Z-1059.3

HOUSE BILL 2799

State of Washington 58th Legislature 2004 Regular Session

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

Read first time 01/21/2004. Referred to Committee on Financial Institutions & Insurance.

AN ACT Relating to establishing a supplemental malpractice insurance program; adding a new section to chapter 18.130 RCW; adding a new chapter to Title 48 RCW; prescribing penalties; making an appropriation; and declaring an emergency.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

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

(1) "Board" means the board of governors created under section 4 of this act.

(2) "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.

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

(4) "Commissioner" means the insurance commissioner.

(5) "Department" means the department of health.

(6) "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.

(7) "Health care provider" or "provider" means a health care provider as defined by RCW 48.43.005.

(8) "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.

(9) "Medical malpractice" means a negligent act, error, or omission in providing or failing to provide professional health care services.

(10) "Program" means the supplemental malpractice insurance program created under section 2 of this act.

(11) "Retained limit" means the dollar amount of loss retained by a facility or provider. A provider or facility may finance claim payments that fall within a retained limit by self-insuring or buying insurance from an insuring entity. Under this chapter, the amount of a retained limit means:

(a) If the facility or provider bought insurance from an insuring entity, the higher of:

(i) The retained limits required under section 13 of this act; or

(ii) Alternative higher limits of underlying coverage purchased by the facility or provider; or

(b) If a provider or facility self-insured medical malpractice claims, the higher of:

(i) The retained limits required under section 13 of this act; or

(ii) Alternative higher retained limits selected by a facility or provider as part of its risk financing program.

(12) "Tail coverage" means extended reporting period coverage.

(13) "Underlying insurance" means any liability insurance policy that provides primary or excess liability insurance coverage for medical malpractice claims.

NEW SECTION. **Sec. 2.** (1) A supplemental malpractice insurance program is created to provide an excess layer of liability coverage for medical malpractice claims. Subject to subsection (2) of this section,

the program will pay claims and related defense costs on behalf of a covered health care facility or provider if the claim is first made against the facility or provider:

(a) After 12:01 a.m. on January 1, 2005; or

(b) The effective date of coverage under the program, if later than 12:01 a.m. on January 1, 2005.

(2) The program will not pay claims:

(a) That the board excludes from coverage when it establishes coverage specifications under section 5(1)(b) of this act;

(b) That fall within the applicable retained limits, subject to subsection (3) of this section;

(c) That exceed the limits of liability coverage purchased by the facility or provider as described in section 15 of this act;

(d) That result from a provider or employee operating a motor vehicle;

(e) That result from an intentional crime, as defined in RCW 7.69.020(1). This exclusion applies whether or not the criminal conduct is the basis for a medical malpractice claim;

(f) Made against an employee of a covered provider or facility if the employee:

(i) Acts outside the scope of his or her employment; or

(ii) Provides health care services without the collaboration, direction, or supervision of a covered provider; or

(g) Made against a partnership or professional corporation organized by health care providers, if the board determines that it is not the primary purpose of the partnership or corporation to provide the health care services. For the purposes of this subsection, if fifty percent or more of the partners, owners, or shareholders are health care providers, the board must determine that it is the entity's primary purpose to provide health care services.

(3) If an aggregate limit of underlying insurance purchased from an insuring entity is exhausted due to claim payments, the program will pay claims that fall within the retained limit. This subsection does not:

(a) Increase the limits of liability provided by the program; or

(b) Apply to self-insurers qualified under section 11 of this act.

(4) The obligation of the program to pay related defense costs

under subsection (1) of this section ends when the program pays the applicable limit of liability purchased by the facility or provider.

(5)(a) To obtain coverage under the program for a medical malpractice claim, a facility or provider must provide documentation to the program of the insurance or self-insurance program in effect at the time the incident occurred and meet the other requirements of this chapter.

(b) All medical malpractice liability insurance purchased by a facility or provider that is applicable to a claim covered by the program must be paid before the program will provide coverage, even if the insurance limits exceed the retained limits.

NEW SECTION. **Sec. 3.** (1) The program has the general corporate powers and authority granted under the laws of Washington state.

