Chapter 48.140 RCW
MEDICAL MALPRACTICE CLOSED CLAIM REPORTING

Sections

RCW 48.140.010 Definitions. The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

(1) "Claim" means a demand for monetary damages for injury or death caused by medical malpractice, and a voluntary indemnity payment for injury or death caused by medical malpractice made in the absence of a demand for monetary damages.

(2) "Claimant" means a person, including a decedent's estate, who is seeking or has sought monetary damages for injury or death caused by medical malpractice.

(3) "Closed claim" means a claim that has been settled or otherwise disposed of by the insuring entity, self-insurer, facility, or provider. A claim may be closed with or without an indemnity payment to a claimant.

(4) "Commissioner" means the insurance commissioner.

(5) "Economic damages" means objectively verifiable monetary losses, including medical expenses, loss of earnings, burial costs, loss of use of property, cost of replacement or repair, cost of obtaining substitute domestic services, loss of employment, and loss of business or employment opportunities.

(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" means subjective, nonmonetary losses including, but not limited to, pain, suffering, inconvenience, mental anguish, disability or disfigurement incurred by the injured party, emotional distress, loss of society and companionship, loss of

consortium, injury to reputation and humiliation, and destruction of the parent-child relationship.

(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. [2023 c 102 § 6; 2006 c 8 § 201.]

RCW 48.140.020 Closed claim reporting requirements. (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 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 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, except a risk retention group, that violates the requirements of this section.

(4) The department of health, department of licensing, or department of social and health services may require a provider or facility to take corrective action to assure compliance with the requirements of this section. [2007 c 32 § 1; 2006 c 8 § 202.]

RCW 48.140.030 Closed claim reports—Information requirements. 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 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;

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

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

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

(8) The dates of:

(a) The incident that was the proximate cause of the claim;

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

(c) Suit, if 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) 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) 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 on behalf of this facility or provider;

(iii) Economic damages;

(iv) Noneconomic damages; and

(v) 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;

(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

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

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

(12) 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. [2006 c 8 § 203.]

RCW 48.140.040 Statistical summaries. 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).

(2) The summaries must be available by April 30th of each year, unless the commissioner notifies legislative committees by March 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. [2006 c 8 § 204.]

***Reviser's note:** RCW 42.56.400 was amended by 2007 c 197 § 7, changing subsection (11) to subsection (10).

RCW 48.140.050 Annual report. Beginning in 2010, the commissioner must prepare an annual report that summarizes and analyzes the closed claim reports for medical malpractice filed under RCW 48.140.020 and 7.70.140 and the annual financial reports filed by authorized insurers 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 RCW 48.140.060(2); 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 RCW 48.140.020 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. [2006 c 8 § 205.]

***Reviser's note:** RCW 42.56.400 was amended by 2007 c 197 § 7, changing subsection (11) to subsection (10).

RCW 48.140.060 Rules. 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, alone or 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 claimants, insuring entities, self-insurers, facilities, and providers. [2006 c 8 § 206.]

RCW 48.140.070 Model statistical reporting standards—Report to legislature. (1) If the national association of insurance

commissioners 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) RCW 48.140.010 through 48.140.060; 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 national association of insurance commissioners 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. [2006 c 8 § 207.]

RCW 48.140.080 Reporting requirements under RCW 48.19.370 not affected. This chapter does not amend or modify the statistical reporting requirements that apply to insurers under RCW 48.19.370. [2006 c 8 § 208.]

RCW 48.140.900 Findings—Intent—Part headings and subheadings not law—Severability—2006 c 8. See notes following RCW 5.64.010.