Department of Legislative Services

Maryland General Assembly
2004 1st Special Session

FISCAL AND POLICY NOTE

Senate Bill 1 (The President)(By Request – Administration)
Rules

Maryland Medical Injury Compensation Reform Act

This emergency Administration bill establishes the Maryland Medical Professional Liability Rate Stabilization Plan and Fund. The bill requires the Governor to include an appropriation for the fund in the annual budget for fiscal 2006 and 2007. The bill also makes several changes to laws affecting patient safety, insurance, and the tort system applicable to medical malpractice claims.

Fiscal Summary

State Effect: Significant general fund expenditure increase in FY 2006 and 2007 to capitalize the Maryland Medical Professional Liability Stabilization Plan Fund. Revenues and expenditures to establish and operate the People's Insurance Counsel in the Office of the Attorney General would increase significantly beginning in FY 2005. General and special fund expenditures would decrease by $630,500 annually by abolishing the Health Claims Arbitration Office when no further claims are pending.

Local Effect: None.

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

Analysis

Bill Summary and Current Law: The bill's provisions apply prospectively and do not affect causes of action arising before its effective date. The provisions fall broadly into three categories: patient safety, insurance, and tort.

Patient Safety

Challenges of Medical Review Committee Decisions

The Bill: In a civil action brought by a party to the proceedings of a medical review committee, the court may award court costs and reasonable attorney's fees to the prevailing party.

Current Law: Generally, attorney's fees are not recoverable as damages in a civil action absent a requirement in statute, in a contractual agreement, or under the Maryland Rules. Under the Maryland Rules, a court must find that the conduct of a party in maintaining or defending a proceeding was in bad faith or without substantial justification before the court may require the offending party, the attorney advising the conduct, or both to pay the adverse party's costs, including reasonable attorney's fees. Attorney's fees are not specifically authorized when a physician challenges the decision of a medical review committee.

Reporting of Adverse Events by Hospitals

The Bill: A hospital or related institution must report an unexpected occurrence resulting in death or serious disability to the Department of Health and Mental Hygiene (DHMH). The Secretary may impose a penalty for failing to comply of up to $5,000 for the first offense and a penalty ranging from $1,000 to $15,000 for subsequent offenses.

Current Law: DHMH may fine a hospital up to $500 per day for the failing to establish a risk management program, which, by regulation, must include a patient safety component. The patient safety regulations require a reporting system for adverse events. An adverse event is an unexpected occurrence related to a patient's medical treatment but not related to the natural course of the patient's illness or underlying disease condition. The regulations also provide for and encourage the voluntary reporting of near misses, defined as a situation that could have resulted in an adverse event but did not because of timely intervention or chance.

Funding for Hospital Safety initiatives

The Bill: The Health Services Cost Review Commission must include a reasonable amount of additional funding in hospital approved rates for hospital safety related initiatives and infrastructure. The additional funding may not exceed one percent of hospital approved rates.

Current Law: The Health Services Cost Review Commission, in DHMH, is responsible for setting the rates that hospitals may charge.

Insurance

Maryland Medical Professional Liability Rate Stabilization Plan

The Bill: A Maryland Medical Professional Liability Rate Stabilization Plan is created as a unit in the Executive Department, under the supervision of a five-member board of directors (three appointed by the Governor, one by the President, and one by the Speaker). The purposes of the plan are to: (1) stabilize rates by allowing a medical professional liability insurer to issue insurance at a rate lower than the approved rate; and (2) make money available to the insurer through reinsurance in an amount equal to the difference between the premium earned by the application of the ceding insurer's stabilized rate and the premium that would have otherwise have been earned. The plan is authorized to enter into reinsurance agreements with medical professional liability insurers.

A Maryland Medical Professional Liabilities Risk Stabilization Plan Fund is also established. The fund may be used for: (1) administrative expenses of the plan and fund, including the purchase of commercial reinsurance by the plan; and (2) to fulfill contractual obligations assumed by the plan under reinsurance agreements issued by the plan.

