HB 547

Department of Legislative Services

Maryland General Assembly
2015 Session

FISCAL AND POLICY NOTE

House Bill 547 (Delegate Dumais, *et al.*)
Judiciary and Health and Government Operations

Medical Liability Efficiency Act of 2015

This bill repeals provisions establishing the Health Care Alternative Dispute Resolution Office (HCADRO) and the Health Claims Arbitration Fund. Thus, the bill repeals HCADRO's role in arbitrating claims against health care providers and instead establishes the direct filing of claims in a circuit court. The bill also establishes additional procedural requirements for claims against health care providers. The Department of Health and Mental Hygiene (DHMH) is required to forward specified court documents to the State Board of Physicians. The bill requires that, at the end of fiscal 2015, any unspent portions of the Health Claims Arbitration Fund revert to the general fund.

The bill takes effect July 1, 2015, and applies to any case filed on or after that date.

Fiscal Summary

State Effect: General fund and special fund expenditures decrease by $381,900 and $46,200, respectively, beginning in FY 2016 due to the bill's elimination of HCADRO. Future years do not reflect inflation or salary increases. General fund revenues likely increase by a minimal amount in FY 2016 due to the bill's requirement that any remaining funds in the Health Claims Arbitration Fund revert to the general fund at the end of fiscal 2015. Otherwise, general and special fund revenues decrease with elimination of the fee that capitalizes the fund.

(in dollars)	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020
GF Revenue	-	(-)	(-)	(-)	(-)
SF Revenue	(-)	(-)	(-)	(-)	(-)
GF Expenditure	($381,900)	($381,900)	($381,900)	($381,900)	($381,900)
SF Expenditure	($46,200)	($46,200)	($46,200)	($46,200)	($46,200)
Net Effect	$428,100	$428,100	$428,100	$428,100	$428,100

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

Local Effect: Circuit courts likely experience an increased workload as a result of more medical malpractice actions being filed directly in court instead of with HCADRO.

Small Business Effect: None.

Analysis

Bill Summary:

Repeal of HCADRO

The bill repeals the establishment of HCADRO as a unit in the Executive Department. The bill also repeals the establishment of the Health Claims Arbitration Fund. As a result, claims against health care providers must be filed directly in a circuit court.

Notice of Intent

At least 90 days before filing a claim against a health care provider for a medical injury, a person must send the health care provider written notice, medical records, and specified releases. The notice must contain (1) the factual basis for the claim, including the claimed injury; (2) the applicable standard of care alleged by the plaintiff; (3) the manner in which the standard of care was allegedly breached; (4) the alleged action that should have been taken to comply with the standard of care; (5) the manner in which the alleged breach was the proximate cause of the claimed injury; and (6) the name of each health care provider that the person is notifying in relation to the claim.

No later than 30 days after providing the notice, the person must also (1) allow each health care provider access to each medical record related to the claim that is in the person's control and (2) furnish a release for each medical record related to the claim that is not in the person's control but of which the person has knowledge.

Certificate of Qualified Expert

A health care provider who attests in a certificate of a qualified expert or a supplemental certificate of a qualified expert, or who testifies in relation to a court proceeding about the compliance or departure from standards of care, must devote at least 80% of the expert's professional activities to activities that directly involve patient care.

A certificate of a qualified expert is required to attest to, within a reasonable degree of medical probability, a departure from standards of care and that the departure from the standards of care is the proximate cause of the alleged injury. The bill makes a

corresponding change to the attestation of matters in a supplemental certificate of a qualified expert.

The clerk of the court must forward copies of the certificates of qualified experts to DHMH. If the action is against a physician, DHMH must forward the certificates to the State Board of Physicians.

Role of DHMH

The clerk of the court must forward a copy of the verdict or other final disposition to DHMH. If the action is against a physician, DHMH must forward the copy to the State Board of Physicians.

Offer of Judgment

If a final judgment is not more favorable to the adverse party than an offer of judgment, the adverse party who received the offer must pay the expert witness fees (in addition to the costs currently provided) of the party making the offer that were incurred after making the offer.

Expression of Regret or Apology

The bill repeals the requirement that an admission of liability or fault that is part of or in addition to an expression of regret or apology is admissible as evidence of an admission of liability or as evidence of an admission against interest.

