**UNOFFICIAL COPY OF HOUSE BILL 1359**
EMERGENCY BILL

C4 5lr2991
CF 5lr1625

By: **The Speaker and Delegates D. Davis and Hurson**
Introduced and read first time: February 11, 2005
Assigned to: Economic Matters and Health and Government Operations

A BILL ENTITLED

AN ACT concerning

**Maryland Patients' Access to Quality Health Care Act of 2004 -**
**Implementation and Corrective Provisions**

FOR the purpose of requiring the Secretary of Health and Mental Hygiene, in consultation with the Maryland Insurance Commissioner when developing certain rates, to consider certain expenses imposed on managed care organizations; providing the Insurance Commissioner with the authority to deny, refuse to renew, suspend, or revoke a certificate of authority if an insurer fails to pay a certain assessment by the People's Insurance Counsel; clarifying the grounds for a circuit court imposing a certain civil penalty for the failure of an insurer to make certain reports under certain circumstances; altering a certain provision of law specifying the information that medical professional liability insurers must submit to the Insurance Commissioner; requiring the Commissioner to adopt certain regulations on the submission of certain information by insurers; requiring the Commissioner to impose a certain civil penalty under certain circumstances; repealing a certain provision of law establishing the Maryland Medical Professional Liability Insurance Rate Stabilization Fund; establishing the Maryland Health Care Provider Rate Stabilization Fund; establishing the purposes of the Fund; 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; 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; establishing that the Fund is comprised of the Rate Stabilization Account and the Medical Assistance Program Account; requiring the Maryland Insurance Commissioner to administer the Fund; requiring the Commissioner to deposit certain premium tax revenue into the Fund; providing that the Commissioner may distribute a certain amount from the Fund for costs associated with administering the Fund; providing for certain allocations from the Fund to the Rate Stabilization Account and the Medical Assistance Program Account; providing for the distribution of certain unallocated balances remaining in the Fund; authorizing the Commissioner to allocate a certain percentage of the Rate Stabilization Account to certain insurers under certain circumstances and to make a certain reduction in certain funds; providing for

the order of distribution of money from the Fund; requiring that certain unused portions of the Rate Stabilization Account be used for certain purposes; requiring that certain disbursements from the Rate Stabilization Account be returned to the State Treasurer under certain circumstances; requiring an insurer to make a certain reduction in subsidy under certain circumstances; requiring an insurer seeking a certain reimbursement to make a certain determination and to send a certain notice to policyholders; requiring an insurer to make a certain calculation of a certain subsidy; providing for a certain procedure for making a certain election not to receive a certain subsidy; requiring insurers to apply to the Rate Stabilization Account on a form and in a manner approved by the Commissioner; requiring insurers to submit certain information when applying to the Rate Stabilization Account; requiring the Commissioner to make certain disbursements from the Rate Stabilization Account within a certain time after receipt of reimbursement; requiring an insurer to provide a certain rate reduction, credit, or refund to certain policyholders; providing that an insurer that is a mutual company may not issue a certain dividend; prohibiting disbursements from the Rate Stabilization Account to the Medical Mutual Liability Insurance Society of Maryland under certain circumstances; requiring the Commissioner or the Commissioner's designee to conduct an annual audit of certain information submitted by insurers; requiring the Commissioner to make a certain determination and to notify certain insurers and a certain committee of the General Assembly of the determination; requiring the Commissioner to make certain disbursements from the Medical Assistance Program Account to the Secretary of Health and Mental Hygiene; requiring the Secretary to use certain disbursements from the Medical Assistance Program Account in a certain manner; requiring the Secretary to make certain health care provider rate increases in consultation with certain groups; requiring the Secretary to submit a certain plan for health care provider rate increases to certain committees of the General Assembly; requiring the Legislative Auditor to conduct an annual audit of the receipts and disbursements of the Fund; requiring the Commissioner to report certain information to the Legislative Policy Committee on or before a certain date each year; repealing a certain provision of law relating to a certain rate increase that would trigger a certain determination by the Insurance Commissioner; authorizing the Commissioner to make a certain determination when a certain rate increase is requested by the Society and when the surplus of the Society is a certain amount; authorizing the Commissioner to reduce a certain rate filing under certain circumstances; repealing a certain provision of law requiring the Society to offer insurance policies directly to policyholders and to offer a premium discount or rebate on those insurance policies; amending the effective date of a certain provision of law relating to the amount of commission to be paid by the Society; repealing a certain provision of law relating to the appointment of the People's Insurance Counsel; providing that the People's Insurance Counsel and certain employees of the People's Insurance Counsel Division may not maintain a certain relationship or hold a certain pecuniary interest; providing that a certain assessment is due and payable in a certain manner; providing for certain fines for failure to pay a certain assessment; requiring the Division to review certain rate increases by certain insurers; clarifying certain

provisions of law relating to depositions by the Division in proceedings before the Commissioner and proceeding in court; requiring the Governor to include in the annual budget certain amounts allocated to the Fund; authorizing the Governor to make a certain amendment through the executive budget amendment process for certain fiscal years; defining certain terms; altering the application of a certain tax imposed on managed care organizations; making this Act an emergency measure; and generally relating to implementation and corrective provisions of the Maryland Patient's Access to Quality Care Act of 2004.

BY repealing and reenacting, with amendments,
Article - Health - General
Section 15-103(b)(18)
Annotated Code of Maryland
(2000 Replacement Volume and 2004 Supplement)

BY repealing and reenacting, with amendments,
Article - Insurance
Section 4-113(a) and 4-401
Annotated Code of Maryland
(2003 Replacement Volume and 2004 Supplement)

BY repealing and reenacting, with amendments,
Article - Insurance
Section 4-405
Annotated Code of Maryland
(2003 Replacement Volume and 2004 Supplement)
(As enacted by Ch. 5 of the Acts of the General Assembly of the 2004 Special Session)

BY repealing
Article - Insurance
Section 19-104.1
Annotated Code of Maryland
(2002 Replacement Volume and 2004 Supplement)
(As enacted by Ch. 5 of the Acts of the General Assembly of the 2004 Special Session)

BY adding to
Article - Insurance
Section 19-801 through 19-808, inclusive, to be under the new subtitle "Subtitle 8. Maryland Health Care Provider Rate Stabilization Fund"; and 24-201(g)
Annotated Code of Maryland

(2002 Replacement Volume and 2004 Supplement)

BY repealing and reenacting, without amendments,
Article - Insurance
Section 24-201(a)
Annotated Code of Maryland
(2002 Replacement Volume and 2004 Supplement)

BY repealing and reenacting, with amendments,
Article - Insurance
Section 24-211(b), 24-212, 24-214, and 27-501(a)
Annotated Code of Maryland
(2002 Replacement Volume and 2004 Supplement)
(As enacted by Ch. 5 of the Acts of the General Assembly of the 2004 Special Session)

BY repealing and reenacting, with amendments,
Article - State Government
Section 6-301, 6-302(c), 6-306, and 6-307(a) and (b)
Annotated Code of Maryland
(2004 Replacement Volume)
(As enacted by Ch. 5 of the Acts of the General Assembly of the 2004 Special Session)

BY repealing and reenacting, without amendments,
Article - State Government
Section 6-302(a)
Annotated Code of Maryland
(2004 Replacement Volume)
(As enacted by Ch. 5 of the Acts of the General Assembly of the 2004 Special Session)

BY adding to
Article - State Government
Section 6-302(f) and 6-304(c)
Annotated Code of Maryland
(2004 Replacement Volume)
(As enacted by Ch. 5 of the Acts of the General Assembly of the 2004 Special Session)

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

**Article - Health - General**

15-103.

