SB 879

Department of Legislative Services

Maryland General Assembly
2020 Session

FISCAL AND POLICY NOTE
First Reader

Senate Bill 879 (Senator Kelley)
Finance and Judicial Proceedings

Public Health – Maryland Infant Lifetime Care Trust Funded by HSCRC and Maryland Patient Safety Center Duties

This bill establishes a system for adjudication and compensation of claims arising from birth-related neurological injuries by establishing the Maryland Infant Lifetime Care Trust. 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, 2021. **The bill takes effect July 1, 2020.**

Fiscal Summary

State Effect: Special fund expenditures increase by $200,000 in FY 2021 and $1.1 million annually thereafter; special fund revenues increase by $1.0 million annually beginning in FY 2022. Medicaid expenditures increase beginning in FY 2022 (not reflected below).

(in dollars)	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025
SF Revenue	$0	$1,000,000	$1,000,000	$1,000,000	$1,000,000
SF Expenditure	$200,000	$1,100,000	$1,100,000	$1,100,000	$1,100,000
Net Effect	($200,000)	($100,000)	($100,000)	($100,000)	($100,000)

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

Maryland Infant Lifetime Care Trust Effect: Nonbudgeted expenditures increase by an estimated $3.0 million in FY 2022; out-years reflect cumulative impacts. Nonbudgeted revenues increase beginning in FY 2022 in an amount sufficient to at least cover costs.

(in dollars)	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025
NonBud Rev.	$0	-	-	-	-
NonBud Exp.	$0	$2,962,400	$4,031,400	$5,085,700	$6,140,200
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: The bill establishes the Maryland Infant Lifetime Care Trust to provide compensation for a limited class of cases of birth-related injuries that result in unusually high costs of custodial care and rehabilitation. The benefits and compensation provided by the trust apply only to injuries caused in relation to births occurring on or after January 1, 2021.

Applicable Definitions

"Birth-related neurological injury" means an injury to the brain or spinal cord of a live infant born in a hospital in the State 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.

"Claimant" means an injured individual, or a person authorized to act on behalf of an injured individual, who asserts a claim against a health care practitioner (specifically, an individual licensed or certified under the Health Occupations Article and whose scope of practice includes the provision of obstetrical services or the practice of midwifery) or hospital for injuries arising from health care services provided in connection with the injured individual's birth, including services provided during labor, delivery, or the resuscitative period after delivery.

"Qualifying health care costs" means reasonable expenses of medical, hospital, and rehabilitative care; family residential services; custodial care; professional residential care; durable medical equipment; assistive technology; medically necessary drugs; related travel; and residential or vehicle modifications necessary to meet the qualified plaintiff's health care needs as determined by their treating physicians, physician assistants, or nurse practitioners. The term includes costs as may otherwise be defined by statute or regulation and specifically includes services that are not medical in nature but are supportive of a plan of care for the qualified plaintiff.

"Qualified plaintiff" means an individual who has been determined to have sustained a birth-related neurological injury in the State that qualifies for payment from the trust or a person authorized to act on behalf of the injured individual.

Certain Settlements and Judgments Are Directed to the Trust for Payment

For claims arising out of a birth-related neurological injury subject to the bill, each settlement agreement that provides for the payment of future medical expenses for a

claimant must also specify that, if a final determination is made that the claimant is a qualified plaintiff, those payments are to be made through the Maryland Infant Lifetime Care Trust. As a condition of court approval, the court must direct the modification of an agreement that does not include this requirement.

In any case in which the jury or court has made an award for future medical expenses arising out of a birth-related neurological injury subject to the bill, any party to the action (or person authorized to act on behalf of the party) may apply to the court to request that, on a final determination that the plaintiff is a qualified plaintiff, the judgment reflect that the future medical expenses of the plaintiff will be paid out of the Maryland Infant Lifetime Care Trust.

On a finding by the court that the applicant has made a *prima facie* showing that the plaintiff is a qualified plaintiff, the court must ensure the judgment provides that the plaintiff is a qualified plaintiff. However, as described below, the trust must make the preliminary determination of whether the plaintiff is a qualified plaintiff, and if the preliminary determination is disputed, the Office of Administrative Hearings (OAH) must make the final determination.

