

Department of Legislative Services
 Maryland General Assembly
 2018 Session

FISCAL AND POLICY NOTE
First Reader

Senate Bill 862 (Senator Kelley, *et al.*)
 Judicial Proceedings and Finance

Maryland No-Fault Birth Injury Fund

This bill establishes a system for adjudication and compensation of claims arising from birth-related neurological injuries by establishing the Maryland No-Fault Birth Injury Fund. The bill must be construed to apply prospectively and may not be applied or interpreted to have any effect on or application to any cause of action arising before January 1, 2020. **The bill takes effect July 1, 2018.**

Fiscal Summary

State Effect: No effect in FY 2019. Medicaid expenditures (60% federal funds, 40% general funds) increase beginning in FY 2020. Federal fund revenues increase correspondingly. Otherwise, State agencies can likely handle the bill’s requirements with existing resources.

Maryland No-Fault Birth Injury Fund Effect: Nonbudgeted expenditures for the new fund increase by \$3.1 million in FY 2020. Future year expenditures reflect annualization and ongoing costs. Nonbudgeted revenues for the fund increase beginning in FY 2020 in an amount sufficient to at least cover costs each year.

(in dollars)	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
NonBud Rev.	\$0	-	-	-	-
NonBud Exp.	\$0	\$3,107,800	\$5,678,600	\$6,735,000	\$7,791,400
Net Effect	\$0	-	-	-	-

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

Local Effect: None.

Small Business Effect: Minimal.

Analysis

Bill Summary: “Birth-related neurological injury” means an injury to the brain or spinal cord of a live infant born in a Maryland hospital that (1) is caused by oxygen deprivation or other injury that occurred or could have occurred during labor, during delivery, or in the resuscitative period after delivery and (2) renders the infant permanently neurologically and physically impaired. A “birth-related neurological injury” does not include a disability or death caused by a genetic or congenital abnormality.

“Qualified health care costs” means reasonable expenses of medical, hospital, rehabilitative, family residential or custodial care, professional residential care, durable medical equipment, medically necessary drugs, and related travel, as well as residential or vehicle modifications that are necessary to meet a claimant’s health care needs – as determined by the claimant’s treating physicians, physician assistants, or nurse practitioners and as otherwise defined by regulation.

“Health care practitioner” means an individual licensed or certified or otherwise authorized to provide obstetrical services or an individual licensed or certified under the Health Occupations Article to practice midwifery.

Malpractice Claims

The bill applies to births occurring on or after January 1, 2020. The rights and remedies under the bill exclude and supplant all other rights and remedies of the infant, personal representative of the infant, and parents, dependents, or next of kin of the infant arising out of or related to the injury to the infant, including claims of emotional distress related to the infant’s injury. However, the bill does not exclude other rights and remedies available to the mother of the infant arising out of or related to a physical injury, separate and distinct from a birth-related neurological injury to the infant, suffered by the mother of the infant during the course of delivery of the infant. Moreover, a civil action is not prohibited against a health care practitioner or hospital if there is clear and convincing evidence that the health care practitioner or hospital *maliciously intended to cause* a birth injury and the claim is filed before and instead of payment of an award under the bill.

If a party in a civil proceeding before a circuit court asserts a claim that involves an eligible birth-related neurological injury, on the motion of such party in the civil proceeding, the court must (1) order a party to file a claim for a birth-related neurological injury with the fund and (2) dismiss the civil proceeding without prejudice. Likewise, if a party in a proceeding before the Health Care Alternative Dispute Resolution Office (HCADRO) asserts a claim that involves an eligible birth-related neurological injury, on the motion of such party in the proceeding, the Director of HCADRO must (1) order a party to file a

claim for a birth-related neurological injury with the fund and (2) dismiss the proceeding before HCADRO without prejudice.

A claim for compensation and benefits under the bill must be filed within established time periods under the Courts and Judicial Proceedings Article and may be filed by a legal representative on behalf of an injured infant and, in the case of a deceased infant, by an administrator, a personal representative, or any other legal representative of the deceased infant.

The limitations period with respect to a civil action that may be brought by, or on behalf of, an injured infant for damages allegedly arising out of, or related to, a birth-related neurological injury are tolled by the filing of a claim under the bill. Thus, the time the claim is pending or is on appeal may not be computed as part of the period within which the civil action may be brought.

