Summary of Legislative Bills Significant to Healthcare Risk Managers Pursuant to the 2016 Legislative Session in Annapolis, Maryland

Prepared by:

The Maryland – DC SHRM Legislative Committee

Chair:	Julia Sibley
Co-Chair:	Erin C. Miller
Members:	Gregory Kirby
	Kristina L. Miller
	Marianne DePaulo Plant
	Erika Alsid Short

2016 Bills Summarized

- SB30 **Maryland Anesthesiologist Assistants Act**
  (Hearing stayed by Senate Education, Health & Environmental Affairs Committee)

- SB418/HB404 **Richard E. Israel and Roger "Pip" Moyer End-of-Life Option Act**
  (Unfavorable reports; withdrawn)

- HB606 **Patient Safety Early Intervention Programs**
  (Third reading passed House; hearing held before Senate Judicial Proceedings Committee without report)

- HB15 **Harford County-Suspected Overdoses–Reporting Requirement** –
  (Unfavorable report; withdrawn)

- HB24 **Public Health-Overdose Response Program–Educational Training Program Requirement**
  (Stayed in House Health & Government Operations)

- SB 97/HB0468 **Public Health–Opioid-Associated Disease Prevention and Outreach Programs**
  (Passed; effective October 1, 2016)

- HB245/SB310 **Child Abuse and Neglect–Failure to Report**
  (Passed; effective October 1, 2016)

- SB574 **Civil Actions-Noneconomic Damages-Catastrophic Injury**
  (Stayed in Senate Judicial Proceedings Committee)

- SB565 **Civil Actions-Offers of Judgment**
  (Stayed Senate Judicial Proceedings Committee)

- SB513/HB377 **Maryland No-Fault Birth Injury Fund**
  (Stayed Senate Judicial Proceedings Committee)

- SB63/HB56 **Investigational Drugs, Biological Products, and Devices-Right to Try Act**
  (Unfavorable report; withdrawn)

- SB566 **Medical Malpractice-Notice of Intent to File Claim**
  (Stayed Senate Judicial Proceedings Committee)

- SB886/HB1272 **Collaborations to Promote Provider Alignment**
  (Stayed Senate Finance Committee/unfavorable report)

- SB636 **Medical Malpractice-Discovery**
  (Stayed Senate Judicial Proceedings Committee)

- HB6 **Criminal Law-Improper Prescription of CDS Resulting in Death**
  (Unfavorable report)

- SB849/CFHB 814 **Task Force to Study The Establishment of Health Courts**
  (Unfavorable report; withdrawn)

- HB 1487/SB450 **Health Care Provider Malpractice Insurance – Scope of Coverage**
  (Passed; signed by Governor; effective October 1, 2016)

- SB661/HB 587 **Hospitals – Patient's Bill of Rights**
  (Unfavorable reports; withdrawn)

- SB71/HB0771 **Public Schools – Administration of Diabetes Care Services (Previously Public and Nonpublic Schools – Student Diabetes Management Program)**
  (Passed; effective July 1, 2016)

- SB12/HB1121 **Health Care Facilities – Closures or Partial Closures of Hospitals – County Board of Health Approval (Emergency Bill)**
  (Stayed in committees)

- SB0242/HB886 **Maryland Medical Assistance Program – Telemedicine – Modification**
  (Passed; effective June 1, 2016)

- HB1103 **Health Care Practitioners – Use of Teletherapy**
  (Unfavorable report; withdrawn)

- SB 928/HB1492 – **Task Force to Study the Nursing Shortage in Maryland**
  (Passed Senate; stayed in House committee)

- SB 734/HB0535 – **Courts and Judicial Proceedings – Structured Settlements – Transfers and Registration of Structured Settlement Transferees**
  (Passed; effective October 1, 2016)

SB 30
Maryland Anesthesiologists Assistants Act
Sponsored by: Senator Conway

Major Points:

- Requires the State Board of Physicians ("BOP") to adopt regulation for licensure of anesthesiologist assistants[1] and the practice of anesthesia care as anesthesiologist assistants.
- Establishes a BOP subcommittee to adopt regulations for licensure, scope and practice of anesthesiologist assistants.
- Allows anesthesiologist assistants to provide delegated medical anesthesia care/acts under the supervision of an anesthesiologist. Supervising anesthesiologists must be approved by the BOP to supervise up to 4 assistants to provide care consistent with the "delegation agreement" which would be submitted to and approved by the Board.
- Allows anesthesiologist assistants to assist the Anesthesiologist to develop and implement anesthesia care plan; obtain informed consent; take a detailed patient history; perform relevant elements of physical exam, est. basic & advanced airway interventions including intubation, administer vasoactive drugs, anesthetic drugs etc.

Significance of Bill to Risk Managers:

- The anesthesiologist assistant would not be recognized as a healthcare professional under current Maryland law, and thus the cap on non-economic damages wouldn't apply to anesthesiologist assistants as defendants.
- The anesthesiologist assistant cannot act independently. The anesthesiologist could be responsible for up to four anesthesiologist assistants at one time.
- The bill language specifically states that the anesthesiologist is "the agent of the supervising anesthesiologist" and "is liable for any act or omission of an anesthesiologist assistant acting under the anesthesiologist's supervision and control."
- Within the written delegation would be "an attestation of the supervising anesthesiologist of the anesthesiologist's *acceptance of responsibility* for any care given by the anesthesiologist's assistant."

Current Bill Status:

- Hearing stayed by Senate Education Health and Environmental Affairs Committee.

[1] Anesthesiologist assistants must first complete a four-year college degree, and then a two-year, master's level anesthesiologist assistant training program. Students complete 600 hours of coursework in the classroom and laboratory, a minimum of 63 didactic hours and 2,000 hours of clinical training. During the clinical portion, students will administer as many as 600 different anesthetics during a variety of surgeries. Students must pass a six-hour certification exam administered by the National Commission for the Certification of Anesthesiologist Assistants.

SB 418/HB404

Richard E. Israel and Roger "Pip" Moyer End-of Life Option Act

Sponsored by: Senators Young, Raskin, Guzzone, Kagan, Astle, Currie, Feldman, Gladden, Kelley, King, Madaleno, Manno, and Pinsky

Major Points:

- Authorizes an individual to request in writing aid in dying under certain parameters and that the individual that the qualified individual may self-administer the medication to bring about his own death.
- Authorizes an attending physician to prescribe medication that a qualified individual to self-administer the medication, under certain circumstances to hasten his/her own death; authorizes a pharmacist to dispense medication for aid in dying to certain individuals in a certain circumstances.
- If the physician is questioning the capacity of the individual to make medical decisions, the physician is to refer the individual to a Psychiatrist to make a determination of the individual's capacity.
- Provides that the death of a qualified individual by reason of self-administration of certain medication shall be deemed to be a death from certain natural causes, for certain purposes.
- Providing that participation by a healthcare provider is voluntary.
- Establishes certain penalties for certain violations and certain provisions of the Act would not limit liability.

