDANTS/CONTRIBUTORS

$_____

(F) TOTAL AMOUNT OF SETTLEMENT OR AWARD (A + B + C + D + E)

$_____

13. (A) WERE COLLATERAL SOURCES, SUCH AS MEDICAL INSURANCE, DISABILITY INSURANCE, SOCIAL SECURITY DISABILITY, OR WORKERS' COMPENSATION AVAILABLE TO THE INJURED PARTY?

_____ YES

_____ NO

_____ UNKNOWN

(B) IF 13(A) IS YES, INDICATE THE TYPE AND AMOUNT.

_____ $_____

14. PROVIDE A SUMMARY OF THE OCCURRENCE FROM WHICH THE CLAIM OR ACTION AROSE, INCLUDING

(A) THE FINAL DIAGNOSIS FOR WHICH TREATMENT WAS SOUGHT OR RENDERED, INCLUDING THE PATIENT'S ACTUAL CONDITION

_____

_____

(B) A DESCRIPTION OF THE MISDIAGNOSIS MADE, IF ANY, OF THE PATIENT'S ACTUAL CONDITION

_____

_____

(C) THE OPERATION, DIAGNOSTIC, OR TREATMENT PROCEDURE

_____

_____

(D) A DESCRIPTION OF THE PRINCIPAL INJURY GIVING RISE TO THE CLAIM; AND

_____

_____

(E) THE SAFETY MANAGEMENT STEPS THAT HAVE BEEN TAKEN BY THE INSURED TO PREVENT SIMILAR OCCURRENCES OR INJURIES IN THE FUTURE

_____

_____

15. (A) WAS A STRUCTURED SETTLEMENT OR PERIODIC PAYMENT USED IN CLOSING THIS CLAIM?

_____YES _____NO

(B) IF 15(A) IS YES, DID THE STRUCTURED SETTLEMENT OR PERIODIC PAYMENT APPLY TO PLAINTIFF'S ATTORNEY'S FEES AS WELL AS INDEMNITY PAYMENTS?

_____YES _____NO

(C) IF 15(A) IS YES, INDICATE AMOUNT OF IMMEDIATE PAYMENT

$_____

(D) IF 15(A) IS YES, INDICATE PRESENT VALUE OF PROJECTED TOTAL FUTURE PAYOUT (PRICE OF ANNUITY IF PURCHASED)

$_____

(E) IF 15(A) IS YES, INDICATE PROJECTED TOTAL FUTURE PAYOUT

$_____

16. INJURED PERSON'S MEDICAL EXPENSES THROUGH DATE OF CLOSING

$_____

17. INJURED PERSON'S ANTICIPATED FUTURE MEDICAL EXPENSE

$_____

18. INJURED PERSON'S WAGE LOSS THROUGH DATE OF CLOSING

$_____

19. INJURED PERSON'S ANTICIPATED FUTURE WAGE LOSS

$_____

20. INJURED PERSON'S OTHER EXPENSES THROUGH DATE OF CLOSING

$_____

21. INJURED PERSON'S ANTICIPATED FUTURE OTHER EXPENSES

$_____

(Over)

22. AMOUNT OF NONECONOMIC DAMAGES

$_____

23. (A) ACTUAL AMOUNT OF PREJUDGMENT INTEREST, IF ANY, PAID ON AWARD

$_____

(B) ESTIMATED AMOUNT OF PREJUDGMENT INTEREST, IF ANY, REFLECTED IN SETTLEMENT

$_____

24. (A) AMOUNT PAID TO OUTSIDE DEFENSE COUNSEL

$_____

(B) AMOUNT OF OTHER ALLOCATED LOSS ADJUSTMENT EXPENSES, SUCH AS COURT COSTS AND STENOGRAPHER'S FEES

$_____

(C) TOTAL ALLOCATED LOSS ADJUSTMENT EXPENSE (A + B)

$_____

(d) A report required under this section shall be filed within 90 days after the end of the quarter during which an event described in subsection (b)(2)(i), (ii), or (iii) of this section occurred.

(e) (1) A report that NAMES OR relates to a physician shall be filed with the State Board of Physicians.

(2) A report that NAMES OR relates to a hospital, MEDICAL DAY CARE CENTER, HOSPICE PROGRAM, ASSISTED LIVING PROGRAM, OR FREESTANDING AMBULATORY CARE FACILITY AS DEFINED IN § 19-3B-01 OF THE HEALTH - GENERAL

ARTICLE shall be filed with the Secretary of Health and Mental Hygiene.

(3) A report that NAMES OR relates to a nurse, dentist, podiatrist, optometrist, or chiropractor shall be filed with the appropriate licensing board for these health care providers.

(f) (1) Subject to paragraph (2) of this subsection, a report filed in accordance with this section shall be treated as a personal record under § 10-624(e) of the State Government Article.

(2) Each report shall be released to the Maryland Health Care Commission BY ELECTRONIC OR OTHER MEANS.

(g) An insurer that reports under this section or its agents or employees, the State Board of Physicians or its representatives, and any appropriate licensing authority that receives a report under this section shall have the immunity from liability described in § 5-701 of the Courts Article for any action taken by them under this section.

(H) (1) ON OR BEFORE MARCH 1 OF EACH YEAR, THE COMMISSIONER SHALL REPORT TO THE GOVERNOR AND, SUBJECT TO § 2-1246 OF THE STATE GOVERNMENT ARTICLE, THE GENERAL ASSEMBLY ON:

(I) THE AVAILABILITY AND AFFORDABILITY OF MEDICAL PROFESSIONAL LIABILITY INSURANCE IN THE STATE;

(II) THE NATURE AND COST OF REINSURANCE IN THE STATE;

(III) THE AMOUNT OF RESERVES FOR CLAIMS INCURRED AND INCURRED BUT UNREPORTED CLAIMS;

(IV) THE AMOUNT OF INVESTMENT INCOME FOR MEDICAL PROFESSIONAL LIABILITY INSURERS IN THE STATE; AND

(V) FOR EACH PHYSICIAN, NURSE, DENTIST, PODIATRIST, OPTOMETRIST, OR CHIROPRACTOR LICENSED UNDER THE HEALTH OCCUPATIONS

ARTICLE OR A HOSPITAL, MEDICAL DAY CARE CENTER, HOSPICE PROGRAM, ASSISTED LIVING PROGRAM, OR FREESTANDING AMBULATORY CARE FACILITY AS DEFINED IN § 19-3B-01 OF THE HEALTH - GENERAL ARTICLE:

1. THE INDIVIDUAL'S SPECIALTY AND PRACTICE LOCATION;

2. THE NUMBER OF CLAIMS AGAINST THE INDIVIDUAL;

3. AN ANALYSIS OF THE LEVEL OF SEVERITY OF EACH CLAIM USING THE NINE-POINT SEVERITY OF INJURY SCALE;

4. THE AMOUNT OF CLAIM SETTLEMENTS AND CLAIM AWARDS;

5. THE NUMBER OF STRUCTURED SETTLEMENTS USED IN PAYMENT OF CLAIMS; AND

6. ANY OTHER INFORMATION THAT THE COMMISSIONER DETERMINES AS RELEVANT.

(2) THE REPORT REQUIRED UNDER PARAGRAPH (1) OF THIS SUBSECTION SHALL BE POSTED ON THE ADMINISTRATION'S WEBSITE.

[(h)] (I) (1) Failure to report in accordance with this section shall result in the imposition by [a circuit court] THE ADMINISTRATION of a civil penalty of up to $5,000.

(2) THE ADMINISTRATION SHALL REMIT ANY PENALTY COLLECTED UNDER THIS SUBSECTION INTO THE GENERAL FUND OF THE STATE.

(J) THE COMMISSIONER MAY ADOPT REGULATIONS ON THE SUBMISSION OF INFORMATION DESCRIBED IN SUBSECTION (C) OF THIS SECTION.

6-101.

(a) The following persons are subject to taxation under this subtitle:

(1) a person engaged as principal in the business of writing insurance contracts, surety contracts, guaranty contracts, or annuity contracts;

(2) A MANAGED CARE ORGANIZATION AUTHORIZED BY TITLE 15, SUBTITLE 1 OF THE HEALTH - GENERAL ARTICLE;

(3) A HEALTH MAINTENANCE ORGANIZATION AUTHORIZED BY TITLE 19, SUBTITLE 7 OF THE HEALTH - GENERAL ARTICLE;

[(2)] (4) an attorney in fact for a reciprocal insurer;

[(3)] (5) the Maryland Automobile Insurance Fund; and

[(4)] (6) a credit indemnity company.

(b) The following persons are not subject to taxation under this subtitle:

(1) a nonprofit health service plan corporation that meets the requirements established under §§ 14-106 and 14-107 of this article;

(2) a fraternal benefit society;

(3) [a health maintenance organization authorized by Title 19, Subtitle 7 of the Health - General Article;

(4)] a surplus lines broker, who is subject to taxation in accordance with Title 3, Subtitle 3 of this article;

[(5)] (4) an unauthorized insurer, who is subject to taxation in accordance with Title 4, Subtitle 2 of this article;

[(6)] (5) the Maryland Health Insurance Plan established under Title 14, Subtitle 5, Part I of this article; or

[(7)] (6) the Senior Prescription Drug Program established under Title 14, Subtitle 5, Part II of this article.

6-102.

(a) A tax is imposed on all new and renewal gross direct premiums of each person subject to taxation under this subtitle that are:

(1) allocable to the State; and

(2) written during the preceding calendar year.

(b) Premiums to be taxed include:

(1) the consideration for a surety contract, guaranty contract, or annuity contract;

(2) GROSS RECEIPTS RECEIVED AS A RESULT OF CAPITATION PAYMENTS, INCLUDING SUPPLEMENTAL OR BONUS PAYMENTS, MADE TO A MANAGED CARE ORGANIZATION FOR PROVIDER SERVICES TO AN INDIVIDUAL WHO IS ENROLLED IN A MANAGED CARE ORGANIZATION;

(3) SUBSCRIPTION CHARGES OR OTHER AMOUNTS PAID TO A HEALTH MAINTENANCE ORGANIZATION ON A PREDETERMINED PERIODIC RATE BASIS BY A PERSON OTHER THAN A PERSON SUBJECT TO THE TAX UNDER THIS SUBTITLE AS COMPENSATION FOR PROVIDING HEALTH CARE SERVICES TO MEMBERS;

[(2)] (4) dividends on life insurance policies that have been applied to buy additional insurance or to shorten the period during which a premium is payable; and

[(3)] (5) the part of the gross receipts of a title insurer that is derived from

insurance business or guaranty business.

6-103.

The tax rate is:

(1) 0% for premiums for annuities; and

(2) 2% for all other premiums, INCLUDING:

(I) GROSS RECEIPTS RECEIVED AS A RESULT OF CAPITATION PAYMENTS MADE TO A MANAGED CARE ORGANIZATION, INCLUDING SUPPLEMENTAL OR BONUS PAYMENTS; AND

(II) SUBSCRIPTION CHARGES OR OTHER AMOUNTS PAID TO A HEALTH MAINTENANCE ORGANIZATION.

6-104.

