Washington State
House of Representatives
Office of Program Research

BILL ANALYSIS

Financial Institutions & Insurance Committee

HB 1933

Brief Description: Requiring the reporting and analysis of medical malpractice related information.

Sponsors: Representatives Schual-Berke, Morrell and Lantz.

Brief Summary of Bill

- Requires insuring entities and self-insurers to report certain data regarding medical malpractice claims. Health care providers and health care facilities must report the data if the information is not reported by an insuring entity or self-insurer.
- Requires a claimant or their attorney to report certain data regarding medical malpractice claims.
- Requires the Insurance Commissioner to aggregate information and make the information available by March 31 of each year.
- Requires the Insurance Commissioner to develop an annual report analyzing the medical malpractice information and the medical malpractice market by June 30 of each year.
- Provides rule-making authority to implement the chapter and protect identifiable information.

Hearing Date: 2/17/05

Staff: Jon Hedegard (786-7127).

Background:

The Insurance Commissioner (Commissioner) is responsible for the licensing and regulation of insurance companies doing business in this state. This includes insurers offering coverage for medical malpractice. Current law does not require insurers, including medical malpractice insurers, to file underwriting standards. In addition, the Commissioner does not receive information about medical malpractice claims, judgments, or settlements.

Under current law, rates and forms are subject to public disclosure when the filing becomes effective. Actuarial formulas, statistics, and assumptions submitted in support of a filing are not subject to public disclosure.

Summary of Bill:

"Insuring entity" includes:
- insurers;
- a joint underwriting association;
- a risk retention group;
- an unauthorized insurer providing surplus lines coverage.

Beginning on April 1, 2006, self-insurers and insuring entities that write medical malpractice insurance must report any closed claim resulting in judgments, settlements, or no payment to the Insurance Commissioner within sixty days after the claim is closed. If an insurer does not report to the Commissioner because of a policy limitation, the provider or facility must report a claim to the Commissioner. The Commissioner may impose a fine against insuring entities who fail to report of up to $250 per day up to a total of $10,000. The Department of Health may impose a fine against a facility or provider that fails to report of up to $250 per day up to a total of $10,000.

Reports by insuring entities and self-insurers.
The reports must contain data, including:
- a unique identifying number for the claim assigned by the insurer or self-insurer;
- the type of health care provider, including the provider's specialty; the type of facility, if any, and the location within the facility where the injury occurred;
- the date of the event that resulted in the claim;
- the county or counties where the event occurred;
- the date the claim was reported to the insuring entity, self-insure, facility or provider;
- the date of the suit, if filed;
- the claimant's age and sex;
- certain specific information if there was a settlement, including date, amount of the settlement, if the settlement was a result of mediation or arbitration was used, and if the settlement occurred before or after trial;
- certain specific information if there was a verdict or judgement that itemized costs, including itemizing economic and noneconomic damages and litigation expenses;
- certain information if there was a verdict or judgement that did not itemize costs, including total damages and litigation expenses;
- certain information if there was no judgment and no settlement, including date and reason for the disposition and the date the claim was closed; and
- the reason for the claim. The Commissioner shall use the same reason coding as is required for reporting to the national practitioner data base.

Aggregate summary of data.
The Commissioner must prepare aggregate statistical summaries of closed claims. The summaries must be available by March 31of each year. Information in an individual closed claim is confidential and not subject to public disclosure.

Annual report.

The Commissioner must prepare an annual report of closed claims based on calendar year data and the annual financial reports of insurers by June 30th of each year. The Commissioner must post a report to the internet within 30 days after it is due. The report must include:

- trends in frequency and severity of claims;
- an itemization of economic and noneconomic damages;
- an itemization of allocated loss adjustment expenses;
- any other information the Commissioner believes illustrates trends in closed claims;
- an analysis of the financial reports of the insurers who write a combined minimum of 90 percent of the medical malpractice premiums in Washington;
- a loss ratio analysis;
- a profitability analysis of each insurer writing medical malpractice;
- a comparison of loss ratios and the profitability of medical malpractice in Washington and other states; and
- a summary of approved medical malpractice rate filings for the prior year, including analyzing the trend of losses compared to prior years.

Rule-making.

- The Commissioner may adopt rules to require insuring entities and self-insurers to report data regarding the frequency and severity of open claims; the aggregate amounts reserved; changes in reserves from the previous reporting period; and other information useful to the Commissioner in monitoring the medical malpractice insurance market.
- The Commissioner shall adopt rules to implement this chapter.
- The Commissioner shall adopt rules to protect the identity of claimants, providers health care facilities, and self-insurers when data is disclosed to the public.

Claimants and their attorneys.

A claimant or their attorney must report to the Commissioner the amount of any court costs, attorneys' fees, or costs of expert witnesses.

Appropriation: None.

Fiscal Note: Not requested.

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