UNOFFICIAL COPY OF HOUSE BILL 2
EMERGENCY BILL

D3 4lr6011

By: **The Speaker**
Introduced and read first time: December 28, 2004
Assigned to: Rules and Executive Nominations

A BILL ENTITLED

AN ACT concerning

Maryland Patients' Access to Quality Health Care Act of 2004

FOR the purpose of requiring a health care provider who attests in certain certificates or testifies in relation to certain proceedings concerning health care malpractice to meet certain qualifications; providing for the termination of certain functions of the Health Claims Arbitration Office on or after a certain date; requiring a person who has a claim for a medical injury against a health care provider after a certain date to file a complaint in a court as provided in the Maryland Rules; providing for the transfer of certain functions of the Office to the clerks of the court and the Department of Health and Mental Hygiene on or after a certain date; providing for certain procedures for a claim for a medical injury against a health care provider filed after a certain date; requiring a claimant or plaintiff to file certain certificates for each defendant in a health care malpractice claim or action under certain circumstances; requiring that an arbitration panel or trier of fact itemize certain health care malpractice awards or verdicts in a certain manner; 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; providing for immunity from suit for individuals who conduct alternative dispute resolution under certain circumstances; requiring parties to file certain supplemental certificates of qualified experts in a health care malpractice action under certain circumstances; requiring certain procedures concerning the supplemental certificates; requiring that a health care malpractice action be dismissed or liability in the action be adjudicated in a certain manner if certain parties fail to file a certain supplemental certificate under certain circumstances; authorizing an arbitration panel chairman 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; requiring the Director of the Health Claims Arbitration Office or court to report certain findings and the names of certain attorneys to the Administrative Office of the Courts; requiring the Administrative Office of the Courts to publish on the website of the Judiciary a certain list of certain attorneys who have been the subject of a certain number of findings within a certain period; prohibiting an attorney from bringing a certain claim or action under certain circumstances;

requiring the appearance of an attorney to be stricken under certain circumstances; providing that the lack of an appearance by an attorney is not grounds for a continuance under certain circumstances; requiring a certain notice; allowing certain parties in health care malpractice actions to make certain offers of judgment; establishing procedures relating to offers of judgment; requiring a party who does not accept an offer of judgment to pay certain costs if the judgment obtained is not more favorable than the offer of judgment; altering certain limitations on noneconomic damages for health care malpractice actions; establishing a certain single limitation on noneconomic damages for a survival action and a wrongful death action concerning health care malpractice; prohibiting a jury from being informed of certain limitations on noneconomic damages; requiring that an award or verdict of economic damages for a medical injury exclude certain amounts for past medical expenses and past or future loss of earnings; establishing certain evidentiary presumptions concerning certain economic damages for a medical injury under certain circumstances; altering the number of jurors required for a jury in a civil action; requiring that proposed expert witnesses in civil actions meet certain criteria; prohibiting the use of certain expressions of regret or apology as evidence of liability or as an admission against interest in certain actions and proceedings under certain circumstances; requiring a hospital or related institution to report certain occurrences within a certain time to the Department of Health and Mental Hygiene under certain circumstances; authorizing a hospital or related institution to report certain occurrences to the Department under certain circumstances; requiring a hospital or related institution to conduct a certain analysis of certain occurrences within a certain time and submit the analysis within a certain time to the Department; establishing a certain penalty for violations of certain reporting requirements; requiring the Secretary of the Department 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; requiring insurers providing professional liability insurance to a health care provider in the State to submit certain information to the Maryland Insurance Commissioner; authorizing the Commissioner to require certain insurers to submit certain reports; requiring the Commissioner to submit a certain report to the Legislative Policy Committee on or before a certain date of each year; 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 an authorized medical professional liability insurer from paying a commission that exceeds a certain rate paid by that insurer on a certain date, minus a certain percentage of the insurance premium; prohibiting an authorized insurer that was not active in the State on a certain date from paying a commission that exceeds a certain rate; prohibiting an insurer from including in a medical professional liability insurance policy coverage for the defense of an insured in disciplinary hearings; authorizing a medical professional liability insurer to offer certain coverage for the defense of an insured in disciplinary hearings; requiring the Medical Mutual Liability

Insurance Society of Maryland to report, not later than a certain date each year, to the Commissioner and the General Assembly certain salaries and other compensation, certain financial statements, and a certain financial evaluation; requiring any rate filing by the Society to include information from the Society's report; requiring the Commissioner to make a certain determination before a certain rate filing may become effective; requiring the Commissioner, in the event a certain determination is made, to order rates filed to be reduced; requiring the Society to provide a certain analysis to the Commissioner, before the Society may pay a dividend or similar distribution; requiring the Commissioner to order the Society to make a certain payment to the State, if the Society's analysis makes a certain determination; requiring the amount paid to the State to be determined based on a certain ratio; 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; requiring the Attorney General's Office to provide money in its annual budget for the People's Insurance Counsel Division; authorizing the Division to retain or hire certain experts; requiring the People's Insurance Counsel to administer and operate the People's Insurance Counsel Division; establishing the People's Insurance Counsel Fund; 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 duties of the Division; establishing certain rights of the Division in appearances before the Commissioner and courts on behalf of insurance consumers; authorizing the Division to appear before any unit of State or federal government to protect the interests of insurance consumers; providing that the Division shall have full access to certain records under certain circumstances; providing that the Division is entitled to the assistance of certain staff under certain circumstances; authorizing the Division to recommend certain legislation to the General Assembly; requiring the Division to report on its activities to the Governor and the General Assembly on or before a certain date each year; establishing the Maryland Medical Professional Liability Insurance Rate Stabilization Fund; establishing the purposes of the Fund; requiring the Maryland Insurance Commissioner to administer 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 that interest on and other income from the Fund be separately accounted for; providing that the debts and obligations of the Fund are not debts and obligations of the State or a pledge of credit of the State; providing that the Fund consists of the revenue imposed from the premium tax on health maintenance organizations and managed care organizations and interest on and other income from the Fund; establishing the Medical Assistance Program Account within the Fund; authorizing the Commissioner to enter into certain agreements with medical professional liability insurers to provide certain disbursements from the Fund for a certain purpose in certain years; requiring certain medical professional liability insurers to establish a certain account for a certain purpose; providing that the Fund may not incur an obligation until a certain time; providing that certain medical professional liability insurers are eligible for disbursements from the Fund based on a certain schedule; requiring medical professional

liability insurers to apply for disbursements from the Fund on a certain form and in a certain manner; providing that for statutory accounting purposes the Commissioner shall allow certain medical professional liability insurers a certain credit for disbursements made from the Fund; requiring disbursements from the Fund to the Maryland Medical Assistance Program to be expended to increase fee-for-service physician rates for certain procedures and to increase payments by managed care organizations for certain specialty physician services; requiring that the receipts and disbursements of the Fund be audited annually; requiring that certain unused portions of the Fund revert to the General Fund of the State; requiring the Commissioner to adopt regulations that specify the information that medical professional liability insurers shall submit to receive disbursement from the Fund; requiring the Commissioner to report certain information to the Legislative Policy Committee on or before a certain date each year; providing that a certain rate filing is subject to a certain provision of the Insurance Article; providing for the termination of certain provisions of this Act; providing that certain amounts may be provided to medical professional liability insurers upon the termination of this Act; requiring that unused money remaining in the Fund shall revert to the General Fund upon the termination of this Act; requiring that unused payments made to medical professional liability insurers for certain reserved claims revert to the General Fund; providing for the application of certain provisions of this Act; requiring the Office of Legislative Audits to audit the Health Claims Arbitration Fund and certain transactions to determine certain obligations as of a certain date; requiring the Office of Legislative Audits to make a certain report by a certain date; requiring the Health Claims Arbitration Office to return certain money to the General Fund by a certain date; requiring the Health Services Cost Review Commission to include in certain rates a certain amount of funding for certain patient safety initiatives and infrastructure; providing that certain persons may not reimburse a health care practitioner less than certain amounts; establishing a task force to study and make recommendations regarding the feasibility and desirability of the State adopting a medical malpractice insurance market model identical or similar to the excess coverage fund in Kansas; providing for the membership, chairs, and duties of the task force; requiring the task force to submit its recommendations to certain persons on or before a certain date; defining certain terms; making stylistic changes; making this Act an emergency measure; providing for an alternative effective date of this Act under certain circumstances; and generally relating to providing for access to health care and providing for health care malpractice and civil justice reforms.

BY repealing and reenacting, with amendments,
Article - Courts and Judicial Proceedings
Section 3-2A-01, 3-2A-02(c), 3-2A-04(a) and (b), 3-2A-05(e), (g), and (h), 3-2A-06(b)(4), (f), and (i), 3-2A-06A(f)(1), 3-2A-06B(i)(1), 3-2A-09, 5-615, 8-306, 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-06D, 3-2A-07A, 3-2A-08A, 3-2A-09, 9-124, 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 and 14-405
Annotated Code of Maryland
(2000 Replacement Volume and 2004 Supplement)

BY repealing and reenacting, with amendments,
Article - Insurance
Section 2-213, 6-101, 6-102(b), 6-103, 6-104(a), 6-107(a), and 10-131
Annotated Code of Maryland
(2003 Replacement Volume and 2004 Supplement)

BY adding to
Article - Insurance
Section 4-405 and 10-133
Annotated Code of Maryland
(2003 Replacement Volume and 2004 Supplement)

BY repealing and reenacting, without amendments,
Article - Insurance
Section 6-102(a)
Annotated Code of Maryland
(2003 Replacement Volume and 2004 Supplement)

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

BY adding to
Article - Insurance
Section 19-104.1 and 24-110
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"
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) "MEDICAL EXPENSES" MEANS ANY COSTS THAT HAVE BEEN OR WILL BE INCURRED BY OR ON BEHALF OF A CLAIMANT OR PLAINTIFF AS A RESULT OF A MEDICAL INJURY, INCLUDING THE COSTS OF MEDICAL AND HOSPITAL, REHABILITATIVE, RESIDENTIAL AND CUSTODIAL CARE AND SERVICE, SPECIAL EQUIPMENT OR FACILITIES, AND RELATED TRAVEL.

(I) "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-02.

(c) (1) In any action for damages filed under this subtitle, the health care provider is not liable for the payment of damages unless it is established that the care given by the health care provider is not in accordance with the standards of practice among members of the same health care profession with similar training and experience situated in the same or similar communities at the time of the alleged act giving rise to the cause of action.

