HB 2

Department of Legislative Services

Maryland General Assembly
2004 1st Special Session

FISCAL AND POLICY NOTE
Revised

House Bill 2 (The Speaker)
Rules and Executive Nominations Rules

Maryland Patients' Access to Quality Health Care Act of 2004

This emergency bill establishes the Maryland Medical Professional Liability Insurance Rate Stabilization Fund, with two accounts, a rate stabilization account and a medical assistance program account. The bill repeals the exemption applicable to HMOs and Medicaid Managed Care Organizations (MCOs) to the 2% premium tax and exempts HMOs and MCOs from the corporate income tax. The premium tax from HMOs and MCOs is allocated to the fund. 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: Special fund premium tax revenues could increase by as much as $29.3 million in FY 2005. Potential $948,000 general fund and $299,300 Transportation Trust Fund (TTF) revenue reductions from the loss of corporate income tax revenues in FY 2005. Out-year estimates reflect annualization and inflation. Special fund revenues and expenditures to establish and operate the People's Insurance Counsel Division would increase beginning in FY 2005. Expenditures for the Legislative Auditor to perform required audits would increase beginning in FY 2006 and would be reimbursed by the Medical Mutual Liability Insurance Society of Maryland.

(in dollars)	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010
Premium Tax Rev.	$29,308,551	$64,427,881	$70,874,647	$78,031,360	$85,980,863	$94,815,975
GF Revenues	(947,961)	(2,070,347)	(2,260,819)	(2,468,815)	(2,695,945)	(2,943,971)
TTF Revenues	(299,356)	(653,794)	(713,943)	(779,626)	(851,351)	(929,626)
Net Effect	$28,061,234	$61,703,740	$67,899,885	$74,782,919	$82,433,567	$90,942,378

Note:() = decrease; GF = general funds; FF = federal funds; SF = special funds; - = indeterminate effect

Local Effect: To the extent carriers increase their premiums as a result of the premium tax exemption repeal, expenditures for local jurisdiction employee health benefits could increase. Corporate income tax revenues that are remanded to local jurisdictions for local highway purposes could decrease by a minimal amount.

Small Business Effect: Minimal.

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

Standard of Review for Physician Discipline by the Board of Physicians

The Bill: Factual findings by the Board of Physicians (BOP) for disciplinary actions against physicians must be by a "preponderance of the evidence" standard. Under this standard, an assertion is proven if it more probably than not occurred.

Current Law: Factual findings for BOP disciplinary actions against physicians for failing to meet the appropriate standard of care must be by a "clear and convincing evidence" standard. Under this standard, an assertion is proven if it is reasonably certain that it occurred. "Clear and convincing" is a greater standard of proof than "preponderance of the evidence," but it is less than "beyond a reasonable doubt."

Reporting of Adverse Events by Hospitals

The Bill: A hospital or related institution must report adverse events to the Department of Health and Mental Hygiene (DHMH). The Secretary may impose a fine of up to $500 per day for failing to comply.

Current Law: DHMH may fine a hospital up to $500 per day for 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 Maryland Health Care Commission must work with the Health Services Cost Review Commission, DHMH, the Maryland Patient Safety Center, BOP, and third-party payers to develop systemic patient safety initiatives. The agencies must report on their efforts by October 1, 2005.

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

Reports of Disciplinary Actions against Physicians

The Bill: BOP may impose a civil penalty of up to $5,000 against a hospital or a related institution for failing to report a disciplinary action against a licensed physician.

Current Law: BOP must apply to a circuit court, and the circuit court may impose a civil penalty against a hospital or related institution for failing to report a disciplinary action against a licensed physician.

Insurance

Maryland Medical Professional Liability Insurance Rate Stabilization Program and Fund

The Bill: The purposes of the fund are to retain health care providers in the State by allowing insurers to charge lower rates, increase fee-for-service rates to specialty physicians participating in the Maryland Medical Assistance Program, and increase capitation payments to MCOs participating in the Maryland Medical Assistance Program to pay network physicians at least 100% of the fee schedule used in the fee-for-service program.

The Insurance Commissioner must administer the fund. The Commissioner may enter into four one-year agreements with a medical professional liability insurer for disbursements from the fund's rate stabilization account. For an agreement covering a 12-month period initiated on or after January 1, 2005, the base premium that an insurer may charge, less the value of the guarantee provided for each specialty, may not exceed the base premium for the previous 12-month period by more than 5%. For an agreement applicable to any other year, the insurer must maintain rates allowed under an approved rate filing for that period, less the value of the guarantee provided. The bill prohibits a

disbursement to the Medical Mutual Liability Insurance Society of Maryland (the society) during a period for which the Commissioner has determined that the society's surplus is excessive. The fund receives money from the premium tax imposed on HMOs and MCOs.