Significance of Bill to Risk Managers:

- The pharmacist would not be recognized as a healthcare professional under current Maryland law, and thus the cap on non-economic damages wouldn't apply to pharmacists as defendants.
- Gives the exact informed consent language that would be contained on the required informed consent document which would have to be signed by the patient and two witnesses (one of which could not be related to the patient).
- The bill would subject pharmacists, prescribing physicians, psychiatrists and healthcare facilities to wrongful death lawsuits. The bill is broad with regards to what makes an individual qualify to opt for end of life. It says they must be an adult with medical decision making capacity, is a resident of the state, has the ability to self-administer medication and has a terminal illness. It defines terminal illness as a medical condition that within reasonable medical judgement involves a prognosis of likely death within 6 months. Reasonable medical judgement, however, is not defined but the bill does require more than one physician to make such a judgement.

Current Bill Status:

- Unfavorable Report by Judicial Proceedings; Withdrawn.

HB606
Patient Safety Early Intervention Programs
Sponsored by: Del. Dumais

Major Points:

- Allows (but does not require) hospitals, related institutions and health care liability insurers to establish a 'patient safety early intervention program' with the following required features:
    - Must provide for timely investigation of each report of an adverse event to determine if harm to the patient occurred and if the care provided deviated from the standard of care.
    - When an investigation reveals that substandard care did result in harm to the patient, the program shall have a process so the following occur timely:
        -Obtaining input from the patient/patient's family about the adverse event;
        -Disclosing to the patient/patient's family the findings of the investigation;
        -Apologizing to the patient for the care provided;
        -Advising the patient/patient's family of their right to legal representation;
        -Allowing the patient/patient's family to participate in efforts to identify and implement system improvements designed to prevent a recurrence of the adverse event;
    - Patients shall be provided a written summary of the hospital's program.
    - Services or support, including financial support, to the patient/patient's family does not affect the right of the patient to fair and reasonable compensation for damages associated with the adverse event available under State law.
- If a hospital, related institution, or health care liability insurer establishes such a program, statements made by a party during a discussion in accordance with this program are not admissible in evidence as an admission of liability or an admission against interest.

Significance of Bill to Risk Managers:

- Risk managers would likely be called upon to play an important role in the implementation of any such program, and all of the processes described above.
- For example, risk managers may be required to give a Miranda-like warning to patients, letting them know they have a right to a lawyer.
- Though the bill is intended to provide protection for these discussions from admission at trial, the language employed leaves many avenues for manipulation by inventive plaintiffs' attorneys.

Current Bill Status:

- HB606 was introduced on February 3, 2016 - 25% progression. Hearing on 2/17/16. Favorable report by Judiciary (117-18). Hearing in Senate Judicial Proceedings and no further action taken.

HB 15
Harford County - Suspected Overdoses - Reporting Requirement
Sponsored by: Delegate Szeliga and Cassilly

Major Points:

- Bill requires physicians, pharmacist, dentist, or nurse who treats or are in charge of a hospital that treats an individual in Harford County for suspected overdose that was caused or shows evidence of having been caused by a Schedule I CDS to notify the local or state police within 48 hours after the individual is treated.
- The reports must include the name and address of the individual who is suspected to have overdosed, a description of the type of overdose, and any other facts concerning the matter that might assist in addressing overdose rates in the county.
- Includes a criminal penalty (misdemeanor and fine of up to $25) for a person that fails to report.
- Intended to respond to drug and intoxication deaths, particularly for heroine related deaths.

Significance of Bill to Risk Managers:

- Raises HIPAA concerns to the extent providers are obligated to disclose a patient's health information.
- Risk managers may need to develop a reporting program to comply.

Current Bill Status:

- House Hearing on February 2, 2016 in the Health and Government Operations. On April 1, 2016, the Health and Government Operations returned an unfavorable report; bill withdrawn.

HB 24
Public Health- Overdose Response Program – Educational Training Program Requirement
Sponsored by: Delegate Szeliga and Cassilly

Major Points:

- Modifies the 2013 Overdose Response Program overseen by the Department of Health and Mental Hygiene to require participants to immediately contact medical services after the administration of naloxone by a certificate holder.
- Intended to respond to drug and intoxication deaths, particularly for heroine related deaths.

Significance of Bill to Risk Managers:

- Providers may see an increase of the number of individuals requiring medical care.

Current Bill Status:

- House Hearing on February 2, 2016 in the Health and Government Operations. No report and no further action taken at this time.

SB97/HB0468
Public Health - Opioid-Associated Disease Prevention and Outreach Programs
Sponsored by: Chair, Finance Committee

Major Points:

- Repealing the Prince George's County AIDS Prevention Sterile Needle and Syringe Program
- Authorizes the establishment of Opioid-Associated Disease Prevention and Outreach Program, operating by a local health department, or specified community-based organization to apply to the DHMH and a local health officer for authorization to operate a Program
- Program requirements:
  - provide security of needle and syringe exchange locations and equipment;
  - allow participants to exchange needles and syringes at any location, if more than one exchange location is available;
  - have appropriate staff expertise in working with individuals who inject drugs;
  - include adequate staff training;
  - disseminate other means for curtailing the spread of HIV and hepatitis C;
  - link individuals to substance-related disorder counseling, treatment, and recovery services;
  - educate individuals who inject drugs on the dangers of contracting HIV and other viruses;
  - establish procedures for identifying program participants in accordance with specified confidentiality provisions;
  - establish methods for identifying and authorizing staff members who have access to needles, syringes, and program records; and
  - develop a plan for data collection and program evaluation

Significance of Bill to Risk Managers:

- The program requires substance-related disorder counseling, treatment and recovery services. Institutions may want to enter into business relationships to provide for such treatment.

Current Bill Status:

- Third-reading of bill passed House and Senate. The bill shall take effect October 1, 2016. All passed bills, except the budget bill and constitutional amendments, must be presented to the Governor within twenty days following adjournment of a session (April 21, 2016). The Governor may veto such bills within thirty days after presentation. If a passed bill is not vetoed, it becomes law.

HB245/SB310
Child Abuse and Neglect - Failure to Report
Sponsored by: Delegate Dumais, Atterbeary, Glass, McComas, Moon, Rey, Smith, Sydnor, Valentino-Smith, and B. Wilson; Senator Raskin, Cassilly, Hough, Lee and Ramirez.

Major Points:

- Requiring an agency that is participating in a child abuse or neglect investigation and that has obtained grounds to believe that a person has knowingly failed to report child abuse as required under a specified provision of law to file a specified complaint with the actors board, agency, institution or facility.
- In the circumstances of a health care practitioner, licensed under the Health Occupations Article, the agency must file a complaint with the appropriate licensing board.

Significance of Bill to Risk Managers:

- Current law does not criminalize the failure of a worker to report suspected abuse or neglect. The licensing boards alone are authorized to discipline workers for failing to report, but there is not a mechanism obligating reporting.
- Risk managers should develop and/or modify current policies to ensure that its practitioners comply with this law, as a worker must report to the local department not later than 48 hours after the contact, examination, or treatment that caused the worker to believe that the child had been subjected to abuse or neglect. A copy of the report must also be provide to the local State's Attorney. Failure to do so, could unnecessarily subject these health care practitioners to board licensing actions.
- Risk managers should keep in mind that individuals who in good faith make or participate in making a report of abuse or neglect or participate in an investigation or resulting judicial proceeding are immune from civil liability or criminal penalties.

