HB 3197 - H AMD **995**
By Representative Schual-Berke

ADOPTED AS AMENDED 02/16/2004

Strike everything after the enacting clause and insert the following:

"NEW SECTION. **Sec. 1.** The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

(1) "Claim" means a demand for payment of a loss caused by medical malpractice.

(a) Two or more claims arising out of a single injury or incident of medical malpractice is one claim.

(b) A series of related incidents of medical malpractice is one claim.

(2) "Claimant" means a person filing a claim against a health care provider or health care facility.

(3) "Commissioner" means the insurance commissioner.

(4) "Health care facility" or "facility" means a clinic, diagnostic center, hospital, laboratory, mental health center, nursing home, office, surgical facility, treatment facility, or similar place where a health care provider provides health care to patients.

(5) "Health care provider" or "provider" means a health care provider as defined in RCW 48.43.005.

(6) "Insuring entity" means:

(a) An insurer;

(b) A joint underwriting association;

(c) A risk retention group; or

(d) An unauthorized insurer that provides surplus lines coverage.

(7) "Medical malpractice" means a negligent act, error, or omission in providing or failing to provide professional health care services, failure to obtain informed consent, or breach of promise of a particular result.

NEW SECTION. **Sec. 2.** (1) Beginning on April 1, 2005, every insuring entity or self-insurer that provides medical malpractice insurance to any facility or provider in Washington state must report to the commissioner by the first of each quarter any claim related to medical malpractice, if the claim resulted in a final:

(a) Judgment in any amount;

(b) Settlement in any amount; or

(c) Disposition of a medical malpractice claim resulting in no indemnity payment on behalf of an insured.

(2) If a claim is not reported by an insuring entity or self-insurer under subsection (1) of this section due to limitations in the medical malpractice coverage of a facility or provider, the facility or provider must report the claim to the commissioner.

(3) Reports under this section must be filed with the commissioner within sixty days after the claim is resolved.

(4)(a) The commissioner may impose a fine of up to two hundred fifty dollars per day per case against any insuring entity or surplus lines producer that violates the requirements of this section. The total fine per case may not exceed ten thousand dollars.

(b) The department of health may impose a fine of up to two hundred fifty dollars per day per case against any facility or provider that violates the requirements of this section. The total fine per case may not exceed ten thousand dollars.

NEW SECTION. **Sec. 3.** The reports required under section 2 of this act must contain the following data in a form prescribed by the commissioner for each claim:

(1) The health care provider's name, address, provider professional license number, and type of medical specialty for which the provider is insured; the name of the facility, if any, and the location within the facility where the injury occurred; and the names and professional license numbers if applicable, of all defendants involved in the claim. This information is confidential and exempt from public disclosure, but may be disclosed:

(a) Publicly, if the provider or facility provides written consent; or

(b) To the commissioner at any time for the purpose of identifying multiple or duplicate claims arising out of the same occurrence;

(2) The provider or facility policy number or numbers;

(3) The date of the loss;

(4) The date the claim was reported to the insuring entity, self-insurer, facility, or provider;

(5) The name and address of the claimant. This information is confidential and exempt from public disclosure, but may be disclosed:

(a) Publicly, if the claimant provides written consent; or

(b) To the commissioner at any time for the purpose of identifying multiple or duplicate claims arising out of the same occurrence;

(6) The date of suit, if filed;

(7) The claimant's age and sex;

(8) Specific information about the judgment or settlement including:

(a) The date and amount of any judgment or settlement;

(b) Whether the settlement:

(i) Was the result of an arbitration, judgment, or mediation; and

(ii) Occurred before or after trial;

(c) An itemization of:

(i) Economic damages, such as incurred and anticipated medical expense and lost wages;

(ii) Noneconomic damages;

(iii) Allocated loss adjustment expense, including but not limited to court costs, attorneys' fees, and costs of expert witnesses; and

(d) If there is no judgment or settlement:

(i) The date and reason for final disposition; and

(ii) The date the claim was closed;

(9) A summary of the occurrence that created the claim, which must include:

(a) The final diagnosis for which the patient sought or received treatment;

(b) A description of any misdiagnosis made by the provider of the actual condition of the patient;

(c) The operation, diagnostic, or treatment procedure that caused the injury;

(d) A description of the principal injury that led to the claim; and

(e) The safety management actions the facility or provider has taken to make similar occurrences or injuries less likely in the future. This reporting requirement does not create a legal duty on the part of a facility or provider to implement safety management actions; and

(10) Any other information required by the commissioner, by rule, that helps the commissioner analyze and evaluate the nature, causes, location, cost, and damages involved in medical malpractice cases.

