HOUSE BILL REPORT
HB 1933

As Reported by House Committee On:
Financial Institutions & Insurance

Title: An act relating to reporting and analysis of medical malpractice related information.

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

Sponsors: Representatives Schual-Berke, Morrell and Lantz.

Brief History:
Committee Activity:
Financial Institutions & Insurance: 2/1/06, 2/2/06 [DP2S].

Brief Summary of Second Substitute 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 April 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. The first report is due in 2010.
- Provides rule-making authority to implement the chapter and protect identifiable information.

HOUSE COMMITTEE ON FINANCIAL INSTITUTIONS & INSURANCE

Majority Report: The second substitute bill be substituted therefor and the second substitute bill do pass. Signed by 8 members: Representatives Kirby, Chair; Ericks, Vice Chair; Tom, Assistant Ranking Minority Member; O'Brien, Santos, Simpson, Strow and Williams.

Minority Report: Do not pass. Signed by 3 members: Representatives Roach, Ranking Minority Member; Newhouse and Serben.

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 Second Substitute Bill:

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

Beginning on January 1, 2008, self-insurers and insuring entities that write medical malpractice insurance must report any closed claim resulting in judgments, settlements, or no payment to the Commissioner within 60 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. The Department of Health (DOH) 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 April 30 of 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 30 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 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.
- The Commissioner may adopt rules requiring the electronic filing of closed claim data.

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

Confidentiality.
Confidentiality provisions are extended to providers and facilities. Confidentiality of data is extended to claimants as well as providers.

No modification of requirements under Chapter 48.19 RCW.
The act does not modify or amend any requirements under Chapter 48.19 RCW.

Second Substitute Bill Compared to Original Bill:

Several definitions are modified including "claim," "claimant," "closed claim," "health care facility," and "health care provider." New definitions of "economic damages" and "noneconomic damages" are added. "Companion claims" is defined. The responsibility for reporting those claims is the specialty primarily responsible for the incident that led to the claim. The provisions requiring facilities and providers to report are modified. The data elements required to be reported are modified. The Commissioner may request other claims-related. The closed claim reporting date is extended from April 1, 2006, to January 1, 2008. The Commissioner may adopt rules requiring the electronic filing of closed claim data. The annual date of the Office of the Insurance Commissioner (OIC) aggregate statistical summaries are due is changed from March 31 to April 30. The Commissioner may issue late summaries if data are not available. The annual report by the Commissioner is modified. The report begins in 2010 instead of 2006. Confidentiality provisions are extended to providers and facilities. Confidentiality of data is extended to claimants as well as providers. The reference to Chapter 42.17 RCW is changed to Chapter 42.56 RCW. A provision is added stating that the new Chapter does not modify or amend any requirements under Chapter 48.19 RCW.

Appropriation: None.

Fiscal Note: Not requested.

Effective Date of Second Substitute Bill: The bill takes effect July 1, 2006.

Testimony For: The Insurance Commissioner supports the bill. The bill has been revised considerably since last year. The recent changes improve the bill. The OIC has completed two closed claim studies. Those efforts gave us a greater understanding of what information is important and how it can be used. A great majority of the issues raised by stakeholders have been resolved. There are still some areas of disagreement and the OIC is committed to continue work on the subject. It is critical that the self-insureds and the coverage in the surplus lines is included in those that must report. Without that component in the bill, the OIC would withdraw its support. The OIC can collect data from the medical malpractice insurers today. It cannot collect data from the self-insureds and surplus lines. Without that information, there cannot be a complete picture of the medical malpractice market. It is needed for the debate by policymakers.

(With concerns) Many of the concerns of the hospitals have been resolved in P2SHB 1933. There is a major issue left. The ability to fine a hospital for not reporting is an issue. This is inconsistent with how hospitals are regulated by the DOH. This ability to fine is not needed to compel hospitals to report this information. It is not wanted by the DOH.

Testimony Against: None

Persons Testifying: Beth Berendt, Office of the Insurance Commissioner.

(With concerns) Lisa Thatcher, Washington State Hospitals Association.

Persons Signed In To Testify But Not Testifying: None.