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HOUSE BILL 1809

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State of Washington

59th Legislature

2005 Regular Session

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

Read first time 02/07/2005. Referred to Committee on Financial Institutions & Insurance.

1 AN ACT Relating to stabilizing the cost of medical malpractice  
2 insurance; adding a new chapter to Title 48 RCW; prescribing penalties;  
3 and declaring an emergency.

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

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

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

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

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

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

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

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

18 (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 person regulated  
6 under Title 18 RCW or chapter 70.127 RCW, to practice health or health-  
7 related services or otherwise practicing health care services in this  
8 state consistent with state law; or an employee or agent of a person  
9 described in this subsection, acting in the course and scope of his or  
10 her employment.

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

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

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

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

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

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

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

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

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

30 (11) "Tail coverage" means extended reporting period coverage.

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

34 (13) "Rate relief" means using appropriated funds to reduce the  
35 premium of a high-risk provider or facility as identified by the board  
36 under section 4 of this act.

37 (14) "High-risk provider or facility" is to be determined by the  
38 board under section 5 of this act.

1 (15) "Premium discount" means premium reduction for providers or  
2 facilities to be determined by the board under section 5 of this act.

3 (16) "Proven patient safety measures" includes programs,  
4 activities, or training undertaken by providers or facilities to reduce  
5 potential loss due to medical malpractice as defined in this section.

6 (17) "Patient safety discounts" means annual premium discounts for  
7 providers or facilities under section 5 of this act.

8 NEW SECTION. **Sec. 2.** (1) A supplemental malpractice insurance  
9 program is created to provide an excess layer of liability coverage for  
10 medical malpractice claims. Subject to subsection (2) of this section,  
11 the program pays claims and related defense costs on behalf of a  
12 covered health care facility or provider if the claim is first made  
13 against the facility or provider:

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

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

17 (2) The program shall not pay claims:

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

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

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

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

26 (e) That result from an intentional crime, as defined in RCW  
27 7.69.020(1). This exclusion applies whether or not the criminal  
28 conduct is the basis for a medical malpractice claim;

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

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

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

34 (g) Made against a partnership or professional corporation  
35 organized by health care providers, if the board determines that it is  
36 not the primary purpose of the partnership or corporation to provide  
37 the health care services. For the purposes of this subsection, if

1 fifty percent or more of the partners, owners, or shareholders are  
2 health care providers, the board must determine that it is the entity's  
3 primary purpose to provide health care services.

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

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

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

10 (4) The obligation of the program to pay related defense costs  
11 under subsection (1) of this section ends when the program pays the  
12 applicable limit of liability purchased by the facility or provider.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

20 (a) The effective date of this act; or

21 (b) A vacancy occurs on the board.

22 (2) The board must comprise:

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

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

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

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

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

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

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

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

4        (a) A schedule for meetings;

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

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

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

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

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

13          (v) Rules the program is to follow when it provides tail coverage;

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

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

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

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

22          (g) A process to determine which high-risk providers and facilities  
23 may be eligible for rate relief and the amount of such relief if money  
24 is appropriated under section 3(4)(b) of this act;

25          (h) A process to determine if a provider or facility has engaged in  
26 a proven patient safety program and the amount of the annual premium  
27 discount the provider or facility is to receive;

28          (i) A review process for providers and facilities receiving premium  
29 discounts for proven patient safety programs to see if the providers  
30 and facilities should maintain the premium discount;

31          (j) Review authority over the basic limits of coverage subject to  
32 sections 13 and 15 of this act; and

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

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

37        (3) The board may amend the plan of operation as needed. All

1 amendments are subject to approval by the commissioner before they take  
2 effect.