(2) The program is not an insurer as defined in RCW 48.01.050, and is exempt from filing:

(a) Forms under RCW 48.18.100 and 48.18.103; and

(b) Rates, except as provided under section 19 of this act.

(3) The program is a separate and distinct legal entity. Liability or a cause of action may not arise against the following for any acts or omissions made in good faith while performing their duties under this chapter:

(a) The program or any member of the board;

(b) The commissioner, any of the commissioner's staff, or any authorized representative of the commissioner;

(c) The secretary of the department of health, any of the department's staff, or any authorized representative of the secretary;

(d) Any person or entity, its agents, or employees reporting data required by sections 22, 23, and 24 of this act.

(4) The program is not a state agency.

(a) The state is not liable for any debts or obligations of the program.

(b) The legislature may appropriate money at its discretion for deposit into the program.

(5) The program is exempt from payment of all fees and all taxes levied by this state or any of its subdivisions, except taxes levied on real or personal property.

(6) The program is not a member of the Washington insurance guaranty association under chapter 48.32 RCW. The Washington insurance guaranty association, Washington state, and any political subdivisions of this state are not responsible for losses sustained by the program.

NEW SECTION. **Sec. 4.** A board of governors will oversee the operations of the program. The management and operations of the program are subject to the supervision and approval of the board.

(1) The commissioner and associations must appoint representatives to the board within thirty days:

(a) After the effective date of this act; or

(b) A vacancy occurs on the board.

(2) The board must comprise:

(a) The commissioner or a designated representative employed by the office of the insurance commissioner, who will serve as chairperson of the board;

(b) Three members of the public appointed by the commissioner for staggered three-year terms;

(c) A person with relevant insurance or risk management experience appointed by the commissioner for a three-year term;

(d) A person selected by the Washington state medical association; and

(e) A person selected by the Washington state hospital association.

(3) The program may reimburse board members for their actual expenses to attend meetings, subject to per diem rates and rules established by the office of financial management.

(4) The program must reimburse the commissioner for any staff services provided at the request of the board or the program.

NEW SECTION. **Sec. 5.** (1) The board must adopt a program plan of operation within sixty days after the members are appointed. The plan of operation must include:

(a) A schedule for meetings;

(b) Specifications for program coverage provisions, including but not limited to:

(i) Types of claims that the program will not cover;

(ii) Limits of coverage available from the program;

(iii) Eligibility criteria for providers and facilities that want to buy excess medical malpractice coverage from the program;

(iv) Circumstances under which a retroactive date will be applied for injuries that occurred before 12:01 a.m. on January 1, 2005; and

(v) Rules the program will follow when it provides tail coverage;

(c) Rules requiring a specific duration of tail coverage that must be offered by insuring entities and self-insurers who provide proof of financial responsibility under section 11 of this act;

(d) Criteria under which the program may purchase reinsurance;

(e) A process that health care facilities and providers must follow to buy coverage from the program;

(f) A process for billing and collecting annual premiums from facilities and providers who buy coverage from the program; and

(g) Any other administrative activities or procedures needed to establish and operate the program.

(2) The plan of operation is subject to approval by the commissioner before it takes effect.

(3) The board may amend the plan of operation as needed. All amendments are subject to approval by the commissioner before they take effect.

NEW SECTION. **Sec. 6.** (1) The board must appoint an administrator to manage the program.

(2) The administrator may:

(a) Hire staff to operate the program; or

(b) Contract for all or part of the services needed to operate the program.

(3) At least annually, each contractor must report to the board. The report must provide information on all expenses incurred and all subcontracting arrangements.

(4) The program must pay for all administrative and contracted services, subject to review and approval of the board.

NEW SECTION. **Sec. 7.** (1) The program must charge an annual premium to health care facilities and providers who decide to buy excess medical malpractice liability coverage from the program. The program must use this money to pay claims, administrative costs, and other expenses of the program.