(b) (18) (i) The Department shall make capitation payments to each managed care organization as provided in this paragraph.

(ii) In consultation with the Insurance Commissioner, the Secretary shall:

1. Set capitation payments at a level that is actuarially adjusted to the benefits provided; and

2. Actuarially adjust the capitation payments to reflect the relative risk assumed by the managed care organization.

(III) IN ACTUARIALLY ADJUSTING CAPITATION PAYMENTS UNDER SUBPARAGRAPH (II)(2) OF THIS PARAGRAPH, THE SECRETARY, IN CONSULTATION WITH THE INSURANCE COMMISSIONER, SHALL TAKE INTO ACCOUNT, TO THE EXTENT ALLOWED UNDER FEDERAL LAW, THE EXPENSES INCURRED BY THE MANAGED CARE ORGANIZATION APPLICABLE TO THE BUSINESS OF PROVIDING CARE TO ENROLLED INDIVIDUALS.

**Article - Insurance**

4-113.

(a) The Commissioner shall deny a certificate of authority to an applicant or refuse to renew, suspend, or revoke a certificate of authority if:

(1) the action is required by any provision of this article OR BY § 6-304(C) OF THE STATE GOVERNMENT ARTICLE;

(2) the insurer no longer meets the requirements for the certificate of authority because of a deficiency in assets or any other reason;

(3) the business of the insurer is fraudulently conducted;

(4) the insurer is insolvent, or its assets are not sufficient for carrying on its business;

(5) the insurer fails to pay taxes on premiums required under this article;

(6) the insurer willfully fails to provide the Commissioner with required information about medical malpractice insurance issued by the insurer in this State or any other state;

(7) the issuance or renewal of a certificate of authority is contrary to the public interest;

(8) the Commissioner finds that the principal management personnel of the insurer is:

(i) untrustworthy or not of good character; or

(ii) so lacking in insurer managerial experience as to make the proposed operation hazardous to the insurance-buying public or to the insurer's stockholders; or

(9) the Commissioner has good reason to believe that the insurer is affiliated, directly or indirectly, through ownership, control, management, reinsurance transactions, or other insurance or business relations with a person whose business operations are or have been marked by the manipulation of assets, accounts, or reinsurance or by bad faith, to the detriment of insureds, stockholders, or creditors.

4-401.

(a) This section applies to:

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

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

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

(2) each self-insured hospital.

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

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

(2) resulted in:

(i) a final judgment in any amount;

(ii) a settlement in any amount; or

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

(c) A report required under this section shall contain THE INFORMATION REQUIRED UNDER § 4-405 (B) OF THIS SUBTITLE[:

(1) the name and address of the insured;

(2) the policy number of the insured;

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

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

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

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

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

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

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

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

(2) A report that relates to a hospital shall be filed with the Secretary of Health and Mental Hygiene.

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

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

(2) Each report shall be released to the Maryland Health Care Commission.

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

(h) Failure to report [in accordance with this section] TO AN ENTITY SPECIFIED IN SUBSECTION (E)(1), (2), OR (3) OF THIS SECTION shall result in the imposition by a circuit court of a civil penalty of up to $5,000.

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] AN INSURER SUBJECT TO REPORTING UNDER PARAGRAPH (1) OF THIS SUBSECTION SHALL NOTIFY THE COMMISSIONER OF ANY INFORMATION THE INSURER CONSIDERS PROPRIETARY AND THIS INFORMATION SHALL BE TREATED AS CONFIDENTIAL AND MAY NOT BE DISCLOSED BY THE COMMISSIONER.

(b) In addition to the information required under subsection (a) of this section, FOR EACH CLAIM FILED WITH THE DIRECTOR OF THE HEALTH CARE ALTERNATIVE DISPUTE RESOLUTION OFFICE UNDER § 3-2A-04 OF THE COURTS ARTICLE, each insurer providing professional liability insurance to a health care provider in the State shall submit to the Commissioner the following information:

(1) (i) name of insurer;

(ii) name of insurer group;

(iii) claim file identification;

(iv) name of person completing form;

(v) telephone number (area code); and

(vi) date form completed;

(2) (i) date of injury;

(ii) date injury reported to insurer; and

(iii) date claim closed;

(3) age AND GENDER of insured person at time of injury;

[(4) whether the injured person was employed at the time of injury;

(5)] (4) (i) type of injury; [and]

(ii) description of injury; AND

(III) IF THE CLAIM IS AGAINST A HEALTH CARE PROVIDER COVERED UNDER A POLICY ISSUED OR DELIVERED BY THE INSURER COMPLETING THIS FORM, THE NAME OF THE HEALTH FACILITY WHERE THE INJURY OCCURRED;

[(6)] (5) (i) type of medical professional liability policy;

[(ii) hospital or related institution classification exposure by number of beds;

(iii) hospital or related institution classification exposure by number of outpatients;]

[(iv)] (II) IF KNOWN, whether the patient was:

1. an inpatient;

2. an emergency room outpatient; or

3. other outpatient;

[(v)] (III) physician ISO classification, OR EQUIVALENT CLASSIFICATION;

[(vi) other health care provider, including dental ISO classification;

(vii)] (IV) health care provider name and license number; and

[(viii)] (V) policy limits for:

1. each claim or medical incident; and

2. annual aggregate;

[(7)] (6) (i) [state] IF KNOWN, THE FACILITY, OFFICE, OR COUNTY where injury occurred;

[(ii) if the injury occurred in Maryland, the county where injury occurred;

(iii) date of filing suit, if any;] and

[(iv)] (II) [if the injury occurred in Maryland,] the CASE NUMBER AND THE NAME AND LOCATION OF THE COURT [county where the suit was filed and the case was tried];

[(8) (i) whether the plaintiff was represented by an attorney;

(ii) whether the insured was represented by an attorney and, if so, at whose expense; and

(iii) whether the insurer was represented by a separate attorney;

(9)] (7) (i) whether settlement was reached or award was made at one of the following stages:

1. arbitration;

2. mediation;

3. before suit was filed;

4. after suit was filed, but before trial;

5. during trial, but before court verdict;

6. court verdict;

7. after verdict; or

8. after appeal was filed;

(ii) if settlement was reached or award was made by court verdict, whether the result was:

1. directed verdict for plaintiff;

2. directed verdict for defendant;

3. judgment notwithstanding the verdict for the plaintiff;

4. judgment notwithstanding the verdict for the defendant;

5. judgment for the plaintiff;

6. judgment for the defendant;

7. for plaintiff, after appeal;