(2) (I) THIS PARAGRAPH APPLIES TO AN ACTION FOR WHICH AN INITIAL COMPLAINT IS FILED IN A COURT ON OR AFTER JANUARY 1, 2005.

(II) 1. IN ADDITION TO ANY OTHER QUALIFICATIONS, A HEALTH CARE PROVIDER WHO ATTESTS IN A CERTIFICATE OF A QUALIFIED EXPERT OR TESTIFIES IN RELATION TO A PROCEEDING BEFORE A COURT CONCERNING A DEFENDANT'S COMPLIANCE WITH OR DEPARTURE FROM STANDARDS OF CARE:

A. SHALL HAVE HAD ACTIVE CLINICAL EXPERIENCE, PROVIDED CONSULTATION RELATING TO ACTIVE CLINICAL PRACTICE, OR TAUGHT MEDICINE IN THE DEFENDANT'S SPECIALTY OR A RELATED FIELD OF HEALTH CARE WITHIN 5 YEARS OF THE DATE OF THE ALLEGED ACT OR OMISSION GIVING RISE TO THE CAUSE OF ACTION; AND

B. EXCEPT AS PROVIDED IN ITEM 2 OF THIS SUBPARAGRAPH, IF THE DEFENDANT IS BOARD CERTIFIED IN A SPECIALTY, SHALL BE BOARD CERTIFIED IN THE SAME OR A RELATED SPECIALTY AS THE DEFENDANT.

2. ITEM (II)1 B OF THIS SUBPARAGRAPH DOES NOT APPLY IF THE DEFENDANT WAS PROVIDING CARE OR TREATMENT TO THE PLAINTIFF UNRELATED TO THE AREA IN WHICH THE DEFENDANT IS BOARD CERTIFIED.

3-2A-04.

(a) (1) (I) THIS PARAGRAPH APPLIES TO A CLAIM FILED BEFORE JANUARY 1, 2005.

(II) A person having a claim against a health care provider for damage due to a medical injury shall file [his] THE claim with the Director[,] and, if the claim is against a physician, the Director shall forward copies of the claim to the State Board of Physicians.

(III) The Director shall cause a copy of the claim to be served upon the health care provider by the appropriate sheriff in accordance with the Maryland Rules.

(IV) The health care provider shall file a response with the Director and serve a copy on the claimant and all other health care providers named therein within the time provided in the Maryland Rules for filing a responsive pleading to a complaint.

(V) The claim and the response may include a statement that the matter in controversy falls within one or more particular recognized specialties.

(VI) EACH CERTIFICATE OF A QUALIFIED EXPERT DESCRIBED IN THIS SECTION SHALL BE FILED WITH THE DIRECTOR FOR A CLAIM SUBJECT TO THIS PARAGRAPH.

(2) (I) 1. A PERSON MAY NOT FILE A CLAIM WITH THE DIRECTOR UNDER PARAGRAPH (1) OF THIS SUBSECTION ON OR AFTER JANUARY 1, 2005.

2. THIS PARAGRAPH APPLIES TO A CLAIM FILED ON OR AFTER JANUARY 1, 2005.

(II) A PERSON WHO HAS A CLAIM FOR A MEDICAL INJURY AGAINST A HEALTH CARE PROVIDER SHALL FILE A COMPLAINT IN A COURT AS PROVIDED BY THE MARYLAND RULES.

(III) 1. THE CLERK OF THE COURT SHALL FORWARD A COPY OF A COMPLAINT TO THE DEPARTMENT OF HEALTH AND MENTAL HYGIENE.

2. IF THE CLAIM IS AGAINST A PHYSICIAN, THE DEPARTMENT OF HEALTH AND MENTAL HYGIENE SHALL FORWARD A COPY OF THE COMPLAINT TO THE STATE BOARD OF PHYSICIANS.

(IV) THE PERSON WHO FILES A CLAIM OR RESPONSE SHALL CAUSE A COPY OF THE CLAIM OR RESPONSE TO BE SERVED ON EACH OTHER PARTY IN ACCORDANCE WITH THE MARYLAND RULES.

(V) A PLEADING CONCERNING A CLAIM MAY INCLUDE A STATEMENT THAT THE MATTER IN CONTROVERSY IS WITHIN ONE OR MORE PARTICULAR RECOGNIZED SPECIALTIES.

(VI) EACH CERTIFICATE OF A QUALIFIED EXPERT DESCRIBED IN THIS SECTION SHALL BE FILED WITH THE CLERK OF THE COURT.

(VII) 1. THE CLERK OF THE COURT SHALL FORWARD TO THE DEPARTMENT OF HEALTH AND MENTAL HYGIENE A COPY OF EACH CERTIFICATE OF A QUALIFIED EXPERT FILED UNDER THIS SUBTITLE.

2. IF THE CLAIM IS AGAINST A PHYSICIAN, THE DEPARTMENT OF HEALTH AND MENTAL HYGIENE SHALL FORWARD A COPY OF EACH CERTIFICATE OF A QUALIFIED EXPERT FILED UNDER THIS SUBTITLE THAT CONCERNS THE PHYSICIAN.

[(2)] (3) A third-party claim shall be filed within 30 days of the response of the third-party claimant to the original claim unless the parties consent to a later filing or a later filing is allowed by the panel chairman OR THE COURT, AS THE CASE MAY BE, for good cause shown.

[(3)] (4) A claimant may not add a new defendant after the arbitration panel has been selected, or 10 days after the prehearing conference has been held, whichever is later.

[(4)] (5) Until all costs attributable to the first filing have been satisfied, a claimant may not file a second claim on the same or substantially the same grounds against any of the same parties.

(b) Unless the sole issue in the claim is lack of informed consent:

(1) (i) 1. Except as provided in subparagraph (ii) of this paragraph, a claim OR ACTION filed after July 1, 1986, shall be dismissed, without prejudice, if the claimant OR PLAINTIFF fails to file FOR EACH DEFENDANT a certificate of a qualified expert [with the Director] attesting to departure from standards of care, and that the departure from standards of care is the proximate cause of the alleged injury, within 90 days from the date of the complaint.

2. The claimant OR PLAINTIFF shall serve a copy of the certificate on all other parties to the claim OR ACTION or their attorneys of record in accordance with the Maryland Rules.

(ii) In lieu of dismissing the claim OR ACTION, the panel chairman OR THE COURT shall grant an extension of no more than 90 days for filing the certificate required by this paragraph, if:

1. The limitations period applicable to the claim OR ACTION has expired; and

2. The failure to file the certificate was neither willful nor the result of gross negligence.

(2) (I) A claim OR ACTION filed after July 1, 1986, may be adjudicated in favor of the claimant OR PLAINTIFF on the issue of liability, if the defendant disputes liability and fails to file a certificate of a qualified expert attesting to compliance with standards of care, or that the departure from standards of care is not the proximate cause of the alleged injury, within 120 days from the date the claimant OR PLAINTIFF served the certificate of a qualified expert set forth in paragraph (1) of this subsection on the defendant.

(II) If the defendant does not dispute liability, a certificate of a qualified expert is not required under this subsection.

(III) The defendant shall serve a copy of the certificate on all other parties to the claim OR ACTION or their attorneys of record in accordance with the Maryland Rules.

(3) (I) The attorney representing each party, or the party proceeding pro se, shall file the appropriate certificate with a report of the attesting expert attached.

(II) Discovery is available as to the basis of the certificate.

(4) [The attesting expert] A HEALTH CARE PROVIDER WHO ATTESTS IN A CERTIFICATE OF A QUALIFIED EXPERT OR WHO TESTIFIES IN RELATION TO A PROCEEDING BEFORE AN ARBITRATION PANEL OR A COURT CONCERNING COMPLIANCE WITH OR DEPARTURE FROM STANDARDS OF CARE may not devote annually more than 20 percent of the expert's professional activities to activities that directly involve testimony in personal injury claims.

(5) An extension of the time allowed for filing a certificate of a qualified expert under this subsection shall be granted for good cause shown.

(6) In the case of a claim OR ACTION against a physician, the Director OR THE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, AS THE CASE MAY BE, shall forward copies of the certificates filed under paragraphs (1) and (2) of this subsection to the State Board of Physicians.

(7) For purposes of the certification requirements of this subsection for any claim OR ACTION filed on or after July 1, 1989:

(i) A party may not serve as a party's expert; and

(ii) The certificate may not be signed by:

1. A party;

2. An employee or partner of a party; or

3. An employee or stockholder of any professional corporation of which the party is a stockholder.

3-2A-05.

(e) (1) The arbitration panel shall first determine the issue of liability with respect to a claim referred to it.

(2) If the arbitration panel determines that the health care provider is not liable to the claimant or claimants the award shall be in favor of the health care provider.

(3) If the arbitration panel determines that a health care provider is liable to the claimant or claimants, it shall then consider, itemize, assess, and apportion appropriate damages against one or more of the health care providers that it has found to be liable.

(4) [The award shall itemize by category and amount any damages assessed for incurred medical expenses, rehabilitation costs, and loss of earnings. Damages assessed for any future expenses, costs, and losses shall be itemized separately.] THE ARBITRATION PANEL SHALL ITEMIZE EACH AWARD ENTERED ON OR AFTER JANUARY 1, 2005, TO REFLECT THE MONETARY AMOUNT INTENDED FOR ANY OF THE FOLLOWING DAMAGES THAT ARE APPLICABLE TO THE CLAIM:

(I) PAST MEDICAL EXPENSES;

(II) FUTURE MEDICAL EXPENSES;

(III) PAST LOSS OF EARNINGS;

(IV) FUTURE LOSS OF EARNINGS;

(V) PAST PECUNIARY LOSSES;

(VI) FUTURE PECUNIARY LOSSES;

(VII) OTHER PAST ECONOMIC DAMAGES;

(VIII) OTHER FUTURE ECONOMIC DAMAGES; AND

(IX) NONECONOMIC DAMAGES.

(g) (1) [The] SUBJECT TO PARAGRAPH (2) OF THIS SUBSECTION, THE arbitration panel shall make its award and deliver it to the Director in writing within 1 year from the date on which all defendants have been served and within 10 days after the close of the hearing.

(2) NOTWITHSTANDING ANY OTHER PROVISION OF THIS SUBTITLE, THE ARBITRATION PANEL SHALL MAKE ITS AWARD AND DELIVER IT TO THE DIRECTOR ON OR BEFORE JUNE 30, 2005.

(3) The Director shall cause a copy of it to be served on each party within 15 days of having received it from the arbitration panel.