With respect to a qualified plaintiff, any defendant or defendant's insurer may not be required to pay for future qualifying health care costs and a judgment may not be made or entered requiring the defendant or defendant's insurer to do so. Nevertheless, the qualified plaintiff's attorney's fee for specified elements of damages must be paid in a lump sum by the defendants and their insurers, and it must be based on the entire sum awarded by the jury or the court or the full sum of the settlement. The qualified plaintiff's attorney must receive payment for court and witness expenses.

Enrollment in the Trust

A claimant must be enrolled in the Maryland Infant Lifetime Care Trust as a qualified plaintiff if three conditions are met. First, any party to the action (or person authorized to act on behalf of the party) has to apply for enrollment of the claimant in the trust, specifically by providing the trust with a certified copy of the judgment or the court-approved settlement agreement. Second, the party (or person authorized to act on behalf of the party) seeking the claimant's enrollment must provide notice to all parties of the application for enrollment. Finally, a final determination that the claimant is a qualified plaintiff has to have been made on the basis of the judgment or settlement agreement and any additional information the trust requests.

The trust must make the preliminary determination as to whether a claimant is a qualified plaintiff and provide written notice to all parties. If that determination is disputed by any party, the final determination must be made by OAH.

Benefits and Compensation to Be Paid

Once enrolled, a qualified plaintiff is eligible for the following benefits and compensation to be paid and provided from the Maryland Infant Lifetime Care Trust:

- actual lifetime expenses for qualifying health care costs, limited to reasonable charges prevailing in the same community for similar treatment of injured individuals when the treatment is paid for by the injured individual; and

- reasonable expenses incurred in connection with the adjudication of any disputed matters.

However, the actual lifetime expenses do not include expenses for items or services that the claimant has received (1) under federal or State laws (except to the extent that the exclusions are prohibited by law); (2) from a prepaid health plan, a health maintenance organization, or any other private insuring entity (or is contractually entitled to receive them); (3) reimbursement for, under the provisions of a health or sickness insurance policy or any other private insurance program (or is contractually entitled to receive such reimbursement); and (4) related to the provision of housing, except for the modification of residential environment.

The qualified plaintiff's attorney's fees may not be paid from the trust; instead, they must be paid by defendants and their insurers.

The trust must also make the preliminary determination as to whether a cost is a qualifying health care cost to be paid from the trust and must provide written notice to all parties. Generally, however, a health care cost that a qualified plaintiff's treating physician, physician's assistant, or nurse practitioner determines to be reasonable and necessary is presumed to be a qualifying health care cost absent clear and convincing evidence that it is not. As for preliminary determinations about enrollment, if a preliminary determination about costs is disputed by any party, the final determination must be made by OAH.

Promptly following a preliminary determination that a cost is a qualifying health care cost, the trust must pay the qualified plaintiff's health care provider – at a rate that is at least 130% of the Medicaid rate of reimbursement – or reimburse the qualified plaintiff the amount certified for payment.

All health care providers must accept, from qualified plaintiffs (or persons authorized to act on their behalf), assignments of the right to receive payments from the trust for qualifying health care costs. Qualifying health care costs are to be paid from the trust only to the extent that health insurers or other collateral sources – except for Medicare or Medicaid – or other persons are not otherwise obligated to make payments. Accordingly,

health insurers, other than Medicare or Medicaid, must be the primary payers of qualifying health care costs of qualified plaintiffs.

How a Preliminary Determination Becomes Final

If any preliminary determination made by the Maryland Infant Lifetime Care Trust is disputed, in writing, by a party within 30 days after notice of that determination is received, the trust must refer the dispute to OAH for adjudication and final determination by an administrative law judge (ALJ). The hearing date must be set between 60 and 120 days after the referral for adjudication. The bill establishes hearing procedures specific to such cases; however, an ALJ must make a decision on any contested preliminary determination within 30 days after the hearing. A decision of OAH constitutes a final decision for purposes of judicial review, and a party may seek judicial review of a final decision, which stays enforcement of the final decision.

OAH must provide specialized training to ALJs who are assigned to adjudicate contested cases.

Any preliminary determination made by the trust that is *not disputed* as described above is a final determination. Thus, a preliminary determination cannot become a final determination until at least 30 days have elapsed after notice is received by the parties.