8. for defendant, after appeal; or

9. any other;

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

(iv) if case did go to trial, whether the case tried by a jury;

[(10) (i) whether there were defendants other than the insured included in the original claim or an amended version of the claim and, if so, how many other defendants there were and whether the other defendants were:

1. physicians or surgeons; or

2. hospitals or other health care providers;

(ii) if a physician or surgeon was a defendant, the defendant's name and license number; and

(iii) if a hospital or other health care provider was a defendant, the defendant's name and license number;

(11) (i) if case was tried to verdict, and if applicable, the percentage of fault assigned to your insured;

(ii) if claim was settled, and if applicable, an estimate of the percentage of fault for the insured; and

(iii) the percentage of the final award or settlement paid by the insurer;

(12)] (8) with respect to the total amount paid to the claimant:

(i) the amount paid by the insurer;

(ii) the amount paid by the insured due to retention or deductible;

(iii) IF KNOWN, the amount paid by an excess carrier;

(iv) IF KNOWN, the amount paid by the insured due to settlement or award in excess of policy limits;

(v) IF KNOWN, the amount paid by other defendants or contributors; and

(vi) the total amount of settlement or award;

[(13) (i) whether there were collateral sources, such as medical insurance, disability insurance, Social Security disability, or workers' compensation available to the injured party; and

(ii) if collateral sources were available, the type and amount;]

[(14)] (9) a summary of the occurrence from which the claim or action arose, including:

(i) [the final diagnosis for which treatment was sought or rendered, including the patient's actual condition;]

[(ii)] a description of the misdiagnosis OR ALLEGED MISDIAGNOSIS made, if any, of the patient's actual condition;

[(iii)] (II) [the operation, diagnostic, or treatment procedure] A DESCRIPTION OF THE PROCEDURE GIVING RISE TO THE CLAIM; AND

[(iv)] (III) a description of the principal injury giving rise to the claim; [and

(v) the safety management steps that have been taken by the insured to prevent similar occurrences or injuries in the future;]

[(15)] (10) (i) whether a structured settlement or periodic payment was used in closing this claim; and

(ii) if a structured settlement or periodic payment was used:

1. [whether the structured settlement or periodic payment applied to plaintiff's attorney's fees as well as indemnity payments;]

[2.] the amount of immediate payment;

[3.] 2. the present value of the projected total future payout (price of annuity if purchased); and

[4.] 3. the projected total future payout;

[(16)] (11) [the injured person's:

(i) medical expenses through date of closing;

(ii) anticipated future medical expense;

(iii) wage loss through date of closing;

(iv) anticipated future wage loss;

(v) other expenses through date of closing; and

(vi) anticipated future other expenses;] IF A NEUTRAL EXPERT WITNESS IS EMPLOYED UNDER § 3-2A-09(D)(2) OF THE COURTS AND JUDICIAL PROCEEDINGS ARTICLE, THE FINDINGS OF A NEUTRAL EXPERT WITNESS AS TO A PLAINTIFF'S FUTURE MEDICAL EXPENSES OR FUTURE LOSS OF EARNINGS;

[(17)] (12) IF CASE WAS TRIED TO VERDICT, the amount of noneconomic damages;

[(18) (i) the actual amount of prejudgment interest, if any, paid on award; and

(ii) the estimated amount of prejudgment interest, if any, reflected in settlement;] and

[(19)] (13) (i) [the amount paid to outside defense counsel] THE TOTAL ALLOCATED LOSS ADJUSTMENT EXPENSE BY FEES AND EXPENSES PAID TO DEFENSE COUNSEL; AND

(ii) [the amount of other allocated loss adjustment expenses, such as court costs and stenographer's fees; and]

[(iii)] the total allocated loss adjustment expense.

(c) The Commissioner:

(1) SHALL ADOPT REGULATIONS ON THE SUBMISSION OF INFORMATION DESCRIBED IN THIS SECTION; AND

(2) 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.

(d) FAILURE TO REPORT IN ACCORDANCE WITH THIS SECTION SHALL RESULT IN THE IMPOSITION BY THE COMMISSIONER OF A CIVIL PENALTY OF UP TO $5,000.

(E) The Commissioner shall report, in accordance with § 2-1246 of the State Government Article, the Commissioner's findings as to the impact of Chapter 5 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.

[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;

(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 2005, $6,000,000 to the Medical Assistance Program Account;

(ii) 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;

(iii) 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;

(iv) 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;

(v) 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

(vi) in fiscal year 2010 and annually thereafter, 100% to the Medical Assistance Program Account.

(j) (1) The Commissioner may enter into four 1-year agreements with a medical professional liability insurer to:

(i) subject to paragraph (2) of this subsection, 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;

(ii) 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;

(iii) 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

(iv) 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.

(2) For an agreement under paragraph (1)(i) of this subsection, the base premium allowed under an approved rate filing, less the value of the guarantee provided under subsection (m) of this section for each specialty, may not exceed the base premium for the previous 12-month period by more than 5%.

(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) (1) 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.

(2) A disbursement may not be made from the Fund to the Medical Mutual Liability Insurance Society of Maryland during any period for which the Commissioner has determined, under § 24-212 of this article, that the surplus of the Society is excessive.

(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) (i) 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.

(ii) 1. Disbursements from the Medical Assistance Program Account shall be made to increase fee-for-service health care provider rates and rates paid to managed care organizations for services identified by the Department in consultation with managed care organizations, Maryland Hospital Association, Med Chi, American Academy of Pediatrics, Maryland Chapter, and the American College of Emergency Room Physicians, Maryland Chapter.

2. The Department shall submit its plan for Medicaid reimbursement rate increases to the Senate Budget and Taxation, Senate Finance, House Appropriations, and House Health and Government Operations committees prior to adopting regulations implementing the increase.

(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.]

SUBTITLE 8. MARYLAND HEALTH CARE PROVIDER RATE STABILIZATION FUND.

19-801.

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

(B) "FUND" MEANS THE MARYLAND HEALTH CARE PROVIDER RATE STABILIZATION FUND.

(C) (1) "HEALTH CARE PROVIDER" MEANS A HEALTH CARE PRACTITIONER:

(I) LICENSED UNDER TITLE 14 OF THE HEALTH OCCUPATIONS ARTICLE; OR

(II) CERTIFIED AS A NURSE MIDWIFE UNDER TITLE 8 OF THE HEALTH OCCUPATIONS ARTICLE.

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

(I) A RESPIRATORY CARE PRACTITIONER;

(II) A RADIATION ONCOLOGY/THERAPY TECHNOLOGIST;

(III) A MEDICAL RADIATION TECHNOLOGIST; OR

(IV) A NUCLEAR MEDICINE TECHNOLOGIST.