(h) (1) A party may apply to the arbitration panel to modify or correct an award as to liability, damages, or costs in accordance with § 3-222 of this [article] TITLE.

(2) (I) The application may include a request that damages be reduced to the extent that the claimant has been or will be paid, reimbursed, or indemnified under statute, insurance, or contract for all or part of the damages assessed.

(II) The panel chairman shall receive such evidence in support and opposition to a request for reduction, including evidence of the cost to obtain such payment, reimbursement, or indemnity.

(III) After hearing the evidence in support and opposition to the request, the panel chairman may modify the award if satisfied that modification is supported by the evidence.

(IV) The award may not be modified as to any sums paid or payable to a claimant under any workers' compensation act, criminal injuries compensation act, employee benefit plan established under a collective bargaining agreement between an employer and an employee or a group of employers and a group of employees that is subject to the provisions of the federal Employee Retirement Income Security Act of 1974, program of the Department of Health and Mental Hygiene for which a right of subrogation exists under §§ 15-120 and 15-121.1 of the Health - General Article, or as a benefit under any contract or policy of life insurance or Social Security Act of the United States.

(V) An award may not be modified as to any damages assessed for any future expenses, costs, and losses unless:

1. [the] THE panel chairman orders the defendant or the defendant's insurer to provide adequate security [or, if]; OR

2. [the] THE insurer is authorized to do business in this State[,] AND maintains reserves in compliance with rules of the Insurance Commissioner to assure the payment of all such future damages up to the amount by

which the award has been modified as to such future damages in the event of termination.

(VI) Except as expressly provided by federal [statute] LAW, no person may recover from the claimant or assert a claim of subrogation against a defendant for any sum included in the modification of an award.

3-2A-06.

(b) (4) The clerk of the court in which an action is filed under this [subsection] SUBTITLE shall forward a copy of the action to the [State Board of Physicians] DEPARTMENT OF HEALTH AND MENTAL HYGIENE.

(f) (1) [Upon timely request, the trier of fact shall by special verdict or specific findings itemize by category and amount any damages assessed for incurred medical expenses, rehabilitation costs, and loss of earnings. Damages assessed for any future expenses, costs, and losses shall be itemized separately. If the verdict or findings include any amount for such expenses, costs, and losses, a] THE TRIER OF FACT SHALL ITEMIZE THE VERDICT TO REFLECT THE MONETARY AMOUNT INTENDED FOR ANY OF THE FOLLOWING DAMAGES THAT ARE APPLICABLE TO THE ACTION:

(I) PAST MEDICAL EXPENSES;

(II) FUTURE MEDICAL EXPENSES;

(III) PAST LOSS OF EARNINGS;

(IV) FUTURE LOSS OF EARNINGS;

(V) PAST PECUNIARY LOSSES;

(VI) FUTURE PECUNIARY LOSSES;

(VII) OTHER PAST ECONOMIC DAMAGES;

(VIII) OTHER FUTURE ECONOMIC DAMAGES; AND

(IX) NONECONOMIC DAMAGES.

(2) A party filing a motion for a new trial may object to the damages as excessive on the ground that the [claimant] PLAINTIFF has been or will be paid, reimbursed, or indemnified to the extent and subject to the limits stated in § 3-2A-05(h) of this subtitle.

(3) The court shall hold a hearing and receive evidence on the objection.

(4) (I) If the court finds from the evidence that the damages are excessive on the grounds stated in § 3-2A-05(h) of this subtitle, subject to the limits and conditions stated in § 3-2A-05(h) of this subtitle, it may grant a new trial as to such damages or may deny a new trial if the [claimant] PLAINTIFF agrees to a

remittitur of the excess and the order required adequate security when warranted by the conditions stated in § 3-2A-05(h) of this subtitle.

(II) In the event of a new trial granted under this subsection, evidence considered by the court in granting the remittitur shall be admissible if offered at the new trial and the jury shall be instructed to consider such evidence in reaching its verdict as to damages.

(III) Upon a determination of those damages at the new trial, no further objection to damages may be made exclusive of any party's right of appeal.

(5) Except as expressly provided by federal law, no person may recover from the [claimant] PLAINTIFF or assert a claim of subrogation against a defendant for any sum included in a remittitur or awarded in a new trial on damages granted under this subsection.

(6) Nothing in this subsection shall be construed to otherwise limit the common law grounds for remittitur.

(i) The clerk of the court shall file a copy of the verdict or any other final disposition CONCERNING A PHYSICIAN with the [Director] STATE BOARD OF PHYSICIANS.

3-2A-06A.

(f) (1) (I) [If] SUBJECT TO SUBPARAGRAPH (II) OF THIS PARAGRAPH, IF the parties mutually agree to a neutral case evaluation, the circuit court or United States District Court, to which the case has been transferred after the waiver of arbitration, may refer the case to the Health Claims Arbitration Office not later than 6 months after a complaint is filed under subsection (c) of this section.

(II) A CASE MAY NOT BE REFERRED UNDER THIS SECTION TO THE HEALTH CLAIMS ARBITRATION OFFICE AFTER DECEMBER 31, 2004.

3-2A-06B.

(i) (1) (I) [If] SUBJECT TO SUBPARAGRAPH (II) OF THIS PARAGRAPH, IF the parties mutually agree to a neutral case evaluation, the circuit court or United States District Court, to which the case has been transferred after the waiver of arbitration, may refer the case to the Health Claims Arbitration Office not later than 6 months after a complaint is filed under subsection (c) of this section.

(II) A CASE MAY NOT BE REFERRED UNDER THIS SECTION TO THE HEALTH CLAIMS ARBITRATION OFFICE AFTER DECEMBER 31, 2004.

3-2A-06C.

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

(2) "ALTERNATIVE DISPUTE RESOLUTION" MEANS MEDIATION, NEUTRAL CASE EVALUATION, NEUTRAL FACT-FINDING, OR A SETTLEMENT CONFERENCE.

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

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

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

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

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

(8) "SETTLEMENT CONFERENCE" HAS THE MEANING STATED IN TITLE 17 OF THE MARYLAND RULES.

(B) (1) THIS SECTION DOES NOT APPLY IF:

(I) ALL PARTIES FILE WITH THE COURT AN AGREEMENT NOT TO ENGAGE IN ALTERNATIVE DISPUTE RESOLUTION; AND

(II) THE COURT FINDS THAT ALTERNATIVE DISPUTE RESOLUTION UNDER THIS SECTION WOULD NOT BE PRODUCTIVE.

(2) IN DETERMINING WHETHER ALTERNATIVE DISPUTE RESOLUTION WOULD NOT BE PRODUCTIVE UNDER PARAGRAPH (1)(II) OF THIS SUBSECTION, THE COURT MAY CONSIDER WHETHER THE 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, NEUTRAL PROVIDER, OR INDIVIDUAL CONDUCTING A SETTLEMENT CONFERENCE 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 ALTERNATIVE DISPUTE RESOLUTION AT THE EARLIEST POSSIBLE 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, NEUTRAL PROVIDER, OR INDIVIDUAL TO CONDUCT A SETTLEMENT CONFERENCE.

(2) IF THE PARTIES CHOOSE A MEDIATOR, NEUTRAL PROVIDER, OR INDIVIDUAL TO CONDUCT A SETTLEMENT CONFERENCE, THE PARTIES SHALL NOTIFY THE COURT OF THE NAME OF THE INDIVIDUAL.

(F) (1) IF THE PARTIES DO NOT NOTIFY THE COURT THAT THEY HAVE CHOSEN A MEDIATOR, NEUTRAL PROVIDER, OR INDIVIDUAL TO CONDUCT A SETTLEMENT CONFERENCE WITHIN THE TIME REQUIRED UNDER SUBSECTION (E) OF THIS SECTION, THE COURT SHALL ASSIGN A MEDIATOR, NEUTRAL PROVIDER, OR INDIVIDUAL TO CONDUCT A SETTLEMENT CONFERENCE TO THE CLAIM WITHIN 30 DAYS.

(2) (I) WITHIN 15 DAYS AFTER THE PARTIES ARE NOTIFIED OF THE IDENTITY OF THE MEDIATOR, NEUTRAL PROVIDER, OR INDIVIDUAL CONDUCTING A SETTLEMENT CONFERENCE, A PARTY MAY OBJECT IN WRITING TO THE SELECTION, STATING THE REASONS FOR THE OBJECTION.

(II) IF THE COURT SUSTAINS THE OBJECTION, THE COURT SHALL APPOINT A DIFFERENT MEDIATOR, NEUTRAL PROVIDER, OR INDIVIDUAL TO CONDUCT A SETTLEMENT CONFERENCE.

(3) A MEDIATOR, NEUTRAL PROVIDER, OR INDIVIDUAL CONDUCTING A SETTLEMENT CONFERENCE SHALL FOLLOW THE "MARYLAND STANDARDS OF PRACTICE FOR MEDIATORS, ARBITRATORS, AND OTHER ADR PRACTITIONERS" ADOPTED BY THE COURT OF APPEALS.

(G) THE MEDIATOR, NEUTRAL PROVIDER, OR INDIVIDUAL CONDUCTING A SETTLEMENT CONFERENCE SHALL SCHEDULE AN INITIAL CONFERENCE WITH THE PARTIES AS SOON AS PRACTICABLE.

(H) (1) AT LEAST 15 DAYS BEFORE THE INITIAL CONFERENCE, THE PARTIES SHALL SEND TO THE MEDIATOR, NEUTRAL PROVIDER, OR INDIVIDUAL CONDUCTING A SETTLEMENT CONFERENCE A BRIEF WRITTEN OUTLINE OF THE STRENGTHS AND WEAKNESSES OF THE PARTY'S CASE.

(2) A PARTY MAY NOT BE REQUIRED TO PROVIDE TO ANOTHER PARTY THE WRITTEN OUTLINE DESCRIBED IN PARAGRAPH (1) OF THIS SUBSECTION.

(I) (1) ALTERNATIVE DISPUTE RESOLUTION UNDER THIS SECTION MAY NOT OPERATE TO DELAY DISCOVERY IN THE ACTION.

