Medical Malpractice Closed Claim Model Statistical Reporting Standards

Report to the Legislature

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Mike Kreidler - State Insurance Commissioner

www.insurance.wa.gov

Executive summary

In 2006, the Washington state Legislature enacted comprehensive health care liability reform legislation (2SHB 2292) to address a number of concerns, including the cost and availability of medical malpractice insurance. In addition, the legislation also created reporting requirements designed to gather more meaningful medical malpractice claim data to support policy decisions.

Under the law, data on medical malpractice claims by insurers and self insurers – such as hospitals and nursing homes – that have been settled with or without a payment (closed claims) must be reported to the insurance commissioner.

Also, the insurance commissioner must report to the Legislature on the differences between Washington law and the reporting standards in the National Association of Insurance Commissioners' (NAIC) Model Law, once adopted, and make recommendations for legislative changes that create uniformity between our two laws.

The NAIC adopted model closed claim reporting standards in 2008. This report provides an analysis of the differences between those standards and Washington law. In general, our law and regulations require more detailed data collection. For instance, our administrative rules require insurers to report both open and closed claims. These data will provide a better picture of future trends for medical malpractice insurance. Aside from this feature, there are four additional differences. The NAIC Model Law:

1. Requires captive insurance companies (formed to insure only the risk of the parent corporation) to report closed claims.

2. Adds three additional data elements that must be reported to the regulator – policy limits, and punitive and non-economic damages.

3. Left the issue of confidentiality of closed claims data up to the discretion of the states. Washington law exempts closed claim data from public disclosure.

4. Does not include reporting requirements. Washington law requires the insurance commissioner to produce regular reports that provide information based on the closed claim data collected under this law.

Based on the comparison, the insurance commissioner is recommending legislative changes to align Washington law with the NAIC Model Law. In addition, he also is recommending changes to the reporting timeline and strengthening the law's

compliance provisions to ensure that future reports to the Legislature are timely and complete.

Legislative recommendations

Uniformity with the National Association of Insurance Commissioners' *Model Closed Claim Reporting Law*

Our new law requires the insurance commissioner to provide a comparative analysis between the reporting standards in Washington state's Health Care Liability Reform Law and the NAIC Model Closed Claim Reporting Law. Below are the four notable differences between the laws and the insurance commissioner's legislative recommendations:

1. The NAIC Model Law requires captive insurance companies (insurance companies formed to insure only the risk of the parent corporation) to report closed claims data.

   Insurance commissioner's recommendation: Amend Washington law to include captive insurance companies in the list of companies required to report.

2. The NAIC Model Law requires the reporting of three additional data elements:

   - Policy limits, if the defendant had insurance that applied to the claim.
   - Punitive damages, if applicable.
   - An estimate of non-economic damages.

   Insurance commissioner's recommendation: Amend Washington law to add the three additional reporting requirements included in the NAIC's Model Law.

3. The NAIC Model Law leaves the issue of confidentiality of closed claim data up to the discretion of each individual state. Washington law exempts closed claim data from public disclosure.[1]

   Insurance commissioner's recommendation: Keep the confidentiality provisions in current law so that information specific to a claimant, insurer or self-insurer remains confidential.

1 RCW 42.56.400(10),

4. The NAIC Model Law does not require state regulators to produce reports. Washington law requires the insurance commissioner to produce statistical summaries[2] and closed claim reports[3] annually.

   Insurance commissioner's recommendation: Retain the reporting requirements. The Legislature was clear that it wanted data concerning the medical malpractice market available to it in the form of annual reports and statistical summaries.

Changing the reporting timeline

Washington law requires the insurance commissioner to produce aggregate statistical summaries of closed claim data by April 30 of each year. On June 15, 2009, the Office of the Insurance commissioner published the first statistical summaries.

Beginning in 2010, the insurance commissioner is required to submit an annual report that summarizes and analyzes the closed claim reports by June 30 of each year.