Duties, Responsibilities, and Management of the Trust

The Maryland Infant Lifetime Care Trust is authorized to (1) receive premiums collected under the bill's funding mechanism provisions (described below); (2) administer the payment of awards for future medical expenses due to birth-related neurological injuries; (3) invest and reinvest surplus money over losses and expenses; (4) reinsure the risks of the trust wholly or partly; (5) employ or retain persons as necessary to perform the administrative and financial transactions and any other necessary and proper functions not prohibited by law; (6) enter into contracts as necessary or proper to carry out the legal and proper business of the trust; and (7) subject to certain provisions, require an uninsured qualified plaintiff to obtain private health insurance (generally when it would be more cost-effective to do so and only if the trust pays the premiums or other costs of the coverage and that insurance is used to provide coverage for the qualified plaintiff's health care).

The bill establishes a seven-member board of trustees of the trust, each of whom is appointed by the Governor and must meet specified qualifications. 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 trust duties as well as reimbursement for reasonable expenses.

The board must choose a chair from among its members and must appoint a trust administrator, who serves at the pleasure of the board. The board must determine the compensation of the trust administrator. The trust administrator must appoint and remove employees of the trust and must determine their compensation with the approval of the board. Employees of the trust are not State employees and are not in the State Personnel Management System.

The trust consists of revenues, premiums, and other receipts of money as provided by law. All operating expenses of the trust must be paid from the money collected by or for the trust. Money and property available to the trust may be used for the general purposes of the trust, including for the payment of awards and for the administrative expenses of the trust. The assets of the trust are not part of the State Treasury, and a debt or obligation of the trust is not debt of the State or a pledge of credit of the State. In accordance with actuarial estimates, when the amount of money in the trust exceeds the amount that the trust administrator believes is likely to be required during a fiscal year, the board may manage the excess as the board considers appropriate and invest the excess in investments legal for casualty insurers under the relevant State law.

Each fiscal year, the trust must engage an independent certified public accountant to audit its accounts and a qualified actuary to review its assets and liabilities, examine the adequacy of its assets, and provide an actuarial opinion concerning the valuation of its assets and liabilities and the adequacy of the assets. Then, each fiscal year, based on the annual statement of actuarial opinion, the board must determine the amount required to finance and administer the trust and provide notice of the amount to the Health Services Cost Review Commission (HSCRC) on or before March 1.

Finally, the trust must provide to each hospital in the State and to each obstetrician practicing in the State written materials containing information about the trust for distribution to obstetrical patients. Those materials must explain a patient's rights, remedies, and limitations under the trust.

Funding Mechanism for the Trust

To fund the Maryland Infant Lifetime Care Trust, on or before the beginning of each fiscal year, HSCRC must:

- assess premiums on hospitals, but only for those hospitals that charge for acute obstetrics, neonatal ICU, newborn nursery, premature nursery, normal newborn, or labor and delivery services;

- increase hospital rates – but only for acute obstetrics, neonatal ICU, newborn nursery, premature nursery, normal newborn, and labor and delivery services – by

an amount, capped at $40.0 million, sufficient to finance and administer the trust for the upcoming fiscal year, as reasonably determined by the board of trustees; and

- collect from hospitals that charge for acute obstetrics, neonatal ICU, newborn nursery, premature nursery, normal newborn, or labor and delivery services the amount needed to sufficiently finance and administer the trust.

HSCRC must adopt regulations detailing the methodology for the assessment of premiums. The assessment methodology must account for geographic differences among hospitals as well as differences among hospitals' historical claims experience involving births. In determining hospital rates, HSCRC must increase rates to account 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.

Annually, by September 1, each hospital assessed a premium must pay it to HSCRC. HSCRC must forward the payments to the trust.

Birth-related Injury Prevention

The board of trustees must allocate a grant of $1.0 million each year to the Maryland Department of Health (MDH) to study and address disparities in and improve maternal and fetal outcomes across the State. MDH must allocate funding each year from this grant to the Maryland Patient Safety Center (MPSC) for the staffing of a Perinatal Clinical Advisory Committee (PCAC) and for program activities. Accordingly, MPSC must convene PCAC to oversee the general dissemination of initiatives, guidance, and best practices to health care facilities for perinatal care. More specifically, PCAC must review the Maryland Infant Lifetime Care Trust claims process and other data available to MDH, formulate best practices for prenatal care and deliveries in Maryland, and develop and implement programs to improve obstetrical care outcomes. MPSC must report annually to the board of trustees and MDH; MDH must report annually to the board of trustees on the use of the grant and the status of maternal and fetal outcomes.