A medical professional liability insurer must establish a separate account that is credited with: (1) earned premium on policies delivered during the agreement; (2) specified investment income; (3) the value of any dividend for a mutual insurer; and (4) the lesser of 10% of the insurer's surplus if the insurer has a risk based capital (RBC) ratio of at least 600% or the excess of the RBC ratio over 600% on the date the agreement is executed. The account must have specified debits, including indemnity payments and reinsurance costs. The fund's rate stabilization account may not incur an obligation under an agreement until the insurer's account exceeds the amount credited to it. Insurers must apply to the Commissioner in order to receive payment.

Disbursements from the medical assistance program account of $15,000,000 must be made to the Maryland Medical Assistance Program to increase both the fee-for-services physicians and capitation payments to MCOs for procedures commonly performed by obstetricians, neurosurgeons, orthopedic surgeons, and emergency medicine physicians. Additional funds from the medical assistance program account must be used to increase payments to physicians and capitation payments to MCOs.

The Commissioner may retain up to 0.5% of the money collected for the fund each year for administrative costs. After that the allocation is as follows:

- In fiscal 2005, $6,000,000 is allocated to the medical assistance program account.

- In fiscal 2006, $40,700,000 of the fund is allocated to the rate stabilization account to reduce medical professional liability insurance premiums for agreements for calendar 2005, and $33,300,000 is allocated to the medical assistance program account.

- In fiscal 2007, $33,400,000 of the fund is allocated to the rate stabilization account, and $46,600,000 is allocated to the medical assistance program account.

- In fiscal 2008, $26,100,000 of the fund is allocated to the rate stabilization account, and the remaining amount is allocated to the medical assistance program account.

- In fiscal 2009, $18,800,000 of the fund is allocated to the rate stabilization account, and the remaining amount is allocated to the medical assistance program account.

- In fiscal 2010 and thereafter, the entire amount is allocated to the medical assistance program account.

The Governor must propose legislation during the 2006 General Assembly session to provide an alternative mechanism for distributing the money in the fund.

Any estimated amount reserved by a medical professional liability insurer in payment of a claim as of December 31, 2013, must be paid from the rate stabilization account to the insurer. Any portion of the rate stabilization account that exceeds the amount necessary to meet the fund's obligations reverts to the medical assistance program account. Any payments from the rate stabilization account to an insurer not used in payment of unresolved claims identified as of December 31, 2013, must be returned to the general fund.

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

People's Insurance Counsel

The Bill: A People's Insurance Counsel, appointed by the Attorney General with the advice and consent of the Senate, is established in the Office of the Attorney General. The People's Insurance Counsel Division may appear before the Insurance Commissioner or in court to represent the interests of homeowners insurance and medical professional liability insurance consumers in the State and must review any proposed rate increase of 10% or more for these insurance consumers. The division has the rights of counsel to a party in a proceeding. The bill establishes a special fund, funded by an assessment on insurers that sell homeowners or medical professional liability insurance, pursuant to a specified formula, to pay the expenses of the division.

Current Law: The Consumer Protection Division within the Office of the Attorney General provides mediation services to consumers to help resolve complaints against businesses and health insurance carriers. The division also brings law enforcement actions against businesses that harm large numbers of Maryland consumers through unfair and deceptive practices.

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.

Insurance Producer Commissions and Agreements

The Bill: A licensed insurance producer may not enter into an exclusive appointment agreement with an insurer. Violation is a misdemeanor and, on conviction, subject to a fine of up to $500 and/or up to six month imprisonment.

From January 1, 2005 through December 31, 2009, a medical professional liability insurer may not pay a commission that exceeds the rate paid by that insurer on November 1, 2004, minus 5% of the premium. An insurer that was not active in the State on November 1, 2004, may not pay a commission that exceeds 5% of the premium.

Current Law: Agreements between insurers and insurance producers, including provisions about the amount of an insurance producer's commission or whether the agreement is exclusive, are not specifically regulated by the State. Instead, they are governed by the common law of contracts.

Information Reporting Requirements

The Bill: The bill requires an insurer that provides professional liability insurance to a health care provider to report on: (1) the nature and cost of reinsurance; (2) the claims experience, by category, or health care providers; (3) the amount of clam settlements and awards; (4) the amount of reserves; (5) the number of structured settlements used; and (6) any other information prescribed by the Commissioner. The Commissioner may require other insurers to provide substantially similar information.

The bill expands and specifies additional information that must be reported by these insurers, including information 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 of the claim.

