Washington State
House of Representatives
Office of Program Research

BILL ANALYSIS

Financial Institutions & Insurance Committee

HB 1809

Brief Description: Stabilizing the cost of medical malpractice insurance.

Sponsors: Representatives Kirby, Simpson, Morrell, O'Brien, Conway, Linville and Moeller; by request of Insurance Commissioner.

Brief Summary of Bill

- Establishes a voluntary supplemental insurance program for medical malpractice.
- Provides eligibility criteria.
- Creates a board to oversee the program.
- Allows for rating discounts for patient safety.
- Requires reporting of medical malpractice claim information.

Hearing Date: 2/17/05

Staff: Jon Hedegard (786-7127).

Background:

The Office of the Insurance Commissioner (OIC) is responsible for the licensing and regulation of insurance companies doing business in this state. This oversight includes medical malpractice liability insurers. Health care providers and health care facilities purchase medical malpractice insurance coverage from insurers in the private market. Insurers often purchase reinsurance to protect against large loss exposures.

Summary of Bill:

The 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 (provider) or health care facility (facility).

Composition of the Board of Governors.
The Board of Governors (Board) is comprised of:

- the Insurance Commissioner or a designated employee of the OIC. This Governor shall serve as Chairperson of the Board;
- three members of the public appointed by the Commissioner;
- a person with insurance or risk management experience appointed by the Commissioner;
- a person selected by the Washington State Medical Association; and
- a person selected by the Washington State Hospital Association.

Responsibilities of the Board of Governors.

The Board must:

- adopt a plan of operation (plan) for the program within 60 days after the Board is appointed;
- hire an administrator, who may hire staff or contract for services;
- review and approve of all administrative and contracted service;
- contract with an actuary for the development of the program's classifications, rates, and rating plans used beginning January 1, 2006; and
- adopt rates and rating plans.

Plan of operation.

The plan must be approved by the Insurance Commissioner before it takes effect. The plan may be amended by the Board as needed. All changes must be approved by the Insurance Commissioner before they take effect. The plan must include a schedule of meetings and specific program coverage provisions, including:

- types of claims excluded from coverage;
- coverage limits;
- eligibility criteria for providers and facilities;
- circumstances to provide coverage for injuries that occurred before January 1, 2005;
- 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 providers and facilities to buy coverage from the program;
- billing, collecting, and other administrative activities;
- a process to determine rate relief for high risk providers if funds are appropriated for that purpose;
- a process to determine if a provider or facility has engaged in proven patient safety programs and set discounts for the provider or facility; and
- a process to review the provider or facility that received a patient safety discount to see if the discount should continue.

Who can buy coverage.

A facility must meet the criteria for financial responsibility (either by purchasing insurance or self-insuring) and be located in Washington and:

- licensed in Washington; or
- is closing and needs to buy tail coverage.

A provider must meet the criteria for financial responsibility (either by purchasing insurance or self-insuring) and be one of the following:

- licensed and doing business principally in Washington;

- a Washington resident; the provider is licensed in Washington; the provider is principally located in Idaho or Oregon; and the provider performs procedures in an Idaho or Oregon facility that is affiliated with a Washington corporation;
- retiring or closing business and need to buy tail coverage; or
- a federal employee who is not covered by the federal tort claims act.

Who cannot buy coverage.

The following providers and facilities are not allowed to buy coverage:

- a provider or facility that has not provided proof of financial responsibility;
- a facility or provider that does not meet criteria established by the Board. A facility or provider that is denied coverage may appeal the decision to the Board;
- a provider who is a federal employee who is covered by the federal tort claims act; and
- a health care facility that is operated by the state or federal government.

Minimum retained limits requirements.

- Providers and facilities must have underlying coverage of $1 million per claim and $3 million annual aggregate limits.
- The Board shall review the limits after one year and determine if adjustments are needed.
- The program will establish alternative rates for providers or facilities who want higher retained limits.
- Retained limits only apply to claim payments and not defense costs.

Program details.