(a) Subject to subsection (b) of this section, in computing the tax under this section, the following deductions from gross direct premiums allocable to the State are allowed:

(1) returned premiums, not including surrender values;

(2) dividends that are:

(i) paid or credited to policyholders; or

(ii) applied to buy additional insurance or to shorten the period during which premiums are payable; AND

(3) returns or refunds made or credited to policyholders because of retrospective ratings or safe driver rewards[; and

(4) premiums received by a person subject to taxation under this subtitle under policies providing health maintenance organization benefits to the extent:

(i) of the amounts actually paid by the person to a nonprofit health maintenance organization authorized by Title 19, Subtitle 7 of the Health - General Article that operates only as a health maintenance organization that is exempt from taxes under § 19-727(b) of the Health - General Article; or

(ii) that the premiums have been paid by a health maintenance organization that is exempt from taxes under § 19-727(b) of the Health - General Article].

6-107.

(a) On or before March 15 of each year, each person subject to taxation under this subtitle shall:

(1) file with the Commissioner:

(i) a report of the new and renewal gross direct premiums less returned premiums written by the person during the preceding calendar year;[and]

(II) A REPORT OF THE GROSS RECEIPTS RECEIVED AS A RESULT OF CAPITATION PAYMENTS, INCLUDING SUPPLEMENTAL OR BONUS PAYMENTS MADE TO A MANAGED CARE ORGANIZATION DURING THE PRECEDING CALENDAR YEAR; AND

[(ii)] (III) if the person issues perpetual policies of fire insurance, a report of the average amount of deposits held by the person during the preceding calendar year in connection with perpetual policies of fire insurance issued on property in the State and in force during any part of that year; and

(2) pay to the Commissioner the total amount of taxes imposed by this subtitle, as shown on the face of the report, after crediting the amount of taxes paid with the declaration of

estimated tax and each quarterly report filed under § 6-106 of this subtitle.

10-118.

(H) IN THE CASE OF MEDICAL PROFESSIONAL LIABILITY INSURANCE, A PRODUCER MAY NOT ENTER INTO AN EXCLUSIVE APPOINTMENT AGREEMENT WITH A MEDICAL PROFESSIONAL LIABILITY INSURER.

[(h)] (I) (1) This subsection applies to:

(i) an insurer;

(ii) an authorized representative of an insurer;

(iii) an insurance producer;

(iv) the Commissioner; and

(v) an organization of which the Commissioner is a member that compiles information required under this section and makes it available to other insurance commissioners or regulatory or law enforcement agencies.

(2) In the absence of actual malice, a person to whom this subsection applies and the agents and employees of the person are not subject to civil liability of any nature as a result of:

(i) any statement or information required by or provided under this section; or

(ii) any information relating to any statement that may be requested in writing by the Commissioner from an insurer or insurance producer.

(3) If a party brings an action against a person that may have immunity under paragraph (2) of this subsection for making a statement required by or under this section or providing

any information relating to any statement that may be requested by the Commissioner, the party bringing the action shall plead specifically in any allegation that paragraph (2) of this subsection does not apply because the person making the statement or providing the information did so with actual malice.

(4) This subsection does not abrogate or modify any existing statutory or common law privileges or immunities.

[(i)] (J) (1) This subsection applies only to any document, material, or other information in the control or possession of the Insurance Administration that is:

(i) furnished by an insurer or insurance producer or an employee or agent acting on behalf of the insurer or insurance producer under this section; or

(ii) otherwise obtained by the Insurance Commissioner in an investigation under this section.

(2) Any document, material, or other information that is subject to this subsection is:

(i) confidential and privileged;

(ii) not subject to Title 10, Subtitle 6 of the State Government Article;

(iii) not subject to subpoena; and

(iv) not subject to discovery or admissible in evidence in any private civil action.

(3) Notwithstanding paragraph (2) of this subsection, the Commissioner may use any document, material, or other information that is subject to this section to further any regulatory or legal action brought as part of the duties of the Commissioner.

(4) The Commissioner and any person who received any document, material, or

other information to which this subsection applies while acting under the authority of the Commissioner may not be allowed or required to testify in any private civil action concerning the document, material, or information.

(5) (i) Provided that the recipient agrees to maintain any confidentiality and privileged status, the Commissioner may share a document, material, or other information, including a document, material, or other information that is confidential and privileged under this subsection, with:

1. other State, federal, or international regulatory agencies;

2. the National Association of Insurance Commissioners and its affiliates or subsidiaries; or

3. State, federal, or international law enforcement authorities.

(ii) If the Commissioner determines that a confidential document, material, or other information that has been shared through a database or other electronic filing system is inaccurate or incomplete in any way, the Commissioner shall update the information in the database or other electronic filing system so that the information is accurate and complete.

(6) (i) The Commissioner may receive a document, material, or information, including a document, material, or information that is otherwise confidential and privileged, from:

1. the National Association of Insurance Commissioners or its affiliates or subsidiaries; or

2. regulatory and law enforcement officials of other foreign or domestic jurisdictions.

(ii) The Commissioner shall maintain as confidential and privileged any document, material, or information received under this paragraph with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the

document, material, or information.

(7) The Commissioner may enter into agreements governing sharing and use of information consistent with this subsection.

(8) There is no waiver of any applicable privilege or claim of confidentiality in a document, material, or information as a result of:

(i) disclosure of the document, material, or information to the Commissioner under this section; or

(ii) sharing of the document, material, or information by the Commissioner under paragraph (5) of this subsection.

(9) This subtitle does not prohibit the Commissioner from releasing final adjudicated actions, including for-cause terminations, that are open to public inspection under Title 10, Subtitle 6 of the State Government Article, to a database or other clearinghouse service maintained by the National Association of Insurance Commissioners or its affiliates or subsidiaries.

[(j)] (K) The Commissioner may adopt regulations to carry out this section.

19-104.

(a) Each policy that insures a health care provider against damages due to medical injury arising from providing or failing to provide health care shall contain provisions that:

(1) are consistent with the requirements of Title 3, Subtitle 2A of the Courts Article; and

(2) authorize the insurer, without restriction, to negotiate and effect a compromise of claims within the limits of the insurer's liability, if the entire amount settled on is to be paid by the insurer.

(b) (1) An insurer may make payments to or on behalf of claimants for reasonable

hospital and medical costs, loss of wages, and expenses for rehabilitation services and treatment, within the limits of the insurer's liability, before a final disposition of the claim.

(2) A payment made under this subsection:

(i) is not an admission of liability to or of damages sustained by a claimant; and

(ii) does not prejudice the insurer or any other party with respect to any right, claim, or defense.

(C) (1) A POLICY ISSUED OR DELIVERED UNDER SUBSECTION (A) OF THIS SECTION MAY NOT INCLUDE COVERAGE FOR THE DEFENSE OF A HEALTH CARE PROVIDER IN A DISCIPLINARY HEARING ARISING OUT OF THE PRACTICE OF THE HEALTH CARE PROVIDER'S PROFESSION.

(2) A POLICY PROVIDING COVERAGE FOR THE DEFENSE OF A HEALTH CARE PROVIDER IN DISCIPLINARY HEARING ARISING OUT OF THE PRACTICE OF THE HEALTH CARE PROVIDER'S PROFESSION MAY BE OFFERED AND PRICED SEPARATELY FROM A POLICY ISSUED OR DELIVERED UNDER SUBSECTION (A) OF THIS SECTION.

19-104.1.

(A) (1) IN THIS SECTION THE FOLLOWING WORDS HAVE THE MEANINGS INDICATED.

(2) "BOARD" MEANS THE MARYLAND PROFESSIONAL LIABILITY INSURANCE RATE STABILIZATION BOARD.

(3) "FUND" MEANS THE MARYLAND MEDICAL PROFESSIONAL LIABILITY INSURANCE RATE STABILIZATION FUND.

(4) (I) "HEALTH CARE PROVIDER" MEANS A HEALTH CARE PRACTITIONER LICENSED UNDER TITLE 14 OF THE HEALTH OCCUPATIONS ARTICLE.

(II) "HEALTH CARE PROVIDER" DOES NOT INCLUDE:

1. A RESPIRATORY CARE PRACTITIONER;

2. A RADIATION ONCOLOGY/THERAPY TECHNOLOGIST;

3. A MEDICAL RADIATION TECHNOLOGIST; OR

4. A NUCLEAR MEDICINE TECHNOLOGIST.

(5) "MEDICAL ASSISTANCE PROGRAM ACCOUNT" MEANS AN ACCOUNT ESTABLISHED WITHIN THE FUND THAT IS AVAILABLE TO THE MARYLAND MEDICAL ASSISTANCE PROGRAM UNDER SUBSECTION (E) OF THIS SECTION.

(6) "MEDICAL INJURY" HAS THE MEANING STATED IN § 3-2A-01 OF THE COURTS ARTICLE.

(7) "MEDICAL PROFESSIONAL LIABILITY INSURER" MEANS AN INSURER THAT:

(I) ON OR BEFORE JANUARY 1, 2005, HOLDS A CERTIFICATE OF AUTHORITY ISSUED BY THE COMMISSIONER UNDER § 4-109 OR § 4-112 OF THIS ARTICLE; AND

(II) ISSUES OR DELIVERS A POLICY IN THE STATE THAT INSURES A HEALTH CARE PROVIDER AGAINST DAMAGES DUE TO A MEDICAL INJURY.

(8) "PROGRAM" MEANS THE MARYLAND MEDICAL PROFESSIONAL LIABILITY INSURANCE RATE STABILIZATION PROGRAM.

(9) "RATE STABILIZATION ACCOUNT" MEANS AN ACCOUNT ESTABLISHED WITHIN THE FUND THAT IS AVAILABLE FOR HEALTH CARE PROVIDER RATE REDUCTIONS OR REBATES UNDER SUBSECTION (D) OF THIS SECTION.

(B) (1) THERE IS A MARYLAND MEDICAL PROFESSIONAL LIABILITY INSURANCE RATE STABILIZATION PROGRAM.

(2) THE PURPOSES OF THE PROGRAM ARE TO:

(I) RETAIN HEALTH CARE PROVIDERS IN THE STATE BY ALLOWING MEDICAL PROFESSIONAL LIABILITY INSURERS TO PROVIDE MEDICAL PROFESSIONAL LIABILITY INSURANCE RATES THAT ARE LESS THAN THE RATES REQUIRED UNDER § 11-201 OF THIS ARTICLE.

(II) INCREASE FEE-FOR-SERVICE RATES TO PHYSICIANS PARTICIPATING IN THE MARYLAND MEDICAL ASSISTANCE PROGRAM;

(III) INCREASE CAPITATION PAYMENTS TO MANAGED CARE ORGANIZATIONS PARTICIPATING IN THE MARYLAND MEDICAL ASSISTANCE PROGRAM TO PAY NETWORK PHYSICIANS AT LEAST 100 PERCENT OF THE FEE SCHEDULE USED IN THE FEE-FOR-SERVICE MARYLAND MEDICAL ASSISTANCE PROGRAM; AND

(IV) SUBSIDIZE THE COSTS INCURRED BY THE BOARD TO ADMINISTER THE PROGRAM.

(C) (1) THERE IS A MARYLAND MEDICAL PROFESSIONAL LIABILITY INSURANCE RATE STABILIZATION BOARD.

(2) THE BOARD CONSISTS OF THE FOLLOWING MEMBERS:

(I) THE SECRETARY OF HEALTH AND MENTAL HYGIENE;

(II) THE COMMISSIONER; AND

(III) THE SECRETARY OF BUDGET AND MANAGEMENT.