Additional HSCRC Duties

Annually, HSCRC must, within a reasonable time after the end of each facility's fiscal year and for the purpose of assessing premiums to fund the Maryland Infant Lifetime Care Trust, study and make available a public report assessing the status of the State's hospital reinsurance market and the cost of self-insurance programs. The study and report must include the availability, adequacy, and affordability of reinsurance and facilities in the State.

In addition, for the purpose of assessing premiums to fund the trust, HSCRC must compile information on costs associated with medical liability, including those associated with obtaining medical liability insurance, as part of rate review and approval. HSCRC must define, by regulation, the methodology used to account for costs associated with medical liability in the rate review process.

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 the Health Care Alternative Dispute Resolution Office (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 $890,000 for causes of action arising on or after October 1, 2020. For causes of action arising on or after October 1, 2021, the cap is $905,000. 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 2020, the cap is $830,000; for causes of action arising in 2021, the cap is $845,000. 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 $1,037,500 in 2020.

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,* MDH (then 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 those 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.

In July 2019, a Baltimore City jury awarded $229 million in a medical malpractice case to a mother and her baby, who was born with brain damage at Johns Hopkins Bayview Medical Center. The trial judge reduced the $25 million the jury awarded for pain and suffering to $740,000, due to the State's cap on noneconomic damages. The rest of the approximately $205 million verdict remains intact, although this case is in the appeals process.

State Fiscal Effect:

Medicaid

The bill increases hospital rates by up to $40.0 million for the upcoming fiscal year, but the rate increase only applies to acute obstetrics, neonatal ICU, newborn nursery, premature nursery, normal newborn, and labor and delivery services. Medicaid typically pays for 45% to 48% of all births in the State, and commercial insurance pays for most other births. (Medicaid expenditures account for approximately 20% of *total* hospital revenues annually.) Thus, as much as $19.2 million of the rate increase could be paid by Medicaid in any year that the cap (of $40.0 million) is reached. If federal participation is not allowed because the rate increase does not apply uniformly across all payers, general funds may have to cover the total assessment to Medicaid. To the extent federal participation is allowed for this purpose, the impact on general fund expenditures is mitigated. At a 60% federal fund participation rate for these services, as much as $7.7 million in general funds could be required to pay the annual rate assessment.

Thus, Medicaid expenditures increase, potentially significantly, beginning in fiscal 2022 due to the bill's requirement that HSCRC increase hospital rates to account for the cost of

the premiums; federal fund revenues increase to the extent federal participation is allowed for this purpose. The amount of the increase depends on the amount of hospital premiums assessed by HSCRC and cannot be precisely determined at this time; however, a lower assessment is likely initially.

To the extent qualified plaintiffs would have been Medicaid or Maryland Children's Health Program recipients, costs that would have gone to their care are offset to some extent. *For illustrative purposes only*, Maryland Medicaid funds a model waiver program, which allows medically fragile individuals who would otherwise be hospitalized and are certified as needing either hospital or nursing facility level of care to receive medically necessary and appropriate services in the community. This program costs approximately $125,133 per person annually.

Health Services Cost Review Commission

HSCRC advises that it requires a consultant to assess the status of the State's hospital reinsurance market and the cost of self-insurance programs and to produce the accompanying report. HSCRC advises its staff has limited experience working on issues of reinsurance and medical liability; thus, HSCRC requires a consultant to perform these analyses and produce the annual report. HSCRC estimates consultant costs at $100,000 per year.

HSCRC needs assistance in developing the initial methodology to account for costs associated with medical liability in the rate review process. HSCRC estimates consultant costs for this purpose of $100,000 in fiscal 2021 only.

Other Agencies

MDH receives and expends the $1.0 million grant awarded to it each year from the trust; this analysis assumes that award is first made in fiscal 2022; a portion of the funding is used by MPSC.

The Judiciary advises that the bill requires additional clerical and court time to review birth injury settlements and to address any appeals. Due to the low number of birth injury claims per year, the Department of Legislative Services (DLS) advises that any such impact is not expected to be significant.

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.

The Maryland Board of Physicians and HCADRO are not materially affected.

Maryland Infant Lifetime Care Trust 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 *2018 Vital Statistics Annual Report*, there were 71,037 live births to Maryland residents in 2018. Thus, approximately 7 qualifying infants are born each year. As claims may only be made for births occurring on or after January 1, 2021, only four valid claims are assumed to be presented in fiscal 2021.