(2) In addition to authority granted under subsection (1) of this section, the program may increase its surplus by issuing a capital call. A capital call requires facilities and providers to pay a sum, in addition to the annual premium, to be eligible to buy or renew coverage from the program. If a facility or provider does not pay the amount of a call, the program may not cancel coverage or deny benefits of existing coverage that are in effect at the time of the capital call. Before issuing a capital call, the program must:

(a) Notify the commissioner at least ninety days before the capital call. This notice must state the:

(i) Specific purpose or purposes of the capital call and the amount of money the program has budgeted for each stated purpose;

(ii) Total amount of money the program intends to raise by issuing the capital call;

(iii) Analytical and factual basis used by the program to determine a capital call is the best option available to the program for raising capital; and

(iv) Alternative method or methods of raising capital the program considered and the reasons the program rejected each alternative in favor of the capital call;

(b) Provide any additional information that the commissioner determines is useful or necessary in evaluating the merits of the proposed capital call; and

(c) Receive approval of the commissioner for the capital call. The commissioner may disapprove a capital call if he or she does not believe it is in the best interest of the program, its participating facilities and providers, or the citizens of the state of Washington. In making this determination, the commissioner may consider:

(i) The financial health of the program and the impact on the medical malpractice marketplace;

(ii) The possible use of other means to raise capital;

(iii) The frequency of previous capital calls by the program;

(iv) The effect of raising premiums instead of a capital call;

(v) The impact on state revenue; and

(vi) Any other factor the commissioner decides is relevant.

(3) All money collected by the program belongs to the program.

(4) The state investment board must:

(a) Manage the assets of the program;

(b) Invest program assets in a manner consistent with chapter 48.13 RCW; and

(c) Charge the program reasonable fees for services provided under this section.

NEW SECTION. **Sec. 8.** (1) The program must file an annual statement with the commissioner by March 1st of each year. The statement must contain information about the program's transactions, financial condition, and operations during the past calendar year. The commissioner may establish rules for the form and content of this statement. The statement must:

(a) Be in the form and according to instructions adopted by the national association of insurance commissioners for property and casualty insurers; and

(b) Include any additional information requested by the commissioner.

(2) The program must maintain its records according to the accounting practices and procedures manual adopted by the national association of insurance commissioners.

(3) The program must provide the commissioner with free access to all the books, records, files, papers, and documents that relate to the operation of the program. The commissioner may call, qualify, and examine all persons having knowledge of the program's operations.

(4) The commissioner may enter and examine the operation and experience of the program at any time.

(a) The commissioner must examine the transactions, financial condition, and operations of the program at least once every three years.

(b) The commissioner must conduct each examination using the procedures prescribed for insurance companies in chapter 48.03 RCW. The program must reimburse the commissioner for the cost of each examination.

NEW SECTION. **Sec. 9.** (1) A health care facility is eligible to buy coverage from the program if the facility is located in Washington state; and

(a) Is licensed by Washington state; or

(b) Ends business operations after January 1, 2005, and needs to buy tail coverage. The facility must maintain financial responsibility as required under section 11 of this act to buy tail coverage.

(2) A health care provider is eligible to buy coverage from the program if:

(a) The provider is licensed by and maintains a principal place of practice in Washington state;

(b) The provider's principal place of practice is Idaho or Oregon; and

(i) The provider is a resident of Washington state;

(ii) The provider is licensed in Washington state; and

(iii) The provider performs procedures in an Idaho or Oregon facility. In this subsection, "Idaho or Oregon facility" means a facility located in Idaho or Oregon that is an affiliate of a corporation organized under the laws of Washington state and maintains:

(A) Its principal office in Washington state; and

(B) A facility in Washington state that is covered by the program;

(c) The provider retires or ceases business operations after January 1, 2005, and needs to buy tail coverage. The provider must maintain financial responsibility as required under section 11 of this act to buy tail coverage; or

(d) The provider meets the description in section 10(2) of this act, but practices his or her profession outside the scope of the exclusion. Coverage under the program applies only to claims arising out of the practice of medicine that is outside the scope of the exclusion in section 10(2) of this act.

NEW SECTION. **Sec. 10.** A health care facility or provider is not eligible for coverage under the program if:

(1) The facility or provider:

(a) Has not provided proof of financial responsibility to the program as required by section 11 of this act; or

(b) Does not meet the criteria established by the board to be eligible for coverage by the program. Any facility or provider denied coverage by the program may appeal the decision to the board;

(2) The provider is a federal employee or contractor covered under the federal tort claims act and is acting within the scope of his or her employment or contractual duties; or

(3) The health care facility is operated by state or federal government.