(3) (I) BASED ON THE FACTORS OUTLINED IN SUBPARAGRAPH (II) OF THIS PARAGRAPH, THE BOARD SHALL DETERMINE BY SPECIALTY AND GEOGRAPHIC REGION:

1. THE HEALTH CARE PROVIDERS IN THE STATE WHO ARE ELIGIBLE TO RECEIVE A RATE REDUCTION OR REBATE TO REDUCE THE COST OF MEDICAL PROFESSIONAL LIABILITY INSURANCE; AND

2. THE AMOUNT OF THE RATE REDUCTION AVAILABLE TO HEALTH CARE PROVIDERS IDENTIFIED IN SUB-SUBPARAGRAPH 1 OF THIS SUBPARAGRAPH.

(II) 1. IN DETERMINING WHICH HEALTH CARE PROVIDERS ARE ELIGIBLE TO RECEIVE A RATE REDUCTION OR REBATE, THE BOARD SHALL GIVE PRIORITY TO HEALTH CARE PROVIDERS WHO ARE MOST AT RISK OF LEAVING THE PRACTICE OF MEDICINE IN THE STATE:

A. DUE TO THE RISING COST OF MEDICAL PROFESSIONAL LIABILITY INSURANCE PREMIUMS; AND

B. WHOSE ABSENCE WOULD CREATE THE GREATEST RISK TO PUBLIC HEALTH AND SAFETY BY DISPROPORTIONATELY LIMITING ACCESS TO ESSENTIAL HEALTH CARE SERVICES; AND

2. IN MAKING THE DETERMINATION REQUIRED UNDER THIS SUBPARAGRAPH, THE BOARD SHALL CONSIDER STUDIES AND INFORMATION AND, AS NECESSARY, RETAIN CONSULTANTS TO DETERMINE:

A. THE COST OF MEDICAL PROFESSIONAL LIABILITY INSURANCE BY MEDICAL SPECIALTY FOR HEALTH CARE PROVIDERS IN THE STATE

RELATIVE TO THE INCOME FOR HEALTH CARE PROVIDERS BY SPECIALTY AND GEOGRAPHIC REGION OF THE STATE;

B. THE FINANCIAL IMPACT OF THE RATE REDUCTION OR REBATE ON THE NET INCOME OF THE HEALTH CARE PROVIDER;

C. THE NUMBER OF HEALTH CARE PROVIDERS WHO PRACTICE THE MEDICAL SPECIALTY IN THE STATE;

D. THE AVAILABILITY OF HEALTH CARE PROVIDERS WHO PRACTICE THE MEDICAL SPECIALTY IN ALL GEOGRAPHIC REGIONS OF THE STATE; AND

E. ANY OTHER RELEVANT CRITERIA AS DETERMINED BY THE BOARD.

(D) (1) (I) THERE IS A MARYLAND MEDICAL PROFESSIONAL LIABILITY INSURANCE RATE STABILIZATION FUND.

(II) THE PURPOSE OF THE FUND IS TO PROVIDE FUNDING TO THE PROGRAM.

(III) THE BOARD SHALL ADMINISTER THE FUND.

(IV) THE FUND IS A SPECIAL, NONLAPSING FUND THAT IS NOT SUBJECT TO § 7-302 OF THE STATE FINANCE AND PROCUREMENT ARTICLE.

(V) THE STATE TREASURER SHALL HOLD THE FUND SEPARATELY AND THE COMPTROLLER SHALL ACCOUNT FOR THE FUND.

(VI) THE STATE TREASURER SHALL INVEST THE MONEY OF THE FUND IN THE SAME MANNER AS OTHER STATE MONEY MAY BE INVESTED.

(2) (I) NOTWITHSTANDING § 2-114 OF THIS ARTICLE, THE COMMISSIONER SHALL DEPOSIT THE REVENUE FROM THE TAX IMPOSED ON HEALTH MAINTENANCE ORGANIZATIONS AND MANAGED CARE ORGANIZATIONS UNDER § 6-102 OF THIS ARTICLE INTO THE FUND.

(II) THE FUND SHALL CONSIST OF:

1. THE REVENUE FROM THE TAX IMPOSED ON HEALTH MAINTENANCE ORGANIZATIONS AND MANAGED CARE ORGANIZATIONS UNDER § 6-102 OF THIS ARTICLE;

2. INTEREST OR OTHER INCOME EARNED ON THE MONEYS IN THE FUND; AND

3. ANY OTHER MONEY FROM ANY OTHER SOURCE ACCEPTED FOR THE BENEFIT OF THE FUND;

(III) THE BOARD SHALL DISTRIBUTE FROM THE FUND TO AN ADMINISTRATIVE COST ACCOUNT AN AMOUNT, NOT TO EXCEED 0.5 PERCENT OF THE TOTAL REVENUE COLLECTED IN EACH YEAR, SUFFICIENT TO COVER THE COSTS OF ADMINISTERING THE PROGRAM.

(IV) AFTER DISTRIBUTING THE AMOUNTS REQUIRED UNDER SUBPARAGRAPH (III) OF THIS PARAGRAPH, THE BOARD SHALL ALLOCATE THE REVENUE REMAINING IN THE FUND ACCORDING TO THE FOLLOWING SCHEDULE:

1. IN FISCAL YEAR 2006:

A. $48,000,000 TO THE RATE STABILIZATION ACCOUNT TO PAY FOR HEALTH CARE PROVIDER REBATES OR RATE REDUCTIONS IN CALENDAR YEAR 2005; AND

B. THE REMAINING BALANCE TO THE MEDICAL ASSISTANCE PROGRAM ACCOUNT;

2. IN FISCAL YEAR 2007:

A. $48,000,000 TO THE RATE STABILIZATION ACCOUNT TO PAY FOR HEALTH CARE PROVIDER REBATES OR RATE REDUCTIONS IN CALENDAR YEAR 2006; AND

B. THE REMAINING BALANCE TO THE MEDICAL ASSISTANCE PROGRAM ACCOUNT;

3. IN FISCAL YEAR 2008:

A. $32,000,000 TO THE RATE STABILIZATION ACCOUNT TO PAY FOR HEALTH CARE PROVIDER REBATES OR RATE REDUCTIONS IN CALENDAR YEAR 2007; AND

B. THE REMAINING BALANCE TO THE MEDICAL ASSISTANCE PROGRAM ACCOUNT;

4. IN FISCAL YEAR 2009:

A. $16,000,000 TO THE RATE STABILIZATION ACCOUNT TO PAY FOR HEALTH CARE PROVIDER REBATES OR RATE REDUCTIONS IN CALENDAR YEAR 2008; AND

B. THE REMAINING BALANCE TO THE MEDICAL ASSISTANCE PROGRAM ACCOUNT; AND

5. IN FISCAL YEAR 2010 AND ANNUALLY THEREAFTER, 100% TO THE MEDICAL ASSISTANCE PROGRAM ACCOUNT.

(3) (I) DISBURSEMENTS FROM THE RATE STABILIZATION ACCOUNT SHALL BE MADE TO MEDICAL PROFESSIONAL LIABILITY INSURERS TO REDUCE THE COST OF MEDICAL PROFESSIONAL LIABILITY INSURANCE TO HEALTH

CARE PROVIDERS IDENTIFIED BY THE BOARD UNDER SUBSECTION (C)(3) OF THIS SECTION.

(II) A MEDICAL PROFESSIONAL LIABILITY INSURER SHALL PROVIDE A RATE REDUCTION OR REBATE IN THE FORM OF A CREDIT AGAINST THE AMOUNT OF PREMIUM OWED BY A HEALTH CARE PROVIDER, A REBATE, OR BOTH AT THE DISCRETION OF THE INSURER.

(III) A MEDICAL PROFESSIONAL LIABILITY INSURER MAY NOT REDUCE RATES OR PROVIDE A REBATE TO THE PORTION OF A HEALTH CARE PROVIDER'S LIABILITY INSURANCE PREMIUM THAT IS DUE TO A PREMIUM SURCHARGE BASED ON LOSS EXPERIENCE.

(IV) DISBURSEMENTS FROM THE RATE STABILIZATION ACCOUNT TO A MEDICAL PROFESSIONAL LIABILITY INSURER THAT IS A MUTUAL INSURER SHALL BE REDUCED BY THE VALUE OF A DIVIDEND THAT MAY BE ISSUED DURING THE PERIOD IN WHICH FUNDING IS PROVIDED BY THE BOARD TO PAY FOR HEALTH CARE PROVIDER REBATES OR RATE REDUCTIONS.

(V) DISBURSEMENTS FROM THE RATE STABILIZATION ACCOUNT TO A MEDICAL PROFESSIONAL LIABILITY INSURER MAY NOT EXCEED THE AMOUNT NECESSARY TO PROVIDE A RATE REDUCTION OR REBATE AS DETERMINED BY THE BOARD UNDER SUBSECTION (C)(3) OF THIS SECTION.

(4) THE DEBTS AND OBLIGATIONS OF THE FUND ARE NOT DEBTS AND OBLIGATIONS OF THE STATE OR A PLEDGE OF THE FULL FAITH AND CREDIT OF THE STATE.

(5) THE BOARD IS NOT REQUIRED TO USE THE ENTIRE BALANCE OF THE RATE STABILIZATION ACCOUNT OR THE MEDICAL ASSISTANCE PROGRAM ACCOUNT WHEN DETERMINING THE AMOUNT OF RATE REDUCTION OR REBATE AVAILABLE UNDER SUBSECTION (C)(3) OF THIS SECTION.

(6) PORTIONS OF THE RATE STABILIZATION ACCOUNT THAT EXCEED THE AMOUNT NECESSARY TO MEET THE OBLIGATIONS OF THE RATE

STABILIZATION ACCOUNT SHALL REVERT TO THE MEDICAL ASSISTANCE PROGRAM ACCOUNT.

(E) (1) DISBURSEMENTS FROM THE MEDICAL ASSISTANCE PROGRAM ACCOUNT SHALL BE MADE TO INCREASE:

(I) FEE-FOR-SERVICE HEALTH CARE PROVIDER RATES FOR PROCEDURES COMMONLY PERFORMED BY HEALTH CARE PROVIDERS IDENTIFIED BY THE BOARD UNDER SUBSECTION (C)(3) OF THIS SECTION; AND

(II) CAPITATION PAYMENTS MADE TO MANAGED CARE ORGANIZATIONS TO INCREASE THE RATES PAID BY THOSE ORGANIZATIONS FOR PROCEDURES COMMONLY PERFORMED BY HEALTH CARE PROVIDERS IDENTIFIED BY THE BOARD UNDER SUBSECTION (C)(3) OF THIS SECTION.

(2) PORTIONS OF THE MEDICAL ASSISTANCE PROGRAM ACCOUNT THAT EXCEED THE AMOUNT NECESSARY TO MEET THE OBLIGATIONS OF THE MEDICAL ASSISTANCE PROGRAM ACCOUNT SHALL BE USED TO SUPPORT THE OPERATIONS OF THE MARYLAND MEDICAL ASSISTANCE PROGRAM.

(3) CAPITATION PAYMENTS TO A MANAGED CARE ORGANIZATION UNDER SUBSECTION (E)(1)(II) OF THIS SECTION SHALL BE USED BY THE MANAGED CARE ORGANIZATION TO PAY AT LEAST 100% OF THE NEW FEE SCHEDULE USED IN THE FEE-FOR-SERVICE MARYLAND MEDICAL ASSISTANCE PROGRAM.

(F) ALL RECEIPTS AND DISBURSEMENTS OF THE FUND SHALL BE AUDITED YEARLY BY THE OFFICE OF LEGISLATIVE AUDITS AND A REPORT OF THE AUDIT SHALL BE INCLUDED IN AND BECOME PART OF THE ANNUAL REPORT REQUIRED UNDER SUBSECTION (H) OF THIS SECTION.