In preparing the 2009 statistical summaries, the insurance commissioner found that many insurers, self-insurers and attorneys waited until the statutory deadline of March 1[4] to file closed claims reports, and some filed reports after the deadline. This left little opportunity to audit data included in these last-minute reports, which contributed to a delay in posting the statistical summaries.

The insurance commissioner proposes changing the reporting date from March 1 to 60 days after the claim closes. This change will allow the Office of the Insurance Commissioner to perform on-going data quality verification, and allow the agency to produce statistical summaries and annual reports on time.[5] As proposed, this change will take effect 90 days after the 2010 legislative session adjourns, so both the statistical summaries and annual report will be delayed in 2010.

If the reporting date change is approved, the Office of the Insurance Commissioner anticipates the statistical summaries and annual report will be produced on time, beginning in 2011.

Insurance commissioner's recommendation: Require entities and individuals to report closed claim data within 60 days after the claim closes.

2 See RCW 48.140.040.
3 See RCW 48.140.050.
4 See RCW 48.140.020(2)
5 Appendix 1, Sec. 2, subsection (3) and Sec. 3, subsection (2).

Strengthening compliance

Obtaining compliance with the reporting law has been a challenge for the insurance commissioner. On March 12, 2009, he notified[6] interested legislators and committees that data reporting for calendar year 2008 was incomplete, and provided a synopsis of extensive outreach efforts by the agency to all insurers, self-insurers and attorneys to encourage timely reporting. As a result, the insurance commissioner was granted an extension until June 15, 2009 to post the statistical summaries. On June 15, 2009, the Office of the Insurance Commissioner posted two statistical summaries:

1. Closed Claim Data Submitted by Insuring Entities and Self-Insurers
2. Lawsuit Settlement and Expense Data Submitted by Attorneys

Since June, nine additional insuring entities[7] and self-insurers[8] have registered to report closed claims, bringing the total number of registered reporting entities to 140.

As reported in March, the nursing home/skilled care facilities segment is the least compliant group of self-insurers. The trade association allied with this group has made some outreach efforts; however, these efforts have not led to much activity. To date, only one additional nursing home organization has registered to report. The insurance commissioner believes there are a number of large organizations that operate on a multi-state basis and self-insure at least a portion of their risk that should be reporting.

Compliance by the plaintiff attorneys has also been disappointing. In June 2009, the Office of the Insurance Commissioner contacted the Administrative Office of the Courts (AOC), and requested data on the number of medical malpractice lawsuits resolved in 2008.[9] [10] The AOC data showed that over 300 lawsuits were resolved in 2008, which means that attorney compliance to the Office of the Insurance Commissioner's reporting requirements is about 50 percent.[11] Since June, only three additional law offices have registered to report settlements, bringing the total number of law offices reporting to 119.

Voluntary reporting has not worked.

6 Appendix 4.
7 See RCW 48.140.010(8).
8 See RCW 48.140.010(11).
9 Appendix 5.
10 The insurance commissioner adjusted these data to avoid double-counting case numbers where more than one attorney was involved in a single legal action.
11 The June 2009 statistical summary of lawsuit settlement and expense data included 155 reports submitted by attorneys.

Insurance commissioner's recommendation: To improve compliance, allow a nursing home or hospital's regulatory authority to take disciplinary action if the facility does not comply with the reporting requirements. Also, allow the Washington State Bar Association (WSBA) to discipline an attorney who does not comply with the reporting requirements of the law.

Recommended technical changes

Under the current law, the Office of the Insurance Commissioner has two weeks to determine if it can produce the statistical summaries on time. Two weeks is too short a period to evaluate data. The insurance commissioner can provide a more accurate assessment to legislators if this date is pushed back one month.[12]

Insurance commissioner's recommendation: Change the date by which the insurance commissioner must notify the Legislature about the availability of statistical summaries to April 15. This gives the agency enough time to evaluate the data and notify the Legislature if an extension is needed.[13]

The insurance commissioner is proposing a change to help the plaintiff's bar determine which attorney has the primary responsibility to report a settlement. In some cases, two or more attorneys are involved in a single lawsuit. The new law and the related administrative rules require aggregate settlement data be reported.