Current Bill Status:

- A similar bill (SB 525/HB1146) passed the Senate and House in 2015, but no further action was taken.
- Senate Hearing on February 18, 2016 in the Judicial Proceedings Committee with favorable report; House Hearing on February 11, 2016 in the Judiciary Committee. Both bills passed.

SB574
Civil Actions- Noneconomic Damages- Catastrophic Injury
Sponsored by: Sen. Ramirez

Major Points:

- Similar in nature to bills proposed in 2014 and in 2015.
- Takes medical malpractice cases that result in a catastrophic injury out of the cap in CJ §3-2A-09, and instead treats them under CJ §11-108 with all other tort claims such that the cap can again be aggregated for estate and wrongful death claims. Further, the bill triples the cap on non-economic damages found in §11-108. Applies to medical malpractice and other tort actions where negligence resulted in catastrophic injury as defined in the bill.
- Catastrophic Injury is defined as:

"death or permanent impairment constituted by: (1) spinal cord injury associated with severe paralysis of an arm, a leg, or the trunk or loss of continence of the bowel or bladder; (2) amputation of an arm, a hand, a foot, or a leg involving the effective loss of use of that appendage; (3) severe brain injury or closed-head injury; (4) blindness; (5) loss of reproductive organs that results in an inability to procreate; or (6) major burns as classified under guidelines issued by the American Burn Association.

- Whether an injury is catastrophic in nature would be determined by the Court or HCADRO panel chair on a post-trial motion following a verdict that was favorable to the plaintiff/claimant.
- The 3-2A-09 cap ($770k for 2016 with an annual escalator of $15k, and aggregate maximum of 125% of the cap when there are multiple beneficiaries in wrongful death case) applies in other non-catastrophic medical malpractice cases.
- By way of example, in a medical liability case involving a below-knee amputation, or a loss of continence of bowel or bladder, the cap on damages for a case arising October 1, 2016 would be **$2,490,000** rather than $770,000—an increase of $1,720,000.
- Moreover, in a medical liability case involving a death where there is both an estate claim and a wrongful death claim with multiple beneficiaries, the cap on damages for a case arising on October 1, 2016 would be **$6,225,000** (150% of the cap of $2,490,000 for wrongful death plus $2,490,000 for the estate claim yields $6.225M) as compared to the aggregate cap as it currently exists under 3-2A-09 at $962,500—an increase of $5,262,500.

Significance of Bill to Risk Managers:

- The current law does not provide a separate limit on noneconomic damages for "catastrophic injury."
- Health care providers and health care practices are subject to dramatically higher exposure to liability under the increased cap for catastrophic injury.

Current Bill Status:

- Hearing on SB574 was conducted in the Senate Judicial Proceedings Committee on February 25, 2016. No further action to date.

SB565
Civil Actions-Offers of Judgment
Sponsored by: Sen. Casilly

Major Points:

- Increases the leverage offered by existing "offer of judgment" statute by expanding the definition of court costs that may be recoverable when an offer of judgment is rejected, and the rejecting party then goes on to a verdict less favorable than the offer of judgment.
- Expands the statute to apply to all civil actions, not just medical malpractice claims.
- Still misses the best leverage that could be applied, because compensation for expert witness fees is only included in the recoverable costs for *court-appointed* experts.
- However, because it is an offer of "judgment" and not an offer of "settlement," there would not be confidentiality as to the amount and, indeed, there would not be a release signed by the parties. If an offer of judgment was timely accepted, the judgment would be entered by the court and would need to be paid immediately to avoid post-judgment interest (10% per annum in Maryland).

Significance of Bill to Risk Managers:

- Should add leverage to negotiations, and may be helpful for particularly difficult cases in which a reasonable settlement offer has been declined.
- May help to discourage plaintiffs' attorneys from trying low-percentage cases, because even a nominal offer of judgment, e.g. $1, would subject them to repaying costs as defined in the statute and in Rule 2-603 in the event of a defense verdict.

Current Bill Status:

- SB565 was introduced on February 4, 2016 - 25% progression. Hearing on 2/25. No further action to date.

SB 513/ HB 377
Maryland No-Fault Birth Injury Fund
*Sponsored by: Senators Nathan-Pulliam (D), Bates (R), DeGrange (D), Ferguson (D), Guzzone (D), Hough (R), Klausmeier (D), Manno (D), McFadden (D), Serafini (R), Young (D); Delegates Morhaim (D), Barve (D), Beitzel (R), Bromwell (D), Carey (D), Cluster (R), Cullison (D), Ebersole (D), Frick (D), Frush (D), Gaines (D), Glenn (D), Hammen (D), Healey (D), Jalisi (D), Jameson (D), Kaiser (D), Kelly (D), Kipke (R), Kittleman (R), Kramer (D), Krebs (R), Krimm (D), Lam (D), Luedtke (D), McComas (R), Miele (R), Morgan (R), Oaks (D), Reznik (D), Robinson (D), Rose (R), Stein (D), Szeliga (R), Valderrama (D), West (R), Wilson (R), Young (D), Zucker (D) (*the number of sponsors has increased significantly from last year)*

Major Points:

- The sponsors of the bill want to provide fair and equitable compensation, on a no-fault basis, for a limited class of catastrophic injuries that result in unusually high costs for custodial care and rehabilitation. Purpose is to establish a system for adjudication of prospective birth-related claims involving permanent neurological injury; excluding specified rights and remedies of a claimant and specified other persons; providing for specified procedures; providing for specified benefits and compensation of a claimant under the Act; requiring the Maryland Patient Safety Center to convene a certain Perinatal Clinical Advisory Committee; establishing the Maryland No-Fault Birth Injury Fund; providing for specified premiums and insurance surcharges to be used to finance and administer the Fund; providing for certain patient safety initiatives; providing for certain credits for certain medical liability coverage for the obstetrical practice or services of certain HCP's and hospitals.
- The Office of Administrative Hearings will determine on the basis of evidence presented in a contested hearing, eligibility, the nature and amount of compensation and benefits.
- Birth-related neurological injury:
    - does NOT include disability or death caused by genetic or congenital abnormality.
    - includes only an injury to the brain or spinal cord of a live infant born in a Maryland hospital.
- The rights and remedies under this statute would supplant all other rights and remedies of the infant, PR of the infant, and parents, dependents or next of kin of the infant arising out of or related to a birth-related neurological injury to the infant, including claims of emotional distress related to the infant's injury. However, it 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. Further, a civil action is not prohibited against a HCP or Hospital if there is clear and convincing evidence that the HCP or Hospital *maliciously intended* to cause a birth injury and the claim if filed before and instead of payment of an award under this subtitle.

Comparison of the 2015 SB/HB Birth Injury Fund to 2016:

- Last year, the SB and HB differed in material ways, including the definition of "birth-related neurological injury", the number of Governor-appointed members of the Board of Trustees of the Fund, and when the legislation would be enacted. This year, the bills are identical. Additionally, the number of Sponsors of the bills has more than doubled.

