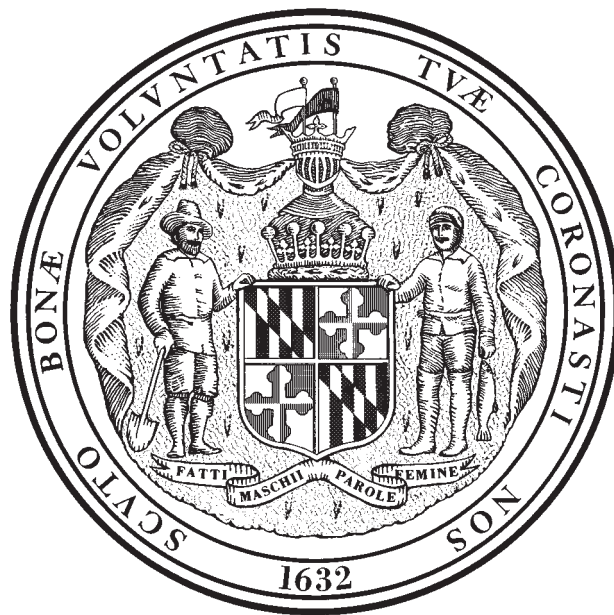


**RECOMMENDATIONS OF THE
SENATE SPECIAL COMMISSION ON MEDICAL
MALPRACTICE LIABILITY INSURANCE**



ANNAPOLIS, MARYLAND
DECEMBER 2004

**Recommendations of the
Senate Special Commission on Medical
Malpractice Liability Insurance**

Annapolis, Maryland

December 2004

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The Senate of Maryland

ANNAPOLIS, MARYLAND 21401-1991

December 17, 2004

The Honorable Thomas V. Mike Miller, Jr.
President of the Senate
State House
Annapolis, Maryland 21401

Dear President Miller:

The Senate Special Commission on Medical Malpractice Liability Insurance respectfully submits its final report containing the commission's recommendations regarding medical malpractice reform initiatives for the State. Having considered patient safety initiatives, comprehensive insurance reform, physicians' reimbursements, medical professional liability insurance rate increases, and tort liability, the commission believes that its final recommendations offer a comprehensive approach to confronting the medical malpractice issue.

The commission greatly appreciates the guidance and leadership that you have provided throughout the course of its activities this interim.

Sincerely,

A handwritten signature in black ink, reading "Brian E. Frosh".

Brian E. Frosh, Chairman
Senate Special Commission on
Medical Malpractice Liability Insurance

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Chapter 1. Introduction

Medical Malpractice Insurance Crisis Overview

Increases in medical malpractice premiums and awards have drawn national attention and, according to the American Medical Association, have contributed to a “crisis” in 20 states. The current crisis is actually the third such crisis in the last 30 years. The first was spurred by massive losses in the medical professional liability insurance market in the 1970s that forced many insurers to leave the market. The second occurred in the 1980s and was driven by rampant increases in the frequency and severity of paid claims. The current crisis appears to be a combination of many factors, including the rise in claim severity nationwide, the exodus from the market of several insurers, declining investment yields, and prior premium rates set low to garner market share.

In June 2003, the General Accounting Office (GAO) published a report that studied the extent of increases in medical malpractice insurance rates, analyzed the factors contributing to these increases, and identified market changes that might make this period of rising insurance premiums different from previous such periods.¹ GAO found that the largest contributor to increased premium rates was insurer losses on medical malpractice claims. This finding is tempered by a lack of comprehensive data available at either the federal or state level. Other contributing factors to current premium rate increases include decreased investment income, artificially low premium rates adopted while insurers competed for market share during boom years, and higher overall costs due largely to increased reinsurance rates for medical malpractice insurers.

The burden of the higher cost of medical professional liability insurance falls on health professionals and facilities. During the second medical malpractice crisis, in the 1980s, health care providers responded to sharply rising liability premiums by passing the cost on to public and private payers. Since then, the advent of managed care in commercial markets has limited a provider’s ability to pass on increased rates as a cost of business. In response to lower reimbursement rates and higher medical professional liability insurance premiums, many health care providers have threatened to quit their practices, reduce hours, move from the State, or retire.