(G) THE FUND, THE RATE STABILIZATION ACCOUNT, AND THE MEDICAL ASSISTANCE PROGRAM ACCOUNT SHALL BE USED FOR THE PURPOSES STATED IN THIS SECTION.

(H) ON OR BEFORE MARCH 1 OF EACH YEAR, THE BOARD SHALL REPORT TO THE LEGISLATIVE POLICY COMMITTEE, IN ACCORDANCE WITH § 2-1246 OF THE STATE GOVERNMENT ARTICLE, ON:

(1) THE HEALTH CARE PROVIDERS, BY SPECIALITY, IDENTIFIED BY THE BOARD AS ELIGIBLE FOR A RATE REDUCTION OR REBATE;

(2) THE AMOUNT OF THE RATE REDUCTION OR REBATE, BY SPECIALTY, AVAILABLE TO HEALTH CARE PROVIDERS;

(3) THE AMOUNT OF MONEY IN THE FUND, THE RATE STABILIZATION ACCOUNT, AND THE MEDICAL ASSISTANCE PROGRAM ACCOUNT ON THE LAST DAY OF THE PREVIOUS CALENDAR YEAR;

(4) THE AMOUNT OF MONEY DISBURSED TO MEDICAL PROFESSIONAL LIABILITY INSURERS FOR A RATE REDUCTION OR REBATE TO HEALTH CARE PROVIDERS DURING THE PREVIOUS CALENDAR YEAR;

(5) THE AMOUNT DISBURSED TO THE MARYLAND MEDICAL ASSISTANCE PROGRAM UNDER SUBSECTION (E) OF THIS SECTION AND THE AMOUNT OF INCREASE IN FEE-FOR-SERVICE HEALTH CARE PROVIDER RATES AND CAPITATION PAYMENT TO MANAGED CARE ORGANIZATIONS;

(6) THE COSTS INCURRED IN ADMINISTERING THE FUND DURING THE PREVIOUS CALENDAR YEAR; AND

(7) THE REPORT OF AUDITED RECEIPTS AND DISBURSEMENTS OF THE FUND AS REQUIRED UNDER SUBSECTION (F) OF THIS SECTION.

19-114.

(A) EACH INSURER THAT ISSUES OR DELIVERS A MEDICAL PROFESSIONAL LIABILITY INSURANCE POLICY IN THE STATE SHALL OFFER, IN ADDITION TO THE

BASIC POLICY, ADDITIONAL POLICIES WITH DEDUCTIBLES IN THE FOLLOWING AMOUNTS:

(1) $10,000;

(2) $25,000;

(3) $50,000;

(4) $100,000; AND

(5) $150,000.

(B) IN A POLICY WITH A DEDUCTIBLE DESCRIBED IN SUBSECTION (A) OF THIS SECTION, THE INSURER SHALL APPLY THE DEDUCTIBLE ONLY TO THE LIABILITY OF THE INSURED UNDER THE POLICY.

(C) (1) AN INSURER THAT ISSUES OR DELIVERS A MEDICAL PROFESSIONAL LIABILITY INSURANCE POLICY WITH A DEDUCTIBLE DESCRIBED IN SUBSECTION (A) OF THIS SECTION MAY CANCEL THE POLICY FOR NONPAYMENT OF THE DEDUCTIBLE WHEN THE DEDUCTIBLE IS DUE AND PAYABLE UNDER THE POLICY.

(2) A MEDICAL PROFESSIONAL LIABILITY INSURER THAT CANCELS A POLICY UNDER PARAGRAPH (1) OF THIS SUBSECTION IS SUBJECT TO THE NOTICE PROVISIONS UNDER § 27-601 OF THIS ARTICLE.

24-201.

(f) "Society" means the Medical Mutual Liability Insurance Society of Maryland.

24-211.

(A) THE LEGISLATIVE AUDITOR ANNUALLY SHALL CONDUCT A FISCAL

AND COMPLIANCE AUDIT OF THE ACCOUNTS AND TRANSACTIONS OF THE SOCIETY.

(B) THE SOCIETY SHALL PAY THE COST OF EACH AUDIT.

27-501.

(a) (1) An insurer or insurance producer may not cancel or refuse to underwrite or renew a particular insurance risk or class of risk for a reason based wholly or partly on race, color, creed, sex, or blindness of an applicant or policyholder or for any arbitrary, capricious, or unfairly discriminatory reason.

(2) (I) THIS PARAGRAPH DOES NOT APPLY TO A MEDICAL PROFESSIONAL LIABILITY INSURER OR INSURANCE PRODUCER THAT ISSUES OR DELIVERS A POLICY IN THE STATE TO A HEALTH CARE PROVIDER WHO HAS BEEN LICENSED FOR MORE THAN 3 YEARS BY THE APPROPRIATE STATE LICENSING BOARD FOR THE HEALTH CARE PROVIDER.

(II) Except as provided in this section, an insurer or insurance producer may not cancel or refuse to underwrite or renew a particular insurance risk or class of risk except by the application of standards that are reasonably related to the insurer's economic and business purposes.

(f) [In] EXCEPT AS PROVIDED IN § 27-505(A)(2) OF THIS SUBTITLE, IN the case of cancellation of or refusal to renew a policy, the policy remains in effect until a finding is issued under § 27-505 of this subtitle if:

(1) the insured asks the Commissioner to review the cancellation or refusal to renew before the effective date of the termination of the policy; and

(2) the Commissioner begins action to issue a finding under § 27-505 of this subtitle.

27-505.

(a) (1) If the Commissioner finds that an insurer has violated § 27-501, § 27-503, or § 27-504 of this subtitle, the Commissioner, in addition to any other power granted by this article, may order the insurer to accept the risk, or accept the business, as appropriate.

(2) (I) WITH RESPECT TO MEDICAL PROFESSIONAL LIABILITY INSURANCE, THE COMMISSIONER SHALL ISSUE A FINDING WITHIN 90 DAYS AFTER RECEIVING A REQUEST TO REVIEW THE CANCELLATION OR REFUSAL TO RENEW UNDER § 27-501(F) OF THIS SUBTITLE.

(II) A MEDICAL PROFESSIONAL LIABILITY INSURER MAY TERMINATE THE POLICY IF:

1. THE COMMISSIONER FAILS TO ISSUE A FINDING WITHIN 90 DAYS AFTER RECEIVING A REQUEST TO REVIEW THE CANCELLATION OR REFUSAL TO RENEW; OR

2. THE COMMISSIONER FINDS THAT THE POLICY MAY BE CANCELED OR NOT RENEWED AND ISSUED THE FINDING WITHIN 90 DAYS AFTER RECEIVING A REQUEST TO REVIEW THE CANCELLATION OR REFUSAL TO RENEW.

(b) A party to a hearing or proceeding under this subtitle may appeal from the hearing, proceeding, or a decision of the Commissioner in accordance with § 2-215 of this article.

Article - State Government

SUBTITLE 3. PEOPLE'S INSURANCE COUNSEL.

6-301.

(A) IN THIS SUBTITLE THE FOLLOWING WORDS HAVE THE MEANINGS INDICATED.

(B) "COMMISSIONER" MEANS THE MARYLAND INSURANCE COMMISSIONER.

(C) "DIVISION" MEANS THE PEOPLE'S INSURANCE COUNSEL DIVISION IN THE OFFICE OF THE ATTORNEY GENERAL.

(D) (1) "HEALTH INSURER" MEANS AN INSURER THAT HOLDS A CERTIFICATE OF AUTHORITY ISSUED BY THE COMMISSIONER TO ENGAGE IN THE BUSINESS OF HEALTH INSURANCE.

(2) "HEALTH INSURER" INCLUDES:

(I) A HEALTH MAINTENANCE ORGANIZATION OPERATING UNDER A CERTIFICATE OF AUTHORITY ISSUED BY THE COMMISSIONER UNDER TITLE 19, SUBTITLE 7 OF THE HEALTH - GENERAL ARTICLE;

(II) A NONPROFIT HEALTH SERVICE PLAN OPERATING UNDER TITLE 14, SUBTITLE 1 OF THE INSURANCE ARTICLE; AND

(III) A DENTAL PLAN OPERATING UNDER TITLE 14, SUBTITLE 4 OF THE INSURANCE ARTICLE.

(3) "HEALTH INSURER" DOES NOT INCLUDE A MANAGED CARE ORGANIZATION AUTHORIZED BY TITLE 15, SUBTITLE 1 OF THE HEALTH - GENERAL ARTICLE.

(E) "INSURANCE CONSUMERS" MEANS PERSONS INSURED UNDER POLICIES OR CONTRACTS OF HEALTH INSURANCE, LIFE INSURANCE, OR PROPERTY AND CASUALTY INSURANCE ISSUED OR DELIVERED IN THE STATE BY A HEALTH INSURER, LIFE INSURER, OR PROPERTY AND CASUALTY INSURER.

(F) (1) "INSURER" MEANS AN INSURER OR OTHER ENTITY AUTHORIZED TO ENGAGE IN THE INSURANCE BUSINESS IN THE STATE UNDER A CERTIFICATE OF AUTHORITY ISSUED BY THE COMMISSIONER.

(2) "INSURER" INCLUDES:

(I) A HEALTH INSURER;

(II) A LIFE INSURER;

(III) A PROPERTY AND CASUALTY INSURER; AND

(IV) THE MARYLAND AUTOMOBILE INSURANCE FUND.

(G) "LIFE INSURER" MEANS AN INSURER THAT HOLDS A CERTIFICATE OF AUTHORITY ISSUED BY THE COMMISSIONER TO ENGAGE IN THE BUSINESS OF LIFE INSURANCE.

(H) (1) "PREMIUM" HAS THE MEANING STATED IN § 1-101 OF THE INSURANCE ARTICLE TO THE EXTENT IT IS ALLOCABLE TO THIS STATE.

(2) "PREMIUM" INCLUDES ANY AMOUNTS PAID TO A HEALTH MAINTENANCE ORGANIZATION AS COMPENSATION ON A PREDETERMINED BASIS FOR PROVIDING SERVICES TO MEMBERS AND SUBSCRIBERS AS SPECIFIED IN TITLE 19, SUBTITLE 7 OF THE HEALTH - GENERAL ARTICLE TO THE EXTENT IT IS ALLOCABLE TO THIS STATE.

(I) (1) "PROPERTY AND CASUALTY INSURER" MEANS AN INSURER THAT HOLDS A CERTIFICATE OF AUTHORITY ISSUED BY THE COMMISSIONER TO ENGAGE IN THE BUSINESS OF PROPERTY AND CASUALTY INSURANCE.

(2) "PROPERTY AND CASUALTY INSURER" INCLUDES THE MARYLAND AUTOMOBILE INSURANCE FUND.

6-302.

(A) (1) THERE IS A PEOPLE'S INSURANCE COUNSEL DIVISION IN THE OFFICE OF THE ATTORNEY GENERAL.

(2) THE ATTORNEY GENERAL SHALL APPOINT THE PEOPLE'S INSURANCE COUNSEL WITH THE ADVICE AND CONSENT OF THE SENATE.

(B) THE PEOPLE'S INSURANCE COUNSEL SERVES AT THE PLEASURE OF THE ATTORNEY GENERAL.