The plan and the Insurance Commissioner must adopt regulations that establish the scope of the risks assumed by a medical professional liability insurer that may be ceded to the plan, and health care providers whose rates are subject to stabilization under reinsurance agreements issued under the plan, and other specified information. If a ceding insurer enters into a reinsurance agreement with the plan, the insurer may only charge its stabilized rate for any policy issued after the cession effective date.

The plan must report annually to the Governor, the President, the Speaker, and the Commissioner on its activities. The plan may not allow any risk to be ceded to it after December 31, 2007. Any money remaining in the fund on January 1, 2013 reverts to the general fund.

Current Law: Insurers that offer medical professional liability insurance may set rates subject to approval of the Insurance Commissioner.

Disclosure Report for Medical Professional Liability Insurers

The Bill: The bill expands the information that must reported by a medical professional liability insurer. An insurer must also report if it provides professional liability insurance to medical day care centers, hospice programs, assisted living programs, or freestanding ambulatory care facilities. Self-insured medical day care centers, hospice programs,

assisted living programs, or freestanding ambulatory care facilities must also report, as must risk retention groups and medical professionals and facilities that obtain insurance through other means. The required form specifies information to be provided on the insurer, the policy, the type of injury, the type of institution at which the incident occurred, the patient status, the health care provider, and the outcome.

Current Law: Insurers must file quarterly reports of any claim or action for damages if the claim or action: (1) is based on an error, omission, or negligence of performing professional services or based on the lack of consent; and (2) resulted in a final judgment, a settlement or a final disposition that does not result in payment. The report must contain: (1) the name and address of the insured; (2) the policy number; (3) the date of occurrence; (4) the date of filing suit; (5) the date and amount of final judgment or settlement, or the reason for final disposition without a settlement or judgment; (6) a summary of the occurrence; and (7) any other information the Maryland Insurance Administration (MIA) requires. The reporting requirements apply to an insurer that provides professional liability insurance to specified licensed medical professionals and licensed hospitals, as well as to self-insured hospitals.

Disclosure Report for Medical Professional Liability Insurers

The Bill: In addition to other required information, medical professional liability insurers must file information on the jurisdiction where a suit is filed and the amount of the final judgment by category of damages. The report must also state whether there was a claim made for extracontractual damages and, if so, the medical professional liability insurer whose rate filing is the subject of the hearing. The report must be filed with the Commissioner. The Commissioner may impose a civil penalty of up to $5,000 for failing to report to the Commissioner.

A medical professional liability insurer must submit to the Commissioner information on: (1) the nature and cost of reinsurance; (2) the claims experience by category of health care providers; (3) the amount of claims settlements and claims awards; (4) the amount of reserves for claims incurred and claims incurred but unreported; (5) the number of structured settlements used in payment of claims; and (6) any other information relating to health care malpractice claims required by the Commissioner. The Commissioner may require other insurers to submit similar reports.

Current Law: Insurers must file quarterly reports of any claim or action for damages if the claim or action: (1) is based on an error, omission, or negligence of performing professional services or based on the lack of consent; and (2) resulted in a final judgment, a settlement or a final disposition that does not result in payment. The report must contain: (1) the name and address of the insured; (2) the policy number; (3) the date of occurrence; (4) the date of filing suit; (5) the date and amount of final judgment or

settlement, or the reason for final disposition without a settlement or judgment; (6) a summary of the occurrence; and (7) any other information MIA requires.

The reporting requirements apply to an insurer that provides professional liability insurance to specified licensed medical professionals and licensed hospitals, as well as to self-insured hospitals. The reports must be filed with the appropriate licensing entity. A court may impose a penalty for failure to report as required.

People's Insurance Counsel

The Bill: A People's Insurance Counsel is established in the Office of the Attorney General appointed by the Attorney General. The People's Insurance Counsel may appear before the Insurance Commissioner and must review any medical professional liability insurance rate increase of 10% or more. If the People's Insurance Counsel determines that such a rate is excessive, inadequate, or unfairly discriminatory, the counsel must: (1) request a hearing; and (2) appear at the hearing before the Commissioner and present an alternative rate. The Insurance People's Counsel and a medical professional liability insurer may cross examine witnesses at a hearing.

The bill requires the Insurance Commissioner to collect an annual assessment from each medical professional liability insurer pursuant to a specified formula to pay the expenses of the People's Insurance Counsel. The Office of the Attorney General must include in its annual budget sufficient money for the counsel.