Current Law: Except for a claim seeking damages within the limit of the District Court's concurrent civil jurisdiction ($30,000 or less), a claim for medical injury against a health care provider is required to be filed with the Director of the Health Care Alternative Dispute Resolution Office (although the parties may elect mutually or unilaterally to waive arbitration of the claim). The director must serve a copy of the claim on the health care provider by the appropriate sheriff in accordance with the Maryland Rules. If the claim is against a physician, the director must also forward a copy of the claim to the State Board of Physicians. The health care provider must file a timely response with the director and serve a copy of the response on the claimant and any other named health care providers. Claims may be decided through the arbitration process or may proceed to trial.

Unless the sole issue in a health care malpractice claim is lack of informed consent, a claim before HCADRO or an action filed in a court must be dismissed without prejudice if the claimant or plaintiff fails to file with the director, within 90 days from the date of the complaint, a certificate of a qualified expert attesting (1) to a departure from standards of care and (2) that the departure is the proximate cause of the alleged injury. (This certificate

is commonly referred to as a "certificate of merit.") However, an extension of at most 90 days for filing the certificate must be granted if (1) the limitations period applicable to the claim or action has expired and (2) the failure to file the certificate was neither willful nor the result of gross negligence. Each party must file the appropriate certificate with an attached report of the attesting expert.

A health care malpractice claim may be adjudicated in favor of the claimant or plaintiff on the issue of liability if the defendant disputes liability and fails to timely file a certificate of a qualified expert attesting (1) to compliance with standards of care or (2) that the departure from standards of care is not the proximate cause of the alleged injury. (This is commonly referred to as a "certificate of meritorious defense.")

A party is required to file with the court, within 15 days after the discovery deadline, a supplemental certificate of a qualified expert, for each defendant, that attests specifically to various matters. An extension of time for filing a supplemental certificate must be granted for good cause shown. On motion by a defendant, the court may dismiss without prejudice the action as to the defendant if a plaintiff fails to file a supplemental certificate. On motion by a plaintiff, the court may adjudicate in favor of the plaintiff on the issue of liability if a defendant fails to file a supplemental certificate.

A health care provider who attests in a certificate of a qualified expert (or who testifies in relation to a proceeding before an arbitration panel or a court concerning compliance with or departure from standards of care) may not devote annually more than 20% of the expert's professional activities to activities that directly involve testimony in personal injury claims. A party may not serve as a party's expert, and the certificate may not be signed by a party, an employee or partner of a party, or an employee or stockholder of any professional corporation of which the party is a stockholder.

Failure to file a proper certificate of a qualified expert is tantamount to not having filed a certificate at all. *D'Angelo v. St. Agnes Healthcare, Inc.*, 157 Md. App. 631, cert. denied, 384 Md. 158 (2004). A certificate of a qualified expert is a condition precedent to a medical malpractice action and must, at a minimum, identify with specificity the licensed professionals against whom the claims are brought, a statement that the licensed professionals breached the standards of care, and that this breach was the proximate cause of the plaintiff's injury; if the certificate is insufficient, the action must be dismissed. *Carroll v. Konits*, 400 Md. 167 (2007).

Background: Maryland courts have repeatedly interpreted the State's health care malpractice claims statute as the General Assembly's attempt to limit the filing of frivolous malpractice claims. *Carroll v. Konits*, 400 Md. 167 (2007). The certificate of a qualified expert, in particular, is intended to help "weed out" nonmeritorious medical malpractice claims. *D'Angelo v. St. Agnes Healthcare, Inc.*, 157 Md. App. 631, cert. denied, 384 Md. 158

(2004). According to the National Conference of State Legislatures, 28 states have requirements for filing an affidavit or certificate of merit in order for a medical liability and malpractice claim to move forward.

According to a 2011 article published in the *American Journal of Mediation*, numerous states require a claimant to provide advance notification to a health care provider before filing a medical malpractice claim. These "pre-suit notification" periods are intended to promote settlement amongst parties so as to avoid litigation, thereby reducing the costs of medical malpractice litigation while still allowing claimants to receive appropriate relief. The required notification periods vary among states. For example, Michigan and Massachusetts require a claimant to provide 182 days advance notice to a health care provider before filing a claim. California's Medical Injury Compensation Reform Act (commonly referred to as MICRA) requires that a claimant provide a health care provider 90-day notice of the claimant's intention to file a claim. Utah, Florida, and the District of Columbia also require 90-day notice. Tennessee, Texas, and Mississippi require 60-day notice, while West Virginia requires only 30-day notice.