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

- 5 (2) The administrator may:  
6 (a) Hire staff to operate the program; or  
7 (b) Contract for all or part of the services needed to operate the  
8 program.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

17 (v) The impact on state revenue; and

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

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

20 (4) The state investment board must:

21 (a) Manage the assets of the program;

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

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

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

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

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



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

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

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

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

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

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

20 (a) Is licensed by Washington state; or

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

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

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

28 (b) The provider's principal place of practice is Idaho or Oregon,  
29 and:

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

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

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

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

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

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

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

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

12 (1) The facility or provider:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

27        (a) For health care providers:

28        (i) One million dollars per claim; and

29        (ii) Annual aggregate limits of three million dollars;

30        (b) For health care facilities:

31        (i) One million dollars per claim; and

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

33        (3) The board, under section 5 of this act, shall review, after one  
34 year, the basic limits of coverage offered, and after reviewing the  
35 program's actuarial data and program participation, determine if the  
36 basic limits of coverage should be adjusted.

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

3 (5)(a) Retained limits of liability apply only to claim payments.  
4 Each insuring entity and self-insurer that provides certification under  
5 subsection (1) of this section must pay defense costs as supplementary  
6 payments.

7 (b) If a medical malpractice claim is large enough that the program  
8 must make claim payments, the insuring entity or self-insurer and the  
9 program shall share defense costs on a pro rata basis based on the  
10 total amount of claim payments.

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

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

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

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

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

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

31 (i) One million dollars per claim; and

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

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

35 (i) One million dollars per claim; and

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

1 (3) The board, under section 5 of this act, shall review, after one  
2 year, the basic limits of coverage offered, and after reviewing the  
3 program's actuarial data and program participation, determine if the  
4 basic limits of coverage should be adjusted.

5 (4) In addition to the basic limits described in subsection (2) of  
6 this section, the program must offer higher limits of coverage to those  
7 providers and facilities that are willing to pay additional premiums if  
8 they meet eligibility criteria established by the board. The board  
9 shall determine the limits of liability available through the program  
10 based on the limits available in the voluntary medical malpractice  
11 insurance market.

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

14 NEW SECTION. **Sec. 16.** From January 1, 2005, through December 31,  
15 2005, the annual program premium billed to each participating facility  
16 or provider shall be determined by the commissioner based on:

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

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

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

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

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

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

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

- 1 (b) Past and prospective operating expenses;  
2 (c) Past and prospective investment income;  
3 (d) A contingency factor to protect the program from adverse loss  
4 development; and  
5 (e) All other relevant factors within and outside Washington state.  
6 (3) The classifications, rates, and rating plan used to develop  
7 premiums for individual facilities and providers must consider:  
8 (a) Past and prospective loss and expense experience for different  
9 types of medical care offered by participating facilities or providers,  
10 including:  
11 (i) The amount of surgery performed by a facility or provider; and  
12 (ii) The risk of diagnostic and therapeutic services provided or  
13 procedures performed;  
14 (b) The bed capacity and occupancy rates in a health care facility;  
15 (c) Differences in financial risk, if any, to the program if a  
16 facility or provider is self-insured;  
17 (d) The risk factors for providers who are semiretired or part-time  
18 professionals;  
19 (e) If appropriate, premium differentials for coverage that  
20 includes a provision that allows a provider to reject a settlement  
21 offered to a claimant by the program;  
22 (f) If a health care provider is a partnership or professional  
23 corporation, the risk factors and past and prospective loss and expense  
24 experience of the partners and employees of that provider;  
25 (g) If a provider's principal place of practice is Oregon or Idaho,  
26 any differences in risk or expense to reflect the fact the provider's  
27 practice is not located in Washington state;  
28 (h) Higher retained limits selected by a facility or provider; and  
29 (i) Higher limits of liability coverage purchased from the program  
30 by a facility or provider.

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

- 34 (1) The experience rating plan:  
35 (a) Must consider the past loss and loss adjustment expense  
36 experience of a facility or an individual provider;

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

3 (i) A facility;

4 (ii) A health care provider; or

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

6 (c) May consider medical malpractice claims:

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

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

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

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

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

16 (ii) The federal institute of medicine;

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

19 (iv) The national quality forum; or

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

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

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

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

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

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

36 (a) To collect or refund the premium, the program may adjust any

1 outstanding semiannual or quarterly installment payments, if  
2 applicable.