- This year, the proposed legislation does not provide for specifics as to funding/assessments. Instead, it now states that the Board of Trustees of the Fund shall determine the amount required to finance and administer the Fund and provide notice to the Commission on or before March 1st of each year. The Commission shall assess premiums for all Maryland hospitals and increase hospital rates totaling the amount determined by the Board of Trustees. The Commission shall adopt regulations that specify the methodology for the assessment of premiums which shall account for geographic differences among hospitals, differences among hospitals' historical claims experience involving births in each hospital, and distinguish between hospitals that provide OB services and those that do not. It also provides that each insurer issuing a personal injury liability policy that provides medical malpractice liability coverage for the OB or midwifery practice of a HCP provide a credit on the HCP's annual medical malpractice premium to account for the availability of the Fund to compensate eligible claimants. The credit also applies to a Hospital's liability policy for OB or midwifery services. The bill does not state the amount of the credit, but that it "shall be in an amount that will produce premiums that are not excessive, inadequate, or unfairly discriminatory, as determined by the Commissioner."

- Damages
  - Actual lifetime expenses for qualified health care costs, limited to reasonable charges prevailing in the same community for similar treatment; EXCLUDING expenses of items or services the infant has received or is eligible to receive under the laws of any state or the U.S.; EXCLUDING expenses the infant has received or is contractually entitled to receive from a prepaid health plan, HMO or any other private insuring entity; EXCLUDING expenses related to the provision of housing, except for modification of residential environment
  - Within the discretion of the Office, an award not exceeding $500,000, payable in periodic payments or as a lump sum
  - Loss of earnings calculated per the statute to be paid in periodic payments beginning on the 18th birthday of the infant (in infant found to have sustained a birth-related neurological injury shall be presumed to have been able to earn income from employment from the age 18 through 65 as if the infant had not been injured in the amount of 50% of the state average weekly wage as determined in accordance with 9-603 of the Labor and Employment Article
  - Reasonable attorney's fees on an hourly basis to be determined by the ALJ pursuant to the standards set forth in MD Rule 2-703(F)(3)
  - Funeral payment of $25,000
  - Reasonable expenses incurred in connection with the filing and prosecution of a claim

Why this bill is important to Risk Managers:

This bill creates a strict liability system for birth injuries that would purportedly mitigate the liability risk of what has been traditionally considered the highest risk services to insure, decrease the potential for highest jury awards and preserve access to Obstetrics services in Maryland while enabling all birth injured babies to receive the care that they need.

Current Bill Status:

- Introduced and read first time: February 4, 2016
- Hearing held February 25, 2016 (Judicial Proceedings); stayed in Committee.

SB 63/HB 56
Investigational Drugs, Biological Products, and Devices-
Right to Try Act
Sponsored by: *Senator Bryan Simonaire (R); Del. Karen Lewis Young (D).*

Major Points:

- Currently, a person diagnosed with a terminal illness that learns about an experimental treatment not yet fully approved by the Food and Drug Administration that might help is not legally permitted to try it. "Right To Try" allows terminally ill patients to try medicines that have passed Phase 1 of the FDA approval process and remain in clinical trials but are not yet on pharmacy shelves. "Right To Try" expands access to potentially life-saving treatments years before patients would normally be able to access them. Because fewer than three percent of terminally ill patients gain access to investigational treatments through clinical trials, "Right to Try" seeks to permit the majority of patients with terminal illness the ability to access investigational drugs/products/devices.
- An "eligible patient" is someone who has a terminal illness attested to by treating physician, has considered all other treatment options currently approved by the FDA, has received a recommendation for use of an investigation drug/product/device, and has given informed consent.
- The informed consent must attest to the fact that the patient concurs with the treating physician in believing that all currently approved and conventionally recognized treatments are unlikely to prolong the patient's life
- Patient's health insurance carrier and health care provider are not obligated to pay for any care or treatments that may be necessary as a result of the use of the investigational drug/device unless they are specifically required to do so by law or contract
- Patient's eligibility for hospice care may be withdrawn if the patient begins curative treatment with the investigation drug/device
- The manufacturer of the investigational drug/product/device may provide same to the patient without compensation, or require the patient to pay the associated costs
- A Health Occupations Board may not take any action against a HCP's license based solely on the HCP's recommendation to an eligible patient regarding access to an investigation drug/product/device, so long as the recommendation is consistent with medical standards of care.

Why this bill is important to Risk Managers:

- Concern exists for how to parse out care and treatment that may be necessary as a result of the use of the investigational drug vs. care and treatment that may be necessary as a result of the terminal illness.

Current Bill Status:

- March 16, 2016- unfavorable report by Finance Committee- bill withdrawn

SB 566
Medical Malpractice - Notice of Intent to File Claim
Sponsored by: Senator Bob Cassilly (Republican, District 34, Harford County)

Major Points:

- The bill requires a claimant to send to a health care provider written notice of the intent to file a medical malpractice / medical injury claim at least 90 days before filing the claim with the Director of the Health Care Alternative Dispute Resolution Office (HCADRO).

- The notice shall include information about the legal basis for the claim, the type and extent of the alleged damages, and the type of medical injury. Of note, claimants are not precluded from raising additional theories of liability as the litigation progresses.

- The notice shall be served on the health care provider at the last known address registered with the appropriate licensing authority.

- A claimant may not file a claim with HCADRO if written notice of intent is not accomplished. However, the Director of HCADRO may excuse the failure to give notice within the time required on a showing of a good faith effort.

- Intention – The "pre-suit notification" periods are intended to promote settlement amongst parties and avoid litigation, which would reduce the costs of medical malpractice litigation while still allowing claimants to receive relief.

Why this bill is important to Risk Managers:

This bill creates an additional procedural hurdle for medical malpractice claimants in order to bring a suit. It is important for risk managers to be aware of the notice of intent to file claim requirement and the attendant timelines to facilitate resolution of the claim, whether through settlement or litigation. Risk managers may also seek to take steps to remind health care providers of the importance of maintaining an up to date address with licensing authorities, as the notice is to be served on the health care provider's last known registered address.

Current Bill Status:

- 2/4/16 – first reading
- 2/25/16 – hearing
- 2/25/16 – to Senate Judicial Proceedings Committee and stayed. No further action to date.

SB 886 / HB 1272
Health - Collaborations to Promote Provider Alignment
Sponsored by Senator Thomas Middleton (Democrat, District 28, Charles County), Delegate Shane Pendergrass (Democrat, District 13, Howard County)

Major Points:

- Background – Maryland currently operates the nation's only all-payer hospital rate regulation system, a system made possible, in part, by Maryland's Medicare waiver. The idea behind the all-payer rate setting system for hospital services is to test whether it is a more effective model for advancing better care while reducing costs. As part of this overall process, in 2015, the Maryland Health Care Commission (MHCC) convened a Provider-Carrier Workgroup to examine the self-referral law for health care practitioners. A consensus item from that workgroup was that the self-referral law should be modernized to allow for the development of additional bona fide value-based payment models, risk-sharing arrangements, and alignment models.

- Purpose – "The purpose of collaborations to promote provider alignment is to achieve the goals of Maryland's all-payer model contract approved by the federal Center for Medicare and Medicaid Innovation."

- The bill defines "collaborations to promote provider alignment," and establishes that such collaborations are exempt from certain prohibitions on patient referrals.