(D) "INCREASED RATE FACTOR" MEANS:

(1) FOR MEDICAL PROFESSIONAL LIABILITY INSURANCE POLICIES SUBJECT TO RATES THAT WERE APPROVED FOR AN INITIAL EFFECTIVE DATE ON OR AFTER JANUARY 1, 2005, BUT PRIOR TO JANUARY 1, 2006, 105% OF THE APPROVED RATES IN EFFECT 1 YEAR PRIOR TO THE EFFECTIVE DATE OF THE POLICY; AND

(2) FOR POLICIES EFFECTIVE FOR THE 3 YEARS SUBSEQUENT TO THE PERIOD SET FORTH IN PARAGRAPH (1) OF THIS SUBSECTION, A PERCENTAGE, AS DETERMINED ANNUALLY BY THE COMMISSIONER, OF THE APPROVED RATES IN EFFECT 1 YEAR PRIOR TO THE EFFECTIVE DATE OF THE POLICY.

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

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

(1) HOLDS A CERTIFICATE OF AUTHORITY ISSUED BY THE COMMISSIONER UNDER § 4-109 OR § 4-112 OF THIS ARTICLE; AND

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

(G) "SECRETARY" MEANS THE SECRETARY OF HEALTH AND MENTAL HYGIENE.

(H) "STABILIZED RATE" MEANS THE APPROVED RATE BY CLASSIFICATION, GEOGRAPHIC TERRITORY, AND THE POLICYHOLDER'S CLAIMS MADE YEAR USING THE RATE TABLES IN EFFECT 1 YEAR PRIOR TO THE EFFECTIVE DATE OF THE POLICY, MULTIPLIED BY THE INCREASED RATE FACTOR.

19-802.

(A) THERE IS A MARYLAND HEALTH CARE PROVIDER RATE STABILIZATION FUND.

(B) THE PURPOSES OF THE FUND ARE TO:

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

(2) INCREASE FEE-FOR-SERVICE RATES PAID BY THE MARYLAND MEDICAL ASSISTANCE PROGRAM TO HEALTH CARE PROVIDERS IDENTIFIED UNDER § 19-807 OF THIS SUBTITLE;

(3) PAY MANAGED CARE ORGANIZATION HEALTH CARE PROVIDERS IDENTIFIED UNDER § 19-807 OF THIS SUBTITLE CONSISTENT WITH FEE-FOR-SERVICE HEALTH CARE PROVIDER RATES;

(4) INCREASE CAPITATION PAYMENTS TO MANAGED CARE ORGANIZATIONS PARTICIPATING IN THE MARYLAND MEDICAL ASSISTANCE

PROGRAM CONSISTENT WITH § 15-103(B)(18) OF THE HEALTH - GENERAL ARTICLE; AND

(5) DURING THE PERIOD THAT AN ALLOCATION IS MADE TO THE RATE STABILIZATION ACCOUNT, SUBSIDIZE UP TO $150,000 ANNUALLY TO PROVIDE FOR THE COSTS INCURRED BY THE COMMISSIONER TO ADMINISTER THE FUND.

(C) THE FUND SHALL CONSIST OF:

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

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

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

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

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

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

(G) THE FUND COMPRISES:

(1) THE RATE STABILIZATION ACCOUNT FROM WHICH DISBURSEMENTS SHALL BE MADE TO PAY FOR HEALTH CARE PROVIDER RATE SUBSIDIES; AND

(2) THE MEDICAL ASSISTANCE PROGRAM ACCOUNT FROM WHICH DISBURSEMENTS SHALL BE MADE TO:

(I) PROVIDE AN INCREASE IN FEE-FOR-SERVICE HEALTH CARE PROVIDER RATES PAID BY THE MARYLAND MEDICAL ASSISTANCE PROGRAM;

(II) PROVIDE AN INCREASE FOR MANAGED CARE ORGANIZATION HEALTH CARE PROVIDERS CONSISTENT WITH FEE-FOR-SERVICE HEALTH CARE PROVIDER RATE INCREASES;

(III) PROVIDE AN INCREASE IN CAPITATION PAYMENTS TO MANAGED CARE ORGANIZATIONS PARTICIPATING IN THE MARYLAND MEDICAL ASSISTANCE PROGRAM CONSISTENT WITH § 15-103(B)(18) OF THE HEALTH - GENERAL ARTICLE; AND

(IV) AFTER 2009, MAINTAIN RATES FOR HEALTH CARE PROVIDERS AND GENERALLY TO SUPPORT THE OPERATIONS OF THE MARYLAND MEDICAL ASSISTANCE PROGRAM.

19-803.

(A) THE COMMISSIONER SHALL ADMINISTER THE FUND.

(B) 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) DURING THE PERIOD AN ALLOCATION IS MADE TO THE RATE STABILIZATION ACCOUNT, THE COMMISSIONER MAY DISTRIBUTE UP TO $150,000 ANNUALLY FROM THE REVENUE ESTIMATED TO BE RECEIVED BY THE FUND IN A FISCAL YEAR TO PROVIDE FOR THE COSTS INCURRED BY THE COMMISSIONER TO ADMINISTER THE FUND;

(3) AFTER DISTRIBUTING THE AMOUNT REQUIRED UNDER PARAGRAPH (2) OF THIS SUBSECTION, THE COMMISSIONER SHALL ALLOCATE THE REVENUE AND UNALLOCATED BALANCE OF THE FUND ACCORDING TO THE FOLLOWING SCHEDULE:

(I) IN FISCAL YEAR 2005, $3,500,000 TO THE MEDICAL ASSISTANCE PROGRAM ACCOUNT;

(II) IN FISCAL YEAR 2006:

1. $52,000,000 TO THE RATE STABILIZATION ACCOUNT TO PAY FOR HEALTH CARE PROVIDER RATE REDUCTIONS, CREDITS, OR REFUNDS IN CALENDAR YEAR 2005; AND

2. $30,000,000 TO THE MEDICAL ASSISTANCE PROGRAM ACCOUNT;

(III) IN FISCAL YEAR 2007:

1. $45,000,000 TO THE RATE STABILIZATION ACCOUNT TO PAY FOR HEALTH CARE PROVIDER RATE REDUCTIONS, CREDITS, OR REFUNDS IN CALENDAR YEAR 2006; AND

2. $45,000,000 TO THE MEDICAL ASSISTANCE PROGRAM ACCOUNT;

(IV) IN FISCAL YEAR 2008:

1. $35,000,000 TO THE RATE STABILIZATION ACCOUNT TO PAY FOR HEALTH CARE PROVIDER RATE REDUCTIONS, CREDITS, OR REFUNDS IN CALENDAR YEAR 2007; AND

2. $65,000,000 TO THE MEDICAL ASSISTANCE PROGRAM ACCOUNT;

(V) IN FISCAL YEAR 2009:

1. $25,000,000 TO THE RATE STABILIZATION ACCOUNT TO PAY FOR HEALTH CARE PROVIDER RATE REDUCTIONS, CREDITS, OR REFUNDS IN CALENDAR YEAR 2008; AND

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

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

(C) (1) ANY REVENUE REMAINING IN THE FUND AFTER FISCAL YEAR 2005 SHALL REMAIN IN THE FUND UNTIL OTHERWISE DIRECTED BY LAW.