Medical Professional Liability Insurance in Maryland

Nationally, signs of a third crisis emerged in 2001 when the St. Paul Companies, the nation’s largest medical professional liability carrier, ceased offering coverage to physicians both in Maryland and nationally. Maryland appeared unaffected until June 2003, when the State’s largest medical professional liability insurer, the Medical Mutual Liability Insurance Society of Maryland (Medical Mutual), received approval from the Maryland Insurance Commissioner for a 28 percent rate increase in insurance premiums, effective January 1, 2004.

¹ Medical Malpractice Insurance “Multiple Factors Have Contributed to Increased Premium Rates” GAO, June 2003.

In June 2004, Medical Mutual requested a rate increase of 41 percent. Among other factors, Medical Mutual pointed to an increase in claim severity as prompting the need for increased rates. In calendar 2002, Medical Mutual paid claims, including defense costs, totaling \$56.0 million as compared to \$93.2 million in 2003. A 33 percent rate increase effective January 1, 2005, was approved and will increase the cost of medical professional liability insurance to be approximately \$150,000 for obstetricians, the highest risk specialty.

The Senate Special Commission on Medical Malpractice Liability Insurance

Medical Mutual's 2004 rate increase prompted several unsuccessful proposals during the 2004 session. Concerned that these proposals did not offer a comprehensive approach to the medical malpractice environment in the State, the Senate President formed the Special Commission on Medical Malpractice Liability Insurance to consider all facets of the medical malpractice issue, including patient safety, comprehensive insurance reform, physicians' reimbursements, and medical malpractice rate increases. The charge of the commission was to consider thoroughly the varied components of medical malpractice and to develop comprehensive reform legislation that would provide immediate relief for doctors as well as long-term reform options to promote stability in the medical professional liability insurance cycle.

Chapter 2. Work of the Commission

Agenda and Presentations

During the course of the 2004 interim, the commission held five briefings, a public hearing, and two decision meetings to address issues of insurance reform, tort liability, and patient safety.

Initial Meeting – Overview

On June 15, 2004, the National Conference of State Legislatures provided an overview presentation to the commission regarding medical malpractice insurance issues from a 50-state perspective. The presentation offered an historical context for the medical professional liability insurance market and how the insurance cycle has affected the availability and affordability of this line of insurance on a national level.

Availability and Affordability of Medical Professional Liability Insurance

On July 6 and October 27, 2004, the commission held briefings to address issues related to medical professional liability insurance. Testimony presented to the commission included presentations by:

- the National Association of Insurance Commissioners regarding how medical professional liability insurance rates are calculated;
- the Maryland Insurance Administration regarding Maryland's regulatory environment;
- the Maryland Hospital Association, LifeSpan, Health Facilities Association of Maryland, MedStar, Xavier Health Care Services, and Senior Network, Inc., regarding health facility insuring practices;
- the Health Services Cost Review Commission regarding the Maryland hospital rate-setting system;
- two former insurance commissioners regarding the business practices of medical professional liability insurers and the process by which rate increases are determined;
- Medical Mutual regarding the experience of the State's largest physician insurer; and
- the Office of the Attorney General regarding the insurance anti-trust exemption.

The Role of the Legal System

A controversial component to the medical malpractice debate has been the role of the legal system. While some suggest that limiting monetary awards for noneconomic damages would reduce insurance premiums, others believe that damage caps unfairly penalize the victims of medical negligence. On August 25 and October 27, 2004, the commission heard presentations from the proponents and opponents of tort liability reform, as well as presentations regarding the mindset of a medical malpractice juror and alternative dispute resolution methods, including:

- Medical Mutual, the Maryland Hospital Association, and MedChi, the Maryland State Medical Society, in support of tort liability reform;
- the Maryland Trial Lawyers Association, lawyers, victims, and the Consumers Union, in opposition to tort liability reform;
- law professors from the University of Baltimore School of Law, the University of Maryland School of Law, and Duke University regarding the tort system from an academic perspective; and
- a retired judge from the Maryland Court of Appeals who specializes in mediation.