- "Collaborations to promote provider alignment" are defined as collaborations that:

  (1) Involve the distribution, either directly or indirectly through a contract, of compensation, either in cash or in-kind:

  (I) Attributable to a risk-sharing arrangement or value-based payment model between (1) a risk-bearing health care entity and (2) a health care practitioner;

  (II) Attributable to a value-based payment model between (1) a payer and (2) a health care practitioner; or

  (III) Under a value-based payment model that meets the criteria established by the federal Centers for Medicare and Medicaid Services

  (2) Promote accountability for the overall care of patients, including the quality and cost of care; and

  (3) Encourage investment in redesigned care processes for high quality and efficient service delivery to patients.

- A "health care practitioner" is defined as "a person who is licensed, certified, or otherwise authorized under the Health Occupations Article to provide health care services in the ordinary course of business or practice of a profession."

- "Risk-bearing health care entity" includes "an acute care hospital," "an academic medical center," "a health care entity, including a group practice that accepts a prospectively determined payment for the provision of a defined service or package of services and quality outcomes, some of which are provided or ordered by other persons or entities," and "any organization that meets the criteria for an accountable care organization established by the federal Department of Health and Human Services."

- Collaborations to promote provider alignment are exempt from the self-referral prohibitions under § 1-302 of the Health Occupations Article. Section 1-302 prohibits a health care practitioner (HCP) from referring a patient to a health care entity (1) in which the HCP or the HCP's immediate family owns a beneficial interest, (2) in which the HCP's immediate family owns a beneficial interest of 3% or greater, or (3) with which the HCP or the HCP's immediate family has a compensation agreement.

- Collaborations to promote provider alignment will also not need to disclose the existence of the beneficial interest.

Differences between the Senate and House bills: (None)

Why this bill is important to Risk Managers:

This bill creates / defines "collaborations to promote provider alignment" and exempts them from the general prohibitions against self-referrals and the required disclosures of beneficial interests in an effort to achieve the goals of Maryland's all-payer model contract.

Current Bill Status:

- 2.5.16 – first reading (finance)
- 3.10.16 – Senate hearing
- Stayed in Senate Finance Committee; No further action to date.

SB636
Medical Malpractice – Discovery
Sponsored by: Senator Cassilly

Major Points:

- Purportedly clarifies and/or changes the discovery procedures in the Health Care Alternative Dispute Resolution Office ("HCADRO").
- Establishing that a defendant in a claim with the HCADRO may seek discovery as to the basis of a certificate of qualified expert filed by the claimant or plaintiff without prejudice to later discovery if the attesting expert is designated as a trial exhibit.
- The bill also prohibits a deposition of a defendant health care provider from being required until the claimant has filed and served a specified certificate of qualified expert on all parties.
- Applies to all prospective health claims filed after October 1, 2016.

Significance of Bill to Risk Managers:

- Current discovery procedures in the HCADRO are subject to judicial interpretation, as the Director claims to have little authority.
- This bill would provide greater protection to health care providers in HCADRO.
- If this bill does not pass, this may prompt claimants to seek depositions of defendant health care practitioners before filing their certificate of qualified merit.
- It also improperly implies that under current procedures a defendant cannot obtain a discovery deposition of a claimant's certifying expert in the HCADRO. Claimants that oppose two discovery depositions of their certifying experts may now have a potential argument that the legislature has not consented to such discovery.
- This bill could prompt claimants to request additional earlier discovery depositions.

Current Bill Status:

- Senate Hearing on February 25, 2016 in the Judicial Proceedings Committee. No report and no further action taken at this time.

HB6
Criminal Law – Improper Prescription of Controlled Dangerous Substance Resulting in Death
Sponsored by: Delegate K. Young

Major Points:

- Prohibiting an authorized provider from prescribing, administering, distributing, or dispensing a controlled dangerous substance if such practice is not in conformity with specified provisions of law and the standards of the authorized provider's profession relating to CDS.
- If a person's use or ingestion of CDS is a contributing cause of the person's death, and prescribed, administered, or distribute in violation of law or standards of care, then the bill establishing penalties of a felony and up to 20 years in prison or a fine of up to $100,000 or both.

Significance of Bill to Risk Managers:

- This bill was prompted by a May 2015, federal grand jury indictment of 16 individuals from Maryland and Virginia for allegedly operating pain management clinics as pill mills and recruiting "runners" and "distributors" for the operation. According to the indictments, "runners" would visit the clinics with fictitious medical complaints to obtain prescriptions, fill the prescriptions, and give the prescribed substances to distributors; the distributors then sold the substances of profits.
- This bill would have subjected treating health care providers to further criminal penalties for unlawful and perhaps negligent prescription practices.

Current Bill Status:

- House hearing on January 19, 2016 in the Judiciary Committee, with unfavorable report. The bill has died.

SB 849/ CF HB 814
Task Force to Study the Establishment of Health Courts
Sponsored by: Senators Kelley, Gladden & Ready

Major Points:

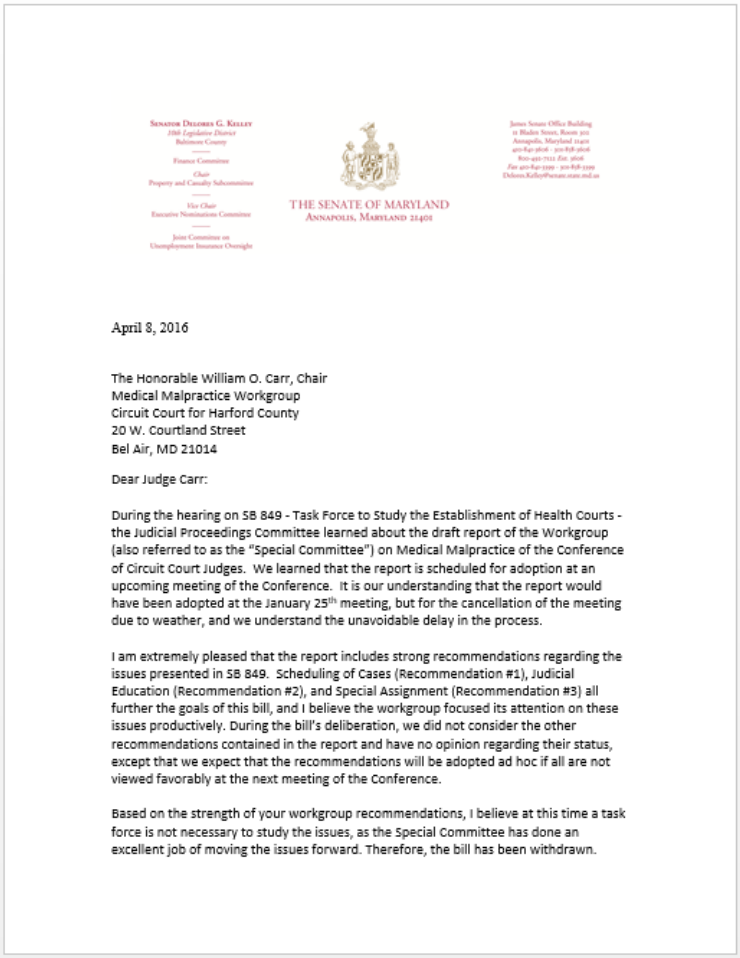
- To establish a Task Force to study the establishment of health courts and in which the Task Force would report its findings and recommendations to the Governor and the General Assembly on or before December 31, 2016

Significance of Bill to Risk Managers:

- If the Task Force were to recommend the establishment of health courts and it were to become law, medical malpractice cases and related motions would be assigned to a specified group of Judges that are familiar and well-versed in health law and medical malpractice related rules.