Filing a Claim for Compensation with the No-Fault Birth Injury Fund

A claimant must file a claim to receive compensation and other benefits from the fund. A claim must include (1) the name and address of the legal representative and the basis for the legal representative's representation of the injured infant; (2) the name and address of the injured infant; (3) the name and address of each health care practitioner who is known to have been present at the birth and the hospital at which the birth occurred; (4) a description of the disability for which the claim is made; (5) the time and place the injury occurred; and (6) a brief statement of the facts and circumstances surrounding the injury and giving rise to the claim.

Within 45 days after filing a claim, the claimant has to provide additional information relating to the claim, including (1) all available relevant medical records relating to the birth-related neurological injury and a list identifying unavailable records known to the claimant and the reasons for their unavailability; (2) appropriate assessments, evaluations, and prognoses and other records and documents reasonably necessary for the determination of the amount of compensation to be paid to, or on behalf of, the injured infant on account of the birth-related neurological injury; (3) documentation of expenses and services incurred to date that identifies the payment made for those expenses and services and the payer; and (4) documentation of any applicable private or governmental source of services or reimbursement relative to the impairments.

The fund must then provide copies of claim materials to all health care practitioners known to have been present at the birth and the hospital at which the birth occurred within 10 days after receipt of a complete claim. The fund has to investigate a claim upon receipt and serve the claimant with its response within 90 days. That response must indicate whether the *fund* determines that the injury alleged is a birth-related neurological injury. The fund

has another 10 days within which it must submit the claim, all materials submitted by the claimant, and its response to the Office of Administrative Hearings (OAH) for adjudication and to the Office of Health Care Quality (OHCQ), the State Board of Physicians (MBP), and the State Board of Nursing (BON) for their review. OHCQ, MBP, and BON may investigate a submitted claim and take appropriate action with respect to the health care facility, physician, or nurse who provided care, respectively.

Evaluation and Determination by the Office of Administrative Hearings

Each determination of eligibility and for compensation and benefits must be delegated to OAH for adjudication and decision by an administrative law judge (ALJ). OAH must provide specialized training to ALJs who are assigned to adjudicate submitted claims. OAH must evaluate and has exclusive jurisdiction to determine whether a claim involves an eligible birth-related neurological injury and the nature and amount of compensation and benefits to be provided to the claimant on the basis of the evidence presented in a contested hearing. OAH must dismiss a claim if it determines that the injury alleged is not a birth-related neurological injury.

If OAH determines an infant has sustained a birth-related neurological injury, the claimant may be awarded one or more benefits and compensation to be paid or provided from the fund. Specifically, an infant may be awarded:

- *actual lifetime expenses* for qualified health care costs, limited to reasonable charges prevailing in the same community for similar treatment of injured persons when the treatment is paid for by the injured person, excluding specified expenses;.
- up to \$500,000, payable in periodic payments or as a lump sum to the injured infant or to the parents or legal guardians of the injured infant for the benefit of the injured infant;
- *loss of earnings* to be paid in periodic payments beginning on the *eighteenth birthday* of the infant; alternatively, a *funeral payment of \$25,000* is awarded if the infant dies before age 18; and/or
- funding for *reasonable expenses incurred* in connection with the filing and prosecution of a claim to assert eligibility and for compensation and benefits (including reasonable attorneys' fees on an hourly basis, subject to the approval and award of the ALJ). An award of expenses requires the immediate payment of expenses previously incurred and that future expenses be paid as incurred.

Hearings Related to a Claim for Benefits and Compensation

OAH must set the date for a hearing on a contested case no sooner than 60 days and no later than 120 days after the written notice of the fund's submission of a claim. The ALJ

has to immediately notify the parties of the time and place of the hearing. The parties to the hearing include the claimant and the fund; third parties may be permitted upon request by a person or entity identified by the claimant in the claim.

A party to the proceeding may, upon application to the ALJ, serve interrogatories or take depositions of witnesses residing in or outside the State. The depositions must be taken after giving notice and must be taken in the manner prescribed at law, except that they must be directed to the ALJ before whom the proceedings may be pending. Costs of interrogatories and depositions are taxed as expenses incurred in connection with the filing of a claim.

An OAH decision constitutes a final decision for the purposes of judicial review, and a party may seek judicial review of a final decision under the Administrative Procedure Act. A petition for judicial review stays enforcement of the final decision.