Improving Patient Safety

The Institute of Medicine reports that up to 98,000 preventable deaths occur each year because of medical errors. Operating under the premise that safer patient care results in less litigation due to medical negligence, and that fewer medical malpractice claims result in lower medical professional liability insurance premiums, on September 15, 2004, the commission heard presentations from various patient safety advocates, including:

- the Josie King Pediatric Patient Safety Program at Johns Hopkins Health System;
- Public Citizen regarding a “systems approach” to making patients safer;
- the National Academy for State Health Policy regarding patient safety initiatives in other states;
- the Urban Institute regarding avoidable classes of events;
- the role of information technology in the patient safety arena;

- the Maryland Board of Physicians and MedChi, the Maryland State Medical Society, regarding physician discipline; and
- the Maryland Health Care Commission and the Department of Health and Mental Hygiene regarding the establishment of the Maryland Patient Safety Center.

The Public Perception

On October 6, 2004, the commission provided an opportunity for members of the public to testify on issues related to medical malpractice. The commission heard five hours of testimony from interested parties including victims of medical malpractice and their families, representatives of health care facilities, health care providers, and attorneys.

Decision Meetings

The commission met to discuss recommendations for inclusion in legislation on November 17 (insurance and patient safety) and on December 1, 2004 (tort liability). The perspectives and recommendations presented during the various briefings and the public hearing were considered by commission members. The incorporation of many of these perspectives and recommendations can be found within the commission's recommendations, contained within Chapter 3 of this report.

Chapter 3. Recommendations

During the two decision meetings of the commission, over 20 options for legislative change were presented to combat the current medical malpractice situation in the State. These options reflected both immediate relief and long-term solutions. The immediate relief included a Rate Stabilization Program. Long-term relief included changes to the laws and regulations governing insurance, patient safety, and tort liability.

The recommendations of the commission are as follows:

Immediate Relief

Physician Premium Assistance

Recommendation 1: Establish the Rate Stabilization Account within the Maryland Medical Professional Liability Insurance Rate Stabilization Program to retain health care services in the State by allowing physicians to purchase liability insurance at a reduced cost through a rebate or insurance rate reduction. The account would be funded by repealing the 2 percent premium tax exemption for health maintenance organizations and managed care organizations.

The commission heard testimony that the recent increases in medical professional liability insurance rates are resulting in physicians limiting services (particularly in the field of obstetrics), declining services to Medicaid enrollees, reducing hours, moving from the State, or retiring. The commission is concerned that the loss of physicians in the State will create a serious risk to public health and safety and that immediate relief is needed to maintain access to health care providers and services.

Medicaid Reimbursement

Recommendation 2: Establish the Medical Assistance Program Account within the Maryland Medical Professional Liability Insurance Rate Stabilization Program to provide increased compensation to physicians offering services under the Maryland Medical Assistance Program. The account would be funded by repealing the 2 percent premium tax exemption for health maintenance organizations and managed care organizations.

Reimbursement levels for health care providers participating in the Maryland Medical Assistance Program (Medicaid Program) are approximately 60 percent of 2004 Medicare rates. The low reimbursement rate in the Medicaid Program coupled with the increasing cost of medical professional liability insurance may result in fewer health care providers willing to participate in the

Medicaid Program. The commission believes that to maintain continued access to health care providers and services in the Medicaid Program, the State must encourage more health care providers to participate in the Medicaid Program by increasing Medicaid reimbursement rates.

Long-term Relief

Insurance Reform

Medical professional liability insurance rate increases are at the forefront of the medical malpractice debate. Depending on the specialty and the state, the median increase in malpractice premiums ranged from 15 to 30 percent in 2003, with some states (e.g., Pennsylvania) experiencing higher rate increases of 26 to 73 percent. The commission considered a number of proposals that sought to reduce the rate of increase in medical professional liability insurance rates.

Among the insurance proposals considered as recommendations by the commission were rate compression and reducing or eliminating producer commissions. The commission expressed concern that rate compression would lead to the “cherry picking” of low risk specialties from the insurance pool of the larger medical professional liability insurers. The commission also expressed concern that reducing or eliminating producer commissions might increase the cost of the insurance product if insurers maintain producers in-house.

