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By: **Delegate Rosenberg**
Introduced and read first time: February 10, 2006
Assigned to: Judiciary

A BILL ENTITLED

AN ACT concerning

Medical Malpractice - Analysis of Information and Reports - University of Maryland and University of Maryland Baltimore County

FOR the purpose of authorizing the University of Maryland, in conjunction with the Center for Health Program Development and Management at the University of Maryland Baltimore County, to be provided access to certain information and reports relating to medical malpractice claims for a certain purpose; requiring a certain analysis to determine the impact of certain requirements for alternative dispute resolution process and supplemental certificates of qualified experts; requiring a certain report to the General Assembly and the Governor; providing that the cost of the analysis and report required under this Act be supported by certain funds allocated to the Insurance Commissioner; providing for the termination of certain provisions of this Act; and generally relating to a certain analysis and report relating to medical malpractice.

BY repealing and reenacting, without amendments,
Article - Courts and Judicial Proceedings
Section 3-2A-06C(d) and 3-2A-06D(b)(1) and (3)
Annotated Code of Maryland
(2002 Replacement Volume and 2005 Supplement)

BY repealing and reenacting, without amendments,
Article - Insurance
Section 4-401 and 4-405
Annotated Code of Maryland
(2003 Replacement Volume and 2005 Supplement)

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

Article - Courts and Judicial Proceedings

3-2A-06C.

(d) Within 30 days of the later of the filing of the defendant's answer to the complaint or the defendant's certificate of a qualified expert under § 3-2A-04 of this subtitle, the court shall order the parties to engage in alternative dispute resolution at the earliest possible date.

3-2A-06D.

(b) (1) Within 15 days after the date that discovery is required to be completed, a party shall file with the court a supplemental certificate of a qualified expert, for each defendant, that attests to:

(i) The certifying expert's basis for alleging what is the specific standard of care;

(ii) The certifying expert's qualifications to testify to the specific standard of care;

(iii) The specific standard of care;

(iv) For the plaintiff:

1. The specific injury complained of;

2. How the specific standard of care was breached;

3. What specifically the defendant should have done to meet the specific standard of care; and

4. The inference that the breach of the standard of care proximately caused the plaintiff's injury; and

(v) For the defendant:

1. How the defendant complied with the specific standard of care;

2. What the defendant did to meet the specific standard of care; and

3. If applicable, that the breach of the standard of care did not proximately cause the plaintiff's injury.

(3) The facts required to be included in the supplemental certificate of a qualified expert shall be considered necessary to show entitlement to relief sought by a plaintiff or to raise a defense by a defendant.

Article - Insurance

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.

(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 to a person specified in subsection (e)(1), (2), or (3) of this section may 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) (i) An insurer subject to the reporting requirement under paragraph (1) of this subsection shall notify the Commissioner of any information that the insurer considers proprietary.

(ii) In accordance with § 10-617(d) of the State Government Article, the Commissioner shall deny inspection of any part of a report submitted under paragraph (1) of this subsection that the Commissioner determines contains confidential commercial information or confidential financial information.

(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) (i) type of injury;

(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;

(5) (i) type of medical professional liability policy;

(ii) if known, whether the patient was:

1. an inpatient;

2. an emergency room outpatient; or

3. other outpatient;

(iii) physician ISO classification, or equivalent classification;

(iv) health care provider name and license number; and

(v) policy limits for:

1. each claim or medical incident; and

2. annual aggregate;

(6) (i) if known, the facility, office, or county where injury occurred; and

(ii) the case number and the name and location of the court where the suit was filed and the case was tried;

(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 the case did go to trial, whether the case was tried by a jury;

(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;

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

(i) a description of the misdiagnosis or alleged misdiagnosis made, if any, of the patient's actual condition;

(ii) a description of the procedure giving rise to the claim; and

(iii) a description of the principal injury giving rise to the claim;

(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. the amount of immediate payment;

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

3. the projected total future payout;

(11) if a neutral expert witness is employed under § 3-2A-09(d)(2) of the Courts Article, the findings of a neutral expert witness as to a plaintiff's future medical expenses or future loss of earnings;

(12) if case was tried to verdict, the amount of noneconomic damages; and

(13) (i) the total allocated loss adjustment expense by fees and expenses paid to defense counsel; and

(ii) 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 may 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 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.

SECTION 2. AND BE IT FURTHER ENACTED, That:

(1) Notwithstanding any other provision of law, the University of Maryland School of Law, in conjunction with the Center for Health Program Development and Management at the University of Maryland Baltimore County, shall be provided access to the information and reports required under §§ 4-401 and 4-405 of the Insurance Article by the applicable State agency for the sole purpose of analyzing the information to determine the impact of the alternative dispute resolution process under § 3-2A-06C of the Courts and Judicial Proceedings Article and the supplemental certificates of qualified experts under § 3-2A-06D of the Courts and Judicial Proceedings Article on the resolution of medical malpractice claims.

(2) The University of Maryland School of Law, in conjunction with the Center for Health Program Development and Management at the University of Maryland Baltimore County, shall analyze the information and reports provided under this section.

(3) The analysis required under this section shall include a review of:

(i) the rates of settlement;

(ii) the length of time between notice of a claim and resolution of the matter for each process;

(iii) the amount of any award;

(iv) the costs; and

(v) whether or not settlements were structured.

(4) The University of Maryland School of Law, in conjunction with the Center for Health Program Development and Management at the University of Maryland Baltimore County, shall in accordance with § 2-1246 of the State Government Article, report the analysis to the General Assembly and the Governor on or before June 30 of each year beginning in June 2007.

(5) The cost of the analysis and report required under this section shall be supported by $50,000 annually from the funds allocated to the Insurance Commissioner under § 19-802(b)(5) of the Insurance Article.

SECTION 3. AND BE IT FURTHER ENACTED, That this Act shall take effect October 1, 2006. Section 2 of this Act shall remain effective for a period of 5 years and,

at the end of September 30, 2011, with no further action required by the General Assembly, Section 2 of this Act shall be abrogated and of no further force and effect.