H-2272.1

SUBSTITUTE HOUSE BILL 1933

State of Washington 59th Legislature 2005 Regular Session

By House Committee on Financial Institutions & Insurance (originally sponsored by Representatives Schual-Berke, Morrell and Lantz)

READ FIRST TIME 03/02/05.

AN ACT Relating to reporting and analysis of medical malpractice related information; adding a new section to chapter 7.70 RCW; adding a new section to chapter 42.17 RCW; adding a new chapter to Title 48 RCW; creating a new section; and prescribing penalties.

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

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

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

(a) Two or more claims, or a single claim naming multiple health care providers or facilities, arising out of a single injury or incident of medical malpractice is one claim.

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

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

(3) "Closed claim" means a claim concluded with or without payment and for which all administrative activity has been finalized by the insuring entity or self-insurer.

(4) "Commissioner" means the insurance commissioner.

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

(6) "Health care provider" or "provider" means a physician licensed under chapter 18.71 RCW, an osteopathic physician licensed under chapter 18.57 RCW, a podiatric physician licensed under chapter 18.22 RCW, a dentist licensed under chapter 18.32 RCW, a chiropractor licensed under chapter 18.25 RCW, an advance registered nurse practitioner licensed under chapter 18.79 RCW, a physician assistant licensed under chapter 18.71A RCW, and a naturopath licensed under chapter 18.36A RCW.

(7) "Insuring entity" means:

(a) An insurer;

(b) A joint underwriting association;

(c) A risk retention group; or

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

(8) "Medical malpractice" means a negligent act, error, or omission in providing or failing to provide professional health care services that is actionable under chapter 7.70 RCW.

(9) "Self-insurer" means any health care provider, facility, or other individual or entity that assumes operational or financial risk for claims of medical malpractice.

NEW SECTION. **Sec. 2.** (1) Beginning April 1, 2006, every self-insurer or insuring entity that provides medical malpractice insurance to any facility or provider in Washington state must report to the commissioner any closed claim related to medical malpractice, if the claim resulted in a final:

(a) Judgment in any amount;

(b) Settlement or payment in any amount; or

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

(2) If a claim is not reported by an insuring entity or self-insurer under subsection (1) of this section due to limitations in the medical malpractice coverage of a facility or provider, the facility or provider must report the claim to the commissioner.

(3) Reports under this section must be filed with the commissioner within sixty days after the claim is closed by the insuring entity or self-insurer.

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

(b) The department of health may impose a fine of up to two hundred fifty dollars per day per case against any facility or provider that violates the requirements of this section. The total fine per case may not exceed ten thousand dollars.

NEW SECTION. **Sec. 3.** The reports required under section 2 of this act must contain the following data in a form and with coding prescribed by the commissioner for each claim:

(1) A unique number assigned to the claim by the insuring entity or self-insurer to serve as an identifier for the claim;

(2) The type of health care provider, including the provider's medical specialty; the type of facility, if any, and the location within the facility where the injury occurred;

(3) The date of the event that resulted in the claim;

(4) The county or counties in which the event that resulted in the claim occurred;

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

(6) The date of suit, if filed;

(7) The claimant's age and sex;

(8) Specific information about the judgment or settlement including:

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

(b) Whether the settlement:

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

(ii) Occurred before or after trial;

(c) For claims that result in a verdict or judgment that itemizes damages:

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

(ii) Noneconomic damages; and

(iii) Allocated loss adjustment expense, including but not limited to court costs, attorneys' fees, and costs of expert witnesses;

(d) For claims that do not result in a verdict or judgment that itemizes damages:

(i) Total damages; and

(ii) Allocated loss adjustment expense, including but not limited to court costs, attorneys' fees, and costs of expert witnesses; and

(e) If there is no judgment or settlement:

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

(ii) The date the claim was closed; and

(9) The reason for the medical malpractice claim. The commissioner shall use the same coding of reasons for malpractice claims as those used for mandatory reporting to the national practitioner data bank, in the federal department of health and human services, as provided in 42 U.S.C. Secs. 11131 and 11134, as amended.

NEW SECTION. **Sec. 4.** The commissioner must prepare aggregate statistical summaries of closed claims based on calendar year data submitted under section 2 of this act.

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

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

(3) Information included in an individual closed claim report submitted by an insurer or self-insurer under this chapter is confidential, is exempt from public disclosure, and may not be made available by the commissioner to the public.

NEW SECTION. **Sec. 5.** Beginning in 2006, the commissioner must prepare an annual report by June 30th that summarizes and analyzes the closed claim reports for medical malpractice filed under section 2 of this act and the annual financial reports filed by insurers writing medical malpractice insurance in this state. The report must include:

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

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

(b) An itemization of economic and noneconomic damages;

(c) An itemization of allocated loss adjustment expenses;

(d) The types of medical malpractice for which claims have been paid; and

(e) Any other information the commissioner determines illustrates trends in closed claims;

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

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

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

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

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

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

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

(6) The commissioner may adopt rules that require insuring entities and self-insurers required to report under section 2(1) of this act to report data related to:

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

(b) The aggregate amounts reserved for incurred claims;

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

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

NEW SECTION. **Sec. 6.** The commissioner shall adopt all rules needed to implement this chapter. To ensure that claimants, health care providers, health care facilities, and self-insurers cannot be

individually identified when data is disclosed to the public, the commissioner shall adopt rules that require the protection of information that, in combination, could result in the ability to identify the claimant, health care provider, health care facility, or self-insurer in a particular claim or collection of claims.

NEW SECTION. **Sec. 7.** A new section is added to chapter 7.70 RCW to read as follows:

In any action filed under this chapter that results in a final:

(1) Judgment in any amount;

(2) Settlement or payment in any amount; or

(3) Disposition resulting in no indemnity payment,

the claimant or his or her attorney shall report to the office of the insurance commissioner on forms provided by the commissioner any court costs, attorneys' fees, or costs of expert witnesses incurred in pursuing the action.

NEW SECTION. **Sec. 8.** If the national association of insurance commissioners adopts model medical malpractice reporting standards, the insurance commissioner must analyze the model standards and report to the legislature on or before the December 1st subsequent to the adoption of the model standards. The report must include an analysis of any differences between the model standards and sections 1 through 6 of this act and make recommendations, if any, regarding possible legislative changes. The report must be made to the house of representatives committees on health care; financial institutions and insurance; and judiciary and the senate committees on health and long-term care; financial institutions, housing and consumer protection; and judiciary.

NEW SECTION. **Sec. 9.** A new section is added to chapter 42.17 RCW to read as follows:

Information in a closed claim report filed under section 3 of this act that alone or in combination could result in the ability to identify a claimant, health care provider, health care facility, or self-insurer involved in a particular claim is exempt from disclosure under this chapter.

NEW SECTION. **Sec. 10.** Sections 1 through 6 of this act constitute a new chapter in Title 48 RCW.

NEW SECTION. **Sec. 11.** If any provision of this act or its application to any person or circumstance is held invalid, the remainder of the act or the application of the provision to other persons or circumstances is not affected.

--- END ---