Recommendation 3: Amend the reporting requirements under § 4-401 of the Insurance Article to include mandatory reporting of medical professional liability insurance claim information to the Maryland Insurance Commissioner and require the commissioner to compile the claim information received and report annually to the Governor and the General Assembly on the status of the availability and affordability of medical professional liability insurance in the State.

The commission expressed serious concerns about the lack of available information necessary to evaluate the frequency, severity, and causes of losses on medical malpractice claims. The lack of data is not unique to Maryland but, as identified in a June 2003 GAO report, is a problem nationwide.² The commission believes that required reporting of detailed claim and policy information will assist interested parties in understanding and identifying the reasons behind increases in medical professional liability insurance rates.

Recommendation 4: Establish a People’s Insurance Counsel within the Office of the Attorney General to protect the interests of insurance consumers and grant the People’s Insurance Counsel the right to conduct investigations and cross-examine witnesses during

² Medical Malpractice Insurance “Multiple Factors Have Contributed to Increased Premium Rates” GAO, June 2003, page 6.

hearings before the Maryland Insurance Commissioner. The People's Insurance Counsel would also be authorized to represent the interests of insurance consumers before State and federal courts.

The commission expressed concerns about the lack of representation of insurance consumers' interests in the rate-making process. The commission expressed particular concern about the quality of information that is made available to the public about insurer rate-making. The commission believes that providing representation of insurance consumers by the People's Insurance Counsel will provide needed balance to the regulatory process and improve public confidence that proposed rate increases are not excessive, inadequate, or unfairly discriminatory.

Recommendation 5: Require the Maryland Insurance Administration to publish comparisons of the various insurance companies' offerings of medical professional liability insurance rate information.

The commission believes that providing this information, both in printed form and on the Maryland Insurance Administration web site, will assist physicians and certain health care facilities in comparing insurance rates and selecting a medical professional liability insurer.

Recommendation 6: Prohibit an insurance producer from entering into an exclusive appointment agreement with a medical professional liability insurer.

Producers selling medical professional liability insurance policies may enter into exclusive arrangements with insurance companies that prohibit a producer from selling a competitor's product unless the company with which the producer holds an exclusivity agreement declines coverage to the health care provider. The commission believes that prohibiting exclusivity agreements in the sale of medical professional liability insurance may provide physicians more options for purchasing medical professional liability insurance.

Recommendation 7: Allow medical professional liability insurance companies more flexibility in underwriting new applicants whose claims history might make them high risks.

The commission heard testimony that when an insurer declines to provide a policy to a health care provider who is new to that company, the Maryland Insurance Administration generally finds that the insurer's decision is not related to "standards that are reasonably related to the insurer's economic and business purposes" as provided under § 27-501 (a)(2) of the Insurance Article. When this finding is made, the insurer must offer the coverage even though the insurer believes that the health care provider is too great a risk for the insurer. This recommendation will allow medical professional liability insurers greater discretion in underwriting new applicants. This recommendation will not affect health care providers who have received a license within the last three years.

Recommendation 8: Reduce from as much as two years to 90 days the time during which the Maryland Insurance Commissioner must issue a finding upon receiving a request to review a cancellation or refusal to renew a medical professional liability insurance policy under § 25-501(f) of the Insurance Article.

The commission heard testimony that if a medical professional liability insurer declines to offer coverage or renew a policy of a physician, current law requires the insurer to continue coverage for that physician while the Maryland Insurance Administration makes a final determination regarding the insurer's action. This process may take up to two years to complete resulting in added risk exposure to the insurer. Requiring the Maryland Insurance Commissioner to issue a finding within 90 days of a request to review the insurer's action to cancel or refuse to renew a policy will allow an insurer to lower its risk exposure during the review period.

Recommendation 9: Prohibit a medical professional liability insurer from tying coverage for the defense of an insured in disciplinary hearings to basic medical professional liability insurance coverage.

A basic medical professional liability policy includes coverage for defense costs (attorney representation, etc.) of a physician during any Board of Physician disciplinary hearing and/or investigation, any hospital peer review/credentialing/privileging activity, and any health maintenance organization investigation. For example, this coverage, referred to as MedGuard by Medical Mutual, typically provides \$50,000 in defense costs. It adds to the cost of the standard liability policy and provides an incentive for an insured to contest a disciplinary action regardless of the merit of the charges or defenses. Although an insurer would be prohibited from offering this coverage as part of a basic policy, an insurer could offer and price this policy as a separate product.