Insurance commissioner's recommendation: To end confusion over which attorney is responsible to collect and report data, require the attorney of record to file the settlement report if more than one attorney represents a plaintiff.[14]

This report to the Legislature satisfies the requirements in RCW 48.140.070 .

Insurance commissioner's recommendation: The insurance commissioner proposes repealing this section since the requirement has been met.[15]

12 Appendix 1, Sec. 5, subsection (2).
13 Appendix 1, subsection 5, section (2).
14 Appendix 1, Sec. 2, subsection (3).
15 Appendix 1, Sec. 6.

Appendix 1

AN ACT Relating to medical malpractice closed claim reporting; amending RCW 7.70.140, 48.140.020, 48.140.030, and 48.140.040; adding a new section to chapter 2.48 RCW; and repealing RCW 48.140.070.

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

NEW SECTION. **Sec. 1.** A new section is added to chapter 2.48 RCW to read as follows:

The supreme court may provide, by court rule, that a member of the bar may be suspended if certified by the insurance commissioner to have failed to file closed claim reports under RCW 7.70.140. The court's rules may provide for review of an application for reinstatement of membership if the insurance commissioner confirms or notifies the bar that the member has complied with RCW 7.70.140.

Sec. 2. 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 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 is involved in a suit, the attorney of record for the claimant or plaintiff must report data required under subsection (2) of this section on behalf of all attorneys involved in the case.

(4) The commissioner may submit certification to the Washington state bar association under section 1 of this act if an attorney does not comply with the requirements of this section.

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

Sec. 3. 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. 4. 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. 5. 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.6.** RCW 48.140.070 (Model statistical reporting standards--Report to legislature) and 2006 c 8 s 207 are each repealed.

Appendix 2

MEDICAL PROFESSIONAL LIABILITY CLOSED CLAIM REPORTING MODEL LAW

Table of Contents

Section 1. Statement of Purpose
Section 2. Definitions
Section 3. Applicability and Scope
Section 4. Reporting Requirements
Section 5. Required Data Elements
Section 6. Confidentiality of Data
Section 7. Authority to Adopt Rules
Section 8. Effective Date

Drafting Introductory Note: This model law pertains to the collection of data necessary to accomplish the purpose stated in Section 1. It is not intended to discourage states from collecting additional data for other purposes.

Section 1. Statement of Purpose

This Act is intended to ensure the availability of closed claim data necessary for thorough analysis and understanding of issues associated with medical professional liability claims, in order to support the establishment and maintenance of sound public policy.

Section 2. Definitions

As used in this Act:

A. "Claim" means:
   (1) A demand for monetary damages for injury or death caused by medical malpractice; or
   (2) A voluntary indemnity payment for injury or death caused by medical malpractice.

B. "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.

C. "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.

D. "Commissioner" means the commissioner of insurance.

E. "Companion claims" means separate claims involving the same incident of medical malpractice made against other providers or facilities.

F. "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 and loss of business or employment opportunities.

G. "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.

H. “Health care provider” or “provider” means:

(1) A person licensed to provide health care or related services, including an acupuncturist, doctor of medicine or osteopathy, a dentist, a nurse, an optometrist, a podiatric physician and surgeon, a chiropractor, a physical therapist, a psychologist, a pharmacist, an optician, a physician’s assistant, a midwife, an osteopathic physician’s assistant, a nurse practitioner or a physician’s trained mobile intensive care paramedic. If the person is deceased, this includes his or her estate or personal representative; or

(2) An employee or agent of a person described in paragraph (1) of this subsection, acting in the course and scope of his or her employment. If the employee or agent is deceased, this includes his or her estate or personal representative.

I. “Insuring entity” means:
(1) An authorized insurer;
(2) A captive insurer;
(3) A joint underwriting association;
(4) A patient compensation fund;
(5) A risk retention group; or
(6) An unauthorized insurer that provides surplus lines coverage.

J. “Medical malpractice” means an actual or alleged negligent act, error, or omission in providing or failing to provide health care services.

