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The New Cap on Non-Economic Damages and Health Claims Arbitration in Maryland—An Overview

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The 1986 Maryland legislature passed a new law which arbitrarily caps or limits the right of catastrophically injured plaintiffs to be fully, fairly and adequately compensated. The law, which became effective on July 1, 1986, places a cap of $350,000.00 for all non-economic losses regardless of the extent of injuries and the circumstances of the specific case.[1] Accordingly, Maryland citizens who are injured at the hands of negligence on or after July 1, 1986, cannot under any circumstances, receive a judgment in excess of $350,000.00 for "non-economic damages" which include pain and suffering, physical impairment, disability, inconvenience, disfigurement, and other non-pecuniary damages.[2]

In addition to creating the cap, the new law requires the trier of fact (whether it is a jury or a Health Claims Arbitration panel) to itemize damages for past medical expenses, future medical expenses, past lost earnings, future lost earnings, non-economic and other damages. Further, if the plaintiff dies prior to the payment of all future medical expenses awarded, the remaining portion of the award reverts to the insurance carrier or the defendant instead of going to the estate of the decedent. Finally, the court or the arbitration panel may also order any and all future economic damages to be paid by periodic payments (commonly referred to as an "annuity") instead of a lump sum.

As is apparent, the rights of seriously injured plaintiffs have been compromised as a result of the liability "insurance crisis" which began over a year ago with artificially skyrocketing premiums and arbitrary cancellation of various liability policies.[3] Municipalities, camps, skating rinks, bus companies, physicians, attorneys and many others experienced exorbitant premium increases or found that insurance was essentially "unavailable". Through public relations and advertising, the insurance industry attempted to fault lawyers, jurors or injured victims for this "crisis."

However, a more objective analysis indicates that the "crisis" resulted from poor management practices by the insurance industry. Insurance carriers have essentially two streams of income from which to pay claims and record a profit: 1) the premium dollars that policyholders pay to purchase insurance coverage; and 2) investment income which is earned on funds that are received and not utilized to pay claims. Accordingly, when interest rates are high (such as they were in the early 1980's) the insurance industry attempts to attract as many policyholders as possible to increase the number of premium dollars received. In order to attract additional funds, the industry cuts premiums to sell as many policies as possible. After receipt of these funds, the carriers invest the money to obtain the highest return on investment, resulting in large profits.

On the other hand, when interest rates fall to reasonable levels (as they did in the mid 1980's), the amount of the investment income earned by the insurance carriers drops dramatically. The industry then attempts to maintain billion dollar profits by increasing premiums.

Clearly this increase in policy premiums has nothing to do with the amount of judgments awarded or the number of cases filed. Rather, the insurance companies increase premiums in an effort to maintain profit margins and recoup lost income due to falling interest rates and poor business practices.[5]

Furthermore, the insurance industry falsely appears to lose money while reaping large profits. This is accomplished by inflating estimated future claims and payouts, while setting aside large "loss reserves" to cover these hypothetical future losses. Incredibly, the insurance companies invest these reserves and earn continuing investment income while claiming them as tax losses. That is how the property/casualty insurance industry made a 75 billion dollar profit between 1975 and 1984, but showed a paper loss, and avoided the payment of income taxes.[6]

Because of such accounting practices, property/casualty insurance industry's stock prices have increased over seventy percent (70%) between January 1, 1984 and June 30, 1986, and the net worth of liability insurance companies have more than quadrupled, from 20 billion dollars to over 91 billion dollars.[8] Further, in 1986, the industry's net worth increased by over 21 billion dollars.[9] Indeed, between 1975 and 1985, the property/casualty insurance companies in Maryland charged more than 18.2 billion dollars in premiums (excluding any investment income) but paid out only 10.02 billion dollars in losses.[10]

Unsatisfied with increased assets of 7.6 billion dollars in 1985[11] and a profit of

11.5 billion dollars in 1986,[12] the industry elected to engage in a coordinated campaign to press for "tort reform" notwithstanding estimated profits of 90 billion dollars in the next four years.[13] The industry's version of reform is to limit the rights of catastrophically injured victims in suing and recovering damages to which they are entitled. By withdrawing from some markets and raising premiums drastically in others, the insurers continue to attempt to curtail the rights of those injured through negligence. The chief executive officer of Geico Insurance Company best explained the insurers' strategy in 1985: "It is right for the industry to withdraw from the insurance market and let the pressures for reform build in the state legislatures."[14]

Thus, a 6.5 million dollar national advertising campaign was launched to create the perception of a "lawsuit crisis" with an emphasis on medical negligence cases.[15] Industry leaders, supported by medical interests, attempted to argue that judgments and settlements were extraordinarily high. In fact, the opposite is true. There is no runaway judgment or award problem in Maryland. Between 1980 and 1984, Medical Mutual (the insurance carrier which insures the majority of Maryland doctors) received approximately 152 million dollars in premiums and investment income. However, the company only paid out approximately 37 million dollars during that same time period.[16] Moreover, malpractice premiums in Maryland make up less than 1% of the total cost of delivering health care to the public.[17] What becomes painfully clear is that Maryland citizens have not abused their right to be adequately compensated when injured through the negligence of a physician or another defendant.