NEW SECTION. **Sec. 11.** To obtain coverage from the program, each eligible health care facility or provider must provide the program with proof of financial responsibility to pay medical malpractice claims that fall within the retained limits. Financial responsibility must include the facility or provider and all officers, agents, and employees while acting in the course and scope of their employment with the facility or provider. A facility or provider may establish proof of financial responsibility by:

(1) Qualifying as a self-insurer under criteria established by the board that will result in financial responsibility equivalent to the retained limits established in section 13 of this act; or

(2) Buying medical malpractice insurance in amounts equal to the retained limits listed in section 13 of this act from an insuring entity accepted by the program.

NEW SECTION. **Sec. 12.** (1) Each insuring entity or self-insurer that provides medical malpractice insurance to health care facilities or providers in Washington state must offer limits of coverage equal to those specified under section 13 of this act.

(2) Each insuring entity or self-insurer that provides certification under section 13(1) of this act:

(a) Must provide medical malpractice tail coverage that meets the criteria established by the board under section 5(1)(c) of this act;

(b) May not cancel or nonrenew coverage unless the facility or provider is given written notice of:

(i) Fifteen days if coverage is canceled for nonpayment of premiums; or

(ii) Ninety days if coverage is canceled or nonrenewed for any reason other than nonpayment of premiums;

(c) Must provide the program with the same notice as required under (b) of this subsection; and

(d) Must keep a copy of each notice issued under (c) of this subsection for at least ten years from the date of mailing or delivery.

NEW SECTION. **Sec. 13.** (1) If a health care facility or provider buys insurance to establish proof of financial responsibility, the insuring entity that provides underlying coverage must certify in writing to the program that the facility or provider has medical malpractice coverage with limits of liability as specified in this section. The limits set forth in this section apply to any joint liability of a provider and his or her corporation or partnership.

(2) The minimum retained limits of liability are:

(a) For health care providers:

(i) Two hundred fifty thousand dollars per claim; and

(ii) Annual aggregate limits of seven hundred fifty thousand dollars;

(b) For facilities with fewer than twenty-five employees that do not provide surgical services:

(i) Two hundred fifty thousand dollars per claim; and

(ii) Annual aggregate limits of one million two hundred fifty thousand dollars;

(c)(i) For hospitals with a capacity of less than one hundred beds:

(A) Five hundred thousand dollars per claim; and

(B) Annual aggregate limits of five million dollars;

(ii) For hospitals with a capacity of one hundred or more beds:

(A) Five hundred thousand dollars per claim; and

(B) Annual aggregate limits of eight million dollars;

(d)(i) For health maintenance organizations that do not provide hospital services:

(A) Five hundred thousand dollars per claim; and

(B) Annual aggregate limits of five million dollars;

(ii) For health maintenance organizations that provide hospital services:

(A) Five hundred thousand dollars per claim; and

(B) Annual aggregate limits of eight million dollars; and

(e) For all other types of health care facilities:

(i) Five hundred thousand dollars per claim; and

(ii) Annual aggregate limits of three million dollars.

(3) The program must establish alternative rates for facilities or providers who elect to maintain higher retained limits.

(4)(a) Retained limits of liability apply only to claim payments.

Each insuring entity and self-insurer that provides certification under subsection (1) of this section must pay defense costs as supplementary payments.

(b) If a medical malpractice claim is large enough that the program must make claim payments, the insuring entity or self-insurer and the program will share defense costs on a prorata basis based on the total amount of claim payments.

NEW SECTION. **Sec. 14.** Subject to the terms, conditions, and exclusions of its contract with a facility or provider, an insuring entity or self-insurer that provides certification under section 13(1) of this act agrees to pay the following costs:

(1) Attorney fees and other costs incurred in the settlement or defense of any claims; and

(2) Any settlement, arbitration award, or judgment imposed against a facility or provider under this chapter up to the retained limits or the limits of all available underlying insurance.