Current Bill Status:

- Unfavorable report by the Senate Judiciary Proceedings and withdrawn.
- See Letter to the Honorable Judge William O. Carr, Chair of the Medical Malpractice Workgroup of the Conference of Circuit Court Judges:



SENATOR DELORES G. KELLEY
30th Legislative District
Baltimore County

Finance Committee
Chair
Property and Casualty Subcommittee
Vice Chair
Executive Nominations Committee
Joint Committee on
Unemployment Insurance Oversight

THE SENATE OF MARYLAND
ANNAPOLIS, MARYLAND 21401

James Senate Office Building
11 Bladen Street, Room 301
Annapolis, Maryland 21401
410-841-3606 · 301-858-3606
800-492-7122 Ext. 3606
Fax 410-841-3399 · 301-858-3399
Delores.Kelley@senate.state.md.us

April 8, 2016

The Honorable William O. Carr, Chair
Medical Malpractice Workgroup
Circuit Court for Harford County
20 W. Courtland Street
Bel Air, MD 21014

Dear Judge Carr:

During the hearing on SB 849 - Task Force to Study the Establishment of Health Courts - the Judicial Proceedings Committee learned about the draft report of the Workgroup (also referred to as the "Special Committee") on Medical Malpractice of the Conference of Circuit Court Judges. We learned that the report is scheduled for adoption at an upcoming meeting of the Conference. It is our understanding that the report would have been adopted at the January 25th meeting, but for the cancellation of the meeting due to weather, and we understand the unavoidable delay in the process.

I am extremely pleased that the report includes strong recommendations regarding the issues presented in SB 849. Scheduling of Cases (Recommendation #1), Judicial Education (Recommendation #2), and Special Assignment (Recommendation #3) all further the goals of this bill, and I believe the workgroup focused its attention on these issues productively. During the bill's deliberation, we did not consider the other recommendations contained in the report and have no opinion regarding their status, except that we expect that the recommendations will be adopted ad hoc if all are not viewed favorably at the next meeting of the Conference.

Based on the strength of your workgroup recommendations, I believe at this time a task force is not necessary to study the issues, as the Special Committee has done an excellent job of moving the issues forward. Therefore, the bill has been withdrawn.

I trust that the Conference and the Council after it will heed the recommendations made by the members of the Special Committee that studied it on their behalf, and look forward to seeing progress as jurisdictions adopt those recommendations as appropriate. Please feel free to contact me by email at delores.kelley@senate.state.md.us or by phone at 410-841-3606 with any questions.

Sincerely,

Delores G. Kelley

DGK/lvf

HB 1487/SB450
Health Care Provider Malpractice Insurance- Scope of Coverage

Sponsored by: Del. Kriselda Valderrama (D); Del. Charles Barkley (D); Sen. Delores Kelly (D); Sen. Edward Reilly (R); Sen. John Astle (D); Sen. Joanne Benson (D); Sen. Brian Feldman (D); Sen. Stephen Hershey (R); Sen. J. Jennings (R); Sen. Katherine Klausmeier (D); Sen. Jim Mathias (D); Sen. Thomas Middleton (D); Sen. Catherine Pugh (D)

Major Points:

- This bill allows a medical malpractice insurance policy to include coverage for the defense of a healthcare provider in a disciplinary hearing arising out of the healthcare 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.
- Previously a healthcare provider had to purchase medical malpractice insurance coverage and disciplinary defense insurance coverage in separate policies. It is believed that this new bill will lead to smaller premiums for those healthcare providers, and some healthcare providers who do not currently have disciplinary defense insurance may choose to purchase it. A major goal of the bill was to reduce overall premium costs for

small business healthcare providers and encourage disciplinary hearing defense coverage where such coverage otherwise might not have been purchased by a healthcare provider.

- In 2014, the Maryland Insurance Administration undertook a survey to investigate the potential fiscal impact of allowing disciplinary hearing defense coverage to be included in a medical malpractice policy. The results of that survey did not provide a good basis for comparing costs because many insurers had continued to include disciplinary hearing defense coverage in their medical liability professional policies even though they were not authorized by law to do so. Insurers responded that they should be allowed to include coverage for disciplinary hearing defense in the professional liability policy because it is valuable coverage that many healthcare providers are not aware is available, all other states allow disciplinary hearing coverage to be included, and it is more cost effective to include both in the same policy.

Current Bill Status:

- Passed in both the House (March 17, 2016- 141/0) and Senate (April 7, 2016- 46/0); Approved by the Governor on April 26, 2016.

SB 661 / HB 587
Hospitals – Patient's Bill of Rights
Sponsored by Senators Benson, Guzzone, King, Lee, Manno, Muse, Raskin, and Salling; Delegates K. Young, Luedtke, and A. Miller

Major Points:

- Requires a hospital administrator to provide each patient a written copy of the patient's bill of rights
- A translator or interpreter must be provided to any patient that does not speak English to assist the patient in understanding and exercising their rights
- Copies of the patient's bill of rights must be conspicuously posted in areas of the hospital accessed by patients
- A hospital administrator must provide annual training to all patient care staff on the patient's bill of rights
- Expands the rights that must be included in a hospital's patient's bill of rights
- Under the statute, the patient's bill of rights must include a statement that a patient has the following rights:
  - Receive treatment without discrimination as to race, color, religion, sex, national origin, disability, sexual orientation, gender identity, age, or source of payment
  - Receive considerate, respectful, and compassionate care in a clean and safe environment free of unnecessary restraints and free from all forms of abuse, neglect, or mistreatment
  - Receive emergency care for any medical condition that will deteriorate from failure to provide prompt treatment
  - Be informed of the name and position of the doctor who will be in charge of the patient's care in the hospital
  - Know the names, positions, and functions of any other hospital staff involved in the patient's care
  - Receive complete and current information about the patient's diagnosis, treatment, risks and prognosis
  - Receive a prompt and reasonable response to questions or requests
  - Receive all information needed to give informed consent to any proposed procedure or treatment, including (I) the possible risks and benefits of the proposed procedure or treatment; and (II) alternatives to the proposed procedure or treatment
  - Make decisions regarding the health care recommended by the physician or medical staff
  - (I) Refuse treatment, examination, or observation by hospital staff without fear of reprisal; and (II) be informed of potential health consequences of refusing treatment, examination, or observation
  - (I) Participate in all decisions about the patient's discharge from the hospital; and (II) receive from the hospital a written description of how to appeal the discharge and remain under hospital care[2]
  - (I) Refuse to take part in research; (II) in deciding whether or not to participate in a research study, receive a full explanation of the potential risks and benefits of the research; and (III) withdraw from a research study at any time without impacting the patient's access to standard care

[2] UMMS expressed concerns to the legislature about the impact of these two sub-requirements, advising that currently only Medicare patients are provided information on how to appeal a discharge and that to establish a discharge appeals system may increase the length of patient stays and hinder medically appropriate discharges.