The Commissioner must report each year to the Legislative Policy Committee on the Commissioner's findings regarding the effect of legislation from the 2004 special session and the effects of Chapter 477 of 1994 on the availability of health care malpractice and other liability insurance.

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 a payment. The report must contain specified information on the claims or actions. The 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. A court may impose a penalty for failure to report as required.

Policy Coverage in a Disciplinary Hearing

The Bill: An insurance policy that insures a health care provider against damages due to medical injury may not include coverage for the defense of a health care provider in a professional disciplinary hearing. A separate policy offering this coverage may be offered and priced separately.

Current Law: A health care provider's professional liability insurance policy must authorize the insurer, without restriction, to negotiate and settle claims within the policy's limits and must be consistent with the requirements of the provisions governing claims for personal injury against a health care provider.

Policy Cancellation

The Bill: An insurer or insurance producer that issues or delivers a medical professional liability policy to a medical professional who has been licensed for three or more years is exempt from the prohibition against canceling or refusing to underwrite or renew a particular insurance risk except by standards that are reasonably related to the insurer's economic and business purposes. If, subsequent to a policy cancellation, the Commissioner issues a finding that the insurer may nor cancel or refuse to renew the policy, the insurer must immediately and retroactively reinstate the policy.

Current Law: Generally, an insurer is prohibited from canceling or refusing to underwrite or renew a particular insurance risk except by standards that are reasonably related to the insurer's economic and business purposes. In the case of cancellation or refusal to renew a policy, the policy remains in effect until the Maryland Insurance Commissioner issues a finding if the insured asks for review before the termination date and the Commissioner begins action to issue a finding.

Comparison of Medical Professional Liability Insurance Rates

The Bill: The Maryland Insurance Administration (MIA) must prepare a comparison guide, on its web site and in printed form, for medical professional liability insurance premiums. The guide must list: (1) base premium charged for physicians with policy limits of $1 million and $3 million; and (2) base premiums for hospitals, medical day care centers, hospice care programs, assisted living programs, and freestanding ambulatory care facilities.

Current Law: MIA is not required to publish insurance rate comparisons. Although not required to do so, MIA does provide a comparison guide for homeowners and automobile insurance rates on its web site.

Policy Deductibles

The Bill: Insurers that issue or offer medical professional liability insurance policies must offer, in addition to the basic policy, policies with deductibles in the amounts of $25,000, $50,000, and $100,000.

Current Law: There are no deductible requirements imposed on medical professional liability insurance policies.

Denial of Coverage by Medical Mutual

The Bill: The society may not deny, cancel, or refuse to renew medical professional liability insurance coverage for a physician based solely on the physician's: (1) employment or provision of services at an assisted living or nursing facility; or (2) provision of mammography or emergency room services.

Current Law: Generally, policies issued by the society to each class of physicians and other health care providers must be essentially uniform in terms and conditions of coverage. However, the society may: (1) establish reasonable classifications; (2) vary the limits, coverages, exclusions, conditions, and loss-sharing provisions among classifications; and (3) establish reasonable variations in terms of coverage, including deductibles and loss-sharing provisions, based on the insured's prior loss experience and current professional training and capability.

Reporting by Medical Mutual

The Bill: The society must report annually to the Commissioner and the General Assembly specified information on officer and director compensation, specified financial information, and management's evaluation of the society's financial wellbeing. The information must also be included in the society's rate filings with the Commissioner.

Current Law: Medical professional liability insurers must submit rates to the Commissioner prior to implementation. Rates may not be excessive, inadequate, or unfairly discriminatory. Generally, an insurer must file with the Commissioner all rates, supplementary rate information, policy forms, endorsements, and all modifications of these items that the insurer proposes to use. If the filing is not accompanied by the information on which the insurer supports the filing and the Commissioner does not have sufficient information to determine whether the filing meets the required standard, the Commissioner must require the insurer to provide supporting information within 60 days.

Generally, the Commissioner is responsible for ensuring the solvency of all insurers. To continue to have authority to do insurance business in the State, an insurer must maintain surplus assets or funds of at least 100% of the minimum capital stock required.

Generally, an insurer must prepare and submit to the Commissioner a report of its risk based capital (RBC) levels as of the end of the immediately preceding calendar year. Insurers must have RBC that meets a prescribed formula. The code prescribes actions that must be taken by the insurer and the Commissioner, including insolvency proceedings, if RBC falls below the prescribed level.

Rate Review for Medical Mutual

The Bill: Before a rate filing by the society that would increase premiums by more than 7.5% in the aggregate may take effect, the Commissioner must determine whether the society's other financial resources could be prudently applied rather than a premium rate increase. If the Commissioner finds that other resources may be used, the Commissioner must order rates reduced.