NEW SECTION. **Sec. 4.** The commissioner must prepare aggregate statistical summaries of closed claims based on calendar year data submitted under section 2 of this act.

(1) At a minimum, data must be sorted by calendar year and calendar accident year. The commissioner may also decide to display data in other ways.

(2) The summaries must be available by March 31st of each year.

NEW SECTION. **Sec. 5.** Beginning in 2006, the commissioner must prepare an annual report by June 30th that summarizes and analyzes the closed claim reports for medical malpractice filed under section 2 of this act and the annual financial reports filed by insurers writing medical malpractice insurance in this state. The report must include:

(1) An analysis of closed claim reports of prior years for which data are collected and show:

(a) Trends in the frequency and severity of claims payments;

(b) An itemization of economic and noneconomic damages;

(c) The types of medical malpractice for which claims have been paid; and

(d) Any other information the commissioner determines illustrates trends in closed claims;

(2) An analysis of the medical malpractice insurance market in Washington state, including:

(a) An analysis of the financial reports of the insurers with a combined market share of at least ninety percent of net written medical malpractice premium in Washington state for the prior calendar year;

(b) A loss ratio analysis of medical malpractice insurance written in Washington state; and

(c) A profitability analysis of each insurer writing medical malpractice insurance;

(3) A comparison of loss ratios and the profitability of medical malpractice insurance in Washington state to other states based on financial reports filed with the national association of insurance commissioners and any other source of information the commissioner deems relevant;

(4) A summary of the rate filings for medical malpractice that have been approved by the commissioner for the prior calendar year, including an analysis of the trend of direct and incurred losses as compared to prior years;

(5) The commissioner must post reports required by this section on the internet no later than thirty days after they are due; and

(6) The commissioner may adopt rules that require insuring entities and self-insurers required to report under section 2(1) of this act to report data related to:

(a) The frequency and severity of open claims for the reporting period;

(b) The aggregate amounts reserved for incurred claims;

(c) Changes in reserves from the previous reporting period; and

(d) Any other information that helps the commissioner monitor losses and claims development in the Washington state medical malpractice insurance market.

NEW SECTION. **Sec. 6.** The commissioner shall adopt all rules needed to implement this chapter. To ensure that claimants and health care providers cannot be individually identified when data is disclosed to the public, the commissioner shall adopt rules that require the protection of information that, in combination, could result in the ability to identify the claimant or health care provider in a particular claim.

NEW SECTION. **Sec. 7.** A new section is added to chapter 7.70 RCW to read as follows:

In any action filed under this chapter that results in a final:

(1) Judgment in any amount;

(2) Settlement in any amount; or

(3) Disposition resulting in no indemnity payment,

the claimant or his or her attorney shall report to the office of the insurance commissioner on forms provided by the commissioner any court costs, attorneys' fees, or costs of expert witnesses incurred in pursuing the action.

NEW SECTION. **Sec. 8.** Sections 1 through 6 of this act constitute a new chapter in Title 48 RCW.

NEW SECTION. **Sec. 9.** If any provision of this act or its application to any person or circumstance is held invalid, the remainder of the act or the application of the provision to other persons or circumstances is not affected."

Correct the title.

EFFECT: (1) Expands definition of medical malpractice to include failure to obtain informed consent or breach of promise of a particular result.

(2) Reporting begins April 1, 2005, rather than March 1, 2005, and data is submitted quarterly rather than monthly.

(3) The time within which a resolved claim must be reported is extended to 60 days, rather than 30.

(4) Maximum amount of fines for violations of reporting requirements in the act are defined.

(5) Requires the commissioner to adopt rules to ensure that claimants and health care providers cannot be individually identified when claims data reported under this act is disclosed to the public.

(6) Requires that claimants or their attorneys report court costs, attorneys' fees, and costs of expert witnesses for medical malpractice claims.

--- END ---