Current Law: The Office of People's Counsel (OPC) performs a similar function to the proposed People's Insurance Counsel. OPC evaluates all matters pending before the Public Service Commission (PSC) to determine if the interests of residential users of public utilities are affected. It appears before PSC, various federal agencies, and the courts on behalf of consumers in all matters or proceedings over which PSC has original jurisdiction and in other matters in which OPC deems its interest to be involved.

Reimbursements for Providers

The Bill: Through the end of December 31, 2007, health benefit providers are prohibited from reimbursing a health care practitioner in an amount less than the global fee, capitation rate, or per unit sum or rate being paid to the practitioner on November 1, 2004.

Tort

Qualifications for Experts

The Bill: For actions filed on or after January 1, 2005, a health care provider who attests in a certificate or supplemental certificate or testifies concerning a defendant's compliance with or departure from standards of care: (1) must have active clinical experience in the defendant's specialty or related field within one year of the incident; and (2) must generally be board certified in the same specialty if the defendant is board certified in a specialty.

A health care provider who attests to the merits of a claim or defense as a qualified expert may not devote more than 20% of the expert's professional activities to activities unrelated to the care or treatment of patients and that lead or could lead to court testimony.

Current Law: A health care provider who attests to the merits of a claim or defense as a qualified expert may not devote more than 20% of the expert's professional activities to activities relating to testifying in personal injury claims. Generally, in order to qualify to give expert testimony, an individual must, by reason of education or specialized experience, possess superior knowledge on a subject about which persons having no particular training are incapable of forming an accurate opinion or deducing correct conclusions.

Supplemental Certificate of Qualified Expert

The Bill: Within 15 days after the date that discovery must be completed, a party must file a supplemental certificate of a qualified expert that attests to: (1) the basis for alleging the specific standard of care; (2) the expert's qualifications; and (3) the standard of care.

For the plaintiff, the supplemental certificate must also attest to: (1) the specific injury; (2) how the standard of care was breached; (3) what the defendant should have done; and (4) the inference that the breach proximately caused the plaintiff's injury.

For the defendant, the supplemental certificate must also attest to: (1) how the defendant complied with the standard of care; (2) what the defendant did to meet that standard; and (3) if applicable, that the breach did not proximately cause the plaintiff's injury.

Failure to file by the plaintiff results in dismissal with prejudice. Failure to file by the defendant results in a ruling by the court for the plaintiff on the issue of liability.

Current Law: No supplemental certificate of qualified expert is required.

Health Claims Arbitration Office

The Bill: The Health Claims Arbitration Office is abolished when it notifies the Department of Legislative Services that there are no claims pending. For claims filed on or after January 1, 2005, the claim must be filed in the appropriate circuit court. The clerk of the court must then forward a copy of the certificate of qualified expert to DHMH. If the claim is against a physician, DHMH must forward a copy to the State Board of Physicians.

Current Law: All claims for a medical injury against a health care provider must be filed with the Health Claims Arbitration Office. The office then refers claims to the arbitration process. Either party may waive the arbitration process so that the claim can proceed directly to circuit court for trial.

Limits on Noneconomic Damages

The Bill: For a medical malpractice judgment for a cause of action arising on or after January 1, 2005, noneconomic damages are limited to $650,000. The bill freezes the limit for three years, through calendar 2007, and then allows the amount to increase by $15,000 annually. This limitation applies in the aggregate to all claims for personal injury and wrongful death arising from the same medical injury regardless of the number of claims, plaintiffs, or defendants. If both a personal injury action and a wrongful death action with more than one claimant are filed, the damages would be apportioned among the two actions and the claimants if the jury awards an amount that exceeds the limit.

Current Law: The limit on noneconomic damages in a civil case is $650,000. The amount increases by $15,000 annually. In a wrongful death case, there are typically two separate claims, one for personal injury (survival action) and one for wrongful death. Currently, a jury may award $650,000 in the personal injury action and $975,000 in a companion claim for wrongful death. The total amount that could be awarded in the two cases is $1,625,000 ($650,000 + $975,000).