(2) IF THE MEDIATOR, NEUTRAL PROVIDER, OR INDIVIDUAL CONDUCTING A SETTLEMENT CONFERENCE FINDS THAT THE PARTIES NEED TO ENGAGE IN DISCOVERY FOR A LIMITED PERIOD OF TIME IN ORDER TO FACILITATE THE ALTERNATIVE DISPUTE RESOLUTION, THE MEDIATOR, NEUTRAL PROVIDER, OR INDIVIDUAL CONDUCTING A SETTLEMENT CONFERENCE MAY MEDIATE THE SCOPE AND SCHEDULE OF DISCOVERY NEEDED TO PROCEED WITH THE ALTERNATIVE DISPUTE RESOLUTION, ADJOURN THE INITIAL CONFERENCE, AND RESCHEDULE AN ADDITIONAL CONFERENCE FOR A LATER DATE.

(J) A NEUTRAL EXPERT MAY BE EMPLOYED IN ALTERNATIVE DISPUTE RESOLUTION UNDER THIS SECTION AS PROVIDED IN TITLE 17 OF THE MARYLAND RULES.

(K) IN ACCORDANCE WITH MARYLAND RULE 17-109, THE OUTLINE DESCRIBED IN SUBSECTION (H) OF THIS SECTION AND ANY WRITTEN OR ORAL COMMUNICATION MADE IN THE COURSE OF A CONFERENCE UNDER THIS SECTION:

(1) ARE CONFIDENTIAL;

(2) DO NOT CONSTITUTE AN ADMISSION; AND

(3) ARE NOT DISCOVERABLE.

(L) UNLESS EXCUSED BY THE MEDIATOR, NEUTRAL PROVIDER, OR INDIVIDUAL CONDUCTING A SETTLEMENT CONFERENCE, THE PARTIES AND THE CLAIMS REPRESENTATIVE FOR EACH DEFENDANT SHALL APPEAR AT ALL CONFERENCES HELD UNDER THIS SECTION.

(M) A PARTY WHO FAILS TO COMPLY WITH THE PROVISIONS OF SUBSECTION (H), (K), OR (L) OF THIS SECTION IS SUBJECT TO THE PROVISIONS OF MARYLAND RULE 1-341.

(N) (1) IF A CASE IS SETTLED, THE PARTIES SHALL NOTIFY THE COURT THAT THE CASE HAS BEEN SETTLED.

(2) IF THE PARTIES AGREE TO SETTLE SOME BUT NOT ALL OF THE ISSUES IN DISPUTE, THE MEDIATOR, NEUTRAL PROVIDER, OR INDIVIDUAL CONDUCTING A SETTLEMENT CONFERENCE SHALL FILE A WRITTEN NOTICE OF PARTIAL SETTLEMENT WITH THE COURT.

(3) IF THE PARTIES HAVE NOT AGREED TO A SETTLEMENT THE MEDIATOR, NEUTRAL PROVIDER, OR INDIVIDUAL CONDUCTING A SETTLEMENT CONFERENCE SHALL FILE A WRITTEN NOTICE WITH THE COURT THAT THE CASE WAS NOT SETTLED.

(O) UNLESS OTHERWISE AGREED BY THE PARTIES, THE COSTS OF ALTERNATIVE DISPUTE RESOLUTION SHALL BE DIVIDED EQUALLY BETWEEN THE PARTIES.

(P) AN INDIVIDUAL WHO CONDUCTS ALTERNATIVE DISPUTE RESOLUTION SHALL HAVE THE IMMUNITY FROM SUIT DESCRIBED UNDER § 5-615 OF THIS ARTICLE.

3-2A-06D.

(A) (1) THIS SECTION APPLIES ONLY TO AN INITIAL COMPLAINT FILED ON OR AFTER JANUARY 1, 2005, FOR WHICH A CERTIFICATE OF A QUALIFIED EXPERT IS REQUIRED TO BE FILED IN ACCORDANCE WITH § 3-2A-04 OF THIS SUBTITLE.

(2) THIS SECTION DOES NOT APPLY IF THE DEFENDANT ADMITS LIABILITY.

(B) (1) WITHIN 15 DAYS AFTER THE DATE THAT DISCOVERY IS REQUIRED TO BE COMPLETED, A PARTY SHALL FILE WITH THE COURT A SUPPLEMENTAL CERTIFICATE OF A QUALIFIED EXPERT THAT ATTESTS TO:

(I) THE CERTIFYING EXPERT'S BASIS FOR ALLEGING WHAT IS THE SPECIFIC STANDARD OF CARE;

(II) THE CERTIFYING EXPERT'S QUALIFICATIONS TO TESTIFY TO THE SPECIFIC STANDARD OF CARE;

(III) THE SPECIFIC STANDARD OF CARE;

(IV) FOR THE PLAINTIFF:

1. THE SPECIFIC INJURY COMPLAINED OF;

2. HOW THE SPECIFIC STANDARD OF CARE WAS BREACHED;

3. WHAT SPECIFICALLY THE DEFENDANT SHOULD HAVE DONE TO MEET THE SPECIFIC STANDARD OF CARE; AND

4. THE INFERENCE THAT THE BREACH OF THE STANDARD OF CARE PROXIMATELY CAUSED THE PLAINTIFF'S INJURY; AND

(V) FOR THE DEFENDANT:

1. HOW THE DEFENDANT COMPLIED WITH THE SPECIFIC STANDARD OF CARE;

2. WHAT THE DEFENDANT DID TO MEET THE SPECIFIC STANDARD OF CARE; AND

3. IF APPLICABLE, THAT THE BREACH OF THE STANDARD OF CARE DID NOT PROXIMATELY CAUSE THE PLAINTIFF'S INJURY.

(2) AN EXTENSION OF THE TIME ALLOWED FOR FILING A SUPPLEMENTAL CERTIFICATE UNDER THIS SECTION SHALL BE GRANTED FOR GOOD CAUSE SHOWN.

(3) THE FACTS REQUIRED TO BE INCLUDED IN THE SUPPLEMENTAL CERTIFICATE OF A QUALIFIED EXPERT SHALL BE CONSIDERED NECESSARY TO SHOW ENTITLEMENT TO RELIEF SOUGHT BY A PLAINTIFF OR TO RAISE A DEFENSE BY A DEFENDANT.

(C) SUBJECT TO THE PROVISIONS OF THIS SECTION:

(1) IF A PLAINTIFF FAILS TO FILE A SUPPLEMENTAL CERTIFICATE OF A QUALIFIED EXPERT, ON MOTION OF THE DEFENDANT THE COURT SHALL DISMISS, WITH PREJUDICE, THE ACTION; OR

(2) IF THE DEFENDANT FAILS TO FILE A SUPPLEMENTAL CERTIFICATE OF A QUALIFIED EXPERT, ON MOTION OF THE PLAINTIFF THE COURT SHALL ADJUDICATE IN FAVOR OF THE PLAINTIFF ON THE ISSUE OF LIABILITY.

(D) (1) THE MARYLAND RULES APPLY TO FILING AND SERVING A COPY OF A CERTIFICATE REQUIRED UNDER THIS SECTION AND IN MOTIONS RELATING TO A VIOLATION OF THIS SECTION.

(2) NOTHING CONTAINED IN THIS SECTION PROHIBITS OR LIMITS A PARTY FROM MOVING FOR SUMMARY JUDGMENT IN ACCORDANCE WITH THE MARYLAND RULES.

(E) FOR PURPOSES OF THE CERTIFICATION REQUIREMENTS OF THIS SECTION:

(1) A PARTY MAY NOT SERVE AS A PARTY'S EXPERT; AND

(2) THE CERTIFICATE MAY NOT BE SIGNED BY:

(I) A PARTY;

(II) AN EMPLOYEE OR PARTNER OF A PARTY; OR

(III) AN EMPLOYEE OR STOCKHOLDER OF ANY PROFESSIONAL CORPORATION OF WHICH THE PARTY IS A STOCKHOLDER.

(F) (1) THE CLERK OF THE COURT SHALL FORWARD TO THE DEPARTMENT OF HEALTH AND MENTAL HYGIENE COPIES OF THE CERTIFICATES FILED UNDER THIS SECTION.

(2) IN THE CASE OF A COMPLAINT AGAINST A PHYSICIAN, THE DEPARTMENT OF HEALTH AND MENTAL HYGIENE SHALL FORWARD TO THE STATE BOARD OF PHYSICIANS COPIES OF THE SUPPLEMENTAL CERTIFICATE OF A QUALIFIED EXPERT FILED UNDER THIS SECTION.

3-2A-07A.

(A) (1) AT THE CONCLUSION OF ARBITRATION BY AN ARBITRATION PANEL OR TRIAL UNDER THIS SUBTITLE, THE PANEL CHAIRMAN 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 CHAIRMAN 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 THE

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 WILLFULLY VIOLATES PARAGRAPH (1) OF THIS SUBSECTION IS SUBJECT TO DISCIPLINARY PROCEEDINGS AS PROVIDED IN THE MARYLAND RULES.

(D) (1) IF AN ACTION IS FILED UNDER THIS SUBTITLE ON OR AFTER JANUARY 1, 2005, THE COURT SHALL CONSULT WITH THE LIST UNDER SUBSECTION (B)(2) OF THIS SECTION.

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

(II) WHEN THE APPEARANCE OF AN ATTORNEY IS STRICKEN UNDER SUBPARAGRAPH (1) OF THIS PARAGRAPH, AND THE 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 LACK OF AN APPEARANCE BY AN ATTORNEY IS NOT GROUNDS FOR A CONTINUANCE.

(III) THE COURT SHALL SEND A NOTICE BY FIRST-CLASS MAIL TO THE PLAINTIFF STATING THAT:

1. IF A NEW ATTORNEY DOES NOT ENTER AN APPEARANCE WITHIN 60 DAYS AFTER THE DATE OF THE NOTICE, THE LACK OF AN APPEARANCE BY AN ATTORNEY IS NOT GROUNDS FOR A CONTINUANCE; AND

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

3-2A-08A.

(A) IN THIS SECTION, "COSTS" MEANS THE COSTS DESCRIBED UNDER MARYLAND RULE 2-603.

(B) THIS SECTION DOES NOT APPLY TO CASES DISMISSED FOLLOWING A SETTLEMENT.

(C) (1) (I) AT ANY TIME NOT LESS THAN 45 DAYS BEFORE THE TRIAL BEGINS, A PARTY TO AN ACTION FOR A MEDICAL INJURY MAY SERVE ON THE ADVERSE PARTY AN OFFER OF JUDGMENT TO BE TAKEN FOR THE AMOUNT OF MONEY SPECIFIED IN THE OFFER, WITH COSTS THEN ACCRUED.