Nevertheless, the new cap discriminates against plaintiffs who have suffered devastating injuries at the hands of negligent defendants by arbitrarily limiting their recoveries regardless of the circumstances of the case. Such legislation supplants the role of the jury or panel in determining the extent and nature of damages to be awarded in a particular case.[18]

Tragically, it is essentially admitted that the cap will not significantly reduce premiums charged by the insurance industry. Indeed, within thirty days of the time, former Governor Hughes signed the cap into law, Medical Mutual requested and was granted a 50% rate increase in premiums.[19] It is obvious that the insurance interests cannot square this conduct with the legislation passed. Further, in Florida where similar restrictions were passed, two major insurance carriers, Aetna and St. Paul Fire and Marine, filed data with the Insurance Commissioner indicating that the "tort reform" legislation would have essentially no impact on premiums charged for insurance. St. Paul concluded that ". . . our best estimate is no effect from the tort changes."[20]

The proper remedy for the industry's self-created "crisis" is legislation to require the disclosure of the accounting practices, reserves, true profits and other data with which to properly regulate the industry. Clearly, the insurance carriers should be held accountable to make premiums charged various policyholders commensurate with legitimate claims and true liability incurred – not paper liabilities designed to retain funds and maximize billion dollar profits in the industry.

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Highlights of Changes Made in Health Claims Arbitration

Health Claims Arbitration involves the vast majority of medical negligence cases in which the negligence occurred on or after July 1, 1976.[21] Each case is heard before a panel comprised of three persons: a lawyer acting as a chairperson, a health care provider and a layman. A verdict is obtained by an affirmative vote of two of the three panel members, who not only determine liability but also assess damages. If any party is aggrieved by the results of the arbitration, an appeal may be taken to the appropriate circuit court with proper venue.[22] On appeal, the proceedings are "*de novo*" but with a "presumption of correctness."[23] In essence, the presumption amounts to an instruction to the jury indicating that the decision of the arbitration panel is "presumed correct." This is a rebuttable presumption which the jury may accept or reject based upon the evidence presented.[24]

In addition to creating the cap, the legislature altered Health Claims Arbitration in six major areas. First, on or after July 1, 1986, a claimant or plaintiff is required to file a certificate of a qualified expert, indicating that there is a violation of the standards of care and that the departure from the standards of care caused the alleged injury. This report or "certificate of merit" must be filed within ninety days of the date the claimant files a claim with the Health Claims Arbitration Office. Failure to do so will result in the claim being dismissed, without prejudice.[25] Obviously, this provision is intended to weed out frivolous cases.

Second, a health care provider defendant is required to file a certificate of a qualified expert attesting to compliance with the standards of care or that any violation of the standards of care did not proximately cause the alleged injury. This certificate must be filed within 120 days after the claimant files the initial certificate. Failure to file the certificate will result in an adjudication in favor of the claimant on the issue of liability.[26] As with the certificate of merit, the defendant's certificate is intended to identify cases which should not be defended.

Third, the legislature placed a limitation on the attesting expert witness who prepares a certificate of merit or meritorious defense, requiring that he or she may not ". . . devote annually more than 20% of the expert's professional activities to activities that directly involve testimony in personal injury claims."[27] This requirement will have a "chilling effect" on any expert's willingness to prepare a certificate because of probable attempts to scrutinize the financial affairs of such an expert. Interestingly experts testifying at trial are not limited to this 20% rule.[28]

Fourth, the new law limits testimony in any arbitration proceeding to two experts in a "designated specialty" unless the panel chairman determines that good cause is shown for additional expert testimony.[29] Essentially, this provision further limits the ability of the claimant, who has the burden of proof throughout the course of the proceedings, to make a full, fair and adequate presentation of the evidence involved. There is no reason for an arbitrary limitation of two experts in any field. In cases of significant injuries, complex med-

ical issues or those involving the overlap of medical fields or sub-specialties, the parties should be permitted to present as much expert testimony as necessary to prove or defend their cases.