Current Law: The society must comply with rate filing requirements applicable to other medical professional liability insurers. In approving an application for a rate increase by the society, the Commissioner must follow the same practices applicable to other insurers.

Permissible Dividends by Medical Mutual

The Bill: Before the society may pay a dividend, it must provide the Commissioner an analysis indicating the extent to which the distribution results from an excess of premiums collected over accumulated losses for incidents arising in any premium year during which the State provided financial assistance to the society. If the analysis shows that money was attributable to a year in which financial assistance was provided, the Commissioner must order the society to pay a portion of the distribution to the State.

Current Law: The society's decisions on whether to distribute a dividend to its members is not directly governed by statute.

Excessiveness of Medical Mutual's Surplus

The Bill: The Commissioner may determine that the society's surplus is excessive if: (1) the total surplus is greater than the appropriate RBC requirements for the immediately preceding calendar year; and (2) the Commissioner, after a hearing, determines that the surplus is unreasonably large. If the Commissioner determines that the society's surplus is excessive, the Commissioner may not approve a rate increase for the society until the surplus is no longer excessive.

Current Law: No mechanism is prescribed for determining whether an insurer's surplus is excessive. However, an insurer's rates may not be inadequate, excessive, or unfairly discriminatory. Further, as part of the determination of whether RBC is adequate, an

insurer must submit a report to the Commissioner on its RBC level. Action by the insurer and the Commissioner is required if RBC falls below a prescribed level.

Direct Purchase and Renewal of Policies

The Bill: The society offer policyholders and potential policyholders the option to purchase and must renew coverage directly. If a policyholder purchases or renews directly, the society must provide a discount or rebate equaling the commission that the society would have paid an insurance producer to sell the same policy less 1% for administrative costs.

Current Law: Generally, a commission, fee, reward, rebate, or other consideration for selling, soliciting, or negotiating insurance may not be paid, directly or indirectly, to a person other than a licensed insurance producer.

Tort

Qualifications for Experts

The Bill: For actions filed on or after January 1, 2005, a health care provider who attests in a certificate of a qualified expert or testifies concerning a defendant's compliance with or departure from standards of care must: (1) have clinical experience, provided consultation relating to clinical practice, or taught medicine in the defendant's specialty or related field or in the field of health care in which the defendant provided care or treatment within five years of the incident; and (2) be board certified in the same specialty if the defendant is board certified in a specialty, unless the defendant was providing care or treatment to the plaintiff unrelated to the area in which the defendant is board certified or the health care provider taught medicine in the same or similar field.

A health care provider who attests to or testifies about the merits of a claim or defense as a qualified expert may not devote more than 20% of the expert's professional activities that directly involve testimony in personal injury claims.

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 for each defendant 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 may result in dismissal without prejudice. Failure to file by the defendant may result 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 bill renames the Health Claims Arbitration Office as the Health Claims Alternative Dispute Office.

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.

Offer of Judgment

The Bill: 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, 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 offeror's costs 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.

Limits on Noneconomic Damages

The Bill: For a medical practice award 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 four years, through calendar 2008, and then allows the amount to increase by $15,000 annually. Generally, this aggregate amount applies to all claims for personal injury and wrongful death arising from the same medical injury, regardless of the number of claims, claimants, plaintiffs, or beneficiaries. However, if there is a wrongful death action in which there is more than one claimant or beneficiary, whether or not there is a personal injury action arising from the same injury, the total amount of noneconomic damages that may be awarded is 125% of the established limit, regardless of the number of claims, plaintiffs, or beneficiaries ($812,500 for four years under the bill). If there is more than one claimant or beneficiary, noneconomic damages would be apportioned among them 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).

Past Medical Expenses

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.

Determination of Future Medical Expenses and Future Earnings

The Bill: A court may on its own motion or the motion of a party employ a neutral expert witness to testify on the issue of a plaintiff's future medical expenses and future loss of earnings. Unless otherwise agreed by the parties, the costs are divided by the parties.

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.

Mandatory Alternative Dispute Resolution

The Bill: 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" (mediation, neutral case evaluation, neutral fact finding, or a settlement conference) at the earliest possible date. Alternative dispute resolution is not required if the court finds that it would not be productive and all parties agree not to use it. 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 pretrial settlement conferences, before trial.

Apologies and Expressions of Sympathy

The Bill: An apology or an expression of regret made on behalf of a health care provider is inadmissible as evidence of an admission of liability or as evidence of an admission against interest. 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.