Birth Injury Prevention

The Maryland Patient Safety Center (MPSC) is charged with developing patient safety initiatives and, through its Perinatal Clinical Advisory Committee (PCAC) must also review fund claims. Accordingly, MPSC must convene PCAC to oversee the general dissemination of initiatives, guidance, and best practices to health care facilities for perinatal care. MPSC must report annually to the board of trustees of the fund. The board of trustees must allocate funding from the fund each year to MPSC for the staffing of PCAC and for program activities.

PCAC must review fund claims, formulate best practices for prenatal care and deliveries, and develop and implement programs to improve obstetrical care outcomes.

The Maryland No-Fault Birth Injury Fund

The bill establishes the Maryland No-Fault Birth Injury Fund. The fund is established to provide compensation and benefits to eligible claimants and is funded from revenues, premiums, and other receipts of money as provided by law. To that end, the fund has to provide each Maryland hospital and obstetrician practicing in Maryland with written materials for distribution to obstetrical patients to inform them of a patient's rights, remedies, and limitations under the fund. All operating expenses of the fund must be paid from the money collected by or for the fund. The assets of the fund are not part of the State Treasury, and the debts and obligations of the fund are not debt of the State or a pledge of credit of the State.

The fund is authorized to (1) receive premiums collected under the bill's provisions; (2) administer the payment of awards for birth-related neurological injuries; (3) invest and

reinvest surplus money over losses and expenses; (4) reinsure the risks of the fund wholly or partly; (5) employ or retain persons as necessary to perform the administrative and financial transactions and other necessary and proper functions not prohibited by law; and (6) enter into contracts as necessary or proper to carry out the legal and proper business of the fund. Employees of the fund are not in the State Personnel Management System.

The bill establishes a board of trustees of the fund that consists of seven members (five of whom must have specified expertise or affiliation and two of whom are citizens) appointed by the Governor with the advice and consent of the Senate. Board member terms are five years, and a member continues to serve at the end of a term until a successor is appointed and qualifies. The board must choose a chair from among its members and must appoint the executive director of the fund, who serves at the pleasure of the board. The board must adopt rules, bylaws, and procedures and may adopt any policy to carry out the bill. Each member of the board is entitled to reasonable per diem compensation for each day actually engaged in the discharge of fund duties.

Each fiscal year the fund must engage an independent certified public accountant to audit the accounts of the fund and a qualified actuary to investigate the requirements of the fund and provide an actuarial opinion of the valuation of the assets and liabilities of the fund.

Fund Premiums

The fund is capitalized by annual premiums from Maryland hospitals.

Each fiscal year, based on the annual statement of actuarial opinion, the board must determine the amount required to finance and administer the fund. The board must notify the Health Services Cost Review Commission (HSCRC) of the amount required by March 1 of each year.

By July 1 of each year, HSCRC must assess premiums for all Maryland hospitals and increase hospital rates totaling the amount determined by the board to be required to finance and administer the fund. HSCRC must adopt regulations specifying the methodology for the assessment of premiums. The methodology must (1) account for geographic differences among hospitals; (2) account for differences among hospitals' historical claims experience involving births in each hospital; and (3) distinguish between hospitals that provide obstetrical services and those that do not. In determining hospital rates, HSCRC must increase rates to account fully for the amount of the premiums; the resulting increase may not be considered in determining the reasonableness of rates or hospital financial performance under HSCRC methodologies.

By September 1 of each year, each hospital must pay the assessed premium amounts to HSCRC. HSCRC must forward the payments to the fund.

Each insurer issuing (or issuing for delivery) in the State a personal injury liability policy that provides medical malpractice liability coverage for the obstetrical or midwifery practice of a health care practitioner practicing in Maryland has to provide a credit on the health care practitioner's annual medical malpractice liability insurance premium to account for the availability of the fund to compensate eligible claimants. That credit must be in an amount that will produce premiums that are not excessive, inadequate, or unfairly discriminatory, as determined by the Insurance Commissioner. Likewise, each insurer issuing (or issuing for delivery) in the State a personal injury liability policy that provides medical malpractice liability coverage for the obstetrical or midwifery services of a hospital in Maryland has to provide a credit on the hospital's annual medical malpractice liability insurance premium to account for the availability of the fund to compensate eligible claimants. That credit must be in an amount that will produce premiums that are not excessive, inadequate, or unfairly discriminatory, as determined by the Insurance Commissioner.