NEW SECTION. **Sec. 15.** (1) Subject to exclusions established by the board, the limitations established in section 2 of this act, and the retained limits agreed to by the facility or provider, the program will pay all sums a covered facility or provider is legally obligated to pay as damages up to the limits of liability purchased from the program.

(2) The coverage limits under this subsection are excess of the retained limits.

(a) The basic limits of excess liability coverage under the program for a health care provider, including providers who provide services in a partnership or as part of a professional corporation, are:

(i) One million dollars per claim; and

(ii) An annual aggregate limit of three million dollars.

(b) The basic limits of excess liability coverage for a health care facility are:

(i) Two million dollars per claim; and

(ii) An annual aggregate limit of six million dollars.

(3) In addition to the basic limits described in subsection (2) of this section, the program must offer higher limits of coverage to those providers and facilities that are willing to pay additional premiums.

The board will determine the limits of liability available through the program based on the limits available in the voluntary medical malpractice insurance market.

(4) Program coverage is always excess to the retained limits provided by the facility or provider.

NEW SECTION. **Sec. 16.** From January 1, 2005, through December 31, 2005, the annual program premium billed to each participating facility or provider will be determined by the commissioner based on:

(1) An analysis of rates and rating plans used by medical malpractice insurers;

(2) Claims experience for medical malpractice insurance; and

(3) Any other factors the commissioner determines are relevant.

NEW SECTION. **Sec. 17.** Beginning January 1, 2006, program premiums charged to facilities and providers must be based on the rates and rating plans adopted by the board and accepted by the commissioner under section 19 of this act.

(1) The board must contract with an actuary experienced in developing medical malpractice rates and rating plans to develop annual funding estimates.

(2) By July 1st of each year, the actuary must submit to the board the classifications, rates, and rating plan the program will use to determine premiums for the next calendar year. The rates and rating plan must consider:

(a) Past and prospective loss experience in Washington state for experience periods acceptable to the commissioner. If data from Washington state are not available or are not statistically credible, the program may use loss experience from those states that are likely to produce loss experience similar to that in Washington state;

(b) Past and prospective operating expenses;

(c) Past and prospective investment income;

(d) A contingency factor to protect the program from adverse loss development; and

(e) All other relevant factors within and outside Washington state.

(3) The classifications, rates, and rating plan used to develop premiums for individual facilities and providers must consider:

(a) Past and prospective loss and expense experience for different types of medical care offered by participating facilities or providers, including:

(i) The amount of surgery performed by a facility or provider; and

(ii) The risk of diagnostic and therapeutic services provided or procedures performed;

(b) The bed capacity and occupancy rates in a health care facility;

(c) Differences in financial risk, if any, to the program if a facility or provider is self-insured;

(d) The risk factors for providers who are semi-retired or part-time professionals;

(e) If a health care provider is a partnership or professional corporation, the risk factors and past and prospective loss and expense experience of the partners and employees of that provider;

(f) If a provider's principal place of practice is Oregon or Idaho, any differences in risk or expense to reflect the fact the provider's practice is not located in Washington state;

(g) Higher retained limits selected by a facility or provider; and

(h) Higher limits of liability coverage purchased from the program by a facility or provider.

NEW SECTION. **Sec. 18.** The rating plan used by the program must include experience and schedule rating plans. The program must apply these plans equitably to all facilities and providers.

(1) The experience rating plan:

(a) Must consider the past loss and loss adjustment expense experience of a facility or an individual provider;

(b) May consider paid medical malpractice claims if the claims result from negligence on the part of:

(i) A facility;

(ii) A health care provider; or

(iii) An employee of a facility or health care provider; and

(c) May consider medical malpractice claims:

(i) Paid on behalf of a facility or provider by the program, an insuring entity, or a self-insurer; and

(ii) Paid on behalf of a facility or provider before or after the program is established.

(2) The schedule rating plan must consider the effect of:

(a) Risk management programs based on evidence-based practices that improve patient safety. Practices that have been identified and recommended by governmental and private organizations, including:

(i) The federal agency for health quality and research;

(ii) The federal institute of medicine;

(iii) The joint commission on accreditation of health care organizations;

(iv) The national quality forum; or

(v) Any other evidence-based program accepted by the board; and

(b) Other objective criteria approved by the board that is expected to reduce either losses or expenses incurred by the program.