(II) WHEN THE LIABILITY OF ONE PARTY TO ANOTHER HAS BEEN DETERMINED BY VERDICT OR ORDER OR JUDGMENT, BUT THE AMOUNT OR EXTENT OF THE LIABILITY REMAINS TO BE DETERMINED BY FURTHER PROCEEDINGS, A PARTY ADJUDGED LIABLE OR A PARTY IN WHOSE FAVOR LIABILITY WAS DETERMINED MAY MAKE AN OFFER OF JUDGMENT NOT LESS THAN 45 DAYS BEFORE THE COMMENCEMENT OF HEARINGS TO DETERMINE THE AMOUNT OR EXTENT OF LIABILITY.

(D) (1) IF WITHIN 15 DAYS AFTER THE SERVICE OF THE OFFER OF JUDGMENT, THE ADVERSE PARTY SERVES WRITTEN NOTICE THAT THE OFFER IS ACCEPTED, EITHER PARTY MAY THEN FILE WITH THE COURT THE OFFER AND NOTICE OF ACCEPTANCE TOGETHER WITH AN AFFIDAVIT OF SERVICE NOTIFYING THE OTHER PARTIES OF THE FILING OF THE OFFER AND ACCEPTANCE.

(2) IF THE COURT RECEIVES THE FILINGS SPECIFIED IN PARAGRAPH (1) OF THIS SUBSECTION, THE COURT SHALL ENTER JUDGMENT.

(E) (1) IF AN ADVERSE PARTY DOES NOT ACCEPT AN OFFER OF JUDGMENT WITHIN THE TIME SPECIFIED IN SUBSECTION (D)(1) OF THIS SECTION, THE OFFER SHALL BE DEEMED WITHDRAWN AND EVIDENCE OF THE OFFER IS NOT ADMISSIBLE EXCEPT IN A PROCEEDING TO DETERMINE COSTS.

(2) AN OFFER OF JUDGMENT THAT IS NOT ACCEPTED DOES NOT PRECLUDE A PARTY FROM MAKING A SUBSEQUENT OFFER OF JUDGMENT IN THE TIME SPECIFIED IN THIS SECTION.

(F) IF THE JUDGMENT FINALLY OBTAINED IS NOT MORE FAVORABLE TO THE ADVERSE PARTY THAN THE OFFER, THE ADVERSE PARTY WHO RECEIVED THE OFFER SHALL PAY THE COSTS OF THE PARTY MAKING THE OFFER INCURRED AFTER THE MAKING OF THE OFFER.

3-2A-09.

(A) THIS SECTION APPLIES TO A JUDGMENT UNDER THIS SUBTITLE FOR A CAUSE OF ACTION ARISING ON OR AFTER JANUARY 1, 2005.

(B) (1) (I) EXCEPT AS PROVIDED IN SUBPARAGRAPH (II) OF THIS SUBSECTION, A JUDGMENT UNDER THIS SUBTITLE FOR NONECONOMIC DAMAGES FOR A CAUSE OF ACTION ARISING BETWEEN JANUARY 1, 2005, AND DECEMBER 31, 2007, INCLUSIVE, MAY NOT EXCEED $650,000.

(II) THE LIMITATION ON NONECONOMIC DAMAGES UNDER SUBPARAGRAPH (I) OF THIS PARAGRAPH SHALL INCREASE BY $15,000 ON JANUARY 1 OF EACH YEAR BEGINNING ON JANUARY 1, 2008.

(III) THE INCREASED AMOUNT UNDER SUBPARAGRAPH (II) OF THIS PARAGRAPH SHALL APPLY TO CAUSES OF ACTION ARISING BETWEEN JANUARY 1 AND DECEMBER 31 OF THAT YEAR, INCLUSIVE.

(2) 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 DEFENDANTS.

(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:

(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. THE COURT SHALL 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; AND

2. THE COURT SHALL 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 IF THERE IS NO AWARD TO A PRIMARY CLAIMANT:

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

2. THE COURT SHALL 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.

(D) (1) A VERDICT FOR PAST MEDICAL EXPENSES SHALL BE LIMITED TO:

(I) THE TOTAL AMOUNT OF PAST MEDICAL EXPENSES PAID BY OR ON BEHALF OF THE PLAINTIFF; AND

(II) THE TOTAL AMOUNT OF PAST MEDICAL EXPENSES INCURRED BUT NOT PAID BY OR ON BEHALF OF THE PLAINTIFF FOR WHICH THE PLAINTIFF OR ANOTHER PERSON ON BEHALF OF THE PLAINTIFF IS OBLIGATED TO PAY.

(2) THE VERDICT FOR PAST OR FUTURE LOSS OF EARNINGS SHALL EXCLUDE ANY AMOUNT FOR FEDERAL, STATE, OR LOCAL INCOME TAXES OR PAYROLL TAXES, INCLUDING SOCIAL SECURITY AND MEDICARE, THAT THE PLAINTIFF WOULD HAVE PAID ON THESE EARNINGS, DETERMINED AT THE TAX RATES IN EFFECT FOR THE PLAINTIFF AT THE TIME THE VERDICT IS ENTERED.

(3) (I) EXCEPT AS OTHERWISE PROVIDED IN THIS PARAGRAPH, THERE IS A REBUTTABLE PRESUMPTION THAT THE MEDICARE REIMBURSEMENT RATES IN EFFECT ON THE DATE OF THE VERDICT FOR THE LOCALITY IN WHICH THE CARE IS TO BE PROVIDED, ADJUSTED FOR INFLATION AS PROVIDED IN SUBPARAGRAPH (V) OF THIS PARAGRAPH, ARE FAIR AND REASONABLE AMOUNTS FOR FUTURE MEDICAL EXPENSES.

(II) IF ON THE DATE OF THE VERDICT, THE MEDICARE WAIVER UNDER § 1814(B) OF THE FEDERAL SOCIAL SECURITY ACT IS IN EFFECT, THERE IS A REBUTTABLE PRESUMPTION THAT THE RATES APPROVED BY THE HEALTH SERVICES COST REVIEW COMMISSION IN EFFECT ON THE DATE OF THE VERDICT FOR THE HOSPITAL FACILITY IN WHICH SERVICES ARE TO BE PROVIDED, ADJUSTED FOR INFLATION AS PROVIDED IN THE ANNUAL RATE UPDATES APPROVED BY THE HEALTH SERVICES COST REVIEW COMMISSION, ARE FAIR AND REASONABLE AMOUNTS FOR FUTURE MEDICAL EXPENSES FOR HOSPITAL FACILITY SERVICES.

(III) THERE IS A REBUTTABLE PRESUMPTION THAT THE STATEWIDE AVERAGE PAYMENT RATE FOR THE MEDICAL ASSISTANCE PROGRAM DETERMINED BY THE DEPARTMENT OF HEALTH AND MENTAL HYGIENE IN EFFECT ON THE DATE OF THE VERDICT, ADJUSTED FOR INFLATION AS PROVIDED IN SUBPARAGRAPH (V) OF THIS PARAGRAPH, IS A FAIR AND REASONABLE AMOUNT FOR FUTURE MEDICAL EXPENSES FOR NURSING FACILITY SERVICES.

(IV) A VERDICT FOR FUTURE MEDICAL EXPENSES FOR WHICH THERE IS NO MEDICARE REIMBURSEMENT RATE, HOSPITAL FACILITY RATE, OR

STATEWIDE AVERAGE PAYMENT RATE SHALL BE BASED ON ACTUAL COST ON THE DATE OF THE VERDICT, ADJUSTED FOR INFLATION AS PROVIDED IN SUBPARAGRAPH (V) OF THIS PARAGRAPH.

(V) 1. FUTURE MEDICAL EXPENSES SHALL BE ADJUSTED FOR INFLATION FOR THE EXPENDITURE CATEGORY OF THE CONSUMER PRICE INDEX PUBLISHED BY THE BUREAU OF LABOR STATISTICS TO WHICH THE EXPENSE APPLIES.

2. THE ADJUSTMENT FOR INFLATION IN THIS PARAGRAPH SHALL BE BASED ON THE AVERAGE RATE OF INFLATION FOR THE 5 YEARS IMMEDIATELY PRECEDING THE AWARD OR VERDICT.

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

[The] EXCEPT AS OTHERWISE PROVIDED IN §§ 3-2A-07A, 3-2A-08A, AND 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[,] OR INDIVIDUAL CONDUCTING ALTERNATIVE DISPUTE RESOLUTION in a health care malpractice claim OR ACTION 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.

8-306.

In a civil action in which a jury trial is permitted, the jury shall consist of AT LEAST 6 jurors.

9-124.

(A) IN A CIVIL ACTION, IF A COURT DETERMINES THAT SCIENTIFIC, TECHNICAL, OR OTHER SPECIALIZED KNOWLEDGE WILL ASSIST THE TRIER OF FACT TO UNDERSTAND THE EVIDENCE OR TO DETERMINE A FACT IN ISSUE, A WITNESS DETERMINED BY THE COURT TO BE QUALIFIED AS AN EXPERT BY KNOWLEDGE, SKILL, EXPERIENCE, TRAINING, OR EDUCATION MAY TESTIFY CONCERNING THE EVIDENCE OR FACT IN ISSUE IN THE FORM OF AN OPINION OR OTHERWISE ONLY IF THE FOLLOWING CRITERIA ARE MET:

(1) THE TESTIMONY IS BASED ON SUFFICIENT FACTS OR DATA;

(2) THE TESTIMONY IS THE PRODUCT OF RELIABLE PRINCIPLES AND METHODS; AND

(3) THE WITNESS HAS APPLIED THE PRINCIPLES AND METHODS RELIABLY TO THE FACTS OF THE CASE.

(B) IF A COURT CONSIDERS IT NECESSARY OR ON MOTION BY A PARTY, THE COURT MAY, AS A PRELIMINARY MATTER AND OUT OF THE PRESENCE OF A JURY, HEAR EVIDENCE REGARDING THE CRITERIA IN SUBSECTION (A) OF THIS SECTION, INCLUDING HEARING TESTIMONY FROM THE PROPOSED EXPERT WITNESS.

10-920.

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

(B) (1) EXCEPT AS PROVIDED IN PARAGRAPH (2) OF THIS SUBSECTION, IN AN ACTION AGAINST A HEALTH CARE PROVIDER UNDER TITLE 3, SUBTITLE 2A OF THIS ARTICLE ARISING ON OR AFTER JANUARY 1, 2005, AN EXPRESSION OF REGRET OR APOLOGY MADE BY OR ON BEHALF OF THE HEALTH CARE PROVIDER, INCLUDING AN EXPRESSION OF REGRET OR APOLOGY MADE IN WRITING, ORALLY, OR BY CONDUCT, IS INADMISSIBLE AS EVIDENCE OF AN ADMISSION OF LIABILITY OR AS EVIDENCE OF AN ADMISSION AGAINST INTEREST.