Current Law: State law distinguishes between ordinary negligence claims and medical malpractice claims. The statute of limitations for filing a medical malpractice claim varies with the claimant's age and type of injury.

Parties to medical malpractice claims are required to file a claim with HCADRO. Claims may proceed through the arbitration process, or claimants or defendants may waive participation and instead transfer the case to the circuit court for trial. Claimants may receive awards for economic and noneconomic damages. Economic damages include past and future medical expenses and lost wages; noneconomic damages include pain and suffering.

The Courts and Judicial Proceedings Article sets various caps on noneconomic damages in civil actions depending on the type of action and when the cause of action arose. These caps generally increase by \$15,000 a year. In an action for damages for personal injury or wrongful death (excluding health care malpractice), the cap is \$860,000 for causes of action arising on or after October 1, 2018. For causes of action arising on or after October 1, 2019, the cap is \$875,000. This limitation applies in a personal injury action to each direct victim of tortious conduct and all persons who claim injury through that victim. The cap also applies separately to a personal injury action and wrongful death action, so that damages may be aggregated. However, in a wrongful death action in which there are two or more claimants or beneficiaries, an award of noneconomic damages may not exceed 150% of the applicable cap, regardless of the number of claimants or beneficiaries.

For health care malpractice actions, the cap for noneconomic damages was set at \$650,000 for causes of action arising between January 1, 2005, and December 31, 2008, increasing by \$15,000 each year, beginning on January 1, 2009. Thus, for causes of action arising in 2018, the cap is \$800,000; for causes of action arising in 2019, the cap is \$815,000. The

cap applies in the aggregate to all claims for personal injury and wrongful death arising from the same medical injury, regardless of the number of claims, claimants, plaintiffs, beneficiaries, or defendants. However, for a wrongful death action in which there are two or more claimants or beneficiaries, the total amount awarded may not exceed 125% of the cap, or \$1,018,750 in 2018.

The Insurance Article requires that each policy insuring a health care provider against damages due to medical injury arising from providing or failing to provide health care must contain provisions that are consistent with certain requirements in the Courts and Judicial Proceedings Article. Additionally, the policy must authorize the insurer, without restriction, to negotiate and effect a compromise of claims within the limits of the insurer's liability, if the entire amount settled on is to be paid by the insurer.

Chapters 209 and 210 of 2016 authorized a medical malpractice insurance policy to include coverage for the defense of a health care provider in a disciplinary hearing arising out of the practice of the health care provider's profession if the cost of the included coverage is (1) itemized in the billing statement, invoice, or declarations for the policy and (2) reported to the Insurance Commissioner.

Background: Virginia, Florida, and New York have birth-related neurological injury compensation plans. Florida enacted the Birth-Related Neurological Injury Compensation Plan in 1988. The Virginia Birth-Related Neurological Injury Compensation Act was enacted in 1987. Both programs provide compensation for medical and certain other expenses of children with severe birth-related neurological injuries. The injury must have been caused by oxygen deprivation or mechanical injury, which occurred during the labor, delivery, or resuscitation in the immediate post-delivery period in a hospital. Doctors and hospitals can choose whether to participate in the compensation plans. In 2011, New York established the New York State Medical Indemnity Fund. Unlike the Virginia and Florida programs, the New York program does not create an administrative procedure for adjudicating patients' claims. Instead, the Medical Indemnity Fund pays the future health care expenses of any "qualified plaintiff" who (1) has been found by a jury or court to have sustained a birth-related neurological injury as the result of medical malpractice or (2) has sustained a birth-related neurological injury as the result of alleged medical malpractice, and has obtained a court-approved settlement of his or her claim.

According to a 2008 *Law Review* article published by Boston University School of Law, both the Virginia and Florida programs are largely considered successful, although the Virginia program has suffered from funding concerns more recently.

The Joint Legislative Audit and Review Commission of the Virginia General Assembly published a 2002 review of the Virginia Birth-Related Neurological Injury Compensation Program which concluded that, while the birth injury program (BIP) "appears largely

beneficial to children served by the program, compared to Virginia’s capped tort system... it is less clear that the program has achieved the societal benefits intended, such as the availability of obstetrical care in rural areas of the State.” In 2002, participants in BIP were satisfied with their compensation, but the fund itself suffered from a long-term deficit in terms of unfunded liability. This was due in large part to a failure to adequately assess fees from eligible payers.