Task Force

The Bill: The bill establishes a task force to study and make recommendations regarding the feasibility and desirability of adopting a medical malpractice insurance market model identical or similar to the excess coverage fund in Kansas. The task force is required to submit its recommendations to the Governor, the President, and the Speaker by October 1, 2005.

State Fiscal Effect: The bill removes the exemption from the premium tax for HMOs and MCOs and dedicates the revenues to the Maryland Medical Professional Liability Insurance Rate Stabilization Fund established under the bill. The premium tax is applicable to capitation payments made to MCOs on or after January 1, 2005, and subscriptions charges or other amounts paid to an HMO on or after January 1, 2005. HMOs and MCOs currently must pay corporate income tax, of which 76% goes to the general fund and the remaining 24% is dedicated to the Transportation Trust Fund (TTF).

Premium tax revenues could increase by as much as $29,308,551 in fiscal 2005 under the bill. This estimate is based on the following facts and assumptions:

- in calendar 2003, actual HMO premiums were $1,537,046,859 and MCO premiums were $1,025,370,962;
- HMO premiums increase 12.4% annually to reflect health insurance inflation;
- MCO premiums increase 5.8% annually to reflect medical inflation in the Medicaid program; and
- revenues were adjusted to reflect fiscal years.

Future year revenue increases reflect annualization and inflation.

The Insurance Commissioner is authorized to retain 0.5% of the premium tax revenues from the rate stabilization fund for administrative costs. The board could thus retain up to approximately $322,100 in fiscal 2006. Actual administrative costs could be less. The remaining special fund revenue would be spent as provided under the bill.

Revenues for the fund under the bill, along with the projected federal match for the fund's Medical Assistance Program Account, are shown in **Exhibit 1** below. The

allocations assume that the board would retain the maximum authorization and account for the bill's required allocation (described above) between the two accounts in the fund. After fiscal 2007, it is assumed that expenditures from both accounts in the fund would roughly equal revenues. 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 2005 under the bill's allocation to the fund's rate stabilization account.

Exhibit 1
Revenue to the Fund

	State Revenues from Repeal of Premium Tax Exemption						Federal Match to Medical Assistance Program Account	
	Premium Tax Revenue	Admin. Allow.	To Fund	Rate Stabiliz. Account	Medical Assistance Program Account	Fund Carry Forward Balance	Potential Match Amount	Total Available to Medicaid
FY 2005	$29,308,551	$146,543	$29,162,008	$0	$6,000,000	$23,162,008	$6,000,000	$12,000,000
FY 2006	64,427,881	322,139	64,105,741	40,700,000	33,300,000	13,267,750	33,300,000	66,600,000
FY 2007	70,874,647	354,373	70,520,274	33,400,000	46,600,000	3,788,024	46,600,000	93,200,000
FY 2008	78,031,360	390,157	77,641,203	26,100,000	55,329,226	0	55,329,226	110,658,453
FY 2009	85,980,863	429,904	85,550,959	18,800,000	66,750,959	0	66,750,959	133,501,918
FY 2010	$94,815,975	$474,080	$94,341,895	$0	$94,341,895	$0	$94,341,895	$188,683,790

Corporate income tax revenues could decrease by as much as $1,247,317 ($299,356 TTF; $947,961 general funds) in fiscal 2005 due to the corporate income tax exemption applied to HMOs and MCOs that would then be paying premium taxes. Future year revenue reductions reflect annualization and inflation.

The People's Insurance Counsel Division established by the bill is financed by an annual assessment on homeowners and medical professional liability insurers. The bill directs the Insurance Commissioner to collect the assessment and deposit the amounts collected to the People's Insurance Counsel Fund. Based on similar 2004 legislation that would have established an independent people's insurance counsel, start-up costs could be as much as approximately $1.9 million split between fiscal 2005 and 2006, including salaries and other operating costs for 18 positions to staff the division, with annual costs of $1.25 million thereafter. Costs under this bill may be somewhat less because of the division's more limited scope and administrative savings realized by housing the People's Insurance Counsel in the Office of the Attorney General.

The bill requires the Legislative Auditor to conduct an annual fiscal and compliance audit of the society's accounts and transactions. These audits represent new duties for the Legislative Auditor. To perform these duties, general fund expenditures could increase by an estimated $102,900 in fiscal 2006, which accounts for an October 1 start-up date. This estimate reflects the cost of hiring two auditors to conduct the audits of the society required under the bill. It includes salaries, fringe benefits, one-time start-up costs, and ongoing operating expenses. Annualized costs to perform these audits would be approximately $127,800 in fiscal 2007. The society must pay the Office of Legislative Audits for the cost of performing these audits.

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: None.

Information Source(s): Department of Legislative Services, Maryland Insurance Administration

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