K. “Noneconomic damages” means subjective, nonmonetary losses, including pain, suffering, inconvenience, mental anguish, disability or disfigurement incurred by the injured party, emotional distress, loss of society and companionship, loss of consortium, humiliation and injury to reputation, and destruction of the parent-child relationship.

L. “Self-insurer” means any health care provider, facility, or other individual or entity that assumes operational or financial risk for claims of medical professional liability.

Drafting Note: Use the title of the chief insurance regulatory official wherever the term “commissioner” appears.

Drafting Note: If some of these terms are already defined elsewhere in this State’s statutes, references to those statutes may be substituted for the definitions above. If some types of insuring entities are defined elsewhere in this State's statutes, those definitions may be cited.

Section 3. Applicability and Scope

This Act shall apply to all medical professional liability claims in this State, regardless of whether or how they are covered by medical professional liability insurance.

Section 4. Reporting Requirements

A. For claims closed on or after January 1, [insert year]:

(1) Every insuring entity or self-insurer that provides medical professional liability insurance to any facility or provider in this State must report each medical professional liability closed claim to the commissioner.

(2) A closed claim that is covered under a primary policy and one or more excess policies shall be reported only by the insuring entity that issued the primary policy. The insuring entity that issued the primary policy shall report the total amount, if any, paid with respect to the closed claim, including any amount paid under an excess policy, any amount paid by the facility or provider, and any amount paid by any other person on behalf of the facility or provider.

(3) 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 situations in which:

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

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

(c) The annual aggregate coverage limits had been exhausted by other claim payments.

(4) If a claim is covered by an insuring entity or self-insurer that fails to report the claim to the commissioner, 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.

(a) 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 Act on behalf of the risk retention group.

(b) 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 Act on behalf of the unauthorized insurer.

(c) If a facility or provider is insured by a captive insurer and the captive 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 Act on behalf of the captive insurer.

Drafting Note: When subsection A(4) applies, the State needs to consider inserting wording regarding who is responsible for notification to facilities and providers. Notification by either the domiciliary state regulator or the insurer must be provided in advance to insureds that they must produce all data required by this act upon behalf of the insurer.

B. Beginning in [insert year], reports required under subsection A of this section must be filed by March 1. These reports must include data for all claims closed in the preceding calendar year and any adjustments to data reported in prior years.

C. The commissioner may adopt rules that require insuring entities, self-insurers, facilities and providers to submit all required closed claim data electronically.

Drafting Note: Many State insurance codes specify penalties for failure to timely file statutorily required reports or for submitting materially incorrect data. Each State should determine the applicability of such penalties to this Act. If it is determined that the State does not possess an adequate means to enforce this Act, the State may wish to consider inserting additional enforcement wording in this section.

Drafting Note: The year inserted in subsection B should be the year following the year inserted in subsection A.

Section 5. Required Data Elements

Reports required under section 4 of this Act must contain the following information in a format and coding protocol prescribed by the commissioner. To the greatest extent possible while still fulfilling the purposes of this Act, the format and coding protocol shall be consistent with the format and coding protocol for data reported to the National Practitioner Data Bank.

A. Claim and incident identifiers, including:
   (1) A claim identifier assigned to the claim by the insuring entity, self-insurer, facility or provider; and
   (2) An incident identifier if companion claims have been made by a claimant;

B. The policy limits of the medical professional liability insurance policy covering the claim;

C. The medical specialty of the provider who was primarily responsible for the medical malpractice incident that led to the claim;

D. The type of health care facility where the medical malpractice incident occurred;

E. The primary location within a facility where the medical malpractice incident occurred;

F. The geographic location, by city and county, where the medical malpractice incident occurred;

G. The injured person's sex and age on the incident date;

H. The severity of malpractice injury using the National Practitioner Data Bank severity scale;

I. The dates of:
   (1) The earliest act or omission by the defendant that was the proximate cause of the claim;

(2) Notice to the insuring entity, self-insurer, facility or provider;
(3) Suit, if a suit was filed;
(4) Final indemnity payment, if any; and
(5) Final action by the insuring entity, self-insurer, facility or provider to close the claim;

