Washington State
House of Representatives
Office of Program Research

BILL ANALYSIS

Insurance, Financial Services & Consumer Protection Committee

HB 1237

Brief Description: Modifying medical malpractice closed claim reporting requirements.

Sponsors: Representatives Kirby and Roach; by request of Insurance Commissioner.

Brief Summary of Bill

- Requires health facilities or providers to report medical malpractice closed claim information if their insurer does not report the information.

Hearing Date: 1/23/07

Staff: Jon Hedegard (786-7127).

Background:

The Office of the Insurance Commissioner (OIC) is responsible for the licensing and regulation of insurance companies doing business in this state. This includes insurers offering coverage for medical malpractice.

Risk retention groups are primarily regulated by the federal government.

Unauthorized insurers may transact insurance in Washington if the insurance coverage cannot be procured from authorized insurers. Standards to determine when insurance is not available from authorized insurers are set in statutes and rules. Unauthorized insurers are not licensed by the OIC; the brokers of insurance placed with unauthorized insurers are licensed by the OIC.

The Department of Health (DOH) oversees licensure and discipline of health facilities and providers.

In 2006, the Legislature passed a law regarding the closed claim reporting of medical malpractice insurance by insuring entities, health facilities, and health providers.

"Insuring entity" includes:

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- insurers;
- a joint underwriting association;
- a risk retention group;
- an unauthorized insurer providing surplus lines coverage.

Self-insurers and insuring entities that write medical malpractice insurance are required to report medical malpractice closed claims that are closed after January 1, 2008, to the Office of the Insurance Commissioner (OIC). Closed claims reports must be filed annually by March 1, and must include data for closed claims for the preceding year.

The reports must contain specified data relating to:
- the type of health care provider, specialty, and facility involved;
- the reason for the claim and the severity of the injury;
- the dates when the event occurred, the claim was reported to the insurer, and the suit was filed;
- the injured person's age and sex; and
- information about the settlement, judgment, or other disposition of the claim, including an itemization of damages and litigation expenses.

If a claim is not covered by an insuring entity or self-insurer, the provider or facility must report the claim to the OIC after a final disposition of the claim. The OIC may impose a fine of up to $250 per day against an insuring entity that is late in filing the required report. The DOH may require a facility or provider to take corrective action to comply with the reporting requirements.

A claimant or the claimant's attorney in a medical malpractice action that results in a final judgment, settlement, or disposition, must report certain data, including the date and location of the incident, the injured person's age and sex, and information about the amount of judgment or settlement, court costs, attorneys' fees, or expert witness costs incurred in the action. The information must be reported to the OIC.

The OIC must use the data to prepare aggregate statistical summaries of closed claims and an annual report of closed claims and insurer financial reports. The annual report must include specified information, such as:
- trends in frequency and severity of claims;
- types of claims paid;
- a comparison of economic and non-economic damages;
- a distribution of allocated loss adjustment expenses;
- a loss ratio analysis for medical malpractice insurance;
- a profitability analysis for medical malpractice insurers;
- a comparison of loss ratios and profitability; and
- a summary of approved medical malpractice rate filings for the prior year, including analyzing the trend of losses compared to prior years.

Any information in a closed claim report that may result in the identification of a claimant, provider, health care facility, or self-insurer is exempt from public disclosure.

Summary of Bill:

A facility or provider must report the required information when a closed claim is not reported by an insuring entity. This includes situations where the insuring entity refuses to report because it is:

- a risk retention group claiming that federal law preempts state law; or
- an unauthorized insurer and is claiming preemption by operation of federal law or the law of some other jurisdiction.

Failure to report by a facility of provider can lead the DOH to take corrective action to comply with the reporting requirements

Risk retention groups cannot be fined for noncompliance with the reporting requirements.

Appropriation: None.

Fiscal Note: Requested on 1/22/2007.

Effective Date: The bill takes effect 90 days after adjournment of session in which bill is passed.