(2) AN ADMISSION OF LIABILITY OR FAULT THAT IS PART OF OR IN ADDITION TO A COMMUNICATION MADE UNDER PARAGRAPH (1) OF THIS SUBSECTION IS ADMISSIBLE AS EVIDENCE OF AN ADMISSION OF LIABILITY OR AS EVIDENCE OF AN ADMISSION AGAINST INTEREST IN AN ACTION DESCRIBED UNDER PARAGRAPH (1) OF THIS SUBSECTION.

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 VERDICT 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:

(1) REPORT AN UNEXPECTED OCCURRENCE RELATED TO AN INDIVIDUAL'S MEDICAL TREATMENT THAT RESULTS IN DEATH OR SERIOUS DISABILITY THAT IS NOT RELATED TO THE NATURAL COURSE OF THE INDIVIDUAL'S ILLNESS OR UNDERLYING DISEASE CONDITION; AND

(2) SUBMIT THE REPORT TO THE DEPARTMENT WITHIN 5 DAYS OF THE HOSPITAL'S OR RELATED INSTITUTION'S KNOWLEDGE OF THE OCCURRENCE.

(B) A HOSPITAL OR RELATED INSTITUTION MAY REPORT TO THE DEPARTMENT AN UNEXPECTED OCCURRENCE OR OTHER INCIDENT RELATED TO AN INDIVIDUAL'S MEDICAL TREATMENT THAT DOES NOT RESULT IN DEATH OR SERIOUS DISABILITY.

(C) A HOSPITAL OR RELATED INSTITUTION SHALL:

(1) CONDUCT A ROOT CAUSE ANALYSIS OF AN OCCURRENCE REQUIRED TO BE REPORTED UNDER SUBSECTION (A) OF THIS SECTION; AND

(2) UNLESS THE DEPARTMENT APPROVES A LONGER TIME PERIOD, SUBMIT THE ROOT CAUSE ANALYSIS TO THE DEPARTMENT WITHIN 60 DAYS OF THE HOSPITAL'S OR RELATED INSTITUTION'S KNOWLEDGE OF THE OCCURRENCE.

(D) IF A HOSPITAL OR RELATED INSTITUTION FAILS TO COMPLY WITH SUBSECTION (A) OR (C) OF THIS SECTION, THE SECRETARY MAY IMPOSE A FINE OF $500 PER DAY FOR EACH DAY THE VIOLATION CONTINUES.

(E) 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 SHALL 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.

Article - Insurance

2-213.

(A) IN THIS SECTION, "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.

4-405.

(A) (1) EACH INSURER PROVIDING PROFESSIONAL LIABILITY INSURANCE TO A HEALTH CARE PROVIDER IN THE STATE SHALL SUBMIT TO THE COMMISSIONER INFORMATION ON:

(I) THE NATURE AND COST OF REINSURANCE;

(II) THE CLAIMS EXPERIENCE, BY CATEGORY, OF HEALTH CARE PROVIDERS;

(III) THE AMOUNT OF CLAIM SETTLEMENTS AND CLAIM AWARDS;

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

(V) THE NUMBER OF STRUCTURED SETTLEMENTS USED IN PAYMENT OF CLAIMS; AND

(VI) ANY OTHER INFORMATION RELATING TO HEALTH CARE MALPRACTICE CLAIMS PRESCRIBED BY THE COMMISSIONER IN REGULATION.

(2) THE COMMISSIONER SHALL ADOPT REGULATIONS ON THE SUBMISSION OF INFORMATION DESCRIBED IN PARAGRAPH (1) OF THIS SUBSECTION.

(B) THE COMMISSIONER MAY ADOPT REGULATIONS THAT REQUIRE INSURERS OF OTHER LINES OF LIABILITY INSURANCE TO SUBMIT REPORTS CONTAINING INFORMATION THAT IS SUBSTANTIALLY SIMILAR TO THE INFORMATION DESCRIBED IN SUBSECTION (A) OF THIS SECTION.

(C) THE COMMISSIONER SHALL REPORT, IN ACCORDANCE WITH § 2-1246 OF THE STATE GOVERNMENT ARTICLE, THE COMMISSIONER'S FINDINGS AS TO THE IMPACT OF CHAPTER ____ OF THE ACTS OF THE 2004 SPECIAL SESSION OF THE

GENERAL ASSEMBLY (H.B. 2) AND CHAPTER 477 OF THE ACTS OF THE GENERAL ASSEMBLY OF 1994 ON THE AVAILABILITY OF HEALTH CARE MALPRACTICE AND OTHER LIABILITY INSURANCE IN THE STATE TO THE LEGISLATIVE POLICY COMMITTEE ON OR BEFORE SEPTEMBER 1 OF EACH YEAR.

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, SUPPLEMENTAL PAYMENTS, AND 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, SUPPLEMENTAL PAYMENTS, AND 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, SUPPLEMENTAL PAYMENTS, AND 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.

10-131.

A person that violates § 10-103(b) or (c) [or § 10-130], § 10-130, OR § 10-133 of this subtitle is guilty of a misdemeanor and on conviction is subject to a fine not exceeding $500 or imprisonment not exceeding 6 months or both for each violation.

10-133.

(A) IN THIS SECTION, "MEDICAL PROFESSIONAL LIABILITY INSURANCE" MEANS INSURANCE PROVIDING COVERAGE AGAINST DAMAGES DUE TO MEDICAL INJURY ARISING OUT OF THE PERFORMANCE OF PROFESSIONAL SERVICES RENDERED OR WHICH SHOULD HAVE BEEN RENDERED BY A HEALTH CARE PROVIDER.

(B) NOTWITHSTANDING § 10-130(A) OF THIS SUBTITLE, AN AUTHORIZED INSURER THAT ISSUES POLICIES OF MEDICAL PROFESSIONAL LIABILITY INSURANCE IN THE STATE SHALL:

(1) OFFER POLICYHOLDERS AND POTENTIAL POLICYHOLDERS THE ABILITY TO PURCHASE AND RENEW COVERAGE DIRECTLY FROM THE AUTHORIZED INSURER; AND

(2) FOR A POLICYHOLDER THAT PURCHASES OR RENEWS COVERAGE DIRECTLY, PROVIDE A PREMIUM DISCOUNT OR REBATE IN AN AMOUNT EQUIVALENT TO THE COMMISSION THE AUTHORIZED INSURER WOULD HAVE PAID AN INSURANCE PRODUCER TO SELL THE SAME POLICY LESS 1% FOR ADMINISTRATIVE EXPENSE.

(C) A LICENSED INSURANCE PRODUCER MAY NOT ENTER INTO AN EXCLUSIVE APPOINTMENT AGREEMENT WITH AN AUTHORIZED INSURER.

(D) (1) BEGINNING JANUARY 1, 2005 UNTIL DECEMBER 31, 2009, AN AUTHORIZED INSURER THAT ISSUES POLICIES OF MEDICAL PROFESSIONAL LIABILITY INSURANCE IN THE STATE MAY NOT PAY A COMMISSION AT A RATE THAT EXCEEDS THE COMMISSION RATE PAID BY THAT AUTHORIZED INSURER ON NOVEMBER 1, 2004 MINUS 5% OF THE PREMIUM; AND

(2) AN AUTHORIZED INSURER THAT WAS NOT ACTIVE IN THE STATE ON NOVEMBER 1, 2004 MAY NOT PAY A COMMISSION AT A RATE THAT EXCEEDS 5%.

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 PROFESSION.

(2) A POLICY PROVIDING 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 MAY BE OFFERED AND PRICED SEPARATELY FROM A POLICY ISSUED OR DELIVERED UNDER SUBSECTION (A) OF THIS SECTION.

24-110.

(A) NOT LATER THAN JUNE 30 OF EACH YEAR, THE SOCIETY SHALL REPORT TO THE COMMISSIONER AND TO THE GENERAL ASSEMBLY:

(1) SALARIES AND OTHER COMPENSATION PAID TO OFFICERS, EXECUTIVES, AND DIRECTORS FOR THE PRECEDING CALENDAR YEAR;

(2) SUMMARY AND DETAILED FINANCIAL STATEMENT FOR THE FOUR PRECEDING CALENDAR YEARS INDICATING AMOUNTS FOR AND CHANGES IN:

(I) INSURANCE RESERVES AND LOSSES;

(II) ASSETS AND LIABILITIES;

(III) INCOME AND EXPENSES; AND

(IV) RETURN ON INVESTED SURPLUS; AND

(3) MANAGEMENT'S EVALUATION OF THE FINANCIAL POSITION OF THE SOCIETY WHICH SHALL INCLUDE AN ANALYSIS INDICATING WHETHER SUFFICIENT RESOURCES EXIST TO JUSTIFY PROVIDING A DIVIDEND OR SIMILAR DISTRIBUTION TO MEMBERS IN THE CURRENT YEAR AND, IF NOT, HOW THE CURRENT CIRCUMSTANCES VARY FROM PRIOR YEARS IN WHICH SUCH DISTRIBUTIONS HAVE BEEN MADE.

(B) (1) ANY RATE FILING BY THE SOCIETY SHALL INCLUDE THE INFORMATION REQUIRED UNDER SUBSECTION (A) OF THIS SECTION.

(2) BEFORE ANY RATE FILING BY THE SOCIETY WHICH WOULD RESULT IN AN AGGREGATE INCREASE IN PREMIUM OF GREATER THAN 7.5% MAY BECOME EFFECTIVE, THE COMMISSIONER SHALL DETERMINE WHETHER OTHER FINANCIAL

RESOURCES OF THE SOCIETY COULD PRUDENTLY BE APPLIED IN LIEU OF INCREASED PREMIUMS.

(3) IF THE COMMISSIONER DETERMINES OTHER FINANCIAL RESOURCES OF THE SOCIETY MAY BE USED IN LIEU OF PREMIUMS, THE COMMISSIONER SHALL ORDER THE RATES FILED TO BE REDUCED.

(C) (1) BEFORE THE SOCIETY MAY PAY TO ITS MEMBERS A DIVIDEND OR SIMILAR DISTRIBUTION, THE SOCIETY SHALL PROVIDE TO THE COMMISSIONER, USING A METHODOLOGY PRESCRIBED BY THE COMMISSIONER, AN ANALYSIS INDICATING THE EXTENT TO WHICH THE DISTRIBUTION RESULTS FROM ANY EXCESS OF PREMIUMS COLLECTED OVER ACCUMULATED LOSSES FOR INCIDENTS ARISING IN ANY PREMIUM YEAR DURING WHICH THE STATE PROVIDED FINANCIAL ASSISTANCE.

