Washington State
House of Representatives
Office of Program Research

BILL ANALYSIS

Financial Institutions & Insurance Committee

HB 2799

Brief Description: Establishing a supplemental malpractice insurance program.

Sponsors: Representatives Schual-Berke, Cody, Campbell, Linville, Edwards, Kagi and Ormsby; by request of Insurance Commissioner.

Brief Summary of Bill

- Establishes a voluntary supplemental insurance program for medical malpractice claims.
- Provides program parameters and a regulatory scheme.
- Provides for $10 million in initial funding for the program.

Hearing Date: 1/28/04

Staff: Carrie Tellefson (786-7127).

Background:

Physicians purchase medical malpractice insurance coverage from insurers in the private market. Insurers, in turn, purchase reinsurance. Reinsurance covers large loss exposures. Many physician specialties have reported difficulties finding medical malpractice insurance coverage. Others have reported a significant rise in premiums.

The Insurance Commissioner (Commissioner) is responsible for the licensing and regulation of insurance companies doing business in this state. This oversight includes medical malpractice liability insurers.

Summary of Bill:

Creates a supplemental malpractice insurance program to provide an additional layer of liability coverage for malpractice claims. The program will pay claims and related defense costs on behalf of a covered health care provider or facility.

Key Definitions:
- "Tail coverage" means extended reporting period coverage.
- "Retained limits" means the dollar amount of loss retained by a facility or provider.

Facilities and Providers Responsibilities:
The program is offered to facilities and individual providers. The program requires the provider or facility to do the following:

- Retain a certain amount of loss before the supplemental program will pay;
- Finance claim payments that fall within a retained limit by purchasing underlying insurance or self-insuring;
- Pay annual premiums to the program (or in semi-annual or quarterly installments) within 30 days of the billing date;
- Accept a settlement agreed upon between the claimant and the program or the claimant and an underlying insurer or self-insurer; and
- Report to the Commissioner any claims resulting in a judgement, settlement, or no payment (if the provider is self insured for purposes of retained earnings or the insurer does not report).

Who Can Buy Coverage:
- A health care facility or provider who has provided proof of financial responsibility (insurance or self-insure) to pay medical malpractice claims that fall within the retained limits;
- A *health care facility* located in Washington; and
  - licensed in Washington; or whose business is closing and needs to buy tail coverage;
- A *health care provider* licensed and doing business principally in Washington; or
- The provider is principally located in Idaho or Oregon;
  - the provider is a Washington resident;
  - the provider is licensed in Washington; and
  - the provider performs procedures in an Idaho or Oregon facility that is affiliated with a Washington corporation; or
- The provider retires or closes business and needs to buy tail coverage; or
- The provider is a federal employee who is not covered by the federal tort claims act.

Who Cannot Buy Coverage:
- A facility or provider that has not provided proof of financial responsibility.
- A provider who is a federal employee who is covered by the federal tort claims act.
- A health care facility that is operated by the state or federal government.

Minimum Retained Limits Requirements:
- For health care providers: $250,000 per claim and $750,000 annual aggregate;
- For facilities with less than 25 employees that do no surgery: $250,000 per claim/$1,200,000 annual aggregate;
- For hospitals w/less than 100 beds:
  - $500,000 per claim/$5 million annual aggregate;
- For hospitals with more than 100 beds:
  - $500,000 per claim/$8 million annual aggregate;
- For HMOs with no hospital services:
  - $500,000 per claim/$5 million annual aggregate;
- For HMOs w/hospital services:
  - $500,000 per claim/$8 million annual aggregate;
- All other types of health care facilities:

    - $500,000 per claim/$3 million annual aggregate;
- For providers or facilities who want higher retained limits, the program will establish alternative rates; and
- Retained limits only apply to claim payments and not defense costs.

Program Details:
The program must pay excess claim amounts up to the limits of the liability policy purchased from the program, after underlying coverage has paid (underlying coverage must pay either retained limits or policy limits, whichever is higher). The program will provide the following coverage:
- Program liability limits for a health care provider:
    - $1 million per claim/$3 million annual aggregate;
- Program liability limits for a health care facility:
    - $2 million per claim/$6 million annual aggregate;
- (The board will determine limits and premiums for providers or facilities that want higher limits and are willing to pay higher premiums);
- Claims that fall within the retained limit if an aggregate limit of underlying insurance (not self-insurance) is exhausted due to claim payments; and
- Defense costs after applicable retained limits have been paid.