- (I) Complain or file a grievance about the care and services the patient is receiving, without fear of reprisal, and receive a written response from the hospital; and (II) if the patient is not satisfied with the hospital's response, complain to the department, which will address the specific complaint in writing
- If the patient is alone in the hospital and disoriented or otherwise incapacitated, have a patient advocate assigned from the hospital staff while a family member or designee is being contacted to ensure the patient's safety and continued care by the medical staff at the hospital[3]
- Maintain privacy and dignity while in the hospital with respect to the patient's medical and personal care, including case discussion, consultation, examination, treatment, and personal hygiene
- (I) Have hospital staff maintain confidentiality of all personal and medical information and records regarding the patient's care; and (II) approve or refuse the release of records to anyone outside the hospital
- Review the patient's medical records without charge
- (I) Obtain a copy of medical records for a reasonable fee set by the hospital; or (II) if the patient cannot afford to pay a reasonable fee for a copy of medical records, receive a copy of medical records without charge or at a negotiated fee
- Receive a clear and understandable itemized bill and explanation of all charges, regardless of source of payment
- Specify those family members and other adults who are to be given priority to visit the patient consistent with the patient's ability to receive visitors[4]
- Receive reasonable continuity of care with respect to staff assignment
- Obtain access, if needed, to a language assistance program to ensure full understanding of and accessibility to the hospital's services and reasonable accommodations
- Expect and receive appropriate assessment, management, and treatment of pain as an integral component of the patient's care.

Differences between the Senate and House bills: (None)

Why this bill is important to Risk Managers:

- Currently, hospital administrators are already responsible for making available to each patient a copy of the patient's bill of rights that the hospital adopted under the Joint Commission requirements. This bill would expand the requirements of the patient's bill of rights and further regulate how and what information is delivered to patients.
- In addition to being redundant to current guidelines, this bill provides expanded, and at times conflicting, requirements for a patient's bill of rights.
- The Joint Commission already requires hospitals to inform every patient about their rights (Standards on Patient Rights and Responsibility). There are additional federal regulations on patient's rights from Centers for Medicare & Medicaid Services and statutes including the Emergency Medical Treatment and Active Labor Act (EMTALA) and the Health Insurance Portability and Accountability Act (HIPAA), as well as

[3] The Maryland Hospital Association (MHA) has noted, in opposing this bill, that this requirement does not recognize the existing policies around establishing patient guardianship.

[4] The MHA argued this visitation policy falls outside the purview of hospitals to regulate visitors and is contrary to the open visiting policy the majority of Maryland's hospitals have implemented.

regulations from the Maryland Health Care Commission and Office of Health Care Quality.

Current Bill Status:

- 4/8/16 – SB 661: Unfavorable report by Finance; withdrawn by sponsor
- 4/9/16 – HB 587: Unfavorable report by Health and Government Operations; withdrawn by sponsor
- Hearing dates – HB 587: 2/18/16; SB 661: 3/10/16

SB71/HB0771
Public Schools – Administration of Diabetes Care Services
(Previously Public and Nonpublic Schools – Student Diabetes Management Program)
Sponsored by: Senator Young and Nathan-Pulliam; Delegates D. Barnes, Angel, B. barnes, Buckel, Fennell, Hornberger, Kelly, Long, Leudtke, Metzgar, Patterson, Platt, Reilly, Shoemaker, Simonaire, Tarlau, Walker, and A. Washington.

Major Points:

- Bill introduced in prior Session 2015 (SB0672).
- Requiring the State Department of Education and the Department of Health and Mental Hygiene to establish guidelines for the administration of certain health care services to students with diabetes.
- Requires the State Department of Education and the Department of Health and Mental Hygiene to consult the Board of Nursing and certain stakeholders to develop a plan for diabetic care services in public schools in the State.
- Schools will be expected to hire a "trained diabetes care provider."
- The guidelines will govern procedures for treating and administering medication, and monitoring blood glucose and ketone levels and developing a "Diabetes Medical Management Plan" in conjunction with a student's physician and parents or guardians.
- School personnel, including teachers, coaches, transportation personnel, among others, will be expected to recognize symptoms of hypoglycemia and hyperglycemia and direct an appropriate response.

Significance of Bill to Risk Managers:

- Counties will be expected to hire a registered nurse or trained diabetes care provider and ensure that this person is available during school hours and, when possible, at school-sponsored activities, including field trips and extracurricular activities. Some Counties will consider contracting these services to local hospitals. This will represent a new area of potential liability risk.

Current Bill Status:

- Approved by the Governor on April 26, 2016 after multiple amendments.

SB12/HB1121
Health Care Facilities – Closures or Partial Closures of Hospitals – County Board of Health Approval (Emergency Bill)
Sponsored by: Senators Rosapepe and Hershey; Delegate Pena-Melnyk.

Major Points:

- Prohibiting a person proposing to close or partially close a hospital that receives State and county funding from closing or partially closing the hospital except under specified circumstances.
- Requiring the county board of health for the county in which the hospital is located, if the county has less than 3 hospitals, to hold a public hearing within 5 miles of the hospital within 30 days of receiving notice of the proposed closure or partial closure.
- Requires the board of health to consider whether the sale or other transfer of the hospital would be a viable option.
- Under current law a certificate of need is not required to close any health care facility or part of a health care facility in the State if notice of the proposed closure is filed with MHCC at least 45 days prior to closure of partial closure.

Significance of Bill to Risk Managers:

- For historical knowledge:

Exhibit 1
Closure of Acute Care Service Lines or Bed Delicensure at Maryland Hospitals
2000-2015

Hospital	Service Closed	Date
Union Memorial Hospital	Obstetric service	March 14, 2003
Mercy Medical Center	Psychiatric service	January 25, 2005
Laurel Regional Hospital	Adolescent psychiatric	February 25, 2005
Chester River Hospital Center	Obstetric service	April 1, 2012
Maryland General Hospital	Obstetric service	May 1, 2013
Peninsula Regional Medical Center	NICU Level IIA	August 28, 2014
Laurel Regional Hospital	Delicensure of 16 beds	September 15, 2015

NICU: Neonatal Intensive Care Unit

Source: Maryland Health Care Commission

- This bill was proposed in response to the closure of Laurel Hospital in Prince George's County.
- If this bill were passed, it would confer additional authority to the board of health and limit the ability of a hospital to close any part of a hospital without public involvement.

Current Bill Status:

- Senate Hearing on February 24, 2016 in the Finance Committee; House of Delegate Hearing on March 10, 2016 in Health and Government Operations Committee. No report in the Senate or House and no further action taken at this time.

SB0242/HB886

Maryland Medical Assistance Program – Telemedicine - Modification

Sponsored by: Senators Kelley, Astle, Conway, Feldman, Jennings, Klausmeier, Lee, Madaleno, Mathias, Pugh, Raskin, Reilly, Rosapepe, Young, Benson, Hershey, and Middleton; Delegate West.

Major Points:

- Repealing and reenacting Md. Ann. Health-General Section 15-105.2
- Requiring the Department of Health and Mental Hygiene, under specified circumstances, to include primary care providers in the types of health care providers eligible to receive reimbursement for health care services that are delivered through telemedicine and provided to Maryland Medical Assistance Program.
- Subject to the limitations of the State budget and to the extent authorized by federal law, the Department may specify by regulation the types of health care providers that are eligible to receive reimbursement and authorize coverage and reimbursement for health care services.
- To participate, the Department may require a health care provider to submit a registration form that includes information required for the processing of claims for the reimbursement of specified health care services.