In response to the 2014 *Joint Chairmen’s Report*, the Maryland Department of Health (MDH) (at that time known as the Department of Health and Mental Hygiene) convened a workgroup of interested stakeholders to study the issue of access to obstetrical care. Among other recommendations, the workgroup recommended that the Maryland General Assembly explore the viability of a No-Fault Birth Injury Fund and hire an actuarial firm to conduct a financial review to determine the best way to fund the projected costs. The workgroup worked with the executive directors of the Florida and Virginia birth injury funds to determine how these programs function; the directors of the respective programs reported overall satisfaction by claimants and families as well as better care outcomes for children covered by the programs compared to the tort system.

Chapter 329 of 2015 established the Workgroup to Study Access to Obstetric Services. The workgroup, convened by the Maryland Hospital Association, consisted of 17 organizations, including medical professional associations and hospitals. In its December 2015 final report, the workgroup reported that Maryland’s 32 birthing hospitals delivered 67,356 babies in calendar 2014. The workgroup also recommended the establishment of a No-Fault Birth Injury Fund to stabilize medical liability costs and provide an incentive for hospitals to continue to provide obstetric services.

State Fiscal Effect: According to an actuarial study done by Pinnacle Actuarial Resources, Inc., which analyzed comparable data from the Virginia and Florida no-fault birth injury programs, Maryland can anticipate that a qualifying birth injury occurs in roughly 1 out of every 10,000 live births. According to MDH’s 2016 *Vital Statistics Annual Report*, there were 73,073 live births to Maryland residents in 2016. Thus, approximately seven qualifying infants are born each year. As claims may only be made for births occurring on or after January 1, 2020, only four valid claims are presented in fiscal 2020.

Office of Administrative Hearings

Due to the anticipated low number of birth-injury claims per year, OAH advises that it can handle the bill’s requirements with existing resources. Additionally, OAH advises that it can absorb the bill’s training requirement within its existing training budget.

Medicaid

Medicaid expenditures increase significantly beginning in fiscal 2020 (60% federal funds, 40% general funds) due to the bill's requirement that HSCRC increase hospital rates to account for the cost of the premiums; however, the amount of the increase depends on the amount of hospital premiums assessed by HSCRC and cannot be estimated at this time. Medicaid expenditures account for approximately 20% of total hospital revenues annually. Federal fund revenues increase correspondingly to reflect federal matching funds.

Other Agencies

The Judiciary advises that it does not anticipate a significant fiscal or operational impact on the caseload of the circuit courts. There may be a record retention impact on the Judiciary (the bill establishes that the statute of limitations for a civil action arising from a birth-related neurological injury is tolled by the filing of a claim with the fund); however, any such impact is not expected to be significant.

HSCRC advises that it can adjust hospital rates to account for premiums with existing resources. However, any impact on insurance premium tax revenues due to credits made to insurance premiums has not been factored into this analysis. Likewise, MBP, BON, OHCQ, and HCADRO are not materially affected.

No-Fault Birth Injury Fund Fiscal Effect:

Nonbudgeted Revenues

This analysis assumes capitalization begins in fiscal 2020, when HSCRC is first able to assess hospital premiums. In fiscal 2019, the fund is not capitalized because a series of actions must first take place. Specifically, the board of trustees must inform HSCRC of the amount required to finance and administer the fund based on a commissioned actuarial analysis; HSCRC must then adopt a methodology to assess hospital premiums by the start of each fiscal year. Given the bill's effective date, HSCRC would not be able to adopt the required methodology by the start of fiscal 2019 and, consequently, hospitals would not be able to pay premiums in fiscal 2019. Moreover, HSCRC will not have required information to adopt the required methodology for the fiscal 2020 assessment either; regardless, this analysis assumes HSCRC can independently develop a methodology to cover premium assessments for fiscal 2020.

Given that premiums are assessed based on a methodology that is yet to be determined by HSCRC, exact fund revenues for fiscal 2020 through 2023 cannot be determined; however, this analysis assumes that revenues must increase, at a minimum, by an amount sufficient to cover the fund's anticipated expenditures, as discussed below. Additional revenue

necessary to cover out-year costs could also be collected through adjusting the HSCRC methodology based on the required yearly actuarial analyses.