(2) IF IN ANY FISCAL YEAR THE ALLOCATIONS MADE UNDER THIS SECTION EXCEED THE REVENUES ESTIMATED FOR THAT YEAR, AMOUNTS AVAILABLE IN THE UNALLOCATED BALANCE OF THE FUND MAY BE SUBSTITUTED TO THE EXTENT OF A FUND DEFICIT.

(D) (1) IF A MEDICAL PROFESSIONAL LIABILITY INSURER PROVIDES COVERAGE TO A HEALTH CARE PROVIDER AND THAT INSURER DID NOT EARN PREMIUMS IN THE PREVIOUS CALENDAR YEAR, THAT INSURER SHALL BE ALLOCATED 5% OF THE BALANCE OF THE RATE STABILIZATION ACCOUNT OR A LESSER AMOUNT AS DETERMINED BY THE COMMISSIONER.

(2) IF AN ALLOCATION IS MADE UNDER PARAGRAPH (1) OF THIS SUBSECTION, THE FUNDS AVAILABLE TO OTHER MEDICAL PROFESSIONAL LIABILITY INSURERS SHALL BE REDUCED ON A PRO RATA BASIS.

19-804.

(A) THE ORDER OF PREFERENCE FOR DISTRIBUTION FROM THE FUND SHALL BE AS FOLLOWS:

(1) DISBURSEMENTS FROM THE RATE STABILIZATION ACCOUNT TO SUBSIDIZE HEALTH CARE PROVIDER RATES UNDER § 19-805 OF THIS SUBTITLE;

(2) DISBURSEMENTS FROM THE MEDICAL ASSISTANCE PROGRAM ACCOUNT SUFFICIENT TO:

(I) PAY FOR INCREASE RATES TO HEALTH CARE PROVIDERS IDENTIFIED UNDER § 19-807 (B)(2) OF THIS SUBTITLE; AND

(II) TO PAY MANAGED CARE ORGANIZATION HEALTH CARE PROVIDERS IDENTIFIED UNDER § 19-807 (B)(2) OF THIS SUBTITLE CONSISTENT WITH THE FEE-FOR-SERVICE HEALTH CARE PROVIDER RATE INCREASES;

(3) DISBURSEMENTS TO MAINTAIN THE INCREASE IN HEALTH CARE PROVIDER REIMBURSEMENTS UNDER § 19-807 (B)(2) OF THIS SUBTITLE;

(4) DISBURSEMENTS TO INCREASE CAPITATION PAYMENTS TO MANAGED CARE ORGANIZATIONS PARTICIPATING IN THE MARYLAND MEDICAL ASSISTANCE PROGRAM CONSISTENT WITH § 15-103(B)(18) OF THE HEALTH - GENERAL ARTICLE; AND

(5) DISBURSEMENTS FROM THE MEDICAL ASSISTANCE PROGRAM ACCOUNT TO:

(I) INCREASE FEE-FOR-SERVICE HEALTH CARE PROVIDER RATES UNDER § 19-807 OF THIS SUBTITLE; AND

(II) TO PAY MANAGED CARE ORGANIZATION HEALTH CARE PROVIDERS CONSISTENT WITH FEE-FOR-SERVICE HEALTH CARE PROVIDER RATES UNDER § 19-807 (B)(3) OF THIS SUBTITLE.

(B) DISBURSEMENTS FROM THE RATE STABILIZATION ACCOUNT TO A MEDICAL PROFESSIONAL LIABILITY INSURER MAY NOT EXCEED THE AMOUNT NECESSARY TO PROVIDE A RATE REDUCTION, CREDIT, OR REFUND TO HEALTH CARE PROVIDERS.

(C) (1) PORTIONS OF THE RATE STABILIZATION ACCOUNT THAT EXCEED THE AMOUNT NECESSARY TO PAY FOR HEALTH CARE PROVIDER SUBSIDIES SHALL REMAIN IN THE RATE STABILIZATION ACCOUNT TO BE USED:

(I) TO PAY FOR HEALTH CARE PROVIDER SUBSIDIES IN CALENDAR YEARS 2006 THROUGH 2008; AND

(II) AFTER THE FISCAL YEAR 2009 ALLOCATION TO THE RATE STABILIZATION ACCOUNT UNDER § 19-803 (B) OF THIS SUBTITLE, BY THE MEDICAL ASSISTANCE PROGRAM ACCOUNT FOR THE PURPOSES SPECIFIED UNDER § 19-807 (B) OF THIS SUBTITLE.

(2) ANY DISBURSEMENTS FROM THE RATE STABILIZATION ACCOUNT TO A MEDICAL PROFESSIONAL LIABILITY INSURER THAT IS NOT USED TO PROVIDE A RATE REDUCTION, CREDIT, OR REFUND TO A HEALTH CARE PROVIDER SHALL BE RETURNED TO THE STATE TREASURER FOR REVERSION TO THE FUND.

(D) A MEDICAL PROFESSIONAL LIABILITY INSURER SHALL REDUCE THE SUBSIDY PAID TO EACH HEALTH CARE PROVIDER ELECTING TO RECEIVE A SUBSIDY IF THE BALANCE OF THE RATE STABILIZATION ACCOUNT IS INSUFFICIENT TO PAY HEALTH CARE PROVIDER SUBSIDIES.

19-805.

(A) ON AT LEAST AN ANNUAL BASIS, A MEDICAL PROFESSIONAL LIABILITY INSURER SEEKING REIMBURSEMENT FROM THE RATE STABILIZATION ACCOUNT SHALL:

(1) DETERMINE THE STABILIZED RATE FOR EACH POLICYHOLDER; AND

(2) SEND A WRITTEN NOTICE TO EACH POLICYHOLDER STATING:

(I) THE AMOUNT OF THE ANNUAL SUBSIDY PROVIDED BY THE STATE; AND

(II) THE PROCEDURE A HEALTH CARE PROVIDER SHALL FOLLOW IF ELECTING NOT TO RECEIVE A RATE REDUCTION, CREDIT, OR REFUND.

(B) SUBJECT TO § 19-804 (D) OF THIS SUBTITLE AND SUBSECTION (C) OF THIS SECTION, THE SUBSIDY PROVIDED TO EACH POLICYHOLDER SHALL EQUAL THE DIFFERENCE BETWEEN:

(1) THE AMOUNT OF THE ANNUAL BASE PREMIUM RATE CHARGED ON THE POLICY BY THE INSURER AT THE APPROVED RATE; AND

(2) THE AMOUNT OF THE ANNUAL BASE PREMIUM RATE CHARGED BY THE INSURER ON THE POLICY AT THE STABILIZED RATE.

(C) THE STATE SUBSIDY CALCULATED UNDER SUBSECTION (B) OF THIS SECTION MAY NOT INCLUDE THE AMOUNT OF A RATE INCREASE RESULTING FROM A PREMIUM SURCHARGE OR THE LOSS OF A DISCOUNT DUE TO A HEALTH CARE PROVIDER'S LOSS EXPERIENCE.