J. Settlement information that identifies the timing and final method of claim disposition, including:

(1) Claims settled by the parties;
(2) Claims disposed of by a court, including the date disposed;
(3) Claims disposed of by alternative dispute resolution, such as arbitration, mediation, private trial and other common dispute resolution methods; and
(4) Whether the settlement occurred before or after trial, if a trial occurred;

K. Specific information about the indemnity payments and defense and cost containment expenses, including:

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

(a) The indemnity payment made on behalf of the defendant;
(b) Economic damages;
(c) Non-economic damages;
(d) Punitive damages, if applicable; and
(e) Defense and cost containment expenses, including court costs, attorneys' fees, and costs of expert witnesses; and

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

(a) The total amount of the settlement on behalf of the defendant;
(b) The insuring entity's or self-insurer's best estimate of economic damages included in the settlement;
(c) The insuring entity's or self-insurer's best estimate of noneconomic damages included in the settlement; and
(d) Defense and cost containment expenses, including court costs, attorneys' fees, and costs of expert witnesses;

L. The reason for the medical professional liability claim. The reporting entity must use the same allegation group and specific allegation codes that are used for mandatory reporting to the National Practitioner Data Bank; and

M. Any other closed claim data the commissioner determines to be necessary to accomplish the purpose of this Act and requires by adopting a rule.

Section 6. Confidentiality of Data

Drafting Note: Each state should determine the extent to which the data collected may be made available to other parties and insert wording consistent with that determination. Options include:

- All data are available to the public.
- All data are subject to release under certain restricted conditions, such as to applicants submitting a research proposal and signing a confidentiality agreement.
- Only individual records that have been "anonymized" may be released. For example, the data can be anonymized to varying degrees by removing elements that may permit identification of

the parties to a case, by removing place references such as counties, and by limiting the representation of dates to the corresponding year.

- All data are confidential except data released in summary or aggregate form. Data would be aggregated to a high enough level that readers would not be able to deduce information on any particular provider, facility, claimant, or claim.

Section 7. Authority to Adopt Rules

The commissioner shall adopt any rules needed for implementing the provisions of this Act.

Section 8. Effective Date

This Act shall take effect on [insert date].

Appendix 3

SECTION 16

16. Medical Professional Liability Reports

16.1 Introduction

This section details specific reporting requirements for and features of medical professional liability annual statistical compilations. The basis for the annual compilation is the Model Medical Professional Liability Statistical Plan that has been adopted by the NAIC. In turn, the Model Regulation uses the Uniform Medical Professional Liability (UMPL) Statistical Plan as its basis.

16.2 Scope of Medical Professional Insurance Data

Medical professional liability insurance or medical “malpractice” insurance provides coverage for tort claims brought against various medical-related institutions and medical professionals.

- Institutions may include hospitals, infirmaries, nursing homes, mental institutions, blood banks, sanitariums and clinics.

- Individual professionals may include physicians, surgeons, dentists, nurses, pharmacists, opticians, optometrists, physiotherapists, chiropractors, laboratory technicians and various specialists.

16.3 Medical Professional Liability Coverages

Virtually all medical professional liability exposures can be classified into five groups:

(1) hospital professional liability;
(2) physicians, surgeons and dentists professional liability;
(3) druggists liability;
(4) osteopaths professional liability; and
(5) miscellaneous medical professional liability.

Hospital policies provide protection to hospitals as institutions against injury arising from acts, errors or omissions of its professional staff and employees in rendering or failing to render services, such as:

(1) medical, surgical, or dental treatment including the furnishing of patient’s food and beverage;
(2) furnishing of drugs, medical supplies and appliances;
(3) post-mortem examinations; and
(4) service performed by a member of hospital’s accreditation or similar professional board.

The term “injury” is not defined in terms of bodily or personal injury, nor property damage, but rather applies to injury caused by a “medical incident.”