(C) THE PEOPLE'S INSURANCE COUNSEL:

(1) SHALL HAVE BEEN ADMITTED TO PRACTICE LAW IN THE STATE;

(2) SHALL HAVE KNOWLEDGE OF AND EXPERTISE IN THE INSURANCE BUSINESS; AND

(3) MAY NOT HOLD AN OFFICIAL RELATION TO OR HAVE ANY PECUNIARY INTEREST IN AN INSURER.

(D) THE PEOPLE'S INSURANCE COUNSEL SHALL DEVOTE FULL TIME TO THE DUTIES OF THE OFFICE.

(E) THE PEOPLE'S INSURANCE COUNSEL IS ENTITLED TO COMPENSATION AS PROVIDED IN THE STATE BUDGET.

6-303.

(A) THE OFFICE OF THE ATTORNEY GENERAL SHALL INCLUDE IN ITS ANNUAL BUDGET SUFFICIENT MONEY FOR THE ADMINISTRATION AND OPERATION OF THE DIVISION.

(B) THE DIVISION MAY RETAIN AS NECESSARY FOR A PARTICULAR MATTER OR EMPLOY EXPERTS IN THE FIELD OF INSURANCE REGULATION, INCLUDING ACCOUNTANTS, ACTUARIES, AND LAWYERS.

(C) THE PEOPLE'S INSURANCE COUNSEL SHALL DIRECT THE DIVISION.

6-304.

(A) THE COMMISSIONER SHALL:

(1) COLLECT AN ANNUAL ASSESSMENT FROM EACH HEALTH INSURER, LIFE INSURER, AND PROPERTY AND CASUALTY INSURER FOR THE COSTS AND EXPENSES INCURRED BY THE DIVISION IN CARRYING OUT ITS DUTIES UNDER THIS SUBTITLE; AND

(2) DEPOSIT THE AMOUNTS COLLECTED INTO THE PEOPLE'S INSURANCE COUNSEL FUND ESTABLISHED UNDER § 6-305 OF THIS SUBTITLE.

(B) THE ASSESSMENT PAYABLE BY A HEALTH INSURER, LIFE INSURER, OR PROPERTY AND CASUALTY INSURER IS THE PRODUCT OF THE FRACTION OBTAINED BY DIVIDING THE GROSS DIRECT PREMIUM WRITTEN BY THE HEALTH INSURER, LIFE INSURER, OR PROPERTY AND CASUALTY INSURER IN THE PRIOR CALENDAR YEAR BY THE TOTAL AMOUNT OF GROSS DIRECT PREMIUM WRITTEN BY ALL HEALTH INSURERS, LIFE INSURERS, AND PROPERTY AND CASUALTY INSURERS IN THE PRIOR CALENDAR YEAR, MULTIPLIED BY THE AMOUNT OF THE TOTAL COSTS AND EXPENSES UNDER SUBSECTION (A)(1) OF THIS SECTION.

6-305.

(A) IN THIS SECTION, "FUND" MEANS THE PEOPLE'S INSURANCE COUNSEL FUND.

(B) THERE IS A PEOPLE'S INSURANCE COUNSEL FUND.

(C) THE PURPOSE OF THE FUND IS TO PAY ALL COSTS AND EXPENSES INCURRED BY THE DIVISION IN CARRYING OUT ITS DUTIES UNDER THIS SUBTITLE.

(D) THE FUND SHALL CONSIST OF:

(1) ALL REVENUE DEPOSITED INTO THE FUND THAT IS RECEIVED THROUGH THE IMPOSITION AND COLLECTION OF THE ASSESSMENT UNDER § 6-304 OF THIS SUBTITLE; AND

(2) INCOME FROM INVESTMENTS THAT THE STATE TREASURER MAKES FOR THE FUND.

(E) (1) EXPENDITURES FROM THE FUND MAY BE MADE ONLY BY:

(I) AN APPROPRIATION FROM THE FUND APPROVED BY THE GENERAL ASSEMBLY IN THE ANNUAL STATE BUDGET; OR

(II) THE BUDGET AMENDMENT PROCEDURE PROVIDED FOR IN § 7-209 OF THE STATE FINANCE AND PROCUREMENT ARTICLE.

(2) (I) IF, IN ANY FISCAL YEAR, THE AMOUNT OF THE ASSESSMENT REVENUE COLLECTED BY THE COMMISSIONER AND DEPOSITED INTO THE FUND EXCEEDS THE ACTUAL COSTS AND EXPENSES INCURRED BY THE DIVISION TO CARRY OUT ITS DUTIES UNDER THIS SUBTITLE, THE EXCESS AMOUNT SHALL BE CARRIED FORWARD WITHIN THE FUND FOR THE PURPOSE OF REDUCING THE ASSESSMENT IMPOSED BY THE COMMISSIONER FOR THE FOLLOWING FISCAL YEAR.

(II) IF, IN ANY FISCAL YEAR, THE AMOUNT OF THE ASSESSMENT REVENUE COLLECTED BY THE COMMISSIONER AND DEPOSITED INTO THE FUND IS INSUFFICIENT TO COVER THE ACTUAL EXPENDITURES INCURRED BY THE DIVISION TO CARRY OUT ITS DUTIES UNDER THIS SUBTITLE, AND EXPENDITURES ARE MADE IN ACCORDANCE WITH THE BUDGET AMENDMENT PROCEDURE PROVIDED FOR IN § 7-209 OF THE STATE FINANCE AND PROCUREMENT ARTICLE, AN ADDITIONAL ASSESSMENT MAY BE MADE.

(F) (1) THE STATE TREASURER IS THE CUSTODIAN OF THE FUND.

(2) THE FUND SHALL BE INVESTED AND REINVESTED IN THE SAME

MANNER AS STATE FUNDS.

(3) THE STATE TREASURER SHALL DEPOSIT PAYMENTS RECEIVED FROM THE COMMISSIONER INTO THE FUND.

(G) (1) THE FUND IS A CONTINUING, NONLAPSING FUND THAT IS NOT SUBJECT TO § 7-302 OF THE STATE FINANCE AND PROCUREMENT ARTICLE.

(2) NO PART OF THE FUND MAY REVERT OR BE CREDITED TO:

(I) THE GENERAL FUND OF THE STATE; OR

(II) A SPECIAL FUND OF THE STATE, UNLESS OTHERWISE PROVIDED BY LAW.

6-306.

(A) (1) THE DIVISION SHALL EVALUATE EACH MATTER PENDING BEFORE THE COMMISSIONER TO DETERMINE WHETHER THE INTERESTS OF INSURANCE CONSUMERS ARE AFFECTED.

(2) IF THE DIVISION DETERMINES THAT THE INTERESTS OF INSURANCE CONSUMERS ARE AFFECTED, THE DIVISION SHALL APPEAR BEFORE THE COMMISSIONER AND COURTS ON BEHALF OF INSURANCE CONSUMERS IN EACH MATTER OR PROCEEDING OVER WHICH THE COMMISSIONER HAS ORIGINAL JURISDICTION.

(B) (1) THE DIVISION SHALL REVIEW ANY PROPOSED RATE INCREASE OF 10% OR MORE FILED WITH THE COMMISSIONER BY A HEALTH INSURER, LIFE INSURER, OR PROPERTY AND CASUALTY INSURER.

(2) IF THE DIVISION FINDS THAT THE PROPOSED RATE INCREASE IS EXCESSIVE OR OTHERWISE ADVERSE TO THE INTERESTS OF INSURANCE

CONSUMERS, THE DIVISION SHALL APPEAR BEFORE THE COMMISSIONER ON BEHALF OF INSURANCE CONSUMERS IN ANY HEARING ON THE RATE FILING.

(C) AS THE DIVISION CONSIDERS NECESSARY, THE DIVISION SHALL CONDUCT INVESTIGATIONS AND REQUEST THE COMMISSIONER TO INITIATE PROCEEDINGS TO PROTECT THE INTERESTS OF INSURANCE CONSUMERS.

6-307.

(A) IN APPEARANCES BEFORE THE COMMISSIONER AND COURTS ON BEHALF OF INSURANCE CONSUMERS, THE DIVISION HAS THE RIGHTS OF COUNSEL FOR A PARTY TO THE PROCEEDING, INCLUDING THE RIGHT TO:

(1) SUMMON WITNESSES, PRESENT EVIDENCE, AND PRESENT ARGUMENT;

(2) CONDUCT CROSS-EXAMINATION AND SUBMIT REBUTTAL EVIDENCE; AND

(3) TAKE DEPOSITIONS IN OR OUTSIDE OF THE STATE, SUBJECT TO REGULATION BY THE COMMISSIONER TO PREVENT UNDUE DELAY, AND IN ACCORDANCE WITH THE PROCEDURE PROVIDED BY LAW OR RULE OF COURT WITH RESPECT TO CIVIL ACTIONS.

(B) THE DIVISION MAY APPEAR BEFORE ANY FEDERAL OR STATE UNIT TO PROTECT THE INTERESTS OF INSURANCE CONSUMERS.

(C) (1) EXCEPT AS OTHERWISE PROVIDED IN THE INSURANCE ARTICLE AND CONSISTENT WITH TITLE 10, SUBTITLE 6 OF THIS ARTICLE AND ANY APPLICABLE FREEDOM OF INFORMATION ACT, THE DIVISION SHALL HAVE FULL ACCESS TO THE COMMISSIONER'S RECORDS, INCLUDING RATE FILINGS AND SUPPLEMENTARY RATE INFORMATION FILED WITH THE COMMISSIONER UNDER TITLE 11 OF THE INSURANCE ARTICLE, AND SHALL HAVE THE BENEFIT OF ALL OTHER FACILITIES OR INFORMATION OF THE COMMISSIONER.

(2) THE DIVISION IS ENTITLED TO THE ASSISTANCE OF THE COMMISSIONER'S STAFF IF:

(I) THE STAFF DETERMINES THAT THE ASSISTANCE IS CONSISTENT WITH THE STAFF'S RESPONSIBILITIES; AND

(II) THE STAFF AND THE DIVISION AGREE THAT THE ASSISTANCE, IN A PARTICULAR MATTER, IS CONSISTENT WITH THEIR RESPECTIVE INTERESTS.

(D) THE DIVISION MAY RECOMMEND TO THE GENERAL ASSEMBLY LEGISLATION ON ANY MATTER THAT THE DIVISION CONSIDERS WOULD PROMOTE THE INTERESTS OF INSURANCE CONSUMERS.

6-308.

ON OR BEFORE JANUARY 1 OF EACH YEAR, THE DIVISION SHALL REPORT TO THE GOVERNOR AND, SUBJECT TO § 2-1246 OF THE STATE GOVERNMENT ARTICLE, TO THE GENERAL ASSEMBLY ON THE ACTIVITIES OF THE DIVISION DURING THE PRIOR FISCAL YEAR.

SUBTITLE 6. REPORTING OF FALSE CLAIMS AGAINST STATE HEALTH PLANS.

12-601.

(A) IN THIS SUBTITLE THE FOLLOWING WORDS HAVE THE MEANINGS INDICATED.

(B) "CLAIM" MEANS A REQUEST OR DEMAND FOR MONEY OR PROPERTY, MADE UNDER CONTRACT OR OTHERWISE, BY A CONTRACTOR, GRANTEE, OR OTHER PERSON WITH AN ALLEGED CLAIM TO MONEY OR PROPERTY IF:

(1) THE STATE PROVIDES ANY PORTION OF THE MONEY OR

PROPERTY THAT IS REQUESTED OR DEMANDED; OR

(2) THE STATE REIMBURSES THE CONTRACTOR, GRANTEE, OR OTHER PERSON FOR ANY PORTION OF THE MONEY OR PROPERTY THAT IS REQUESTED OR DEMANDED.