(D) A HEALTH CARE PROVIDER MAY ELECT NOT TO RECEIVE A RATE REDUCTION, CREDIT, OR REFUND BY:

(1) NOTIFYING THE MEDICAL PROFESSIONAL LIABILITY INSURER WITHIN 15 DAYS OF RECEIVING THE NOTICE UNDER SUBSECTION (A) OF THIS SECTION OF THE HEALTH CARE PROVIDER'S INTENT NOT TO ACCEPT A RATE REDUCTION, CREDIT, OR REFUND; AND

(2) PAYING, EITHER IN FULL, OR ON AN INSTALLMENT BASIS, THE AMOUNT OF PREMIUM BILLED BY THE MEDICAL PROFESSIONAL LIABILITY INSURER.

(E) (1) ON AT LEAST AN ANNUAL BASIS, A MEDICAL PROFESSIONAL LIABILITY INSURER SEEKING REIMBURSEMENT FROM THE RATE STABILIZATION ACCOUNT ON BEHALF OF HEALTH CARE PROVIDERS SHALL APPLY TO THE RATE STABILIZATION ACCOUNT ON A FORM AND IN A MANNER APPROVED BY THE COMMISSIONER.

(2) THE COMMISSIONER SHALL ADOPT REGULATIONS THAT SPECIFY THE INFORMATION THAT MEDICAL PROFESSIONAL LIABILITY INSURERS SHALL SUBMIT TO RECEIVE MONEY FROM THE RATE STABILIZATION ACCOUNT.

(3) THE INFORMATION REQUIRED SHALL INCLUDE:

(I) BY HEALTH CARE PROVIDER CLASSIFICATION AND GEOGRAPHIC TERRITORY, THE AMOUNT OF THE BASE PREMIUM RATE CHARGED BY THE INSURER AT THE APPROVED RATE;

(II) BY HEALTH CARE PROVIDER CLASSIFICATION AND GEOGRAPHIC TERRITORY, THE AMOUNT OF THE BASE PREMIUM RATE CHARGED BY THE INSURER AT THE STABILIZED RATE;

(III) THE NUMBER OF HEALTH CARE PROVIDERS IN EACH CLASSIFICATION AND GEOGRAPHIC TERRITORY;

(IV) THE TOTAL AMOUNT OF REIMBURSEMENT REQUESTED FROM THE RATE STABILIZATION ACCOUNT;

(V) THE NAME, CLASSIFICATION, AND GEOGRAPHIC TERRITORY OF EACH HEALTH CARE PROVIDER ELECTING NOT TO RECEIVE A RATE REDUCTION, CREDIT, OR REFUND; AND

(VI) ANY OTHER INFORMATION THE COMMISSIONER CONSIDERS NECESSARY TO DISBURSE MONEY FROM THE RATE STABILIZATION ACCOUNT.

(F) ON A QUARTERLY BASIS AND WITHIN 60 DAYS OF RECEIPT OF A REQUEST FOR REIMBURSEMENT FROM THE FUND, THE COMMISSIONER SHALL DISBURSE MONEY FROM THE RATE STABILIZATION ACCOUNT TO MEDICAL PROFESSIONAL LIABILITY INSURERS TO BE USED TO PROVIDE A RATE REDUCTION, CREDIT, OR REFUND TO HEALTH CARE PROVIDERS.

(G) IN ANTICIPATION OF REIMBURSEMENT OR ON REIMBURSEMENT FROM THE RATE STABILIZATION ACCOUNT, A MEDICAL PROFESSIONAL LIABILITY INSURER SHALL PROVIDE A RATE REDUCTION, CREDIT, OR REFUND TO A POLICYHOLDER AS FOLLOWS:

(1) FOR PREMIUMS PAID ON AN INSTALLMENT BASIS, THE RATE REDUCTION OR CREDIT SHALL BE APPLIED AGAINST THE BASE PREMIUM RATE DUE ON THE NEXT INSTALLMENT; AND

(2) IF THE AMOUNT OF THE RATE REDUCTION OR CREDIT IS MORE THAN THE AMOUNT DUE ON THE NEXT INSTALLMENT, OR IF A POLICY IS PAID IN FULL, THE POLICYHOLDER MAY ELECT THAT EITHER A REFUND BE ISSUED OR THAT A CREDIT BE APPLIED AGAINST THE BASE PREMIUM RATE DUE ON THE POLICYHOLDER'S NEXT RENEWAL.

(H) DURING THE PERIOD IN WHICH DISBURSEMENTS ARE MADE FROM THE RATE STABILIZATION ACCOUNT TO PAY FOR HEALTH CARE PROVIDER RATE REDUCTIONS, CREDITS, OR REFUNDS:

(1) A DISBURSEMENT FROM THE RATE STABILIZATION ACCOUNT TO A MEDICAL PROFESSIONAL LIABILITY INSURER CONDUCTING BUSINESS AS A MUTUAL COMPANY SHALL BE REDUCED BY THE VALUE OF A DIVIDEND THAT MAY BE ISSUED BY THE INSURER; AND

(2) A DISBURSEMENT MAY NOT BE MADE FROM THE RATE STABILIZATION ACCOUNT TO THE MEDICAL MUTUAL LIABILITY INSURANCE SOCIETY OF MARYLAND DURING ANY PERIOD FOR WHICH THE COMMISSIONER HAS

DETERMINED, UNDER § 24-212 OF THIS ARTICLE, THAT THE SURPLUS OF THE SOCIETY IS EXCESSIVE.

(I) THE COMMISSIONER OR THE COMMISSIONER'S DESIGNEE SHALL CONDUCT AN ANNUAL AUDIT TO VERIFY THE INFORMATION SUBMITTED BY A MEDICAL PROFESSIONAL LIABILITY INSURER APPLYING FOR REIMBURSEMENT FROM THE RATE STABILIZATION ACCOUNT.

19-806.

(A) ON OR BEFORE NOVEMBER 1 OF EACH YEAR FROM 2005 THROUGH 2007, THE COMMISSIONER SHALL DETERMINE THE INCREASED RATE FACTOR FOR THE FOLLOWING CALENDAR YEAR BASED ON THE TOTAL DOLLAR AMOUNT ALLOCATED TO THE RATE STABILIZATION ACCOUNT FOR THAT CALENDAR YEAR.

(B) ON OR BEFORE DECEMBER 1 OF EACH YEAR FROM 2005 THROUGH 2007, THE COMMISSIONER SHALL:

(1) ISSUE A BULLETIN ADVISING MEDICAL PROFESSIONAL LIABILITY INSURERS OF THE INCREASED RATE FACTOR FOR THE FOLLOWING CALENDAR YEAR; AND

(2) REPORT TO THE LEGISLATIVE POLICY COMMITTEE, IN ACCORDANCE WITH § 2-1246 OF THE STATE GOVERNMENT ARTICLE, ON:

(I) THE INCREASED RATE FACTOR FOR THE FOLLOWING CALENDAR YEAR;

(II) THE MONEY AVAILABLE TO EACH MEDICAL PROFESSIONAL LIABILITY INSURER; AND

(III) THE NUMBER OF HEALTH CARE PROVIDERS BY CLASSIFICATION AND GEOGRAPHIC TERRITORY ELIGIBLE TO RECEIVE A SUBSIDY FROM THE RATE STABILIZATION ACCOUNT.