Itemization of Damages

The Bill: The trier of fact must itemize a malpractice verdict to show: (1) past medical expenses; (2) future medical expenses; (3) past loss of earnings; (4) future loss of earnings; (5) past pecuniary loss; (6) future pecuniary loss; (7) other past economic damages; (8) other future economic damages; and (9) noneconomic damages.

Current Law: Upon timely request, the trier of fact must itemize damages assessed for: (1) incurred medical expenses; (2) rehabilitation costs; and (3) loss of earnings. Future expenses, costs, and losses must be itemized separately.

Past Medical Expense

The Bill: Past medical expenses are limited to the total amount paid plus the total amount incurred but not paid, if the plaintiff or another person on the plaintiff's behalf is obligated.

Current Law: Generally, economic damages include loss of earnings and medical expenses. These damages may be reduced by an arbitration panel, on application of a party. 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 for some or all of the damages assessed. If a defendant objects to the damages amounts as excessive after a trial, the court must hold a hearing. If the court finds that the damages are excessive, the court may then grant a new trial on damages or, if the plaintiff agrees, grant a remittitur.

Past and Future Earnings

The Bill: Awards for past and future earnings are discounted for the proper amount of income and payroll taxes.

Current Law: Awards for past and future earnings are not discounted for taxes that would have been paid.

Determination of Future Medical Expenses

The Bill: For claims arising after January 1, 2005, there is a rebuttable presumption that a verdict for future medical expenses must be based solely on Medicare reimbursement rates in effect on the date of the verdict for the locality in which the care is to be provided. A verdict for future medical expenses for hospital services must be based solely on rates approved by the Health Services Cost Review Commission, if the federal Medicare waiver is still in effect. A verdict for future medical expenses for nursing facility services must be based solely on the statewide average payment rate for the Medicaid program in effect on the date of the verdict. A verdict for future medical expenses for which there is no specified rate must be based on actual cost on the date of the verdict. All verdicts for future medical expenses are adjusted for inflation based the consumer price index published by the Bureau of Labor Statistics.

Current Law: Generally, economic damages include loss of earnings and medical expenses. These damages may be reduced by an arbitration panel, on application of a

party. 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 for some or all of the damages assessed. If a defendant objects to the damages amounts as excessive after a trial, the court must hold a hearing. If the court finds that the damages are excessive, the court may then grant a new trial on damages or, if the plaintiff agrees, grant a remittitur.

A court or health claims arbitration panel may order that all or part of the future economic damages be paid in the form of an annuity or other financial instrument, or that they be paid in periodic or other payments, consistent with the plaintiff's needs, funded by the defendant or the defendant's insurer. If the plaintiff dies before the final periodic payment, the unpaid balance of the award for future loss of earnings reverts to the plaintiff's estate, and the unpaid balance for future medical expenses reverts to the defendant or the defendant's insurer.

Offer of Judgment

The Bill: Not less than 45 days before the triad begins, a party to an action for a medical injury may serve on the adverse party an offer of judgment, with costs then accrued. A party may also make an offer of judgment not less than 45 days before hearing on the extent of liability after liability has already been determined. The court must enter judgment after the filing of specified information on the offer and acceptance. If an offer is declined, evidence of the offer is not admissible except to determine costs. If the offer is denied and at trial the verdict is not more favorable to the adverse party than the offer, the party receiving the offer must pay the costs of the party making the offer incurred after making the offer.

Current Law: A party may offer to settle a case at any time before or during trial. Generally, statements made pertaining to settlement offers are not admissible. There is no penalty for failing to accept a settlement offer. However, if a plaintiff rejects an arbitration panel's award and receives less in a trial, the costs of the judicial proceedings must be assessed against the rejecting party.

Definition of Practice of Medicine

The Bill: The definition of the "practice of medicine" includes testifying as or offering an opinion as a medical expert witness regarding the conduct of practicing medicine for purposes of subjecting an individual to discipline by the State Board of Physicians.

Current Law: An individual offering an opinion as a medical expert in a legal proceeding need not be licensed to practice medicine in the State. An individual's acts in testifying are not subject to review by the Board of Physicians.