Physicians, Surgeons and Dentists policies, as well as Osteopaths policies, cover a wide assortment of medical professionals. Both claims-made and occurrence forms are available. Policies provide coverage against injury caused by a “medical incident,” signifying any act or omission in the furnishing of professional medical or dental services.

Druggists policies provide (1) professional liability and (2) products liability coverage. Such policies cover the liability of druggists for bodily injury or property damage arising from the sale and preparation of goods or products, including drugs and medicines.

Miscellaneous medical professional liability coverage is available on a claims-made and occurrence basis. These policies provide coverage for professionals such as nurses, optometrists and podiatrists, as well as associations such as visiting nurse associations, blood banks and X-ray laboratories.

16.4 Statistical Plan Reporting Requirements

The minimum data items required for medical professional liability reporting are specified in the Model Medical Professional Liability Statistical Plan. They include:

- Company Number
- Accounting/Calendar Date
- Transaction Identifier and Amounts
- Subline Identifier
- Classification
- State Indicator
- Territory Indicator
- Policy Effective Year
- Type of Program Indicator
- Date of Entry into the Claims-Made Program
- Type of Policy Contract Identifier
- Exposure
- Claim Count

The required data items are to be reported for direct business only. Therefore, reporting

shall not include premiums received from or losses paid to other carriers on account of reinsurance assumed by the reporting carrier; nor shall any deductions be made by the reporting carrier for premiums added to or for losses recovered from other carriers on account of reinsurance ceded. Losses are to be reported net as to third party recoveries (salvage and subrogation).

16.5 Who Reports Data: Minimum Reporting Standards for Insurers

The statutory requirement to report statistics applies to all licensed insurers. In establishing the standards for reporting to the statistical agents, regulators recognize the need for efficiency by permitting companies with limited premium volume to report less detailed statistics.

The model regulation has established the following standards for statistical reporting. All carriers, including JUAs and "Doctors Mutuals," are required to report statistics as described below:

(1) An insurer must report in accordance with the Model Medical Professional Statistical Plan if it is in the top 98th percentile of the total statewide written premium for medical professional liability.

(2) An insurer that does not meet the above criterion must report its statewide experience in accordance with the specifications of the medical professional statistical plan adopted by the Commissioner.

16.6 Specific Report Features

The standard annual report for medical professional liability has the following specific features.

Standard Annual Report

- Each state shown separately by type of policy contract identifier (claims-made, occurrence) and by subline identifier:
  1. hospitals;
  2. physicians, surgeons and dentists;
  3. other health care professional liability; and
  4. all remaining sublines.

Reports available on request

- The standard annual report but in further detail. Hospital professional experience would be shown in the two subcategories hospitals and other health care facilities. Physicians, surgeons and dentists experience would each be shown individually. Likewise, experience for the remaining sublines would be shown separately for druggists, osteopaths, nurses and other classifications.

All reports give premiums on a collected earned basis. Incurred losses are separated into basic and excess limit components (including loss adjustment expenses). Furthermore, basic and excess losses will be developed to 135 months. In addition, the report also shows total limits loss ratios based on developed losses.

Five policy years of data will be exhibited for each report.

All reports include at least the experience of companies meeting the criteria specified in part (1) of Section 16.5.

16.7 Time Frame

Statistical agents distribute medical professional liability annual reports approximately 39 months after the beginning of the policy year. This allows for loss evaluation and statistical agent processing and compilation.

Model Medical Professional Liability Statistical Plan

LIST OF DATA ITEMS

1. Company Number
2. Accounting/Calendar Date
3. Transaction Identifier and Amounts
4. Subline Identifier
5. Classification
6. State Indicator
7. Territory Indicator
8. Policy Effective Year
9. Type of Program Indicator
10. Date of Entry into the Claims-Made Program
11. Type of Policy Contract Identifier
12. Exposure
13. Claim Count

DATA ITEMS

1. Company Number

Experience is to be reported by the company number assigned by the statistical agent.