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

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

8 (1) Facilities or providers may pay program premiums annually, or  
9 in semiannual or quarterly installments. Semiannual and quarterly  
10 installments must include the prorated premium and a fee that covers  
11 unearned interest or investment income and administrative costs  
12 incurred because the facility or provider has decided to pay the  
13 premium in installments.

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

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

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

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

29 (b) The insuring entity responsible for the delinquency is liable  
30 for the premium due plus a penalty equal to ten percent of the amount  
31 of the overdue premium.

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



1        NEW SECTION.    **Sec. 21.** A provider or facility, the program, an  
2 insuring entity, or a self-insurer that provides medical malpractice  
3 coverage may voluntarily make payments for medical expenses prior to  
4 any determination of fault.

5        (1) These payments:

6            (a) Are not an admission of fault;

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

9            (c) Must be deducted from any judgment, settlement, or arbitration  
10 award; and

11           (d) Are not to be repaid by the claimant regardless of the amount  
12 of judgment, settlement, or award.

13        (2) This section does not restrict a right of contribution or  
14 indemnity under the laws of Washington state.

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

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

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

24            (a) The loss reserve is established; or

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

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

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

32            (a) Pay its expenses; and

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

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

6        (a) Judgment in any amount;

7        (b) Settlement in any amount; or

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

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

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

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

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

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

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

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

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

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

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

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

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

1 (4) The date of the loss;

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

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

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

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

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

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

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

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

14 (10) Specific information about the judgment or settlement  
15 including:

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

17 (b) Whether the settlement:

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

19 (ii) Occurred before or after trial;

20 (c) An itemization of:

21 (i) Economic damages, such as incurred and anticipated medical  
22 expenses and lost wages;

23 (ii) Noneconomic damages;

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

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

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

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

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

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

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

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

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

36 (c) The operation, diagnostic, or treatment procedure that caused  
37 the injury;

1 (d) A description of the principal injury that led to the claim;  
2 and

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

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

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

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

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

16 NEW SECTION. **Sec. 26.** (1) Beginning in 2006, the commissioner  
17 must prepare an annual report by June 30th that summarizes and analyzes  
18 the closed claim reports for medical malpractice filed under section 23  
19 of this act and the annual financial reports filed by insurers writing  
20 medical malpractice insurance in this state. The report must include:

21 (a) An analysis of closed claim reports of prior years for which  
22 data are collected and show:

23 (i) Trends in the frequency and severity of claims payments;

24 (ii) An itemization of economic and noneconomic damages;

25 (iii) The types of medical malpractice for which claims have been  
26 paid; and

27 (iv) Any other information the commissioner determines illustrates  
28 trends in closed claims;

29 (b) An analysis of the medical malpractice insurance market in  
30 Washington state, including:

31 (i) An analysis of the financial reports of the insurers with a  
32 combined market share of at least ninety percent of net written medical  
33 malpractice premiums in Washington state for the prior calendar year;

34 (ii) A loss ratio analysis of medical malpractice insurance written  
35 in Washington state; and

1 (iii) A profitability analysis of each insurer writing medical  
2 malpractice insurance;

3 (c) A comparison of loss ratios and the profitability of medical  
4 malpractice insurance in Washington state to other states based on  
5 financial reports filed with the national association of insurance  
6 commissioners and any other source of information the commissioner  
7 deems relevant; and

8 (d) A summary of the rate filings for medical malpractice that have  
9 been approved by the commissioner for the prior calendar year,  
10 including an analysis of the trend of direct and incurred losses as  
11 compared to prior years.

12 (2) The commissioner must post reports required by this section on  
13 the internet no later than thirty days after they are due.

14 (3) The commissioner may adopt rules that require persons and  
15 entities required to report under section 23 of this act to report data  
16 related to:

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

19 (b) The amounts reserved for incurred claims;

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

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

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

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

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

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

1        NEW SECTION.   **Sec. 30.**   This act is necessary for the immediate  
2   preservation of the public peace, health, or safety, or support of the  
3   state government and its existing public institutions, and takes effect  
4   immediately.

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