19-807.

(A) THE COMMISSIONER SHALL DISBURSE MONEY FROM THE MEDICAL ASSISTANCE PROGRAM ACCOUNT TO THE SECRETARY.

(B) (1) IN FISCAL YEAR 2005, DISBURSEMENTS FROM THE MEDICAL ASSISTANCE PROGRAM ACCOUNT SHALL BE USED BY THE SECRETARY TO INCREASE CAPITATION RATES PAID TO MANAGED CARE ORGANIZATIONS.

(2) BEGINNING IN FISCAL YEAR 2006 AND ANNUALLY THEREAFTER TO MAINTAIN THE RATE INCREASES PROVIDED UNDER THIS PARAGRAPH, DISBURSEMENTS FROM THE MEDICAL ASSISTANCE PROGRAM ACCOUNT OF $15,000,000 SHALL BE USED BY THE SECRETARY TO INCREASE FEE-FOR-SERVICE HEALTH CARE PROVIDER RATES AND TO PAY MANAGED CARE ORGANIZATION

HEALTH CARE PROVIDERS CONSISTENT WITH FEE-FOR-SERVICE HEALTH CARE PROVIDER RATES FOR PROCEDURES COMMONLY PERFORMED BY:

(I) OBSTETRICIANS;

(II) NEUROSURGEONS;

(III) ORTHOPEDIC SURGEONS; AND

(IV) EMERGENCY MEDICINE PHYSICIANS.

(3) PORTIONS OF THE MEDICAL ASSISTANCE PROGRAM ACCOUNT THAT EXCEED THE AMOUNT PROVIDED UNDER PARAGRAPH (2) OF THIS SUBSECTION SHALL BE USED BY THE SECRETARY ONLY TO:

(I) INCREASE CAPITATION PAYMENTS TO MANAGED CARE ORGANIZATIONS CONSISTENT WITH § 15-103(B)(18) OF THE HEALTH - GENERAL ARTICLE;

(II) INCREASE FEE-FOR-SERVICE HEALTH CARE PROVIDER RATES;

(III) PAY MANAGED CARE ORGANIZATION HEALTH CARE PROVIDERS CONSISTENT WITH THE FEE-FOR-SERVICE HEALTH PROVIDER RATES; AND

(IV) AFTER FISCAL YEAR 2009:

1. MAINTAIN INCREASED CAPITATION PAYMENTS TO MANAGED CARE ORGANIZATIONS;

2. MAINTAIN INCREASED RATES FOR HEALTH CARE PROVIDERS; AND

3. SUPPORT GENERALLY THE OPERATIONS OF THE MARYLAND MEDICAL ASSISTANCE PROGRAM.

(C) (1) HEALTH CARE PROVIDER RATE INCREASES UNDER SUBSECTION (B)(2) AND (3)(II), (III), AND (IV)2 OF THIS SECTION SHALL BE DETERMINED BY THE SECRETARY IN CONSULTATION WITH MANAGED CARE ORGANIZATIONS, THE MARYLAND HOSPITAL ASSOCIATION, THE MARYLAND STATE MEDICAL SOCIETY, THE AMERICAN ACADEMY OF PEDIATRICS, MARYLAND CHAPTER, AND THE AMERICAN COLLEGE OF EMERGENCY ROOM PHYSICIANS, MARYLAND CHAPTER.

(2) THE SECRETARY SHALL SUBMIT THE PLAN FOR MEDICAID HEALTH CARE PROVIDER RATE INCREASES UNDER PARAGRAPH (1) OF THIS SUBSECTION TO THE SENATE BUDGET AND TAXATION COMMITTEE, SENATE FINANCE COMMITTEE, HOUSE APPROPRIATIONS COMMITTEE, AND HOUSE HEALTH AND GOVERNMENT OPERATIONS COMMITTEE PRIOR TO ADOPTING THE REGULATIONS IMPLEMENTING THE INCREASE.

19-808.

(A) EACH YEAR THE OFFICE OF LEGISLATIVE AUDITS SHALL AUDIT THE RECEIPTS AND DISBURSEMENTS OF THE FUND AND THE COMMISSIONER SHALL INCLUDE THE AUDIT AS A PART OF THE ANNUAL REPORT REQUIRED UNDER SUBSECTION (C) OF THIS SECTION.

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

(C) ON OR BEFORE MARCH 15 OF EACH YEAR, THE COMMISSIONER SHALL REPORT TO THE LEGISLATIVE POLICY COMMITTEE, IN ACCORDANCE WITH § 2-1246 OF THE STATE GOVERNMENT ARTICLE, ON:

(1) FOR EACH YEAR THAT AN ALLOCATION IS MADE TO THE RATE STABILIZATION ACCOUNT:

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

(II) BY CLASSIFICATION AND GEOGRAPHIC TERRITORY, THE AMOUNT OF MONEY DISBURSED TO MEDICAL PROFESSIONAL LIABILITY INSURERS ON BEHALF OF HEALTH CARE PROVIDERS DURING THE PREVIOUS CALENDAR YEAR;

(III) BY CLASSIFICATION AND GEOGRAPHIC TERRITORY, THE NUMBER OF HEALTH CARE PROVIDERS ELECTING NOT TO RECEIVE A RATE REDUCTION, CREDIT, OR REFUND IN THE PREVIOUS CALENDAR YEAR; AND

(IV) THE AMOUNT OF MONEY AVAILABLE IN THE RATE STABILIZATION ACCOUNT ON THE LAST DAY OF THE PREVIOUS CALENDAR YEAR;

(2) THE AMOUNT OF MONEY AVAILABLE IN THE FUND AND THE MEDICAL ASSISTANCE PROGRAM ACCOUNT ON THE LAST DAY OF THE PREVIOUS CALENDAR YEAR;

(3) (I) THE AMOUNT OF MONEY DISBURSED TO THE MARYLAND MEDICAL ASSISTANCE PROGRAM UNDER § 19-807 OF THIS SECTION;

(II) THE AMOUNT OF INCREASE IN FEE-FOR-SERVICE HEALTH CARE PROVIDER RATES; AND

(III) THE AMOUNT OF INCREASE IN CAPITATION PAYMENTS TO MANAGED CARE ORGANIZATIONS; AND

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

24-201.

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

(G) "SURPLUS" DOES NOT INCLUDE DEBT OF THE SOCIETY INCURRED IN ACCORDANCE WITH § 3-116(B) OF THIS ARTICLE TO ENABLE IT TO COMPLY WITH A SURPLUS REQUIREMENT.

24-211.

(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.]

24-212.

(a) [Notwithstanding any other provision of this article, the Commissioner may determine that the surplus of the Society is excessive if:

(1) the total surplus is greater than the appropriate risk based capital requirements, as determined by the Commissioner, for the immediately preceding calendar year; and

(2) after a hearing, the Commissioner determines that the surplus is unreasonably large.] IF THE SOCIETY REQUESTS A RATE INCREASE OF MORE THAN 7.5% AND, AT THE TIME OF THE RATE FILING, THE SOCIETY'S SURPLUS IS MORE THAT 500% OF ITS AUTHORIZED CONTROL LEVEL RISK-BASED CAPITAL, THE COMMISSIONER MAY DETERMINE WHETHER THE SOCIETY'S SURPLUS IS EXCESSIVE.