Note: Statistical agents will be required to convert company numbers to NAIC group and company code numbers, if requested.

2. Accounting/Calendar Date

- Accounting Quarter (where applicable)
- Accounting Year

3. Transaction Identifier and Amounts

Identify the following items and their respective amounts:

- Written Premium
- Paid Losses
- Paid Allocated Loss Adjustment Expenses
- Outstanding Losses
- Outstanding Allocated Loss Adjustment Expense

4. Subline Identifier

- Hospital Professional and Other Health Care Facilities Liability
- Physicians, Surgeons, and Dentists Professional Liability
- Other Health Care Professional Liability
- All Composite Rated Risks
- Indivisible Premium Policy Experience

5. Classification

Individual industry classification codes describing specific coverage will be used.

6. State Indicator

Experience is to be reported by the applicable state code.

7. Territory Indicator

Common industry territorial breakdowns currently in use will be maintained.

8. Policy Effective Year

- This is the effective date of the policy, defined as the beginning date of the declarations page or renewal certificate.
- For claims-made tail coverage, the date on which tail coverage began is required.

9. Type of Program Indicator

- Monoline
- Package

10. Date of Entry into the Claims-Made Program

- The date of entry into the claims-made program is the retroactive date employed in claims-made coverage in order to exclude coverage for occurrences that took place prior to that date even though claims resulting from such occurrences are made within the policy period.
- Claims-made tail coverage records shall include, in the date of entry into the claims-made program field, the date applicable to the basic and excess coverage.

11. Type of Policy Contract Identifier

- Claims-Made Coverage – Basic and Excess
- Claims-Made Coverage – Tail
- Occurrence Coverage

12. Exposure

The applicable exposure is required for each of the subdivisions of experience for which separate classification codes and exposure bases exist.

13. Claim Count

- Number Paid
- Number Outstanding

Appendix 4

<Date>

The Honorable <Name>

<Committee>

<House>

<Address>

<City_State_Zip>

Dear <Salutation>:

In 2006, the Legislature passed 2SHB 2292, comprehensive health care liability reform legislation, to address a number of concerns, including insufficient availability of medical malpractice claim data to support policy decisions. Section 204 of the bill requires the Office of the Insurance commissioner(OIC) to post statistical summaries of claim data by April 30, 2009, “unless the commissioner notifies legislative committees by March 15th that data are not available, and informs the committees when the summaries will be completed.”

I am requesting an extension until June 15, 2009 to post the statistical summary for claims closed in 2008, for the following reason.

Although my staff has gone to extraordinary lengths to reach out to people and entities that must report under this law, we have met with limited success. We have:

- Actively involved stakeholders in the rule-writing process, and invited them to participate in the testing process of a web-based claim reporting application that went “live” last July, and

- Proactively contacted insurers, risk retention groups, health care facilities, nursing homes, state and local government, and attorneys to encourage them to register and report claims as required under this law.

As I said, this has been a tremendous, time-consuming effort for my staff, and the results have been mixed, for a variety of reasons. Below are brief summaries of activity for the major stakeholder groups.

Insurers and Risk Retention Groups

These groups actively participated in the rule-making process and were very involved in developing our web-based reporting application. In particular, two insurance companies – Physicians Insurance and Washington Casualty – took an active lead in testing the application. Many of the companies in the medical malpractice marketplace registered and began reporting early.

In December 2008, the agency identified 122 admitted insurers, surplus line insurers, and risk retention groups that may have closed medical malpractice claims in 2008. Of those, 34 had registered to report closed claims. The OIC proactively contacted the remaining 88 entities, and followed up with an additional 59 contacts to facilitate full compliance with the law. Every entity identified with the exception of one risk retention group has either registered or informed us they did not close any claims in 2008. Some reports have not yet been completed, but we feel we are close to having universal compliance by the insurers and risk retention groups. Here are the numbers as of March 11, 2009:

Entity	Registered	Reported "0" Claims	Will not report citing Federal Preemption
Admitted Insurers	45	22	
Surplus Lines Insurers	28	9	
Risk Retention Groups	12	4	1

Self-insurers

The commitment from self-insurer organizations has generally been very good. In particular, the Washington State Hospital Association has been extremely helpful in communicating information to its members, and has helped my office provide training, including a presentation before the Washington Health Care Risk Management Society in April 2008. The hospital association has taken steps to inform its members of the law, including a final bulletin issued in early January of this year.