The program is responsible for:

- charging an annual premium to facilities and providers;
- using premium funds to pay claims, administrative costs and expenses;
- providing the commissioner with free access to all books, records, and files that relate to the operation of the program;
- using an experience rating plan and a schedule rating plan. The experience rating plan must consider a provider or facility's past loss experience. The schedule rating plan must consider the effects of risk management programs that improve patient safety;
- filing an annual statement with the Commissioner;
- maintaining its records according to accounting practices established by the National Association of Insurance Commissioners; and
- using its discretion to increase surplus by issuing a capital call.

Program coverage limitations.

The program will not cover claims that:

- are excluded from coverage by the Board;
- 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;
- are made before all other medical malpractice liability insurance coverage is exhausted;
- are made against a partnership or professional corporation if it's not the partnership or professional corporation's purpose to provide health care services; and

- that are made on or after January 1, 2005, or the effective date of coverage under the program, if later than January 1, 2005 unless allowed by the Board.

Defense costs limitations.
The program will not pay defense costs when the applicable limit of liability is purchased by the provider or facility.

Responsibilities of providers and facilities.
The program requires providers and facilities to:
- purchase underlying insurance or self-insuring up to specified amounts if they participate in the program;
- pay premiums to the program within 30 days of the billing date to participate; 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 the claim).

Responsibilities for medical malpractice insuring entities and self-insurers.
Medical malpractice insuring entities and self-insurers must:
- offer limits of underlying coverage equal to those required by the Plan;
- 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 adequate notice before cancelling or nonrenewing coverage. Fifteen days notice for nonpayment of premiums and 90 days notice for any other reason;
- keep a copy of the notice for 10 years;
- pay defense or settlement costs as within the retained limits;
- share defense costs with the program if a claim is large enough that the program pays on the claim;
- notify the program within 10 days after it establishes a loss reserve for a claim exceeding $300,000. These notices are not subject to public disclosure; and
- collect premiums from participants on behalf of the program and forward program premiums to the program.

Reporting requirements for insuring entities, providers, and facilities.
Medical malpractice insuring entities and self-insurers must make monthly reports to the Commissioner any malpractice claim that resulted in a judgement, a settlement, or was closed with no payment. If a claim is not reported by an insurer or self-insurer, it must be reported by the provider or facility. The Commissioner may fine an insuring entity $250 per violation up to $10,000.

Responsibilities of the Insurance Commissioner.
The Insurance Commissioner must:
- appoint representatives to the Board within 30 days after the act is effective;
- approve the Board's plan of operation;
- review requests for and either approve or disapprove capital calls;
- examine the transactions, financial conditions, and operation of the program at least every three years;
- conduct examinations of the program according to procedures in Chapter 48.03 RCW;

- determine the initial premium rates based on an 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 subsequent rates and rating plan to determine that the rates will result in premiums that are not excessive, inadequate, or unfairly discriminatory, and determine that the annual funding estimate is actuarially sound;
- prepare aggregate statistical summaries of closed claims each calendar year by March 31 of each year; and
- prepare an annual report by fiscal year-end summarizing closed claim reports and an analysis of the medical malpractice insurance market in Washington. The annual report is first required in 2006 and is due each June 30th.

Responsibilities of the Department of Health.

The Department of Health may:
- discipline or fine providers who don't not comply with reporting requirements;
- electronically access medical malpractice claim information reported to the Insurance Commissioner; and
- request that the Insurance Commissioner adopt rules to assist the department in analyzing medical malpractice cases.

The Program's legal status.

The program is:
- a separate legal entity;
- able to receive appropriations at the Legislature's discretion;
- exempt from payment of all state fees and taxes; and
- exempt from filing forms and rates, except for the initial rates.

The program is not:
- an insurer as defined in the insurance code;
- a state agency;
- able to obligate the state for the debts or obligations of the program; or
- a member of the Washington Insurance Guaranty Association.

Appropriation: None.

Fiscal Note: Requested on February 2, 2005.

Effective Date: The bill takes effect 90 days after adjournment of session in which bill is passed.