Department of Legislative Services

Maryland General Assembly
2007 Session

FISCAL AND POLICY NOTE

Senate Bill 881 (Senators Harris and Zirkin)
Judicial Proceedings

No-Fault Cerebral Palsy Insurance Fund

This bill establishes a No-Fault Cerebral Palsy Insurance Fund financial through the Medical Assistance Program Account in the Maryland Health Care Provider Rate Stabilization Fund.

The bill takes effect July 1, 2007. The bill does not apply to an individual born before July 1, 2007.

Fiscal Summary

State Effect: The bill authorizes expenditures for a different purpose from the Medical Assistance Program Account. The overall amount of expenditures from the account would not be affected. Revenues would not be affected.

Local Effect: None.

Small Business Effect: Minimal.

Analysis

Bill Summary: If a health care provider's response to a complaint filed with the Health Claims Alternative Dispute Resolution Office asserts that the claim is subject to the exclusive procedures of the fund established under the bill, the director of that office must stay the proceedings. The claimant must then file a claim with the fund.

Portions of the Medical Assistance Program Account in the Maryland Health Care Provider Rate Stabilization Fund that exceed the $15 million provided to the Maryland

Medical Assistance Program to increase both the fee-for-services physicians and capitation payments to managed care organizations (MCOs) for specified procedures must be used to pay medically necessary and other related expenses of individuals with birth-related injuries.

The purpose of the fund is to pay to claimants who are diagnosed as having a birth-related neurological impairment the medically necessary and reasonable expenses of medical, hospital, rehabilitative, residential, and custodial care and service, special equipment or facilities, and related travel necessitated by the birth-related neurological impairment and associated disabilities. The Maryland Insurance Commissioner must appoint the director of the no-fault fund.

Generally, the rights and remedies granted under the bill to a claimant who is diagnosed with a birth-related neurological impairment exclude all other rights and remedies against a health care provider or a health care facility regardless of the injury's cause. However, a claimant or a claimant's legal representative is not precluded from filing a civil action if there is clear and convincing evidence that a health care provider or a health care facility deliberately caused the birth-related neurological impairment.

If an initial claim for coverage is not filed by the claimant's third birthday, the compensation from the fund is limited to expenses incurred on or after the date of filing.

The director may require any person with information about the claim to provide information that the director considers necessary for evaluating the claim. The director may require a claimant to submit to examination or testing. As soon as practicable after filing a claim, the director must evaluate the claim and determine whether the claimant has a birth-related neurological impairment. If the director is unable to make such a determination, the director must issue a determination that the diagnosis is presently uncertain.

A claimant may appeal an uncertainty determination to an arbitration panel or resubmit the claim at least one year but no more than three years after the uncertainty determination. The bill establishes procedures for appointing arbitration panels and for the conduct of a panel in its determination. A determination by a panel is binding on the fund. A panel's determination of uncertainty may be resubmitted to the fund on the same terms as an uncertainty determination by the director. A panel's determination may be appealed to the circuit court for the county where the claimant was born within 30 days after receiving notification of the panel's decision. Panel members are paid a fee established by the director. If a panel determines that the appeal was frivolous, the panel may assess its fees and costs against the appealing party.

Payments from the fund are limited to $30,000 per claimant annually and may be made only for expenses incurred before the claimant turns 21 years of age. At the beginning of each fiscal year, the director must adjust the limit to take into account increases in the cost of medical care. Payments from the fund may not include expenses for items that the claimant has received or is entitled to receive under other State or federal law or from any sort of health insurance policy.

A person may not charge or collect compensation for legal services in connection with any claims arising under the fund unless the compensation is approved by the director.

The director must report claims to the State Board of Physicians for the board's review and determination of whether disciplinary action is warranted.

A medical professional liability insurer must identify in its rate filing any savings that result from the bill and decrease its rates to reflect that savings.