Recommendation 10: Require medical professional liability insurers to offer insurance policies with higher deductibles.

Medical Mutual estimates premium savings for higher deductibles as follows:

- \$10,000 = .05 percent premium savings
- \$25,000 = 2.2 percent premium savings
- \$50,000 = 4.9 percent premium savings
- \$100,000 = 10 percent premium savings
- \$150,000 = 15 percent premium savings

The commission believes that requiring a medical professional liability insurer to offer a higher deductible product, but not requiring a physician to purchase a policy with a higher deductible, will provide physicians more options for purchasing medical professional liability insurance.

Recommendation 11: Prohibit a person from knowingly making a false health claim against one of the State’s Medicaid programs and provide civil penalties for making the false health claim. Permit a private citizen to file a civil action on behalf of the State against a person who has made a false health claim.

False claims made against the State’s Medicaid programs increase the cost of providing health care in the State. Current law only permits the Medicaid Fraud Control Unit of the Attorney General’s Office to investigate and prosecute provider fraud. Since many victims of provider fraud do not have access to the State court system, the commission believes that providing this access to private citizens may help to reduce the number of false claims made against the State’s Medicaid programs.

Patient Safety Initiatives

Since the issuance of the 1999 Institute of Medicine report, “To Err Is Human, Building a Safer Health System,” national attention has focused on patient safety and reducing errors in the health care system. These medical errors have been the result of both systemic hospital failure and personal physician error. With the establishment of the Maryland Patient Safety Center in June 2004, Maryland created a repository for the reporting of adverse events and near misses, as well as created a centralized facility for the training and education of the prevention of medical errors. Although the center is a great asset to the State, the commission also recommends patient safety initiatives as part of the medical malpractice reform package.

Recommendation 12: Change the standard of review for physician discipline from “clear and convincing evidence” applied in standard-of-care cases to be a “preponderance of the evidence.”

For the discipline of violations other than standard of care violations of the title relating to the licensure and regulation of physicians in the State, the standard of review is a preponderance of the evidence. Changing the standard in standard-of-care cases would eliminate the bifurcation of the standard of review for physician discipline. Of the approximately 700 investigations conducted by the Maryland Board of Physicians (MBP) during fiscal 2004, the following breakdown represents the majority of cases reviewed:

- 7 individuals were investigated for fraudulently or deceptively using a license;
- 257 individuals were investigated for immoral or unprofessional conduct;

- 8 individuals were investigated for abandoning a patient;
- 24 individuals were investigated for making or filing a false report or record;
- ***349 individuals were investigated for failing to meet appropriate standards of care;***
- 16 individuals were investigated for submitting false statements to collect unearned fees;
- 8 individuals were investigated for selling/prescribing drugs for illegal or immoral purposes; and
- 3 individuals were investigated for failing to comply with the Centers for Disease Control guidelines on universal precautions.

The commission notes that the change in the standard of review for physician standard-of-care cases would create parity among all of the health practitioners in the State. All other health occupations boards use a preponderance of the evidence standard of review for disciplinary cases.

Recommendation 13: Authorize MBP to impose the existing fine for failure to report disciplinary actions against physician licensees administratively rather than judicially.

Although current law authorizes the imposition of a \$5,000 fine for the failure of a hospital or a related institution to report a disciplinary action against a physician licensee, the fine is rarely imposed due to the administrative burden of petitioning the court for imposition of the fine. MBP reports that despite repeated failures to report, no fines were sought or imposed during fiscal 2004.

Recommendation 14: Provide express authority to the Department of Health and Mental Hygiene (DHMH) to investigate and fine hospitals up to \$10,000 for the failure to report adverse events.

Under current law, DHMH has the authority to fine a hospital \$500 per day for the failure to establish a risk management program, which, pursuant to regulation, must include a patient safety component. The patient safety regulations require a reporting system for adverse events, defined as unexpected occurrences related to a patient's medical treatment but not related to the natural course of the patient's illness or underlying disease condition. The regulations also provide for and encourage the voluntary reporting of near misses, defined as a situation that could have resulted in an adverse event but did not because of timely intervention or chance.