Fifth, the new law permits authenticated hospital records and records of treating health care providers to be admitted at the arbitration proceedings without any custodian or other witness sponsoring them, subject to the opposing party's right to take a deposition.[30] This is ostensibly designed to "expedite" the arbitration proceedings by eliminating the necessity for testimony by a custodian of records.

Sixth, the new law incorporates all Maryland Rules of Procedure into Health Claims Arbitration.[31] Additionally, if an arbitration panel finds "that the conduct of any party in maintaining or defending any action is in bad faith or without substantial justification" the panel may order the offending party, his counsel, or both to pay costs plus reasonable expenses including attorney's fees.[32]

Conclusion

As is patently clear, the newly created cap will penalize persons whose lives have already been shattered through the negligence of others without significantly reducing insurance premiums. The legislation simply represents the erosion of plaintiffs' rights across the State of Maryland for adequate, fair and complete compensation for injuries sustained as a result of proven negligence on the part of health care providers and other defendants. The legislation, as it exists, should be repealed or declared unconstitutional, with legislation passed to permit full scrutiny and regulation of the insurance industry.

Notes

[1] Md. Cts. & Jud. Proc. Code Ann. § 11-108(c) (July 1, 1986).
[2] Md. Cts. & Jud. Proc. Code Ann. § 11-108(A)(1) (July 1, 1986).
[3] Report of the Governor's Task Force to Study Liability Insurance at 43 (December 1, 1985).
[4] "Medical Malpractice: Insurance Costs Increased but Varied Among Physicians and Hospitals," United States General Accounting Office, Doc. No. GAO/HRD-86-112 at 1 (September, 1986).
[5] Levinson, "Crisis, What Crisis?", State News (Delaware), August 31, 1986.
[6] Address by Natwar Gandhi, (United States General Accounting Office) to the Insurance Tax Conference (November 7, 1985).
[7] National Association of Insurance Commissioners' Report on Profitability (1985).
[8] A.M. Best's Aggregates and Averages, 47th ed. (1986).
[9] "A.M. Best's Executive Data Service," Report A2, Experience by State (1984).
[10] "A.M. Best's Executive Data Service," Report A2, Experience by State (1984).
[11] A.M. Best's Aggregates and Averages, 47th ed., (1986).
[12] A.M. Best's Aggregates and Averages, 47th ed., (1986).
[13] Property/Casualty Insurance Organizations; Five Year Review and Outlook, (1985).
[14] "Insurers Told: Exit Some Lines," Journal of Commerce and Commercial, June 18, 1985 at 10A, col. 1.
[15] Journal of Commerce and Commercial, March 19, 1986.
[16] J. Robert Hunter, Study on Medical Negligence Insurance Rates in Maryland (1985).
[17] "A.M. Best's Executive Data Service," Report A2, Experience by State (1985).
[18] Md. Const. art. XV, § 6.
[19] "Malpractice Rates Jump Despite New Law," Montgomery Journal, July 3, 1986.
[20] Aetna Casualty and Surety Company and St. Paul Fire and Marine Insurance Co., Rate Revision Filing, Insurance Commissioner of Florida, (August, 1986). (Florida passed legislation including a cap, abrogation of the collateral source rule, a restricted doctrine of joint and several liability, and other "tort reform.")
[21] Md. Cts. & Jud. Proc. Code Ann. § 3-2A-02 (July 1, 1986).
[22] Md. Cts. & Jud. Proc. Code Ann. § 3-2A-06(f) (July 1, 1986).
[23] Md. Cts. & Jud. Proc. Code Ann. § 3-2A-06(d) (July 1, 1986).
[24] Md. Cts. & Jud. Proc. Code Ann. § 3-2A-06(d) (July 1, 1986).
[25] Md. Cts. & Jud. Proc. Code Ann. § 3-2A-04(B)(1) (July 1, 1986).
[26] Md. Cts. & Jud. Proc. Code Ann. § 3-2A-04(B)(2) (July 1, 1986).
[27] Md. Cts. & Jud. Proc. Code Ann. § 3-2A-04(B)(4) (July 1, 1986).
[28] Md. Cts. & Jud. Proc. Code Ann. § 3-2A-04(B)(4) (July 1, 1986).
[29] Md. Cts. & Jud. Proc. Code Ann. § 3-2A-05(D) (July 1, 1986).
[30] Md. Cts. & Jud. Proc. Code Ann. § 3-2A-05(b)(3) (July 1, 1986).
[31] Md. Cts. & Jud. Proc. Code Ann. § 3-2A-02(c) (July 1, 1986).
[32] Md. Cts. & Jud. Proc. Code Ann. § 3-2A-07(A) (July 1, 1986).

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