The program is responsible for the following:
- Charge an annual premium to facilities and providers;
- Use premium funds to pay claims, administrative costs and expenses;
- Provide the commissioner with free access to all books, records, files, etc.;
- Use a rating plan that includes experience and schedule rating plans, to include:
    - a provider or facility's past loss experience,
    - previous paid malpractice claims resulting from negligence, and
    - risk management programs in place that improve patient safety;
- File an annual statement with the Commissioner;
- Maintain its records according to accounting practices established by the National Association of Insurance Commissioners; and
- May increase surplus by issuing a capital call, subject to certain requirements.

Program Coverage Limitations:
The program will not cover claims that:
- fall within the retained limits;
- exceed the liability limits purchased from the program;
- result from a motor vehicle accident or intentional crime;
- are made against a provider or facility's employee, if acting outside the scope of employment or without consultation and supervision of a covered provider; and
- are made against a partnership or professional corporation if it's not the partnership or professional corporation's purpose to provide health care services.

Medical Malpractice Insurers' Responsibilities under the Plan:
- Offer limits of coverage equal to those required by this act;
- Certify to the program a list of the facilities or providers that have purchased medical malpractice coverage;
- Provide tail coverage that meets the criteria of the Board;
- Provide the following notices before cancelling or nonrenewing coverage:

    - 15 days notice for nonpayment of premiums,
    - 90 days notice for any other reason;
- Keep a copy of the notice for 10 years;
- Pay defense or settlement costs as supplementary payments within the retained limits;
- Share defense costs with the program if a claim is large enough that the program pays;
- Notify the program within 10 days after it establishes a loss reserve for a claim exceeding $125,000;
- On the first of each month, report to the Commissioner any malpractice claim that resulted in a judgement; a settlement; or no payment using the form prescribed by the commissioner; and
- Collect premiums from participants on behalf of the program and forward program premiums to the program.

Insurance Commissioner Responsibilities:
- Appoint representatives to the Board within 30 days;
- Approve the Board's plan of operation;
- Review a request for, approve or disapprove a capital call;
- Establish the form and content of the program's annual statement;
- Examine transactions, financial conditions, and operation of the program at least every 3 years
- Conduct examinations of the program;
- Determine the annual program premium based on:
    - analysis of rates and rating plans used by medical malpractice insurers,
    - claims experience for medical malpractice insurers, and
    - anything else the commissioner determines to be relevant;
- Independently evaluate the rate and rating plan to determine:
    - rates will result in premiums that are not excessive, inadequate, or unfairly discriminatory, and
    - annual funding estimate is actuarially sound;
- Prepare aggregate statistical summaries of closed claims each calendar year;
- Prepare an annual report by fiscal year-end summarizing closed claim reports and medical malpractice insurers' annual financial reports;
- May impose a fine of $250 per day per case against an insurer or surplus lines carrier that fails to provide timely notification of claims; and
- May adopt rules to implement the law.

Department of Health Responsibilities:
- Provide the program with available information to set premiums; and
- Thoroughly investigate a health care professional if he or she has had three claims paid within the last five years and the total indemnity payment for each claim was $50,000 or more.

The Board of Governors:
The Board of Governors (Board) is comprised of the Insurance Commissioner or his/her designee; three members of the public appointed by the Commissioner; a person with insurance or risk management experience; a person selected by the Washington State Medical Association; and a person selected by the Washington State Hospital Association. The Board must:
- Oversee operations of the program;
- Hire an administrator, who may hire staff or contract for services;

- Adopt a program plan of operation including:
  - a schedule of meetings,
  - specific program coverage provisions, including:
    - types of claims excluded,
    - coverage limits,
    - eligibility criteria for providers and facilities, and
    - program rules for the purchase of tail coverage;
  - rules regarding duration of tail coverage that must be offered by insurers and self insurers;
  - criteria under which the program may purchase reinsurance;
  - process for buying coverage from the program;
  - billing, collecting, and other administrative activities;
  - contract with an actuary for the development of the program's classifications, rates, and rating plans; and
  - adopt rates and rating plans.

The Program's Legal Status:

The program is:
- a separate legal entity,
- exempt from payment of all state fees and taxes, and
- exempt from filing insurer forms.

The program is not:
- an insurer as defined in the insurance code,
- a state agency, and
- a member of the Washington Insurance Guaranty Association.

Program Implementation Dates:

The program will pay claims and defense costs for claims first made:
- On or after January 1, 2005; or
- The effective date of coverage under the program, if later than January 1, 2005.

Appropriation: The sum of $10 million is appropriated for the biennium ending June 30, 2005, from the Health Services Account to the Department of Health to provide capital and surplus to the supplemental malpractice program and pay administrative expenses incurred in establishing the program.

Fiscal Note: Requested on January 22, 2004.

Effective Date: The bill contains an emergency clause and takes effect immediately.