(C) "DOCUMENTARY MATERIAL" INCLUDES:

(1) THE ORIGINAL OR A COPY OF:

(I) A BOOK;

(II) A RECORD;

(III) A REPORT;

(IV) A MEMORANDUM;

(V) A PAPER;

(VI) A COMMUNICATION;

(VII) A TABULATION;

(VIII) A CHART;

(IX) A DOCUMENT; OR

(X) A DATA COMPILATION STORED IN OR ACCESSIBLE THROUGH A COMPUTER OR OTHER INFORMATION RETRIEVAL SYSTEM;

(2) INSTRUCTIONS OR ANY MATERIAL NECESSARY TO USE OR INTERPRET A DATA COMPILATION; AND

(3) ANY PRODUCT OF DISCOVERY.

(D) "EMPLOYEE" MEANS AN INDIVIDUAL WHO PERFORMS SERVICES:

(1) FOR AND UNDER THE CONTROL AND DIRECTION OF AN EMPLOYER; AND

(2) UNDER AN EMPLOYER'S PROMISE OR IMPLIED PROMISE OF PAYMENT OF WAGES OR REMUNERATION.

(E) (1) "EMPLOYER" MEANS A PERSON OR GROUP OF PERSONS WHO, ACTING DIRECTLY OR INDIRECTLY ON BEHALF OF ANOTHER PERSON OR GROUP OF PERSONS:

(I) ALLOWS AN EMPLOYEE TO PERFORM SERVICES UNDER THE EMPLOYER'S CONTROL AND DIRECTION; AND

(II) PROMISES OR IMPLIES THAT THE EMPLOYEE WILL RECEIVE WAGES OR OTHER REMUNERATION IN PAYMENT FOR THE PERFORMANCE OF THOSE SERVICES.

(2) "EMPLOYER" INCLUDES:

(I) THE STATE;

(II) A LOCAL GOVERNMENT; OR

(III) A UNIT OF THE STATE OR A LOCAL GOVERNMENT.

(F) "RETALIATORY ACTION" MEANS:

(1) THE DISCHARGE, SUSPENSION, OR DEMOTION OF THE EMPLOYEE;

(2) ANY ADVERSE EMPLOYMENT ACTION TAKEN AGAINST THE

EMPLOYEE RELATING TO THE EMPLOYEE'S TERMS OR CONDITIONS OF EMPLOYMENT IF UNDERTAKEN IN RESPONSE TO AN INITIATION OF, OR PARTICIPATION IN, AN ACTION BY AN EMPLOYEE UNDER THIS SUBTITLE.

(G) (1) "STATE HEALTH PLAN" MEANS:

(I) THE STATE MEDICAL ASSISTANCE PLAN ESTABLISHED IN ACCORDANCE WITH THE FEDERAL SOCIAL SECURITY ACT OF 1939;

(II) A MEDICAL ASSISTANCE PLAN ESTABLISHED BY THE STATE; OR

(III) A PRIVATE HEALTH INSURANCE CARRIER, HEALTH MAINTENANCE ORGANIZATION, MANAGED CARE ORGANIZATION AS DEFINED IN § 15-101 OF THE HEALTH - GENERAL ARTICLE, HEALTH CARE COOPERATIVE OR ALLIANCE, OR OTHER PERSON THAT PROVIDES OR CONTRACTS TO PROVIDE HEALTH CARE SERVICES THAT ARE WHOLLY OR PARTLY REIMBURSED BY OR ARE A REQUIRED BENEFIT OF HEALTH PLAN ESTABLISHED IN ACCORDANCE WITH THE FEDERAL SOCIAL SECURITY ACT OF 1939 OR BY THE STATE.

(2) "STATE HEALTH PLAN" INCLUDES A PERSON THAT PROVIDES, CONTRACTS, OR SUBCONTRACTS TO PROVIDE HEALTH CARE SERVICES FOR AN ENTITY DESCRIBED IN PARAGRAPH (1) OF THIS SUBSECTION.

(H) "SUPERVISOR" MEANS AN INDIVIDUAL WITH AN EMPLOYER'S ORGANIZATION WHO HAS THE AUTHORITY TO:

(1) DIRECT AND CONTROL THE WORK PERFORMANCE OF AN EMPLOYEE; AND

(2) TAKE CORRECTIVE ACTION REGARDING THE VIOLATION OF A LAW OR REGULATION THAT IS THE SUBJECT OF A COMPLAINT OR CHARGE UNDER THIS SUBTITLE.

12-602.

(A) A PERSON MAY NOT:

(1) KNOWINGLY PRESENT OR CAUSE TO BE PRESENTED TO AN OFFICER OR EMPLOYEE OF THE STATE A FALSE OR FRAUDULENT STATE HEALTH PLAN CLAIM FOR PAYMENT OR APPROVAL;

(2) KNOWINGLY MAKE, USE, OR CAUSE TO BE MADE OR USED A FALSE RECORD OR STATEMENT TO GET A FALSE OR FRAUDULENT STATE HEALTH PLAN CLAIM PAID OR APPROVED BY THE STATE;

(3) CONSPIRE TO DEFRAUD A STATE HEALTH PLAN BY GETTING A FALSE OR FRAUDULENT STATE HEALTH PLAN CLAIM APPROVED OR PAID;

(4) WITH INTENT TO DEFRAUD A STATE HEALTH PLAN:

(I) POSSESS, TAKE CUSTODY OF, OR CONTROL PROPERTY OR MONEY USED OR TO BE USED BY THE STATE; AND

(II) DELIVER OR CAUSE TO BE DELIVERED LESS PROPERTY OR MONEY THAN THE AMOUNT FOR WHICH THE PERSON RECEIVES A CERTIFICATE OR RECEIPT;

(5) WITH INTENT TO DEFRAUD A STATE HEALTH PLAN:

(I) AUTHORIZE TO MAKE OR DELIVER A DOCUMENT CERTIFYING RECEIPT OR PROPERTY USED, OR TO BE USED, BY THE STATE; AND

(II) MAKE OR DELIVER A RECEIPT WITHOUT KNOWING THAT THE INFORMATION CONTAINED IN THE RECEIPT IS TRUE;

(6) KNOWINGLY BUY OR RECEIVE, AS A PLEDGE OR AN OBLIGATION OR DEBT, PUBLICLY OWNED PROPERTY FROM AN OFFICER OR EMPLOYEE OF A STATE HEALTH PLAN WHO LAWFULLY MAY NOT SELL OR PLEDGE THE PROPERTY;

(7) KNOWINGLY MAKE, USE, OR CAUSE TO BE MADE OR USED A FALSE RECORD OR STATEMENT TO CONCEAL, AVOID, OR DECREASE AN OBLIGATION TO PAY OR TRANSMIT MONEY OR PROPERTY TO A STATE HEALTH PLAN; OR

(8) KNOWINGLY MAKE ANY OTHER FALSE CLAIM AGAINST A STATE HEALTH PLAN.

(B) (1) EXCEPT AS PROVIDED IN PARAGRAPH (2) OF THIS SUBSECTION, A PERSON WHO IS FOUND TO HAVE VIOLATED SUBSECTION (A) OF THIS SECTION IS LIABLE TO THE STATE FOR:

(I) A CIVIL FINE NOT MORE THAN $10,000; AND

(II) AN ADDITIONAL AMOUNT EQUAL TO NOT MORE THAN THREE TIMES THE AMOUNT OF DAMAGES THAT THE STATE SUSTAINS AS A RESULT OF THE ACT FOR WHICH THE PERSON IS FINED.

(2) AS AN ALTERNATIVE TO PARAGRAPH (1)(II) OF THIS SUBSECTION, A COURT MAY ASSESS NOT MORE THAN TWO TIMES THE AMOUNT OF DAMAGES THAT THE STATE SUSTAINS AS A RESULT OF A PERSON COMMITTING A VIOLATION OF THIS SUBTITLE IF THE COURT FINDS THAT:

(I) WITHIN 30 DAYS AFTER THE DATE ON WHICH THE PERSON FIRST OBTAINED THE INFORMATION, THE PERSON FURNISHED STATE OFFICIALS RESPONSIBLE FOR INVESTIGATING THE FALSE CLAIM VIOLATIONS WITH ALL DOCUMENTARY MATERIAL KNOWN TO THE PERSON ABOUT THE VIOLATION;

(II) THE PERSON FULLY COOPERATED WITH ANY STATE INVESTIGATION OF THE VIOLATION; AND

(III) AT THE TIME THE PERSON FURNISHED THE STATE WITH THE DOCUMENTARY MATERIAL ABOUT THE VIOLATION:

1. A CIVIL OR ADMINISTRATIVE ACTION RELATING TO THE VIOLATION HAD NOT BEEN BROUGHT UNDER THIS SUBTITLE; AND

2. THE PERSON DID NOT HAVE ACTUAL PRIOR KNOWLEDGE OF THE EXISTENCE OF AN INVESTIGATION OF THE VIOLATION.

(C) THE PENALTIES PROVIDED IN SUBSECTION (B) OF THIS SECTION ARE IN ADDITION TO ANY CRIMINAL, CIVIL, OR ADMINISTRATIVE PENALTIES PROVIDED UNDER ANY OTHER STATE OR FEDERAL STATUTE OR REGULATION.

(D) A PERSON WHO IS ACCUSED OF VIOLATING SUBSECTION (A) OF THIS SECTION SHALL BE ENTITLED TO A TRIAL BY JURY.

12-603.

(A) (1) A PERSON MAY FILE A CIVIL ACTION ON BEHALF OF THE PERSON AND THE STATE IN A COURT OF COMPETENT JURISDICTION WITHIN THE STATE AGAINST A PERSON WHO HAS MADE A FALSE CLAIM AGAINST A STATE HEALTH PLAN IN VIOLATION OF § 12-602 OF THIS SUBTITLE.

(2) A PERSON FILING AN ACTION UNDER THIS SECTION MAY SEEK:

(I) ANY REMEDY AVAILABLE IN COMMON LAW TORT;

(II) THE PENALTIES PROVIDED UNDER § 12-602(B) OF THIS SUBTITLE;

(III) COMPENSATORY DAMAGES TO COMPENSATE THE STATE FOR INJURIES INCURRED AS A DIRECT RESULT OF A VIOLATION OF § 12-602 OF THIS SUBTITLE; AND

(IV) COURT COSTS AND ATTORNEY'S FEES.

(B) (1) (I) THE PERSON SHALL SERVE ON THE STATE A COPY OF THE COMPLAINT AND A WRITTEN DISCLOSURE OF SUBSTANTIALLY ALL MATERIAL EVIDENCE AND INFORMATION THAT THE PERSON POSSESSES, IN ACCORDANCE WITH THE PROVISIONS OF TITLE 2 OF THE MARYLAND RULES FOR SERVICE OF PROCESS ON THE STATE.

(II) THE COMPLAINT SHALL BE FILED IN SECRET AND SHALL REMAIN UNDER SEAL FOR AT LEAST 60 DAYS OR UNTIL THE COURT ORDERS THE COMPLAINT SERVED ON THE DEFENDANT.