Significance of Bill to Risk Managers:

- This supplements the Department's authority under COMAR 10.09.49.01 *et seq.*, which governs Medicaid telehealth programs.
- Because it authorizes reimbursement of telemedicine for primary care providers, risk managers may expect to see increased collaboration between employed physicians and a patient's treating providers.

Current Bill Status:

- Favorable reports in the Senate and Hearing and the bill returned passed in both the House and Senate April 11, 2016. It will be effective June 1, 2016.

HB1103
Health Care Practitioners – Use of Teletherapy
Sponsored by: Delegates Reznik, McKay, and Valentino-Smith.

Major Points:

- Authorizing health care practitioners, who provide clinical behavioral health services and are licensed by the State boards of Nursing, Physicians, Professional Counselor and Therapists, Psychologists, and Social Workers to use "teletherapy."
- "Teletherapy" means the use of interactive audio, video or other telecommunications or electronic technology by a health care practitioner to deliver clinical behavioral health services at a site other than the site at which the patient is located.
- Proposing that the board must adopt regulations for the use of teletherapy, including guidelines over the technology, informed consent, and information required before the first teletherapy session, and otherwise establishing safety and emergency protocols.

Significance of Bill to Risk Managers:

- The use of telecommunications technologies in the provision of mental health therapy has increased in recent years due to ongoing development of new technologies and the expansion of payment for telemedicine services. Industry associations, such as the American Psychological Association and American Telemedicine Association, have developed guidelines for the provisions of such services. These guidelines address such issues as the competence of practitioners, patient safety, standards of care, informed consent, confidentiality/security/disposal of data and information, testing and assessment, and interjurisdictional practice.
- Bills governing telemedicine and teletherapy are gaining traction. Previous SB162/HB451 of 2015 would have established a Task Force to Study Regulation of Teletherapy, but was withdrawn.
- Consider development of policies and procedures to address teletherapy and telemedicine.

Current Bill Status:

- Unfavorable report by the Health and Government Operations; withdrawn.

SB 928/ CF HB 1492
Task Force to Study the Nursing Shortage in Maryland
Sponsored by: Senators Middleton & Nathan-Pulliam

Major Points:
To establish a Task Force to Study the Nurse Shortage in Maryland; provides for the composition, chair, and staffing of the Task Force; prohibits Task Force members from receiving certain compensation, but authorizing the reimbursement of certain expenses; requires the Task Force to study and make recommendations regarding certain matters relating to changes in the nursing profession that have resulted in a shortage of nurses in the State and nation and reporting those findings back to the Governor and legislature.

Significance of Bill to Risk Managers:
Nurses are a key component of the healthcare delivery model. The shortage not only affects the quality of healthcare delivery but the safety of patient care and may be associated with an increased risk for bad outcomes or medical malpractice claims. With the aging population, the shortage is only likely to increase.

Current Bill Status:
- Passed in Senate as favorable with amendments; Hearing in House with no further action.

SB734/HB535
Courts and Judicial Proceedings – Structured Settlements – Transfers and Registration of Structured Settlement Transferees
At the Request of the Office of Attorney General
Sponsored by: Senators Raskin, Brochin, Feldman, Gladden, Kagan, Lee, Muse, Pugh; Delegates Rosenberg, Haynes, and Angel

Major Points:

- This bill is generated based on an August 2015 *The Washington Post* exposé of Maryland's factoring industry and the extent to which current law adequately protects vulnerable payees from aggressive and misleading business practices. It was also prepared in response to the Standing Committee on Rules of Practice and Procedure submitted a report to the Maryland Court of Appeals recommending certain changes to the Maryland Rules. The rules went into effect on January 1, 2016.
- The General Assembly unanimously finds and declares that regulation and transfers of structured settlement payment rights is necessary to (1) ensure that the transfers are effectuated on fair and reasonable terms and are in the best interest of payees, and (2) to protect payees against deceptive practices.
- Requires a registration program for transferees under the Office of Attorney General.
- Authorizes the Attorney General to adopt regulations to carry out the purposes of Maryland's Structured Settlement Protection Act (Title 5, Subtitle 11 of the Courts and Judicial Proceedings Article). The Attorney General may impose a civil penalty for each violation with a maximum of $1,000 for the first violation and $5,000 for each subsequent violation.
- Modifies Maryland structured settlement protection law, enacted in 2000, and establishes specified requirements on a proposed transfer of structured settlement payment rights if the settlement was established in resolution of a tort claim seeking compensation for cognitive injuries arising from childhood exposure to lead paint; etc.
- The bill prohibits the direct or indirect transfer of structured settlement rights, unless the transfer is authorized in a court order based on express findings that:
    - The transfer is necessary, reasonable, and appropriate and in the best interests of the payee, taking into account the welfare and support of the payee's dependents;
    - The financial terms of the transfer agreement are fair to all parties, taking into account the difference between the amount payable to the payee and the discounted present value of the payments to be transferred and the discount rate applicable to the transfer;
    - The payee received independent professional advice concerning the proposed transfer; and
    - At least 10 days before the date on which the payee signed the transfer agreement, the transferee provided to the payee a separate disclosure statement that includes specified information, including (1) the amounts and due dates of the structured settlement payments to be transferred; (2)

the aggregate amount of the payments to be transferred; (3) the discounted present value of the payments to be transferred; (4) the amount payable to the payee in exchange for the payments to be transferred; (5) specified information about various fees, costs, and charges; (6) the net amount payable to the payee after deduction of specified costs, expenses, and charges; (7) the discount rate applicable to the transferee; (8) the amount of any penalty or liquidated damages payable by the payee in the event of any breach of the transfer agreement by the payee; and (9) a statement that the payee has the right to cancel the transfer agreement, without penalty or further obligation, at any time before the transfer is authorized by a court.

- The venue shall be in the circuit court for the county where the payee resides (if the payee is a Maryland resident). If the payee is not a Maryland resident, the petition must be filed in the circuit court that approved the settlement agreement or in which the settled claim was pending when the parties entered into the structured settlement agreement.
- If the structured settlement was established in resolution of a tort claim seeking compensation for cognitive injuries, including any claim arising from childhood exposure to lead paint, the transferee must notify the court in its petition that the payee may be cognitive impaired; attach to the petition a copy of any complaint that was pending when the structured settlement was established; and identify any allegations or statements in the complaint that describe the nature, extent, or consequences of the payee's cognitive injuries.
- The court must also consider whether to appoint a guardian ad litem for the payee or to require the payee to be examined by an independent mental health specialist designated by the court. The transferee must be responsible for the payment of any fees of the guardian or independent mental health specialists.

Significance of Bill to Risk Managers:

- The General Assembly has unanimously acknowledged the benefit of structured settlements.
- All interested parties, now defined to include the structured settlement obligor, are notified of a potential transfer action.
- The new filing requirements could impact how retained attorneys fashion confidentiality agreements, particularly structured settlement, to ensure that any petition to transfer is filed under seal.

Current Bill Status:

- Passed unanimously in Senate as favorable with amendments (133-0); passed unanimously in House (133-0).

4845-5739-0639, v. 2