Nonbudgeted Expenditures

Expenditures for the fund in fiscal 2020 total \$3.1 million, as discussed below, and include a full-time executive director, board compensation, required annual actuarial and audit reports, distribution of pamphlets, administrative costs for MPSC/PCAC, and payment of awards to claimants. The estimate assumes a September 1, 2019 start date for the board; although board members may be appointed prior to this date, the estimate assumes that the board could not be formally convened nor could board duties be undertaken until the fund is capitalized (hospital premiums must be collected by September 1, 2019). The bill requires that all operating expenses of the fund (which includes the board) be paid from the money collected by or for the fund. However, as a result of the September 1 start date, the board has a compressed amount of time in which to prepare for the claim eligibility date of January 1, 2020, and, thus, may need to meet more frequently during this time.

The estimate for the executive director’s position includes a salary, fringe benefits, one-time start-up costs, and ongoing operating expenses. The estimate includes \$70,000 annually for per diem expenses for members of the board of trustees, based on seven board members receiving \$500 per day for approximately 20 days per year – including in fiscal 2020 when the board must meet more frequently to establish the fund. Annual costs of \$125,000 are assumed to perform the required actuarial study and audit. The estimate also includes \$10,800 annually for the cost of publishing materials to inform obstetric patients and obstetricians about the fund and their rights under the bill. This assumes a pamphlet with the necessary information costs approximately \$0.15 each, and that an average of 72,000 individuals must receive the materials.

Position	1
Salary and Fringe Benefits	\$97,543
Per diem Expenses for Board Members	70,000
Pamphlets	10,800
Actuarial and Audit Reports	125,000
Other Operating Expenses	5,409
MPSC/PCAC Funding	199,000
Payments to Claimants	<u>2,600,000</u>
Total FY 2020 Nonbudgeted Expenditures	\$3,107,752

The bill also requires the board to allocate funding each year from the fund for MPSC to staff PCAC and conduct program activities. This analysis assumes that costs for MPSC begin in fiscal 2020, when the fund is capitalized. In addition to administrative and

overhead costs, MPSC advises that it must hire administrative personnel to meet the bill's requirements, for a total cost of \$199,000 per fiscal year.

Additionally, this analysis reflects claimants receiving \$2.6 million in payments in fiscal 2020. The estimate assumes that, since claimants cannot begin receiving funds until January 1, 2020, at the earliest, only four claimants receive awards in fiscal 2020. Annually thereafter, however, an additional seven claimants receive awards each year. Thus, in fiscal 2023, claimants receive almost \$7.3 million in payments from the fund. Each claimant is assumed to be awarded the maximum \$500,000 one-time lump sum payment as well as approximately \$150,000 each year to cover actual expenses for qualified health care costs. As these expenses are incurred for the lifetime of the claimant, they have a cumulative impact on the payments from the fund. Any awards associated with loss of earnings are not reflected in the estimate, as they are not payable until the eighteenth birthday of the infant – thus, additional liability is incurred beginning in fiscal 2038 for these costs. Any awards for reasonable expenses incurred in filing the claim have not been factored into this estimate.

Future year expenditures also reflect a full salary with annual increases and employee turnover as well as ongoing operating expenses.

Additional Comments: Beginning in fiscal 2020, costs to commercial insurers increase significantly annually as a result of increased hospital rates associated with the cost of premiums. Commercial insurance comprises about 35% of total hospital revenues annually. Commercial insurers may pass this cost on to consumers by increasing premiums.

Additional Information

Prior Introductions: SB 877 of 2017 received a hearing in the Senate Judicial Proceedings Committee, but no further action was taken. Its cross file, HB 1347, received a hearing in the House Health and Government Operations Committee, but no further action was taken. SB 513 of 2016, a similar bill, received a hearing in the Senate Judicial Proceedings Committee, but no further action was taken. Its cross file, HB 377, received a hearing in the House Health and Government Operations Committee and in the House Judiciary Committee, but no further action was taken. Similar legislation was also introduced in the 2015 and 2014 sessions.

Cross File: HB 909 (Delegate Cullison, *et al.*) - Health and Government Operations and Judiciary.

Information Source(s): Judiciary (Administrative Office of the Courts); Maryland Department of Health; Office of Administrative Hearings; Maryland Health Care Alternative Dispute Resolution Office; Maryland Insurance Administration; Pinnacle Actuarial Resources, Inc.; Department of Legislative Services

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