NEW SECTION. **Sec. 19.** (1) Before the rates and rating plans described in sections 17 and 18 of this act become effective, the commissioner's staff must independently evaluate the rates and rating plan and agree that:

(a) The rates and rating plan will result in premiums that are not excessive, inadequate, or unfairly discriminatory; and

(b) The annual funding estimate is actuarially sound.

(2) The program may collect the premiums that are in effect for the previous year if the classifications, rates, and rating plan have not been approved by the board and the commissioner by September 30th. If new classifications, rates, and a rating plan are later approved, the program must collect or refund the balance of the premium from the provider or facility.

(a) To collect or refund the premium, the program may adjust any outstanding semiannual or quarterly installment payments, if applicable.

(b) To save administrative expenses, the program may decide not to collect, refund, or adjust for nominal amounts of premium.

NEW SECTION. **Sec. 20.** Each facility or provider must pay an annual premium to buy excess medical malpractice coverage from the program.

(1) Facilities or providers may pay program premiums annually, or in semiannual or quarterly installments. Semiannual and quarterly installments must include the prorated premium and a fee that covers

unearned interest or investment income and administrative costs incurred because the facility or provider has decided to pay premium in installments.

(2) A facility or provider must pay premiums to their selected insuring entity within thirty days of the billing date. If the insuring entity does not receive the premium due within thirty days, coverage under the program ends at 12:01 a.m. on the thirty-first day. The program and the insuring entity are not required to provide additional notice of cancellation for nonpayment of premium.

(3) An insuring entity must bill and collect program premiums the same way it collects premiums for underlying insurance or coverage within the retained limit. The insuring entity must pay premium to the program within twenty days after receipt from a facility or provider.

(4) If the insuring entity does not pay premium to the program on time:

(a) The commissioner may suspend the certificate of authority, charter, or license of the insuring entity until the premium is paid.

(b) The insuring entity or surplus lines producer responsible for the delinquency is liable for the premium due plus a penalty equal to ten percent of the amount of the overdue premium.

(5) A self-insurer must pay premium to the program within thirty days after the program sends the self-insurer a premium bill. If the program does not receive the premium due within thirty days, coverage under the program ends at 12:01 a.m. on the thirty-first day. The program is not required to provide additional notice of cancellation for nonpayment of premium.

NEW SECTION. **Sec. 21.** (1)(a) To encourage prompt payment of claims and control defense costs, a facility or provider may not reject any settlement agreed upon between a claimant and:

(i) The program; or

(ii) An insuring entity or self-insurer that provides certification under section 13 of this act.

(b) If a facility or provider feels a claim paid under (a) of this subsection was without merit and the payment results in a higher premium charge through application of the experience rating plan, the provider or facility may appeal to the board for reconsideration of the premium increase. In evaluating the appeal, the board must consider:

(i) The merits of the claim and the likelihood the program would prevail at trial;

(ii) Actual claim payments and defense costs incurred by the program;

(iii) The estimated cost of defense for a particular claim; and

(iv) The likelihood further negotiation or litigation would result in lower payments for claim and defense costs by the program.

(2) A provider or facility, the program, an insuring entity, or a self-insurer that provides medical malpractice coverage may voluntarily make payments for medical expenses prior to any determination of fault. These payments:

(a) Are not an admission of fault;

(b) Are not admissible as evidence of fault in a formal or informal legal proceeding;

(c) Will be deducted from any judgment, settlement, or arbitration award; and

(d) Will not be repaid by the claimant regardless of the amount of judgment, settlement, or award.

(3) Subsection (2) of this section does not restrict a right of contribution or indemnity under the laws of Washington state.

NEW SECTION. **Sec. 22.** (1) Each insuring entity or self-insurer that provides medical malpractice coverage to a facility or provider covered by the program must notify the program if it establishes a loss reserve for a claim that exceeds one hundred twenty-five thousand dollars.