(2) (I) TO THE EXTENT THE ANALYSIS REQUIRED UNDER PARAGRAPH (1) OF THIS SUBSECTION DETERMINES THAT FUNDS AVAILABLE FOR DISTRIBUTION ARE ATTRIBUTED TO A YEAR IN WHICH FINANCIAL ASSISTANCE IS PROVIDED, THE COMMISSIONER SHALL ORDER THE SOCIETY TO PAY A PORTION OF THE DISTRIBUTION TO THE STATE.

(II) THE AMOUNT PAID TO THE STATE SHALL BE DETERMINED BASED ON THE RATIO OF STATE EXPENDITURES FOR FINANCIAL ASSISTANCE TO TOTAL PREMIUMS EARNED FOR EACH PREMIUM YEAR FOR WHICH STATE FINANCIAL ASSISTANCE WAS MADE.

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 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 THAT 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 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 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 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.

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 the Laws of Maryland read as follows:

Article - Insurance

19-104.1.

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

(2) "AGREEMENT" MEANS A CONTRACT BETWEEN THE MARYLAND INSURANCE ADMINISTRATION AND A MEDICAL PROFESSIONAL LIABILITY INSURER UNDER SUBSECTION (J) OF THIS SECTION.

(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 THE TERMS PROVIDED UNDER SUBSECTION (Q) 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) "RATE STABILIZATION ACCOUNT" MEANS AN ACCOUNT ESTABLISHED WITHIN THE FUND THAT IS AVAILABLE TO SUBSIDIZE AGREEMENTS UNDER SUBSECTION (J) OF THIS SECTION.

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

(C) THE PURPOSES OF THE FUND ARE TO:

(1) RETAIN HEALTH CARE PROVIDERS IN THE STATE BY ALLOWING MEDICAL PROFESSIONAL LIABILITY INSURERS TO CHARGE MEDICAL PROFESSIONAL LIABILITY INSURANCE RATES THAT ARE LESS THAN THE RATES APPROVED UNDER § 11-201 OF THIS ARTICLE;

(2) INCREASE THE FEE-FOR-SERVICE RATES PAID BY THE MARYLAND MEDICAL ASSISTANCE PROGRAM TO PHYSICIANS IDENTIFIED UNDER SUBSECTION (Q) OF THIS SECTION;

(3) INCREASE CAPITATION PAYMENTS MADE TO MANAGED CARE ORGANIZATIONS THAT PARTICIPATE IN THE MARYLAND MEDICAL ASSISTANCE PROGRAM TO PAY NETWORK PHYSICIANS IDENTIFIED UNDER SUBSECTION (Q) OF THIS SECTION AT LEAST 100% OF THE FEE SCHEDULE USED IN FEE-FOR-SERVICE RATES PAID BY THE MARYLAND MEDICAL ASSISTANCE PROGRAM; AND

(4) SUBSIDIZE THE COSTS INCURRED BY THE COMMISSIONER TO ADMINISTER THE FUND.

(D) THE COMMISSIONER SHALL ADMINISTER THE FUND.

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

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

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

(H) 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.

(I) NOTWITHSTANDING § 2-114 OF THIS ARTICLE:

(1) THE COMMISSIONER SHALL DEPOSIT THE REVENUE FROM THE TAX IMPOSED ON HEALTH MAINTENANCE ORGANIZATIONS AND MANAGED CARE ORGANIZATIONS UNDER § 6-102 OF THIS ARTICLE IN THE FUND;

(2) SUBJECT TO ITEMS (3) AND (4) OF THIS SUBSECTION, THE FUND SHALL CONSIST OF:

(I) THE REVENUE FROM THE TAX IMPOSED ON MANAGED CARE ORGANIZATIONS AND HEALTH MAINTENANCE ORGANIZATIONS UNDER § 6-102 OF THIS ARTICLE SHALL BE DEPOSITED IN THE FUND;

(II) INTEREST OR OTHER INCOME EARNED ON THE MONEYS IN THE FUND; AND

(III) ANY OTHER MONEY FROM ANY OTHER SOURCE ACCEPTED FOR THE BENEFIT OF THE FUND;

(3) THE COMMISSIONER SHALL DISTRIBUTE FROM THE FUND AN AMOUNT, NOT TO EXCEED 0.5% OF THE TOTAL REVENUE COLLECTED IN EACH YEAR, SUFFICIENT TO COVER THE COSTS OF ADMINISTERING THE FUND; AND

(4) AFTER DISTRIBUTING THE AMOUNTS REQUIRED UNDER ITEM (3) OF THIS SUBSECTION, THE REVENUE REMAINING IN THE FUND SHALL BE ALLOCATED ACCORDING TO THE FOLLOWING SCHEDULE:

(I) IN FISCAL YEAR 2006:

1. $40,700,000 TO THE RATE STABILIZATION ACCOUNT TO SUBSIDIZE AGREEMENTS FOR CALENDAR YEAR 2005; AND

2. $39,300,000 TO THE MEDICAL ASSISTANCE PROGRAM ACCOUNT;

(II) IN FISCAL YEAR 2007:

1. $33,400,000 TO THE RATE STABILIZATION ACCOUNT TO SUBSIDIZE AGREEMENTS FOR CALENDAR YEAR 2006; AND

2. $46,600,000 TO THE MEDICAL ASSISTANCE PROGRAM ACCOUNT;

(III) IN FISCAL YEAR 2008:

1. $26,100,000 TO THE RATE STABILIZATION ACCOUNT TO SUBSIDIZE AGREEMENTS FOR CALENDAR YEAR 2007; AND

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

(IV) IN FISCAL YEAR 2009:

1. $18,800,000 TO THE RATE STABILIZATION ACCOUNT TO SUBSIDIZE AGREEMENTS FOR CALENDAR YEAR 2008; AND

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

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

(J) THE COMMISSIONER MAY ENTER INTO FOUR 1-YEAR AGREEMENTS WITH A MEDICAL PROFESSIONAL LIABILITY INSURER TO:

(1) FOR AN AGREEMENT APPLICABLE TO A 12-MONTH PERIOD INITIATED ON OR AFTER JANUARY 1, 2005, MAINTAIN MEDICAL PROFESSIONAL LIABILITY INSURANCE POLICIES ISSUED OR DELIVERED IN THE STATE AT RATES ALLOWED UNDER AN APPROVED RATE FILING FOR THAT PERIOD, LESS THE VALUE OF THE GUARANTEE PROVIDED UNDER SUBSECTION (M) OF THIS SECTION;

(2) FOR AN AGREEMENT APPLICABLE TO A 12-MONTH PERIOD INITIATED ON OR AFTER JANUARY 1, 2006, MAINTAIN MEDICAL PROFESSIONAL LIABILITY INSURANCE POLICIES ISSUED OR DELIVERED IN THE STATE AT RATES ALLOWED UNDER AN APPROVED RATE FILING FOR THAT PERIOD, LESS THE VALUE OF THE GUARANTEE PROVIDED UNDER SUBSECTION (M) OF THIS SECTION;

(3) FOR AN AGREEMENT APPLICABLE TO A 12-MONTH PERIOD INITIATED ON OR AFTER JANUARY 1, 2007, MAINTAIN MEDICAL PROFESSIONAL LIABILITY INSURANCE POLICIES ISSUED OR DELIVERED IN THE STATE AT RATES ALLOWED UNDER AN APPROVED RATE FILING FOR THAT PERIOD, LESS THE VALUE OF THE GUARANTEE PROVIDED UNDER SUBSECTION (M) OF THIS SECTION; AND

(4) FOR AN AGREEMENT APPLICABLE TO A 12-MONTH PERIOD INITIATED ON OR AFTER JANUARY 1, 2008, MAINTAIN MEDICAL PROFESSIONAL LIABILITY INSURANCE POLICIES ISSUED OR DELIVERED IN THE STATE AT RATES

ALLOWED UNDER AN APPROVED RATE FILING FOR THAT PERIOD, LESS THE VALUE OF THE GUARANTEE PROVIDED UNDER SUBSECTION (M) OF THIS SECTION.

(K) (1) A MEDICAL PROFESSIONAL LIABILITY INSURER ENTERING INTO AN AGREEMENT WITH THE COMMISSIONER SHALL ESTABLISH A SEPARATE ACCOUNT:

(I) THAT IS CREDITED WITH:

1. EARNED PREMIUMS ON MEDICAL PROFESSIONAL LIABILITY INSURANCE POLICIES ISSUED OR DELIVERED IN THE STATE DURING THE PERIOD IN WHICH AN AGREEMENT IS IN EFFECT;

2. INVESTMENT INCOME EARNED ON THE AVERAGE MONTHLY BALANCE OF THE ACCOUNT AT A STATED MONTHLY RATE OF INTEREST EQUIVALENT TO THE 2-YEAR UNITED STATES TREASURY RATE OF INTEREST, AS PUBLISHED BY THE FEDERAL RESERVE BOARD, IN EFFECT ON THE EFFECTIVE DATE OF THE AGREEMENT PLUS 50 BASIS POINTS;

3. FOR A MEDICAL PROFESSIONAL LIABILITY INSURER THAT IS A MUTUAL INSURER, THE VALUE OF A DIVIDEND, IF ANY, THAT MAY BE ISSUED DURING THE PERIOD IN WHICH AN AGREEMENT IS IN EFFECT; AND

4. THE LESSER OF 10% OF THE SURPLUS OF A MEDICAL PROFESSIONAL LIABILITY INSURER WITH A RISK-BASED CAPITAL RATIO AT OR ABOVE 600%, OR THE EXCESS OF THE RISK-BASED CAPITAL RATIO OVER 600% ON THE DATE THAT AN AGREEMENT IS EXECUTED; AND

(II) THAT IS DEBITED WITH:

1. INDEMNITY PAYMENTS;

2. ALLOCATED LOSS ADJUSTMENT EXPENSE PAYMENTS;

3. UNDERWRITING EXPENSE INCURRED;

4. UNALLOCATED LOSS ADJUSTMENT EXPENSE INCURRED;

5. PROVISION FOR DEATH, DISABILITY, AND RETIREMENT;

6. REINSURANCE COST INCURRED;

7. GENERAL OPERATING EXPENSES; AND

8. UNDERWRITING PROFITS AS ALLOWED UNDER THE LAST APPROVED RATE FILING PRIOR TO JANUARY 1, 2005.

(2) A MEDICAL PROFESSIONAL LIABILITY INSURER SHALL HOLD AND INVEST THE FUNDS IDENTIFIED WITH THE ACCOUNT ESTABLISHED UNDER PARAGRAPH (1) OF THIS SUBSECTION IN THE SAME MANNER AS OTHER COMPANY FUNDS.