A number of self-insurers, including Providence Health & Services, the Office of Financial Management's Risk Management Office, Virginia Mason, and Group Health, assisted my staff with application testing. We currently have 35 self-insurers of various types registered to report closed claims. Smaller facilities that purchase insurance do not report claims directly; rather, their insurers have the principal responsibility to report most claims.

One important group with medical malpractice claims to report is the nursing home segment/skilled care facilities. We reminded the Washington Health Care Association in early December and again in February that their self-insured members must report medical malpractice closed claims. To date, only one nursing home organization has registered to report. We believe there are a number of large organizations that operate on a multi-state basis and self-insure at least a portion of their risk. We will be working actively over the next few months to ensure that they register and report closed claim data to our office.

Plaintiff Attorneys

The Washington State Association for Justice (WSAJ), formerly known as the Washington State Trial Lawyers Association, actively participated in the development of Chapter 284-24D RCW, Medical Malpractice Closed Claim Reporting Rules for Facilities and Providers.

However, the level of compliance with the new law has been disappointing. We have made a number of outreach efforts to the WSAJ to assist with compliance, but the association was non-responsive until this January, when I went before their governing board and insisted that they contact their members and encourage them to comply with the law. In response, the WSAJ sent a notice to 2,000 of its members in January,

encouraging them to register and report closed claims. By mid-February, however, only 28 attorneys or law firms had responded.

In February, I also sent a letter to 196 attorneys or law firms, asking them to register and report closed claim data, and I followed up with a second letter in early March. To date, 86 attorneys or law firms have registered, who have collectively filed 106 claim reports. However, data we obtained from the Administrator for the Courts (AOC) for suits filed in 2007 and 2008 indicates that 50 additional attorneys or law firms should register, and we should expect to receive over 160 reports. Medical malpractice claims tend to stay open for over three years, so we believe the number based on AOC data number is low. To date, insurers, risk retention groups and self-insurers have submitted 828 reports, and these data indicate that the trial bar should file over 300 reports.

I have instructed my staff to continue contacting plaintiff attorneys until they are satisfied with the number of reports submitted by this group. Over the interim, I also will be talking with legislators about proposing legislation next session to state that failure to report claims under Chapter 7.70.140 RCW is evidence of unprofessional conduct under Chapter 2.48 RCW.

As you can see, implementation of 2SHB 2292 has been a very work-intensive effort for my staff, and I am proud of them. However, despite all of their hard work, we still have more to do to ensure that the appropriate individuals and organizations required to report under this law do so. I would be happy to provide an update on these efforts during the legislative weekend in June.

If you have any questions about this information or would like to discuss it further, please feel free to contact me.

Sincerely,

Mike Kreidler

Insurance Commissioner

Appendix 5

Below is a summary of data obtained from the Office of the Administrator for the Courts. It shows the number of medical malpractice lawsuits were resolved in 2008.

2008 Medical Malpractice Lawsuit Dispositions	
Type of Disposition	Number
CHANGE OF VENUE/JURISDICTION	3
CLOSED BY COURT ORDER AFTER A HEARING	4
CONSOLIDATED CASE	11
COURT DECISION AFTER TRIAL	2
DISMISSAL BY CLERK	16
DISMISSAL WITHOUT TRIAL	105
JURY VERDICT AFTER TRIAL	23
SETTLED BY ARBITRATION AWARD	6
SETTLED BY PARTIES AND/OR AGREED JUDGMENT	128
SUMMARY JUDGMENT	15
UNCONTESTED RESOLUTION	3
Grand Total	**316**
Public Data provided by the Administrator for the Courts	

2238-OIC-Medical malpractice 11/09