Nonbudgeted Revenues

This analysis assumes capitalization of the trust begins in fiscal 2022, when HSCRC is first able to assess hospital premiums. In fiscal 2021, the trust 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 trust 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 2021 and, consequently, hospitals would not be able to pay premiums in fiscal 2021. Moreover, HSCRC will not have the required information to adopt the required methodology for the fiscal 2022 assessment either; regardless, this analysis assumes HSCRC can independently develop a methodology to cover premium assessments (and related rate increases) for fiscal 2022. DLS notes that, even though the cause of action eligibility date is January 1, 2021 (fiscal 2021), this analysis assumes the trust cannot be capitalized until fiscal 2022.

Given that premiums are assessed based on a methodology that is yet to be determined by HSCRC, exact trust revenues for fiscal 2022 through 2025 cannot be determined; however, this analysis assumes that revenues must increase, at a minimum, by an amount sufficient to cover the trust's anticipated expenditures, as discussed below. Additional revenues 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 trust in fiscal 2022 are assumed to total almost $3.0 million, as discussed below, and include a full-time trust administrator, board compensation, required annual actuarial and audit reports, distribution of pamphlets, grant funding for MDH (and MPSC), and payment of qualifying health care costs for qualified plaintiffs. The estimate assumes a September 1, 2021 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 trust is capitalized (hospital premiums must be collected by September 1, 2021). The bill requires that all operating

expenses of the trust (which includes the board) be paid from the money collected by or for the trust.

The estimate for the trust administrator 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. 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 trust 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 – Trust Administrator	1.0
Salary and Related Benefits	$101,176
Per Diem Expenses for Board Members	70,000
Pamphlets	10,800
Actuarial and Audit Reports	125,000
Other Operating Expenses	5,417
Annual MDH Grant	1,000,000
Payments for Qualifying Health Care Costs	1,650,000
Total FY 2022 Nonbudgeted Expenditures	**$2,962,393**

The bill also requires the board to allocate a grant of $1.0 million each year to MDH to study and address disparities in and improve maternal and fetal outcomes in the State. MDH must allocate funding each year from this grant to MPSC to staff PCAC and for other program activities. This analysis assumes that the grant begins in fiscal 2022 when the trust is capitalized.

Additionally, this analysis reflects payments of $1.65 million for qualifying health care costs in fiscal 2022. The estimate assumes payments are made for 11 qualified plaintiffs in fiscal 2022 (the 7 qualified plaintiffs that are eligible in 2022 and the 4 qualified plaintiffs that are eligible in fiscal 2021 but have to wait to receive payment until the trust is capitalized). Annually thereafter, payments increase to cover the qualifying health care costs for those qualified plaintiffs as well as 7 more qualified plaintiffs each year. Thus, in fiscal 2025, payments from the trust for qualifying health care costs are assumed to total $4.8 million. As qualifying health care costs are incurred for the lifetime of the qualified plaintiff, they have a cumulative impact on the payments from the trust.

DLS notes that actual lifetime expenses for qualifying health care costs and other reasonable expenses vary on a case-by-case basis. For the purposes of this analysis, each qualified plaintiff is assumed to have approximately $150,000 of such costs paid each year.

To the extent those costs are higher or lower, payments from the trust further increase or are mitigated.

Additional Comments: Beginning in fiscal 2022, costs to commercial insurers increase significantly as a result of increased hospital rates due to the assessment under the bill. Although commercial insurance comprises about 35% of *total* hospital revenues annually, their share of the services subject to the assessment is greater – likely closer to 50%. Commercial insurers may pass this cost on to consumers by increasing premiums. This would affect insurance premium tax revenues, which have not been factored into this estimate.

Additional Information

Prior Introductions: Legislation with a similar purpose has been considered in recent legislative sessions. SB 869 of 2019 received a hearing in the Senate Judicial Proceedings Committee, but no further action was taken. Its cross file, HB 1320, was referred to the House Rules and Executive Nomination Committee, but no further action was taken. HB 909 of 2018 received a hearing before the House Health and Government Operations and House Judiciary committees, but no further action was taken. Its cross file, SB 862, received a hearing in the Senate Judicial Proceedings Committee, but no further action was taken. Similar legislation was also introduced in the 2017, 2016, 2015, and 2014 sessions.

Designated Cross File: HB 1563 (Delegate Cullison) - Judiciary and Appropriations.

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; Department of Legislative Services

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