H-4791.1

SECOND SUBSTITUTE HOUSE BILL 1933

State of Washington 59th Legislature 2006 Regular Session

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

READ FIRST TIME 2/3/06.

1 AN ACT Relating to reporting and analysis of medical malpractice
2 related information; amending RCW 42.56.400; adding a new section to
3 chapter 7.70 RCW; adding a new chapter to Title 48 RCW; prescribing
4 penalties; and providing an effective date.

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

6 NEW SECTION. **Sec. 1.** The definitions in this section apply
7 throughout this chapter unless the context clearly requires otherwise.
8 (1) "Claim" means a demand for monetary damages for injury or death
9 caused by medical malpractice, and a voluntary indemnity payment for
10 injury or death caused by medical malpractice made in the absence of a
11 demand for monetary damages.
12 (2) "Claimant" means a person, including a decedent's estate, who
13 is seeking or has sought monetary damages for injury or death caused by
14 medical malpractice.
15 (3) "Closed claim" means a claim that has been settled or otherwise
16 disposed of by the insuring entity, self-insurer, facility, or
17 provider. A claim may be closed with or without an indemnity payment
18 to a claimant.
19 (4) "Commissioner" means the insurance commissioner.

(5) "Economic damages" has the same meaning as in RCW 4.56.250(1)(a).

(6) "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, and includes entities described in RCW 7.70.020(3).

(7) "Health care provider" or "provider" has the same meaning as in RCW 7.70.020 (1) and (2).

(8) "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.

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

(10) "Noneconomic damages" has the same meaning as in RCW 4.56.250(1)(b).

(11) "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) For claims closed on or after January 1, 2008:

(a) Every insuring entity or self-insurer that provides medical malpractice insurance to any facility or provider in Washington state must report each medical malpractice closed claim to the commissioner.

(b) If a claim is not covered by an insuring entity or self-insurer, the facility or provider named in the claim must report it to the commissioner after a final claim disposition has occurred due to a court proceeding or a settlement by the parties. Instances in which a claim may not be covered by an insuring entity or self-insurer include, but are not limited to, situations in which the:

(i) Facility or provider did not buy insurance or maintained a self-insured retention that was larger than the final judgment or settlement;

(ii) Claim was denied by an insuring entity or self-insurer because it did not fall within the scope of the insurance coverage agreement; or

(iii) Annual aggregate coverage limits had been exhausted by other claim payments.

(2) Beginning in 2009, reports required under subsection (1) of this section must be filed by March 1st, and include data for all claims closed in the preceding calendar year and any adjustments to data reported in prior years. The commissioner may adopt rules that require insuring entities, self-insurers, facilities, or providers to file closed claim data electronically.

(3) The commissioner may impose a fine of up to two hundred fifty dollars per day against any insuring entity that violates the requirements of this section.

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

NEW SECTION. **Sec. 3.** Reports required under section 2 of this act must contain the following information in a form and coding protocol prescribed by the commissioner that, to the extent possible and still fulfill the purposes of this act, are consistent with the format for data reported to the national practitioner data bank:

(1) Claim and incident identifiers, including:

(a) A claim identifier assigned to the claim by the insuring entity, self-insurer, facility, or provider; and

(b) An incident identifier if companion claims have been made by a claimant. For the purposes of this section, "companion claims" are separate claims involving the same incident of medical malpractice made against other providers or facilities;

(2) The medical specialty of the provider who was primarily responsible for the incident of medical malpractice that led to the claim;

(3) The type of health care facility where the medical malpractice incident occurred;

(4) The primary location within a facility where the medical malpractice incident occurred;

1 (5) The geographic location, by city and county, where the medical
2 malpractice incident occurred;
3 (6) The injured person's sex and age on the incident date;
4 (7) The severity of malpractice injury using the national
5 practitioner data bank severity scale;
6 (8) The dates of:
7 (a) The incident that was the proximate cause of the claim;
8 (b) Notice to the insuring entity, self-insurer, facility, or
9 provider;
10 (c) Suit, if filed;
11 (d) Final indemnity payment, if any; and
12 (e) Final action by the insuring entity, self-insurer, facility, or
13 provider to close the claim;
14 (9) Settlement information that identifies the timing and final
15 method of claim disposition, including:
16 (a) Claims settled by the parties;
17 (b) Claims disposed of by a court, including the date disposed; or
18 (c) Claims disposed of by alternative dispute resolution, such as
19 arbitration, mediation, private trial, and other common dispute
20 resolution methods; and
21 (d) Whether the settlement occurred before or after trial, if a
22 trial occurred;
23 (10) Specific information about the indemnity payments and defense
24 expenses, as follows:
25 (a) For claims disposed of by a court that result in a verdict or
26 judgment that itemizes damages:
27 (i) The total verdict or judgment;
28 (ii) If there is more than one defendant, the total indemnity paid
29 by or on behalf of this facility or provider;
30 (iii) Economic damages;
31 (iv) Noneconomic damages; and
32 (v) Allocated loss adjustment expense, including but not limited to
33 court costs, attorneys' fees, and costs of expert witnesses; and
34 (b) For claims that do not result in a verdict or judgment that
35 itemizes damages:
36 (i) The total amount of the settlement;
37 (ii) If there is more than one defendant, the total indemnity paid
38 by or on behalf of this facility or provider;