(L) THE RATE STABILIZATION ACCOUNT MAY NOT INCUR AN OBLIGATION UNDER AN AGREEMENT UNTIL THE AMOUNT DEBITED TO AN ACCOUNT ESTABLISHED UNDER SUBSECTION (K) OF THIS SECTION EXCEEDS THE AMOUNT CREDITED TO THE ACCOUNT.

(M) (1) EXCEPT AS OTHERWISE PROVIDED IN THIS SECTION, FOR EACH YEAR AN AGREEMENT IS IN EFFECT, A MEDICAL PROFESSIONAL LIABILITY INSURER THAT ENTERS INTO AN AGREEMENT UNDER SUBSECTION (J) OF THIS SECTION IS ELIGIBLE TO RECEIVE DISBURSEMENTS FROM THE FUND PROPORTIONATE TO THAT INSURER'S SHARE OF TOTAL PREMIUMS EARNED BY AUTHORIZED INSURERS IN CALENDAR 2004.

(2) IN THE EVENT AN INSURER THAT DID NOT EARN PREMIUMS IN CALENDAR 2004 ENTERS AN AGREEMENT, THAT INSURER SHALL BE ALLOCATED 5% OF THE BALANCE IN THE FUND OR SUCH LESSER AMOUNT AS THE COMMISSIONER SHALL DETERMINE AND THE FUNDS AVAILABLE TO OTHER INSURERS SHALL BE REDUCED PRO RATA.

(3) THE CALCULATIONS REQUIRED UNDER THIS SECTION SHALL BE COMPLETED BEFORE ANY AGREEMENT FOR ANY YEAR MAY BE FORMALLY EXECUTED.

(N) TO RECEIVE PAYMENT FROM THE RATE STABILIZATION ACCOUNT, A MEDICAL PROFESSIONAL LIABILITY INSURER SHALL APPLY TO THE COMMISSIONER ON A FORM AND IN A MANNER APPROVED BY THE COMMISSIONER.

(O) FOR STATUTORY ACCOUNTING PURPOSES, THE COMMISSIONER SHALL ALLOW A CREDIT FOR REINSURANCE RECOVERABLE, EITHER AS AN ASSET OR A DEDUCTION FROM LIABILITY, FOR DISBURSEMENTS MADE FROM THE RATE STABILIZATION ACCOUNT TO A MEDICAL PROFESSIONAL LIABILITY INSURER.

(P) DISBURSEMENT FROM THE FUND MAY NOT EXCEED THE REVENUE FROM THE PREMIUM TAX IMPOSED UNDER § 6-102 OF THIS ARTICLE ON MANAGED CARE ORGANIZATIONS AND HEALTH MAINTENANCE ORGANIZATIONS, INCLUDING INTEREST EARNED.

(Q) (1) DISBURSEMENTS FROM THE MEDICAL ASSISTANCE PROGRAM ACCOUNT OF $15,000,000 SHALL BE MADE TO THE MARYLAND MEDICAL ASSISTANCE PROGRAM TO INCREASE BOTH FEE-FOR-SERVICE PHYSICIAN RATES AND CAPITATION PAYMENTS TO MANAGED CARE ORGANIZATIONS FOR PROCEDURES COMMONLY PERFORMED BY:

(I) OBSTETRICIANS;

(II) NEUROSURGEONS;

(III) ORTHOPEDIC SURGEONS; AND

(IV) EMERGENCY MEDICINE PHYSICIANS.

(2) PORTIONS OF THE MEDICAL ASSISTANCE PROGRAM ACCOUNT THAT EXCEED THE AMOUNT PROVIDED FOR UNDER PARAGRAPH (1) OF THIS SUBSECTION SHALL BE USED ONLY TO INCREASE PAYMENTS TO PHYSICIANS AND CAPITATION PAYMENTS TO MANAGED CARE ORGANIZATIONS.

(R) 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 (T) OF THIS SECTION.

(S) THE COMMISSIONER SHALL ADOPT REGULATIONS THAT SPECIFY THE INFORMATION THAT A MEDICAL PROFESSIONAL LIABILITY INSURER SHALL SUBMIT TO RECEIVE A DISBURSEMENT FROM THE RATE STABILIZATION ACCOUNT.

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

(1) 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;

(2) THE AMOUNT OF MONEY APPLIED FOR BY MEDICAL PROFESSIONAL LIABILITY INSURERS DURING THE PREVIOUS CALENDAR YEAR;

(3) THE AMOUNT OF MONEY DISBURSED TO MEDICAL PROFESSIONAL LIABILITY INSURERS DURING THE PREVIOUS CALENDAR YEAR;

(4) THE COSTS INCURRED IN ADMINISTERING THE FUND DURING THE PREVIOUS FISCAL YEAR; AND

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

SECTION 3. AND BE IT FURTHER ENACTED, That §§ 3-2A-01, 3-2A-05(h), 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 4. AND BE IT FURTHER ENACTED, That §§ 3-2A-04(b), 3-2A-06(b), (f), and (i), 3-2A-06C, 3-2A-06D, 3-2A-08A, 8-306, and 9-124 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 5. AND BE IT FURTHER ENACTED, That the Office of Legislative Audits shall audit the Health Claims Arbitration Fund under § 3-2A-03A of the Courts Article and the transactions of the Health Claims Arbitration Office to

determine the amount of any money remaining in the Health Claims Arbitration Fund and any outstanding obligations of the Health Claims Arbitration Office as of October 1, 2005. On or before December 1, 2005, the Office of Legislative Audits shall submit a report of the audit, subject to § 2-1246 of the State Government Article, to the Legislative Policy Committee. On or before January 1, 2006, the Health Claims Arbitration Office shall return any unspent money identified in the audit report to the General Fund.

SECTION 6. AND BE IT FURTHER ENACTED, That, notwithstanding any other provision of law, the premium tax imposed under § 6-102 of the Insurance Article, as enacted by Section 1 of this Act, shall be applicable to:

(1) capitation payments, supplemental payments, and bonus payments, made to managed care organizations on or after January 1, 2005; and

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

SECTION 7. AND BE IT FURTHER ENACTED, That § 19-104(c) of the Insurance Article, as enacted by Section 1 of this Act, shall apply to all health care provider professional liability insurance policies and contracts issued, delivered, or renewed after the effective date of this Act.

SECTION 8. AND BE IT FURTHER ENACTED, That, for taxable years beginning after December 31, 2004, 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 9. AND BE IT FURTHER ENACTED, That:

(a) Any estimated amount reserved by a medical professional liability insurer in payment of a claim as of December 31, 2013, shall be paid from the Rate Stabilization Account to the medical professional liability insurer;

(b) Any portion of the Rate Stabilization Account that exceeds the amount necessary to meet the obligations of the Maryland Medical Professional Liability Insurance Rate Stabilization Fund, including payments made under paragraph (a) of this section, shall revert to the Medical Assistance Program Account as enacted by Section 2 of this Act; and

(c) Any payments from the Rate Stabilization Account to a medical professional liability insurer not used in payment of unresolved claims identified as of December 31, 2013, shall be returned to the State Treasurer for reversion to the General Fund of the State.

SECTION 10. AND BE IT FURTHER ENACTED, That the State has placed a high priority on improving patient safety in Maryland hospitals. Recent efforts have

included the Maryland Health Care Commission's designation of the Maryland Patient Safety Center with funding support from the Health Services Cost Review Commission, adoption of enhanced patient safety regulations by the Department of Health and Mental Hygiene, and new patient safety criteria for hospital capital expenditures under the certificate of need program. In order to further these efforts, the Health Services Cost Review Commission shall include a reasonable amount of additional funding in hospital approved rates for hospital patient safety related initiatives and infrastructure. The additional funding provided in accordance with this section may not exceed an amount equal to 1% of hospital approved rates.

SECTION 11. AND BE IT FURTHER ENACTED, That an insurer, nonprofit health service plan, health maintenance organization, dental plan, organization, or any other person that provides health benefit plans subject to regulation by the State may not reimburse a health care practitioner in an amount less than the global fee, capitation rate, or per unit sum or rate being paid to the health care practitioner on November 1, 2004.

SECTION 12. AND BE IT FURTHER ENACTED, That Section 11 of this Act shall take effect January 1, 2005. It shall remain effective for a period of 3 years and, at the end of December 31, 2007, with no further action required by the General Assembly, Section 11 of this Act shall be abrogated and of no further force and effect.

SECTION 13. AND BE IT FURTHER ENACTED, That:

(a) A task force shall be established to study and make recommendations regarding the feasibility and desirability of the State adopting a medical malpractice insurance market model identical or similar to the excess coverage fund in Kansas.

(b) (1) The task force shall consist of 15 members, of whom:

(i) three shall be members of the House of Delegates appointed by the Speaker of the House of Delegates;

(ii) three shall be members of the Senate appointed by the President; and

(2) the following members shall be appointed by the Governor:

(i) the Insurance Commissioner or the Commissioner's designee;

(ii) the Executive Director of the Medical and Chirurgical Faculty of Maryland;

(iii) a representative of the Maryland Hospital Association;

(iv) four representatives of insurers that write professional liability insurance coverage in the State;

(v) the Executive Director of the Maryland Health Insurance Plan; and

(vi) the Executive Director of the Maryland Automobile Insurance Fund.

(3) The President and the Speaker shall appoint co-chairs from among the members.

(c) In developing its recommendations, the task force shall consider:

(1) whether an excess coverage model will:

(i) improve the affordability of medical professional liability insurance in the State;

(ii) improve the accessibility of medical professional liability insurance in the State;

(iii) foster greater competition in the medical professional liability insurance market in the State; and

(iv) help prevent disruptions in the State's health care delivery system; and

(2) any other criteria or factors the task force determines are appropriate.

(d) The task force shall submit its recommendations to the Governor, the President of the Senate of Maryland , and the Speaker of the House of Delegates no later than October 1, 2005.

SECTION 14. AND BE IT FURTHER ENACTED, That, subject to Section 12 of this Act, 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.