
SENATE BILL 6328

State of Washington

58th Legislature

2004 Regular Session

By Senators Deccio, Winsley, Kline, Brown, Rasmussen and Franklin; by request of Insurance Commissioner

Read first time 01/16/2004. Referred to Committee on Health & Long-Term Care.

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

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

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

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

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

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

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

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

18 (4) "Commissioner" means the insurance commissioner.

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

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

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

7 (8) "Insuring entity" means:

8 (a) An insurer;

9 (b) A joint underwriting association;

10 (c) A risk retention group; or

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4 (a) After 12:01 a.m. on January 1, 2005; or
5 (b) The effective date of coverage under the program, if later than
6 12:01 a.m. on January 1, 2005.

7 (2) The program will not pay claims:

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

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

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

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

16 (e) That result from an intentional crime, as defined in RCW
17 7.69.020(1). This exclusion applies whether or not the criminal
18 conduct is the basis for a medical malpractice claim;

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

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

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

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

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

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

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

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

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

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

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

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

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

16 (a) Forms under RCW 48.18.100 and 48.18.103; and

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

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

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

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

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

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

29 (4) The program is not a state agency.

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

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

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

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

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

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

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

11 (b) A vacancy occurs on the board.

12 (2) The board must comprise:

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

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

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

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

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

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

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

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

31 (a) A schedule for meetings;

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

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

35 (ii) Limits of coverage available from the program;

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

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

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

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

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

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

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

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

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

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

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

23 (2) The administrator may:

24 (a) Hire staff to operate the program; or

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

34 (v) The impact on state revenue; and

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

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

37 (4) The state investment board must:

38 (a) Manage the assets of the program;

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

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

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

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

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

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

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

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

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

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

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

35 (a) Is licensed by Washington state; or

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

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

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

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

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

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

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

16 (A) Its principal office in Washington state; and

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

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

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

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

29 (1) The facility or provider:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

8 (2) The minimum retained limits of liability are:

9 (a) For health care providers:

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

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

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

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

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

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

19 (A) Five hundred thousand dollars per claim; and

20 (B) Annual aggregate limits of five million dollars;

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

22 (A) Five hundred thousand dollars per claim; and

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

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

26 (A) Five hundred thousand dollars per claim; and

27 (B) Annual aggregate limits of five million dollars;

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

30 (A) Five hundred thousand dollars per claim; and

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

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

33 (i) Five hundred thousand dollars per claim; and

34 (ii) Annual aggregate limits of three million dollars.

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

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

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

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

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

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

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

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

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

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

- 28 (i) One million dollars per claim; and
- 29 (ii) An annual aggregate limit of three million dollars.

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

- 32 (i) Two million dollars per claim; and
- 33 (ii) An annual aggregate limit of six million dollars.

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

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

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

6 NEW SECTION. **Sec. 16.** From January 1, 2005, through December 31,
7 2005, the annual program premium billed to each participating facility
8 or provider will be determined by the commissioner based on:

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

11 (2) Claims experience for medical malpractice insurance; and

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

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

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

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

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

29 (b) Past and prospective operating expenses;

30 (c) Past and prospective investment income;

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

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

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

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

4 (i) The amount of surgery performed by a facility or provider; and
5 (ii) The risk of diagnostic and therapeutic services provided or
6 procedures performed;

7 (b) The bed capacity and occupancy rates in a health care facility;
8 (c) Differences in financial risk, if any, to the program if a
9 facility or provider is self-insured;

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

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

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

18 (g) Higher retained limits selected by a facility or provider; and
19 (h) Higher limits of liability coverage purchased from the program
20 by a facility or provider.

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

24 (1) The experience rating plan:

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

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

29 (i) A facility;

30 (ii) A health care provider; or

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

32 (c) May consider medical malpractice claims:

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

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

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

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

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

5 (ii) The federal institute of medicine;

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

8 (iv) The national quality forum; or

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

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

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

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

18 (b) The annual funding estimate is actuarially sound.

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

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

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

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

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

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

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

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

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

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

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

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

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

30 (i) The program; or

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

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

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

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

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

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

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

12 (a) Are not an admission of fault;

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

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

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

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

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

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

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

32 (a) The loss reserve is established; or

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

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

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

4 (a) Pay its expenses; and

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

8 NEW SECTION. **Sec. 23.** (1) Beginning on March 1, 2005, every
9 insuring entity or self-insurer that provides medical malpractice
10 insurance to any facility or provider in Washington state must report
11 to the commissioner by the 1st of each month any claim related to
12 medical malpractice, if the claim resulted in a final:

13 (a) Judgment in any amount;

14 (b) Settlement in any amount; or

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

17 (2) If a claim is not reported by an entity listed in subsection
18 (1) of this section, the facility or provider must report the claim to
19 the commissioner.

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

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

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

26 (a) Insuring entities and self-insurers; and

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

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

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

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

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

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

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

10 (4) The date of the loss;

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

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

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

16 (b) To the department at any time; or

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

19 (7) The date of suit, if filed;

20 (8) The claimant's age and sex;

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

23 (10) Specific information about the judgment or settlement
24 including:

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

26 (b) Whether the settlement:

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

28 (ii) Occurred before or after trial;

29 (c) An itemization of:

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

32 (ii) Noneconomic damages;

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

34 (iv) All other paid allocated loss adjustment expense;

35 (d) If there is no judgment or settlement:

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

37 (ii) The date the claim was closed; and

38 (e) Any other information required by the commissioner;

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

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

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

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

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

11 (e) The safety management steps the facility or provider has taken
12 to make similar occurrences or injuries less likely in the future; and

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

17 NEW SECTION. **Sec. 25.** The commissioner must prepare aggregate
18 statistical summaries of closed claims based on calendar year data
19 submitted under section 23 of this act.

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

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

24 NEW SECTION. **Sec. 26.** Beginning in 2006, the commissioner must
25 prepare an annual report by June 30th that summarizes and analyzes the
26 closed claim reports for medical malpractice filed under section 23 of
27 this act and the annual financial reports filed by insurers writing
28 medical malpractice insurance in this state. The report must include:

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

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

32 (b) An itemization of economic and noneconomic damages;

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

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

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

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

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

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

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

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

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

21 (6) The commissioner may adopt rules that require persons and
22 entities required to report under section 23 of this act to report data
23 related to:

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

26 (b) The amounts reserved for incurred claims;

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

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

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

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

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

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

3 (1) As used in this section:

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

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

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

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

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

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

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

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

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

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

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

28 NEW SECTION. **Sec. 31.** If any provision of this act or its
29 application to any person or circumstance is held invalid, the
30 remainder of the act or the application of the provision to other
31 persons or circumstances is not affected.

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

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

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