Z-1093.2

SENATE BILL 6412

State of Washington 61st Legislature 2010 Regular Session

By Senator Hobbs; by request of Insurance Commissioner

Read first time 01/14/10. Referred to Committee on Financial Institutions, Housing & Insurance.

AN ACT Relating to medical malpractice closed claim reporting; amending RCW 7.70.140, 48.140.020, 48.140.030, and 48.140.040; and repealing RCW 48.140.070.

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

Sec. 1. RCW 7.70.140 and 2006 c 8 s 209 are each amended to read as follows:

(1) As used in this section:

(a) "Attorney" means a person authorized to practice law as defined in Washington state rules of court, general rule 24.

(b) "Claim" has the same meaning as in RCW 48.140.010(1).

((~~(b)~~)) (c) "Claimant" has the same meaning as in RCW 48.140.010(2).

((~~(c)~~)) (d) "Commissioner" has the same meaning as in RCW 48.140.010(4).

((~~(d)~~)) (e) "Medical malpractice" has the same meaning as in RCW 48.140.010(9).

(2)(a) For claims settled or otherwise disposed of on or after January 1, 2008, the claimant or his or her attorney must promptly

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.

(3) Attorneys must submit reports required under subsection (2) of this section to the commissioner within sixty days after the claim is settled or otherwise resolved. If more than one attorney represents any party involved in the claim, the attorney of record for that party is responsible for the reporting of data required under subsection (2) of this section.

(4) If an attorney who is obligated to report under this section has not done so within sixty days after the claim is settled or otherwise resolved, the commissioner may impose and collect a penalty of fifty dollars from the attorney. The commissioner may impose and collect an additional fifty dollar penalty from the attorney for every subsequent thirty-day period that the claim goes unreported. All penalties collected under this section must be deposited to the general fund.

(5) The commissioner may adopt rules to implement this section.

Sec. 2. RCW 48.140.020 and 2007 c 32 s 1 are each amended to read as follows:

(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.

(c) If a facility or provider is insured by a risk retention group and the risk retention group refuses to report closed claims and asserts that the federal liability risk retention act (95 Stat. 949; 15 U.S.C. Sec. 3901 et seq.) preempts state law, the facility or provider must report all data required by this chapter on behalf of the risk retention group.

(d) If a facility or provider is insured by an unauthorized insurer or captive insurer and the ((~~unauthorized~~)) insurer refuses to report closed claims and asserts a federal exemption or other jurisdictional preemption, the facility or provider must report all data required by this chapter on behalf of the unauthorized insurer.

(2) Beginning in 2009, reports required under subsection (1) of this section must be ((~~filed~~)) submitted to the commissioner within sixty days after the claim is closed, unless the commissioner has agreed in writing to accept electronic transmission of data from that entity. If the commissioner agrees to accept electronic transmission of data from an entity, all data must be transmitted 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~~)) allow 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, except a risk retention group, that violates the requirements of this section.

(4) A regulatory entity including, but not limited to, the department of health, department of licensing, or department of social and health services ((~~may~~)) must require a provider or facility to take corrective action to assure compliance with the requirements of this section. If the provider or facility does not take corrective action required by the regulatory entity, the regulatory entity may take disciplinary action.

Sec. 3. RCW 48.140.030 and 2006 c 8 s 203 are each amended to read as follows:

Reports required under RCW 48.140.020 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 chapter, 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 policy limits of the liability insurance policy or policies covering the claim;

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

((~~(3)~~)) (4) The type of health care facility where the medical malpractice incident occurred;

((~~(4)~~)) (5) The primary location within a facility where the medical malpractice incident occurred;

((~~(5)~~)) (6) The geographic location, by city and county, where the medical malpractice incident occurred;

((~~(6)~~)) (7) The injured person's sex and age on the incident date;

((~~(7)~~)) (8) The severity of malpractice injury using the national practitioner data bank severity scale;

((~~(8)~~)) (9) The dates of:

(a) The ((~~incident~~)) earliest act or omission by the defendant that was the proximate cause of the claim;

(b) Notice to the insuring entity, self-insurer, facility, or provider;

(c) Suit, if a suit was filed;

(d) Final indemnity payment, if any; and

(e) Final action by the insuring entity, self-insurer, facility, or provider to close the claim;

((~~(9)~~)) (10) Settlement information that identifies the timing and final method of claim disposition, including:

(a) Claims settled by the parties;

(b) Claims disposed of by a court, including the date disposed; or

(c) Claims disposed of by alternative dispute resolution, such as arbitration, mediation, private trial, and other common dispute resolution methods; and

(d) Whether the settlement occurred before or after trial, if a trial occurred;

((~~(10)~~)) (11) Specific information about the indemnity payments and defense expenses, as follows:

(a) For claims disposed of by a court that result in a verdict or judgment that itemizes damages:

(i) The total verdict or judgment;

(ii) ((~~If there is more than one defendant,~~)) The ((~~total~~)) indemnity ((~~paid by or~~)) payment made on behalf of ((~~this facility or provider~~)) the defendant;

(iii) Economic damages;

(iv) Noneconomic damages; ((~~and~~))

(v) Punitive damages, if applicable; and

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

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

(i) The total amount of the settlement on behalf of the defendant;

(ii) ((~~If there is more than one defendant, the total indemnity paid by or on behalf of this facility or provider;~~

~~(iii)~~)) Paid and estimated economic damages; ((~~and~~))

(iii) An estimate of noneconomic damages; and

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

((~~(11)~~)) (12) The reason for the medical malpractice claim. The reporting entity must use the same allegation group and ((~~act or omission~~)) specific allegation codes used for mandatory reporting to the national practitioner data bank; and

((~~(12)~~)) (13) Any other claim-related data the commissioner determines to be necessary to monitor the medical malpractice marketplace, if such data are reported:

(a) To the national practitioner data bank; or

(b) Voluntarily by members of the physician insurers association of America as part of the association's data-sharing project.

Sec. 4. RCW 48.140.040 and 2006 c 8 s 204 are each amended to read as follows:

The commissioner must prepare aggregate statistical summaries of closed claims based on data submitted under RCW 48.140.020.

(1) At a minimum, the commissioner must summarize data by calendar year and calendar/incident year. The commissioner may also decide to display data in other ways if the commissioner:

(a) Protects information as required under RCW 48.140.060(2); and

(b) Exempts from disclosure data described in RCW 42.56.400((~~(11)~~)) (10).

(2) The summaries must be available by April 30th of each year, unless the commissioner notifies legislative committees by ((~~March~~)) April 15th that data are not available and informs the committees when the summaries will be completed.

(3) Information included in an individual closed claim report submitted by an insuring entity, self-insurer, provider, or facility under this chapter is confidential and exempt from public disclosure, and the commissioner must not make these data available to the public.

NEW SECTION. **Sec. 5.** RCW 48.140.070 (Model statistical reporting standards--Report to legislature) and 2006 c 8 s 207 are each repealed.

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