Current Law: Generally, a claim for personal injury resulting from a health care providers' alleged malpractice must be filed with the Health Claims Alternative Dispute Resolution Office. A case filed with that office is referred to an arbitration panel for resolution. However, either party may waive out of arbitration. If a party waives arbitration, the case is brought for trial in circuit court. 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 Maryland Health Care Provider Rate Stabilization Fund receives money from the premium taxes imposed on HMOs and managed care organizations (MCOs).

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 paid by the Maryland Medical Assistance Program, pay specified MCO health care providers consistent with fee-for-service health care provider rates, and increase capitation payments to MCOs participating in the Maryland Medical Assistance Program.

The fund consists of two accounts: the Rate Stabilization Account and the Medical Assistance Program Account. The Insurance Commissioner is required to administer the fund.

During the period when an allocation is made to the Rate Stabilization Account (fiscal 2006-2009,) the Commissioner may retain up to $350,000 to administer the fund. The remaining revenue and unallocated balance in the fund is allocated as follows:

- in fiscal 2005, $3,500,000 to the Medical Assistance Program Account;

- in fiscal 2006, $52,000,000 to the Rate Stabilization Account to pay for health care provider rate reductions, credits, or refunds in calendar 2005, and $30,000,000 to the Medical Assistance Program Account;

- in fiscal 2007, $45,000,000 to the Rate Stabilization Account for calendar 2006 reductions, credits, or refunds, and $45,000,000 to the Medical Assistance Program Account;

- in fiscal 2008, $35,000,000 to the Rate Stabilization Account for calendar 2007 reductions, credits, or refunds, and $65,000,000 to the Medical Assistance Program Account;

- in fiscal 2009, $25,000,000 to the Rate Stabilization Account for calendar 2008 reductions, credits, or refunds, and the remaining amount to the Medical Assistance Program Account; and

- in fiscal 2010 and thereafter, the entire amount is allocated to the Medical Assistance Program Account.

Any revenue remaining in the fund after fiscal 2005 must remain in the fund until otherwise directed by law. If the allocations made in a fiscal year exceed revenues estimated for that year, the fund's unallocated balance may be substituted to the extent of the deficit.

Disbursements from the Medical Assistance Program Account of $15 million 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.

Amounts above the $15 million from the Medical Assistance Program Account must be used to:

- increase payments to health care providers and capitation payments to MCOs;

- pay MCO health care providers consistent with fee-for-service health provider rates, support the provision of office-based specialty care, diagnostic testing, and laboratory testing for individuals with family income of up to 200% of the federal poverty level; and

- support generally the operations of the Maryland Medical Assistance Program.

State Expenditures: The bill does not change overall expenditures from the Medical Assistance Program Account, but it does redirect some of those expenditures to the fund established under the bill.

The number of cases that would be filed cannot be accurately estimated. Over the past four years, an average of 63 cases annually, have been reported to have been filed against obstetricians by the Health Claims Alternative Dispute Resolution Office. The percentage of those cases that involved a birth-related neurological impairment or resulted in a payment (through a settlement, in arbitration to a claimant, or in a verdict to a plaintiff) is unknown. Because the fund established under the bill does not require proof of fault but merely that the injury was birth-related, it is assumed that the percentage of the claims filed that result in a payment from the fund could be high. More cases could be filed with the fund than are currently filed with the Health Claims Alternative Dispute Resolution Office because the standard of proof for compensation is that the injury be birth-related rather than a negligence standard.

The bill limits the annual payment allowable per claimant to $30,000, but this amount is likely to increase in subsequent years as the bill allows the director to adjust the payment for medical inflation. *For illustrative purposes only*, if all of the average annual cases reportedly filed against an obstetrician were eligible for the maximum coverage available under the bill, expenditures from the bill's fund would be $1,890,000. The bill provides that a claimant may be paid for a birth-related neurological injury from the fund until the claimant reaches age 21.

Additional Information

Prior Introductions: A nearly identical bill, SB 682 of 2005, was jointly assigned to the Senate Finance Committee and the Senate Judicial Proceedings Committee. The bill received an unfavorable report.

Cross File: None.

Information Source(s): Department of Health and Mental Hygiene, Maryland Insurance Administration, Health Claims Alternative Dispute Resolution Office, Department of Legislative Services

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