(b) If AFTER A HEARING, the Commissioner [has determined] DETERMINES that the surplus [of the Society] is excessive, the Commissioner [shall not approve a rate increase sought by the Society until the Commissioner determines that the surplus of the Society is no longer excessive] MAY ORDER THE RATES FILED TO BE REDUCED.

24-214.

[(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, the Society shall:

(1) offer policyholders and potential policyholders the ability to purchase and renew coverage directly from the Society; 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 Society would have paid an insurance producer to sell the same policy less 1% for administrative expense.

(c)] [Beginning January 1, 2005] FOR POLICIES THAT TAKE EFFECT ON OR AFTER JANUARY 11, 2005 AND until December 31, 2009, [an authorized insurer that issues policies of medical professional liability insurance in the State]THE SOCIETY may not pay a commission at a rate that exceeds 5% of the premium.

27-501.

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

(2) [(i) This paragraph does not apply to a medical professional liability insurer or insurance producer that issues or delivers a policy in the State to a health care provider who has been licensed for more than 3 years by the appropriate State licensing board for the health care provider.

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

**Article - State Government**

6-301.

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

(b) "Commissioner" means the Maryland Insurance Commissioner.

(c) "Division" means the People's Insurance Counsel Division in the Office of the Attorney General.

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

(E) "HOMEOWNERS INSURER" MEANS AN INSURER THAT ISSUES OR DELIVERS A POLICY OR CONTRACT OF HOMEOWNER'S LIABILITY INSURANCE IN THE STATE.

(F) "Insurance consumers" means persons insured under policies or contracts of medical professional liability insurance, and homeowners insurance issued or delivered in the State by a medical professional liability insurer or a homeowners insurer.

[(e)] (G) "Insurer" means a medical professional liability insurer or a homeowners insurer authorized to engage in the insurance business in the State under a certificate of authority issued by the Commissioner.

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

(I) "MEDICAL PROFESSIONAL LIABILITY INSURER" MEANS AN INSURER THAT ISSUES OR DELIVERS A POLICY IN THE STATE THAT INSURES A HEALTH CARE PROVIDER AGAINST DAMAGES DUE TO MEDICAL INJURY.

(J) "Premium" has the meaning stated in § 1-101 of the Insurance Article to the extent it is allocable to this State.

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.

(c) The People's Insurance Counsel[:

(1)] shall have been admitted to practice law in the State[;

(2) shall have knowledge of and expertise in the insurance business; and

(3) may not hold an official relation to or have any pecuniary interest in an insurer].

(F) THE PEOPLE'S INSURANCE COUNSEL AND EMPLOYEES OF THE DIVISION MAY NOT HOLD AN OFFICIAL RELATION TO OR HAVE ANY PECUNIARY INTEREST IN AN INSURER, INSURANCE AGENCY, OR INSURANCE TRANSACTION, OTHER THAN AS A POLICYHOLDER OR CLAIMANT UNDER A POLICY.

6-304.

(C) (1) THE ASSESSMENT COLLECTED UNDER THIS SECTION IS:

(I) IN ADDITION TO ANY PENALTIES OR PREMIUM TAX IMPOSED UNDER THE INSURANCE ARTICLE; AND

(II) DUE AND PAYABLE TO THE COMMISSIONER ON OR BEFORE A DATE DETERMINED BY THE COMMISSIONER EACH YEAR.

(2) (I) FAILURE BY AN INSURER TO PAY AN ASSESSMENT FEE ON OR BEFORE THE DUE DATE SHALL SUBJECT THE INSURER TO THE PROVISIONS OF §§ 4-113 AND 4-114 OF THE INSURANCE ARTICLE.

(II) IN ADDITION TO THE PENALTY IMPOSED UNDER SUBPARAGRAPH (I) OF THIS PARAGRAPH, IF AN ASSESSMENT FEE IS NOT PAID ON OR BEFORE THE DUE DATE, THE COMMISSIONER MAY IMPOSE A PENALTY OF 5% OF THE AMOUNT DUE AND INTEREST AT THE RATE DETERMINED UNDER § 13-701 (B)(1) OF THE TAX - GENERAL ARTICLE FROM THE DUE DATE UNTIL PAYMENT IS MADE TO THE COMMISSIONER.

6-306.

(a) (1) The Division shall evaluate each MEDICAL PROFESSIONAL LIABILITY INSURANCE AND HOMEOWNERS INSURANCE 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] MAY 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 medical professional liability insurer or homeowners insurer.

(2) If the Division finds that the [proposed] rate increase is excessive, INADEQUATE, OR UNFAIRLY DISCRIMINATORY [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] AN ACTION OR PROCEEDING to protect the interests of insurance consumers.

6-307.

(a) In appearances before the Commissioner and courts on behalf of insurance consumers, the Division has the rights of counsel for a party to the proceeding, including the right to:

(1) summon witnesses, present evidence, and present argument;

(2) conduct cross-examination and submit rebuttal evidence; and

(3) take depositions in or outside of the State:

(I) IN PROCEEDINGS BEFORE THE COMMISSIONER, subject to regulation by the Commissioner to prevent undue delay[,]; and

(II) IN PROCEEDINGS IN COURT, 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] TRIBUNAL OR AGENCY, IN A JUDICIAL OR ADMINISTRATIVE ACTION, to protect the interests of insurance consumers.

SECTION 2. AND BE IT FURTHER ENACTED, That:

(1) the Governor shall include in the annual budget the amounts specified to be distributed from the Medical Professional Liability Insurance Rate Stabilization Fund under § 19-803(b) of the Insurance Article as enacted by Section 1 of this Act; and

(2) for fiscal years 2005 and 2006, in the event these amounts are not appropriated through the budget bill, the Governor is authorized to amend the budget through the executive budget amendment process to appropriate those funds to implement the purposes of this Act.

SECTION 3. AND BE IT FURTHER ENACTED, That:

(1) Notwithstanding any other provision of law, and except as otherwise provided in this section, the premium tax imposed under § 6-102 of the Insurance Article, as enacted by Chapter 5 of the Acts of the 2004 Special Session of the General Assembly, applies to capitation payments, including supplemental or bonus payments, made to a managed care organization on or after April 1, 2005.

(2) The premium tax imposed under § 6-102 of the Insurance Article, as enacted by Chapter 5 of the Acts of 2004 Special Session of the General Assembly, does not apply to capitation payments, including supplemental or bonus payments, made to a managed care organization before April 1, 2005.

SECTION 4. AND BE IT FURTHER ENACTED, That this Act is an emergency measure, is necessary for the immediate preservation of the public health or safety, has been passed by a yea and nay vote supported by three-fifths of all the members elected to each of the two Houses of the General Assembly, and shall take effect from the date it is enacted. If this Act does not secure sufficient votes to pass an emergency measure, it shall take effect March 1, 2005, pursuant to Article III, § 31 of the Maryland Constitution.