Apologies and Expressions of Sympathy

The Bill: An apology or an expression of regret made on behalf of a health care provider may not be admitted in court under specified circumstances. Admissions of liability or fault that are part of or in addition to an apology or expression of regret are admissible.

Current Law: An apology or expression of sympathy by a health care provider may be introduced as evidence as an admission against interest or as an admission of liability.

Mandatory Alternative Dispute Resolution

The Bill: Unless all parties file an agreement not to engage in "alternative dispute resolution" (mediation, neutral case evaluation, method fact finding, or a settlement conference) and the court finds that it would not be productive, within 30 days after the later of the filing of the defendant's answer to the complaint or the defendant's certificate of a qualified expert, the court must order the parties to engage in alternative dispute resolution at the earliest possible date. The bill specifies mediation procedures and establishes requirements for individuals who serve as mediators. Mediators are immune from suit for any act or decision made during mediation and within the scope of authority.

Current Law: Under the Maryland Rules, a circuit court may order alternative dispute resolution, including mediation, neutral fact finding, neutral case evaluation, or pre-trial settlement conferences, before trial.

Three Strikes for Frivolous Cases

The Bill: At the conclusion of a malpractice trial, the court may make a finding that the malpractice case has been brought in bad faith or without substantial justification and report the attorney who brought the case to the Administrative Office of the Courts (AOC). An attorney who has been reported to AOC three or more times in a five-year period may not bring another medical malpractice case for 10 years.

Current Law: Generally, attorney discipline is governed by the Maryland Rules. Under the supervision of the Court of Appeals, the Attorney Grievance Commission supervises and administers the discipline of attorneys. Under the Maryland Rules, if a court in any civil action finds that a party's conduct is in bad faith or without substantial justification, the court may require the offending party, the attorney advising the conduct, or both, to pay the adverse party's costs, including reasonable attorney's fees. In a medical malpractice case heard by an arbitration panel where the panel finds that a party's conduct is in bad faith or without substantial justification, the panel may require the

offending party, the attorney advising the conduct, or both, to pay the adverse party's costs, including reasonable attorney's fees.

Jury Size

The Bill: A civil jury must consist of at least six jurors.

Current Law: A civil jury must consist of six jurors.

State Fiscal Effect: The bill requires the Governor to include an appropriation in the annual budgets for fiscal 2006 and 2007 to finance the Maryland Medical Professional Liability Rate Stabilization Plan. No amount is specified. Based on insurance industry projections, it is estimated that approximately $48 million would be required to hold medical professional liability insurance rates at their 2004 level in 2005. Based on this, medical professional liability insurance rates could increase somewhat in calendar 2005 to the extent the fiscal 2006 appropriation is less than $48 million.

The People's Insurance Counsel established by the bill is financed by an annual assessment on medical professional liability insurers. The bill directs the Insurance Commissioner to collect the assessment and pay it to the Attorney General. The Attorney General may only use this money for the operations of the People's Insurance Counsel. Thus, expenditures to establish and staff the People's Insurance Counsel would increase beginning in fiscal 2005. For 2004 legislation that would have established an independent people's insurance counsel, start-up costs were estimated at $1.9 million to cover salaries and operating costs for 18 positions for a full year. Because of the limited scope and powers of the People's Insurance Counsel under this bill, it is assumed that the start-up and ongoing operating costs for this bill would be less because fewer staff would be required.

The bill repeals references to the Health Claims Arbitration Fund. It is assumed that the money in that fund would be transferred to the general fund. The fiscal 2005 appropriation (mainly general funds) for the Health Claims Arbitration Office is approximately $630,500. The bill abolishes the office when the office notifies the Department of Legislative Services that no further claims are pending, producing annual savings of about $630,500.

General fund revenues could increase minimally due to the bill's enhanced penalty provisions. Any other increase in administrative costs is assumed to be minimal and absorbable within existing resources.

Additional Information

Prior Introductions: Similar legislation, HB 1299, passed the House during the 2004 session. The bill was referred to the Judicial Proceedings Committee in the Senate, where no further action was taken.

Cross File: HB1 (The Speaker)(By Request – Administration)

Information Source(s): Department of Legislative Services

Fiscal Note History: First Reader - December 28, 2004
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