The constitutionality of some of these pre-suit notification statutes has been challenged in state courts, with mixed results. While courts have upheld the Michigan, Mississippi, and Florida statutes, the Washington statute (which required 90-day notice) was ruled unconstitutional as a violation of separation of powers. Specifically, in *Waples v. Yi*, 234 P.3d 187 (Wash. 2010), the Washington Supreme Court held that the statutory notice requirement conflicted with a court procedural rule, thereby conflicting with the power of the judiciary to establish court procedures; since the statute and the court rule could not be harmonized, the judiciary's procedural rule prevailed. The Washington legislature repealed the notice requirement in 2013.

During calendar year 2014, HCADRO handled a total of 650 cases. Of these, parties in 528 cases waived the office's services and proceeded directly to circuit court; 73 were dismissed by the office as ineligible for services; 43 were settled or otherwise ended by the parties; 1 was arbitrated by the office.

The Health Claims Arbitration Fund is a special, continuing nonlapsing fund that is used exclusively to pay the fees of arbitrators and other operational expenses of HCADRO. The fund consists of filing fees from claims filed with HCADRO. The fee to file a claim, including any third-party claim, is $40; the fee to file a response to the claim is $25. The director of HCADRO collects the fees and pays all fees to the Comptroller; 20% of the fees are distributed to the general fund and the balance is distributed to HCADRO.

State Fiscal Effect: The Governor's proposed fiscal 2016 operating budget includes $381,899 in general funds and $46,151 in special funds for HCADRO. As a result of the bill eliminating HCADRO, general fund expenditures decrease by about $381,899 annually

and special fund expenditures decrease by about $46,151 annually beginning in fiscal 2016. This estimate does not factor in any inflationary or salary increase adjustments.

Additionally, the bill eliminates the Health Claims Arbitration Fund and the fees that capitalize it. A portion of those fees is also distributed to the general fund. Thus, general and special fund revenues decrease beginning in fiscal 2016. However, because the bill requires all remaining funds in the Health Claims Arbitration Fund at the end of fiscal 2015 to revert to the general fund, general fund revenues may instead increase minimally in fiscal 2016, depending on how much remains in the fund at the end of the current fiscal year. As of the end of fiscal 2014, the fund had $31,181.

The Judiciary advises that the number of medical malpractice cases filed with circuit courts may increase as a result of the bill; however, the Judiciary is unsure of the proportion of cases currently being screened out by HCADRO that would actually reach the circuit courts or how many cases might settle pre-trial. HCADRO advises that circuit courts may experience an increased workload related to discovery and other pre-trial procedures; HCADRO currently handles the bulk of these procedures for medical malpractice actions, even for those cases that ultimately proceed to trial.

HCADRO additionally advises that it currently serves as a centralized location for the public to inquire about claims made against health care practitioners. As a result of the bill's changes, the public may need to consult each local circuit court for information about such claims. Furthermore, HCADRO handles more than 5,000 requests per year for credentialing letters for physicians who wish to practice out of state; should HCADRO be terminated, another agency (possibly the State Board of Physicians) would need to process these requests. The bill also shifts responsibility from HCADRO to DHMH for notifying the State Board of Physicians when a claim is filed against a health care practitioner; DHMH must coordinate with local circuit courts to receive this information. It is unclear whether this shift has a material impact on operations or finances of DHMH or the State Board of Physicians.

Additional Comments: The bill does not apply to any case filed before July 1, 2015. Therefore, HCADRO may continue to receive claims prior to this date; however, HCADRO is eliminated on the bill's effective date regardless of whether there are any pending claims before the office. It is unclear how any pending claims would proceed if HCADRO is eliminated before final adjudication. The bill does not establish a process for adjudicating these claims, nor does it establish a deadline by which claims must be filed with HCADRO before its elimination.

Additional Information

Prior Introductions: None.

Cross File: None.

Information Source(s): Department Legislative Services - Office of Legislative Audits, Department of Budget and Management, Maryland Health Claims Alternative Dispute Resolution Office, Department of Health and Mental Hygiene, Maryland Insurance Administration, Judiciary (Administrative Office of the Courts), *American Journal of Mediation*, National Conference of State Legislatures, Department of Legislative Services

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