1 (iii) Paid and estimated economic damages; and
2 (iv) Allocated loss adjustment expense, including but not limited
3 to court costs, attorneys' fees, and costs of expert witnesses;
4 (11) The reason for the medical malpractice claim. The reporting
5 entity must use the same allegation group and act or omission codes
6 used for mandatory reporting to the national practitioner data bank;
7 and
8 (12) Any other claim-related data the commissioner determines to be
9 necessary to monitor the medical malpractice marketplace, if such data
10 are reported:
11 (a) To the national practitioner data bank; or
12 (b) Voluntarily by members of the physician insurers association of
13 America (PIAA) as part of the PIAA data-sharing project.

14 NEW SECTION. **Sec. 4.** The commissioner must prepare aggregate
15 statistical summaries of closed claims based on data submitted under
16 section 2 of this act.
17 (1) At a minimum, the commissioner must summarize data by calendar
18 year and calendar/incident year. The commissioner may also decide to
19 display data in other ways if the commissioner:
20 (a) Protects information as required under section 6(2) of this
21 act; and
22 (b) Exempts from disclosure data described in RCW 42.56.400(11).
23 (2) The summaries must be available by April 30th of each year,
24 unless the commissioner notifies legislative committees by March 15th
25 that data are not available and informs the committees when the
26 summaries will be completed.
27 (3) Information included in an individual closed claim report
28 submitted by an insuring entity, self-insurer, provider, or facility
29 under this chapter is confidential and exempt from public disclosure,
30 and the commissioner must not make these data available to the public.

31 NEW SECTION. **Sec. 5.** Beginning in 2010, the commissioner must
32 prepare an annual report that summarizes and analyzes the closed claim
33 reports for medical malpractice filed under sections 2 and 9 of this
34 act and the annual financial reports filed by authorized insurers
35 writing medical malpractice insurance in this state. The commissioner

must complete the report by June 30th, unless the commissioner notifies legislative committees by June 1st that data are not available and informs the committees when the summaries will be completed.

(1) The report must include:

(a) An analysis of reported closed claims from prior years for which data are collected. The analysis must show:

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

(ii) A comparison of economic and noneconomic damages;

(iii) A distribution of allocated loss adjustment expenses and other legal expenses;

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

(v) Any other information the commissioner finds relevant to trends in medical malpractice closed claims if the commissioner:

(A) Protects information as required under section 6(2) of this act; and

(B) Exempts from disclosure data described in RCW 42.56.400(11);

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

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

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

(iii) A profitability analysis of the authorized insurers with a combined market share of at least ninety percent of direct written medical malpractice premium in Washington state for the prior calendar year;

(c) 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; and

(d) 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 incurred losses as compared to prior years.

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

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

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

(b) Any other closed claim information that helps the commissioner monitor losses and claim development patterns in the Washington state medical malpractice insurance market.

NEW SECTION. **Sec. 6.** The commissioner must adopt all rules needed to implement this chapter. The rules must:

(1) Identify which insuring entity or self-insurer has the primary obligation to report a closed claim when more than one insuring entity or self-insurer is providing medical malpractice liability coverage to a single health care provider or a single health care facility that has been named in a claim;

(2) Protect information that, in combination with other data, could result in the ability to identify a claimant, health care provider, health care facility, or self-insurer involved in a particular claim or collection of claims; and

(3) Specify standards and methods for the reporting by insuring entities, self-insurers, facilities, and providers.