In the absence of explicit language in statute or regulation, the commission seeks to clarify that DHMH does have the authority to investigate whether a hospital lawfully reports adverse events.

Given the importance of this reporting requirement, the commission will provide DHMH the authority to impose a penalty of up to \$10,000 for the failure to report an adverse event.

Recommendation 15: Authorize a judge presiding over a legal action by a physician against a hospital or a hospital peer review committee to award attorney fees and costs to the prevailing party.

In cases where a hospital peer review committee recommends that a physician be disciplined (whether or not the action arises from a medical malpractice claim), the hospital typically takes disciplinary action against the physician. In some instances, the disciplined physician will challenge the hospital's disciplinary action and file suit against the hospital's peer review committee or the hospital itself. The Maryland Hospital Association reports that hospitals spend a significant amount of money in defense of these suits despite being the prevailing party approximately 90 percent of the time.

Recommendation 16: Require reporting to MBP the names of physicians named in a claim, or an amended claim, regardless of whether the physician or the physician's insurer contributes to the settlement.

MBP has the authority to investigate any alleged violation of law or regulation relating to physician licensure in the State. An investigation does not need to be predicated upon a legal complaint. Several of the reporting requirements for hospitals and insurers to MBP are designed to give notice to MBP of potential physician wrongdoing and to facilitate consequent investigations where appropriate.

MBP reports that when a settlement in a medical malpractice case is reached that only names the hospital, either within the original or an amended complaint, MBP does not receive notice of the name of the physician involved in the claim. In such instances, the hospital effectively shields the physician involved in the alleged wrongdoing. The commission believes that notifying MBP of the physician involved in the claim by amending the reporting requirements of insurers, health care practitioners, and health care facilities is in the best interest of the public. (*See Recommendation 2 under the Insurance Reform section of this chapter for further recommended changes to insurer reporting laws.*)

Tort Liability

Recommendation 17: Require mandatory mediation before trial of a medical malpractice case filed in State circuit court.

Mediation provides an opportunity for the parties to seek an agreement to settle a case. The commission believes that requiring the parties to meet before a neutral mediator, before discovery has been completed, will facilitate productive discussions with the goal of potentially avoiding the contentious and costly litigation process.

Recommendation 18: Reduce the total cap on noneconomic damages in wrongful death cases from 2.5 to 1.5 times the statutory cap when more than one claimant is involved. If both a survival action and a wrongful death action with more than one claimant is filed, the total cap would be reduced to \$975,000 from the current \$1,625,000. Noneconomic damages would also be apportioned among the two actions and the claimants if the jury awards an amount exceeding the noneconomic damages cap. Where there is only one claimant in a wrongful death action, the total noneconomic damages cap would remain at \$650,000.

In wrongful death cases, there are typically two separate claims, one for personal injury (survival action) and one for wrongful death. Current law permits the award of \$650,000 in the survival action and \$975,000 in a companion claim for wrongful death. The commission believes that it is appropriate to reduce the “double cap” in cases of medical negligence resulting in death.

Recommendation 19: Freeze the cap on noneconomic damages during the four-year duration of the Rate Stabilization Fund.

The commission believes that the cap on noneconomic damages should remain stable at \$650,000 for the four years that the Rate Stabilization Program is in effect. After that time, the cap would increase by \$15,000 on January 1, 2009, and annually thereafter.

Recommendation 20: Prohibit an apology or an expression of sympathy (benevolent gesture) from being admitted in court as an admission against interest or as an admission of liability.

There is evidence that victims of medical errors and their families frequently feel alienated when questions about medical errors go unanswered. Health care providers find that they are unable to answer questions or express compassion due to a fear of being sued. The commission believes that prohibiting the introduction into evidence of an expression of sympathy or an apology allows the health care provider to lessen the sense of alienation felt by a victim and would foster communication between the health care provider and the victim.

Recommendation 21: Prohibit an attorney who brings three or more frivolous medical malpractice lawsuits in a five-year period from bringing another medical malpractice case for a period of 10 years.

The commission believes that imposing sanctions on attorneys who bring multiple frivolous malpractice lawsuits will provide a disincentive to bringing frivolous cases.