(III) THE PERSON MAY NOT SERVE THE COMPLAINT ON THE DEFENDANT UNTIL THE COURT ORDERS THE COMPLAINT SERVED, AND THE DEFENDANT MAY NOT BE REQUIRED TO RESPOND TO A COMPLAINT FILED UNDER THIS SECTION UNTIL 30 DAYS AFTER THE COMPLAINT IS:

1. UNSEALED; AND

2. SERVED ON THE DEFENDANT IN ACCORDANCE WITH TITLE 2 OF THE MARYLAND RULES.

(2) (I) WITHIN 120 DAYS AFTER THE STATE RECEIVES THE COMPLAINT AND THE MATERIAL EVIDENCE AND INFORMATION, THE STATE MAY INTERVENE AND PROCEED WITH THE ACTION.

(II) 1. FOR GOOD CAUSE SHOWN, THE STATE MAY REQUEST THAT THE COURT ORDER AN EXTENSION OF THE 120-DAY PERIOD FOR THE STATE TO INTERVENE.

2. THE COMPLAINT SHALL REMAIN UNDER SEAL DURING ANY EXTENSION OF THE PERIOD FOR THE STATE TO INTERVENE.

(3) BEFORE THE LATER OF ANY EXPIRATION OF THE 120-DAY PERIOD OR ANY EXTENSION OF THE 120-DAY PERIOD, THE STATE SHALL:

(I) PROCEED WITH THE ACTION IN A COURT OF COMPETENT JURISDICTION WITHIN THE STATE; OR

(II) NOTIFY THE COURT THAT IT WILL NOT PROCEED WITH THE ACTION.

(4) IF THE STATE NOTIFIES THE COURT THAT IT WILL NOT PROCEED WITH THE ACTION, THE PERSON WHO INITIATED THE ACTION MAY CONDUCT THE ACTION.

(5) (I) DURING AN INVESTIGATION BY THE STATE CONDUCTED EITHER INDEPENDENTLY OR IN CONJUNCTION WITH A SUIT FILED UNDER THIS SUBTITLE, THE ATTORNEY GENERAL SHALL HAVE THE SAME RIGHTS OF DISCOVERY AS A CIVIL LITIGANT IN THE COURT UNDER TITLE 2, SUBTITLE 4 OF THE MARYLAND RULES.

(II) A PERSON FROM WHOM THE ATTORNEY GENERAL SEEKS DISCOVERY SHALL BE CONSIDERED A PARTY UNDER TITLE 2, SUBTITLE 4 OF THE MARYLAND RULES.

(6) (I) IF THE STATE PROCEEDS WITH THE ACTION, IT HAS THE PRIMARY RESPONSIBILITY FOR PROCEEDING WITH THE ACTION AND IS NOT BOUND BY ANY ACT OF THE PERSON WHO INITIATED THE ACTION.

(II) SUBJECT TO THE LIMITATIONS SET FORTH IN SUBSECTIONS (C) AND (D) OF THIS SECTION, THE PERSON WHO INITIATED THE ACTION MAY CONTINUE AS A PARTY TO THE ACTION.

(C) (1) NOTWITHSTANDING THE OBJECTIONS OF THE PERSON INITIATING THE ACTION, THE STATE MAY PETITION THE COURT TO DISMISS THE ACTION IF:

(I) THE PERSON INITIATING THE ACTION IS NOTIFIED BY THE

STATE OF THE FILING OF THE MOTION TO DISMISS; AND

(II) THE COURT PROVIDES THE PERSON INITIATING THE ACTION WITH AN OPPORTUNITY FOR A HEARING ON THE MOTION TO DISMISS.

(2) NOTWITHSTANDING THE OBJECTIONS OF THE PERSON INITIATING THE ACTION, IF THE COURT DETERMINES AFTER A HEARING THAT A PROPOSED SETTLEMENT IS FAIR, ADEQUATE, AND REASONABLE UNDER THE CIRCUMSTANCES, THE STATE MAY SETTLE A CIVIL ACTION UNDER THIS SECTION.

(D) (1) THE COURT MAY IMPOSE LIMITATIONS ON THE PARTICIPATION OF THE PERSON INITIATING AN ACTION UNDER THIS SECTION IF:

(I) THE STATE SHOWS THAT THE PERSON'S UNRESTRICTED PARTICIPATION IN THE ACTION WOULD:

1. INTERFERE WITH OR UNDULY DELAY THE STATE IN ITS PURSUIT OF THE CIVIL ACTION; OR

2. BE REPETITIOUS, IRRELEVANT, OR HARASSING TO THE PERSON CHARGED WITH VIOLATING THIS SUBTITLE; OR

(II) THE PERSON CHARGED WITH VIOLATING THE SUBTITLE SHOWS THAT UNRESTRICTED PARTICIPATION BY THE PERSON INITIATING THE ACTION WOULD HARASS OR CAUSE THE PERSON CHARGED AN UNDUE BURDEN OR UNNECESSARY EXPENSE.

(2) LIMITATIONS IMPOSED BY THE COURT MAY INCLUDE:

(I) A LIMITATION ON THE NUMBER OF WITNESSES THE PERSON MAY CALL TO TESTIFY;

(II) A LIMITATION ON THE LENGTH OF THE TESTIMONY OF WITNESSES CALLED BY THE PERSON; OR

(III) A LIMITATION ON THE PERSON'S CROSS-EXAMINATION OF WITNESSES.

(E) (1) IF THE STATE ELECTS NOT TO PROCEED WITH THE ACTION, THE PERSON INITIATING THE ACTION HAS THE RIGHT TO PROCEED WITH THE ACTION.

(2) NOTWITHSTANDING THE STATE'S ELECTION NOT TO PROCEED, IF THE STATE REQUESTS, THE COURT SHALL ORDER THAT THE STATE BE SERVED AT ITS OWN EXPENSE WITH COPIES OF:

(I) ALL PLEADINGS FILED IN THE ACTION; AND

(II) ALL DEPOSITION TRANSCRIPTS.

(3) (I) WITHOUT LIMITING THE STATUS AND RIGHTS OF THE PERSON INITIATING THE ACTION, THE COURT MAY ALLOW THE STATE TO INTERVENE AT A LATER DATE ON A SHOWING OF GOOD CAUSE.

(II) IF THE STATE INTERVENES, THE PERSON INITIATING THE ACTION SHALL THEREAFTER BE SUBJECT TO THE LIMITATIONS PROVIDED UNDER SUBSECTIONS (C) AND (D) OF THIS SECTION.

(F) (1) INSTEAD OF PROCEEDING WITH THE CIVIL ACTION, THE STATE MAY PURSUE ANY ALTERNATIVE REMEDY AVAILABLE TO THE STATE, INCLUDING ANY APPROPRIATE ADMINISTRATIVE PROCEEDING TO CONSIDER A CIVIL MONEY PENALTY.

(2) IF THE STATE SEEKS AN ALTERNATIVE REMEDY IN ANOTHER PROCEEDING, THE PERSON INITIATING THE ACTION SHALL HAVE THE SAME RIGHTS IN THE ALTERNATIVE PROCEEDING AS THE PERSON WOULD HAVE HAD IF THE ACTION HAD CONTINUED UNDER THIS SUBTITLE.

(3) A FINDING OF FACT OR CONCLUSION OF LAW MADE IN ANY ALTERNATIVE PROCEEDING THAT HAS BECOME FINAL SHALL BE CONCLUSIVE ON ALL PARTIES AS IF IN AN ACTION BROUGHT UNDER THIS SUBTITLE.

12-604.

(A) (1) IF THE STATE PROCEEDS WITH AN ACTION BROUGHT BY A PERSON INITIATING AN ACTION UNDER § 12-603 OF THIS SUBTITLE AND THE STATE PREVAILS BY A PREPONDERANCE OF THE EVIDENCE, THE COURT SHALL AWARD THE PERSON INITIATING THE ACTION AN AMOUNT THAT IS:

(I) NOT LESS THAN 10% AND NOT MORE THAN 25% OF:

1. ANY DAMAGES RECOVERED IN THE ACTION THAT RESULT FROM THE INFORMATION CONTAINED IN THE ORIGINAL ACTION BROUGHT BY THE PERSON; OR

2. ANY SETTLEMENT OF THE CLAIM; AND

(II) PROPORTIONAL TO THE AMOUNT OF TIME AND EFFORT THAT THE PERSON CONTRIBUTED TO THE FINAL RESOLUTION OF THE CIVIL ACTION.

(2) THE AWARD UNDER PARAGRAPH (1) OF THIS SUBSECTION TO THE PERSON INITIATING THE ACTION SHALL BE PAID OUT OF THE PROCEEDS OF THE ACTION.

(3) IN ADDITION TO THE AMOUNT PROVIDED UNDER PARAGRAPH (1) OF THIS SUBSECTION, A COURT SHALL AWARD A PERSON INITIATING AN ACTION:

(I) AN AMOUNT FOR REASONABLE EXPENSES THAT THE COURT FINDS TO HAVE BEEN NECESSARILY INCURRED; AND

(II) REASONABLE ATTORNEY'S FEES AND COSTS.

(4) ALL EXPENSES, FEES, AND COSTS AWARDED UNDER PARAGRAPH (3) OF THIS SUBSECTION SHALL BE AWARDED AGAINST THE PERSON FOUND TO HAVE VIOLATED THIS SUBTITLE.

(B) IF THE ACTION IS ONE WHICH THE COURT FINDS IS BASED PRIMARILY ON SPECIFIC DOCUMENTARY MATERIALS OR INFORMATION DISCLOSED BY A PERSON OTHER THAN THE PERSON WHO INITIATED THE ACTION, THE COURT MAY MAKE AN AWARD TO THE PERSON WHO MADE THE DISCLOSURE THAT:

(1) THE COURT CONSIDERS APPROPRIATE; AND

(2) DOES NOT EXCEED 10% OF THE PROCEEDS OF THE ACTION.

(C) (1) IF THE STATE DOES NOT PROCEED WITH AN ACTION UNDER THIS PARAGRAPH AND THE PERSON INITIATING THE ACTION PREVAILS, THE COURT SHALL AWARD THE PERSON INITIATING THE ACTION AN AMOUNT THAT IS REASONABLE FOR COLLECTING THE CIVIL PENALTY AND DAMAGES ON THE STATE'S BEHALF.

(2) AN AMOUNT AWARDED UNDER PARAGRAPH (1) OF THIS SUBSECTION SHALL BE:

(I) NOT LESS THAN 25% OR MORE THAN 30% OF THE PROCEEDS OF THE ACTION OR SETTLEMENT OF THE CLAIM; AND

(II) PAID OUT OF THE PROCEEDS.

(3) THE COURT ALSO SHALL AWARD THE PERSON INITIATING THE ACTION AN AMOUNT FOR THAT PERSON'S REASONABLE ATTORNEY'S FEES AND COSTS.

(D) ALL EXPENSES, FEES, AND COSTS AWARDED UNDER SUBSECTION (C)(3)

OF THIS SECTION SHALL BE AWARDED AGAINST THE INDIVIDUAL FOUND TO HAVE BROUGHT THE FALSE CLAIM.

(E) (1) WHETHER OR NOT THE STATE PROCEEDS WITH AN ACTION, IF A COURT FINDS THAT THE ACTION WAS BROUGHT BY A PERSON WHO DELIBERATELY PARTICIPATED IN THE VIOLATION ON WHICH THE ACTION WAS BASED, THE COURT MAY, TO THE EXTENT IT CONSIDERS APPROPRIATE, REDUCE THE SHARE OF THE PROCEEDS OF THE ACTION THAT THE INDIVIDUAL WOULD OTHERWISE HAVE RECEIVED UNDER THIS SECTION.