(2) Each facility or provider that is self-insured must notify the program if a claim is made that exceeds one hundred twenty-five thousand dollars.

(3) Notices required under subsections (1) and (2) of this section must be sent by certified mail to the program within ten working days after the date:

(a) The loss reserve is established; or

(b) The facility or provider is notified of the claim.

(4) Notices and all related communications and correspondence provided under this section are confidential and are not available to any person or any public or private agency.

(5) The program may elect to participate in the defense of a facility or provider. If the program has the right but not the duty to defend and decides to participate in the defense the program will:

(a) Pay its expenses; and

(b) Not contribute to the expenses of the facility, provider, insuring entity, or self-insurer until the applicable retained limit has been paid.

NEW SECTION. **Sec. 23.** (1) Beginning on March 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 1st of each month 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 entity listed in subsection (1) of this section, the facility or provider must report the claim to the commissioner.

(a) Reports under this subsection must be filed with the commissioner within thirty days after the claim is resolved.

(b) If a facility or provider violates the requirements of this subsection, the facility or provider license is subject to a fine or disciplinary action by the department.

(3) The reporting requirements under this section apply to all:

(a) Insuring entities and self-insurers; and

(b) Providers and facilities, regardless of whether they buy coverage from the program.

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

(5) The commissioner will provide the department with electronic access to all information received under this section related to licensed facilities and providers.

NEW SECTION. **Sec. 24.** The reports required under section 23 of this act must contain the following data in a form prescribed by the commissioner:

(1) The health care provider's name, address, provider professional license number, and type of medical specialty for which the provider is insured;

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

(3) The name of the facility, if any, and the location within the facility where the injury occurred;

(4) The date of the loss;

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

(6) 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;

(b) To the department at any time; or

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

(7) The date of suit, if filed;

(8) The claimant's age and sex;

(9) The names, and professional license numbers if applicable, of all defendants involved in the claim;

(10) 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) The loss adjustment expense paid to defense counsel; and

(iv) All other paid allocated loss adjustment expense;

(d) If there is no judgment or settlement:

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

(ii) The date the claim was closed; and

(e) Any other information required by the commissioner;

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

(a) The final diagnosis for which the patient sought or received treatment, including the actual condition of the patient;

(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 steps the facility or provider has taken to make similar occurrences or injuries less likely in the future; and

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

NEW SECTION. **Sec. 25.** The commissioner must prepare aggregate statistical summaries of closed claims based on calendar year data submitted under section 23 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. 26.** 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 23 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 persons and entities required to report under section 23 of this act to report data related to:

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

(b) The amounts reserved for incurred claims;

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

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

(e) Any additional information requested by the department or the board.

NEW SECTION. **Sec. 27.** The commissioner may adopt all rules needed to implement this chapter.

NEW SECTION. **Sec. 28.** Sections 1 through 27 of this act constitute a new chapter in Title 48 RCW.

NEW SECTION. **Sec. 29.** A new section is added to chapter 18.130 RCW to read as follows:

(1) As used in this section:

(a) "Claim" has the same meaning as section 1(2) of this act.

(b) "Health care professional" means a person engaged in a profession listed in RCW 18.130.040.

(c) "Supplemental malpractice insurance program" has the same meaning as section 1(10) of this act.

(2) The department must provide the program with any available information needed to set premiums, including data on hospital bed capacity and occupancy rates.

(3) The department must thoroughly investigate a health care professional if:

(a) A health care professional has three claims paid within the most recent five-year period; and

(b) The total indemnity payment for each claim was fifty thousand dollars or more.

(4) The department may adopt any rules needed to implement this section.

NEW SECTION. **Sec. 30.** The sum of ten million dollars, or as much thereof as may be necessary, is appropriated for the biennium ending June 30, 2005, from the health services account to the department of health to:

(1) Provide capital and surplus to the supplemental malpractice insurance program; and

(2) Pay administrative expenses incurred to establish the supplemental malpractice insurance program.

NEW SECTION. **Sec. 31.** 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.

NEW SECTION. **Sec. 32.** This act is necessary for the immediate preservation of the public peace, health, or safety, or support of the

state government and its existing public institutions, and takes effect immediately.

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