NEW SECTION. **Sec. 7.** (1) If the national association of insurance commissioners (NAIC) adopts revised model statistical reporting standards for medical malpractice insurance, the commissioner must analyze the new reporting standards and report this information to the legislature, as follows:

(a) An analysis of any differences between the model reporting standards and:

(i) Sections 1 through 6 of this act; and

(ii) Any statistical plans that the commissioner has adopted under RCW 48.19.370; and

(b) Recommendations, if any, about legislative changes necessary to implement the model reporting standards.

(2) The commissioner must submit the report required under subsection (1) of this section to the following legislative committees by the first day of December in the year after the NAIC adopts new model medical malpractice reporting standards:

(a) The house of representatives committees on health care; financial institutions and insurance; and judiciary; and

(b) The senate committees on health and long-term care; financial institutions, housing and consumer protection; and judiciary.

NEW SECTION. **Sec. 8.** This act does not amend or modify the statistical reporting requirements that apply to insurers under RCW 48.19.370.

NEW SECTION. **Sec. 9.** A new section is added to chapter 7.70 RCW to read as follows:

(1) As used in this section:

(a) "Claim" has the same meaning as in section 1(1) of this act.

(b) "Claimant" has the same meaning as in section 1(2) of this act.

(c) "Commissioner" has the same meaning as in section 1(4) of this act.

(d) "Medical malpractice" has the same meaning as in section 1(9) of this act.

(2)(a) The claimant or his or her attorney must report data to the commissioner if any action filed under this chapter results in a final:

(i) Judgment in any amount;

(ii) Settlement or payment in any amount; or

(iii) Disposition resulting in no indemnity payment.

(b) As used in this subsection, "data" means:

(i) The date of the incident of medical malpractice that was the principal cause of the action;

(ii) The principal county in which the incident of medical malpractice occurred;

(iii) The date of suit, if filed;

(iv) The injured person's sex and age on the incident date; and

(v) Specific information about the disposition, judgment, or settlement, including:

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

(B) Court costs;

(C) Attorneys' fees; and

(D) Costs of expert witnesses.

Sec. 10. RCW 42.56.400 and 2005 c 274 s 420 are each amended to read as follows:

The following information relating to insurance and financial institutions is exempt from disclosure under this chapter:

(1) Records maintained by the board of industrial insurance appeals that are related to appeals of crime victims' compensation claims filed with the board under RCW 7.68.110;

(2) Information obtained and exempted or withheld from public inspection by the health care authority under RCW 41.05.026, whether retained by the authority, transferred to another state purchased health care program by the authority, or transferred by the authority to a technical review committee created to facilitate the development, acquisition, or implementation of state purchased health care under chapter 41.05 RCW;

(3) The names and individual identification data of all viators regulated by the insurance commissioner under chapter 48.102 RCW;

(4) Information provided under RCW 48.30A.045 through 48.30A.060;

(5) Information provided under RCW 48.05.510 through 48.05.535, 48.43.200 through 48.43.225, 48.44.530 through 48.44.555, and 48.46.600 through 48.46.625;

(6) Information gathered under chapter 19.85 RCW or RCW 34.05.328 that can be identified to a particular business;

(7) Examination reports and information obtained by the department of financial institutions from banks under RCW 30.04.075, from savings banks under RCW 32.04.220, from savings and loan associations under RCW 33.04.110, from credit unions under RCW 31.12.565, from check cashers and sellers under RCW 31.45.030(3), and from securities brokers and investment advisers under RCW 21.20.100, all of which is confidential and privileged information;

(8) Information provided to the insurance commissioner under RCW 48.110.040(3);

(9) Documents, materials, or information obtained by the insurance commissioner under RCW 48.02.065, all of which are confidential and privileged; ((~~and~~))

(10) Confidential proprietary and trade secret information provided to the commissioner under RCW 48.31C.020 through 48.31C.050 and 48.31C.070; and

(11) Data filed under sections 2, 3, 5(6), and 9 of this act that, alone or in combination with any other data, may reveal the identity of a claimant, health care provider, health care facility, insuring entity, or self-insurer involved in a particular claim or a collection of claims. For the purposes of this subsection:

(a) "Claimant" has the same meaning as in section 1(2) of this act.

(b) "Health care facility" has the same meaning as in section 1(6) of this act.

(c) "Health care provider" has the same meaning as in section 1(7) of this act.

(d) "Insuring entity" has the same meaning as in section 1(8) of this act.

(e) "Self-insurer" has the same meaning as in section 1(11) of this act.

NEW SECTION. **Sec. 11.** Sections 1 through 8 of this act constitute a new chapter in Title 48 RCW.

NEW SECTION. **Sec. 12.** This act takes effect July 1, 2006.

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