(2) IN REDUCING THE SHARE OF THE PROCEEDS OF THE PERSON INITIATING THE ACTION UNDER THIS SUBSECTION, THE COURT SHALL CONSIDER:

(I) THE ROLE OF THE PERSON IN ADVANCING THE CASE TO LITIGATION; AND

(II) ANY RELEVANT CIRCUMSTANCES RELATING TO THE VIOLATION.

(F) (1) IF A PERSON INITIATING A CIVIL ACTION UNDER § 12-603 OF THIS SUBTITLE IS CONVICTED OF CRIMINAL CONDUCT ARISING FROM A VIOLATION OF THIS SUBTITLE PRIOR TO A FINAL DETERMINATION OF THE ACTION, THE COURT SHALL DISMISS THE PERSON FROM THE ACTION SO THAT THE PERSON DOES NOT RECEIVE A SHARE OF THE PROCEEDS OF THE ACTION.

(2) THE DISMISSAL OF THE PERSON INITIATING THE ACTION SHALL NOT PREJUDICE THE RIGHT OF THE STATE OR OF ANY OTHER PERSON TO CONTINUE THE ACTION.

(G) IF A PERSON INITIATING A CIVIL ACTION UNDER § 12-603 OF THIS SUBTITLE IS CONVICTED OF CRIMINAL CONDUCT ARISING FROM A VIOLATION OF THIS SUBTITLE AFTER THE PROCEEDS FROM THE ACTION ARE AWARDED TO THAT PERSON, THE COURT SHALL ORDER THE PERSON TO REPAY THE PROCEEDS PREVIOUSLY AWARDED.

(H) A COURT MAY AWARD REASONABLE ATTORNEY'S FEES AND EXPENSES TO A PERSON CHARGED WITH MAKING A FALSE CLAIM AND AGAINST THE PERSON INITIATING THE ACTION IF:

(1) THE DEFENDANT PREVAILS IN THE ACTION;

(2) THE COURT FINDS THAT THE CLAIM OF THE PERSON INITIATING THE ACTION WAS CLEARLY FRIVOLOUS, VEXATIOUS, OR BROUGHT PRIMARILY FOR PURPOSES OF HARASSMENT; AND

(3) THE STATE DID NOT PROCEED WITH THE ACTION.

(I) THE STATE MAY NOT BE SUED AS A DEFENDANT UNDER THIS SUBTITLE.

12-605.

(A) AN EMPLOYER MAY NOT TAKE A RETALIATORY ACTION AGAINST AN EMPLOYEE BECAUSE THE EMPLOYEE:

(1) DISCLOSES OR THREATENS TO DISCLOSE TO A SUPERVISOR OR TO A UNIT OF STATE OR LOCAL GOVERNMENT AN ACTIVITY, POLICY, OR PRACTICE OF THE EMPLOYER THAT THE EMPLOYEE REASONABLY BELIEVES IS IN VIOLATION OF THIS SUBTITLE OR A REGULATION ADOPTED UNDER THE SUBTITLE;

(2) PROVIDES INFORMATION TO, OR TESTIFIES BEFORE, A UNIT OF STATE OR LOCAL GOVERNMENT CONDUCTING AN INVESTIGATION, HEARING, OR INQUIRY INTO A VIOLATION BY THE EMPLOYER UNDER THIS SUBTITLE OR A REGULATION ADOPTED UNDER THIS SUBTITLE; OR

(3) OBJECTS TO OR REFUSES TO PARTICIPATE IN ANY ACTIVITY, POLICY, OR PRACTICE THAT THE EMPLOYEE REASONABLY BELIEVES IS IN

VIOLATION OF THIS SUBTITLE OR A REGULATION ADOPTED UNDER THIS SUBTITLE.

(B) (1) THE STATE OR AN EMPLOYEE OTHER THAN A STATE EMPLOYEE MAY FILE A CIVIL ACTION AGAINST AN EMPLOYER OTHER THAN A SUPERVISOR IN STATE GOVERNMENT, AN APPOINTING AUTHORITY IN STATE GOVERNMENT, OR THE HEAD OF A PRINCIPAL UNIT IN STATE GOVERNMENT IF THE EMPLOYER TAKES A RETALIATORY ACTION AGAINST THE EMPLOYEE.

(2) THE STATE OR THE EMPLOYEE MAY SEEK IN THE CIVIL ACTION:

(I) AN INJUNCTION TO RESTRAIN A CONTINUING VIOLATION OF THIS SUBTITLE;

(II) REINSTATEMENT OF THE EMPLOYEE TO THE SAME POSITION HELD BEFORE THE RETALIATORY ACTION OR TO AN EQUIVALENT POSITION;

(III) REINSTATEMENT OF FULL FRINGE BENEFITS AND SENIORITY RIGHTS;

(IV) COMPENSATION FOR LOST WAGES, BENEFITS, AND OTHER REMUNERATION;

(V) PAYMENT BY THE EMPLOYER OF REASONABLE COSTS AND ATTORNEY'S FEES;

(VI) PUNITIVE DAMAGES; OR

(VII) AN ASSESSMENT OF A FINE:

1. NOT EXCEEDING $1,000 FOR THE FIRST VIOLATION; AND

2. NOT EXCEEDING $5,000 FOR EACH SUBSEQUENT

VIOLATION.

(3) THE REMEDIES PROVIDED UNDER THIS SECTION DO NOT DIMINISH OR AFFECT THE RIGHTS, PRIVILEGES, OR REMEDIES AVAILABLE TO THE EMPLOYEE UNDER:

(I) ANY OTHER FEDERAL OR STATE LAW OR REGULATION; OR

(II) ANY COLLECTIVE BARGAINING AGREEMENT OR EMPLOYEE CONTRACT.

(C) A STATE EMPLOYEE WHO IS SUBJECT TO A RETALIATORY ACTION:

(1) MAY FILE A COMPLAINT UNDER TITLE 5, SUBTITLE 3 OF THE STATE PERSONNEL AND PENSIONS ARTICLE; BUT

(2) MAY NOT FILE A CIVIL ACTION UNDER SUBSECTION (B) OF THIS SECTION.

12-606.

(A) A CIVIL ACTION UNDER THIS SUBTITLE MAY NOT BE BROUGHT:

(1) MORE THAN 6 YEARS AFTER THE DATE ON WHICH THE VIOLATION OCCURS; OR

(2) MORE THAN 3 YEARS AFTER THE DATE WHEN FACTS MATERIAL TO THE RIGHT OF ACTION ARE KNOWN OR REASONABLY SHOULD HAVE BEEN KNOWN BY THE OFFICIAL OF THE STATE CHARGED WITH THE RESPONSIBILITY FOR ACTING UNDER THE CIRCUMSTANCES.

(B) IN AN ACTION BROUGHT UNDER THIS SUBTITLE, THE STATE OR THE PERSON INITIATING THE ACTION SHALL PROVIDE ALL ESSENTIAL ELEMENTS OF

THE CAUSE OF ACTION, INCLUDING DAMAGES, BY A PREPONDERANCE OF THE EVIDENCE.

12-607.

AN EMPLOYER SHALL:

(1) CONSPICUOUSLY DISPLAY NOTICES OF ITS EMPLOYEES' PROTECTIONS AND OBLIGATIONS UNDER THIS SUBTITLE; AND

(2) USE ANY APPROPRIATE MEANS TO INFORM ITS EMPLOYEES OF THE PROTECTIONS AND OBLIGATIONS PROVIDED UNDER THIS SUBTITLE.

12-608.

(A) ANY REMEDY PROVIDED UNDER THIS SUBTITLE IS IN ADDITION TO ANY OTHER APPROPRIATE LEGAL OR EQUITABLE RELIEF PROVIDED UNDER ANY OTHER STATE OR FEDERAL STATUTE OR REGULATION.

(B) THE COMPTROLLER SHALL DEPOSIT ANY FINE ASSESSED UNDER THIS SUBTITLE INTO THE GENERAL FUND OF THE STATE.

Article - Tax - General

10-104.

The income tax does not apply to the income of:

(1) a common trust fund, as defined in § 3-501(b) of the Financial Institutions Article;

(2) except as provided in §§ 10-101(e)(3) and 10-304(2) of this title, an organization that is exempt from taxation under § 408(e)(1) or § 501 of the Internal Revenue Code;

(3) a financial institution that is subject to the financial institution franchise tax;

(4) a person subject to taxation under Title 6 of the Insurance Article;

(5) except as provided in § 10-102.1 of this subtitle, a partnership, as defined in § 761 of the Internal Revenue Code;

(6) except as provided in § 10-102.1 of this subtitle and § 10-304(3) of this title, an S corporation;

(7) except as provided in § 10-304(4) of this title, an investment conduit or a special exempt entity; or

(8) except as provided in § 10-102.1 of this subtitle, a limited liability company as defined under Title 4A of the Corporations and Associations Article to the extent that the company is taxable as a partnership, as defined in § 761 of the Internal Revenue Code.

SECTION 2. AND BE IT FURTHER ENACTED, That §§ 3-2A-01 and 5-615 of the Courts Article and § 1-401 of the Health Occupations Article, as enacted by Section 1 of this Act, shall be construed to apply only prospectively and may not be applied or interpreted to have any effect on or application to any cause of action arising before the effective date of this Act.

SECTION 3. AND BE IT FURTHER ENACTED, That §§ 3-2A-06C and 10-920 of the Courts Article and § 14-405 of the Health Occupations Article, as enacted by Section 1 of this Act, shall be construed to apply only prospectively and may not be applied or interpreted to have any effect on or application to any claim filed in the Health Claims Arbitration Office or case filed in a court before the effective date of this Act.

SECTION 4. AND BE IT FURTHER ENACTED, That on or before June 1, 2005, the Governor shall process a budget amendment in accordance with § 7-209 of the State Finance and Procurement Article for $1,000,000 in special funds for the purpose of establishing and operating the People's Insurance Counsel Division in the Office of the Attorney General.

SECTION 5. AND BE IT FURTHER ENACTED, That notwithstanding any other provision of law:

(a) The premium tax imposed on health maintenance organizations and managed care organizations under § 6-102 of the Insurance Article, as enacted by Section 1 of this Act, shall be applicable to:

(1) capitation payments, including supplemental or bonus payments, made to a managed care organization on or after July 1, 2005; and

(2) subscription charges or other amounts paid to a health maintenance organization on or after July 1, 2005, regardless of when the policy, contract, or health benefit plan as to which the payment was made was issued, delivered, or renewed.

(b) For a health maintenance organization or managed care organization, the report required to be filed with the Insurance Commissioner for calendar year 2005 under § 6-107 of the Insurance Article shall include a statement of the amounts paid to the health maintenance organization or managed care organization from July 1, 2005, through December 31, 2005.

SECTION 6. AND BE IT FURTHER ENACTED, That, for taxable years beginning after December 31, 2005, the exemption under § 10-104 of the Tax - General Article is applicable to managed care organizations and health maintenance organizations that are subject to the insurance premium tax under Title 6 of the Insurance Article.

SECTION 7. AND BE IT FURTHER ENACTED, That this Act is an emergency measure, is necessary for the immediate preservation of the public health or safety, has been passed by a yea and nay vote supported by three-fifths of all the members elected to each of the two Houses of the General Assembly, and shall take effect from the date it is enacted. If this Act does not secure sufficient votes to pass as an emergency measure, it shall take effect January 1, 2005, pursuant to Article III, § 31 of the Maryland Constitution.".

AMENDMENT NO. 2

On pages 1 through 60, strike in their entirety the lines beginning with line 2 on page 1 through line 37 on page 60, inclusive.