COUNCIL OF THE DISTRICT OF COLUMBIA
COMMITTEE ON CONSUMER AND REGULATORY AFFAIRS
COMMITTEE REPORT

TO: All Councilmembers
FROM: Councilmember Jim Graham, Chairperson, Committee on Consumer and Regulatory Affairs
DATE: December 4, 2006
SUBJECT: Bill 16-334 "Medical Malpractice Amendment Act of 2006"

The Committee on Consumer and Regulatory Affairs, to which Bill 16-334 the "Medical Malpractice Insurance Reform Amendment Act of 2005" (renamed by the Committee the "Medical Malpractice Amendment Act of 2006") was referred, reports favorably on the proposed legislation to authorize the Commissioner to consider a malpractice insurer's surplus in ratemaking when the surplus is unreasonably large. Additionally, it would provide for regulation of certain insurance rates in the District of Columbia to require prior approval of rate increases exceeding 7%; authorize refunds to physicians who have paid excessive rates, enable physicians and consumers to challenge rate increases, and make rate filings public information. The committee print also incorporates the substance of the committee prints from the Committee on Health and the Committee on the Judiciary on Bill 16-418 "The Medical Malpractice Reform Act of 2005".

The Committee recommends that the Council vote favorably on the proposed legislation.

I. PURPOSE AND BACKGROUND

Bill 16-334, was introduced by Chairperson Graham, Chairman Cropp, and Councilmembers Brown, Fenty and Barry, and co-sponsored by Councilmembers Evans, Catania, Mendelson, Orange, Ambrose, and Gray. The bill would amend the Risk-Based Capital Act of 1996 to authorize the Commissioner to consider a malpractice insurer's surplus in ratemaking if the surplus is unreasonably large; and it would provide for regulation of certain insurance rates in the District of Columbia and for other purposes to require prior approval of rate increases exceeding 7%, to authorize refunds to physicians who have paid excessive rates, to enable physicians and consumers to challenge rate increases, and make rate filings public information.

II. LEGISLATIVE HISTORY

June 7, 2005

Bill 16-334, is introduced by Chairperson Graham, Chairman Cropp, and Councilmembers Brown, Fenty and Barry, and co-sponsored by Councilmembers Evans, Catania, Mendelson, Orange, Ambrose, and Gray.

Bill 16-334 is referred to the Committee on Consumer and Regulatory Affairs.
June 17, 2005 Notice of the Council's intent to act on Bill 16-334 is published in the District of Columbia Register.

March 3, 2006 Notice of a public hearing on Bill 16-334 is published in the District of Columbia Register.

March 20, 2006 The Committee on Consumer and Regulatory Affairs holds a Public Hearing on Bill 16-334.

December 4, 2006 The Committee on Consumer and Regulatory Affairs meets to consider and mark-up the report and committee print of Bill 16-334.

III. COMMITTEE REASONING

Insurance regulation, and particularly insurance ratemaking regulation, is a highly technical field. There are several different approaches taken by the different states and the District to ensure that rates are reasonable, adequate and not excessive. The bottom line is simple: consumer protection. Medical malpractice insurance regulation, the subject of this legislation, is significant because insurance rates not only affect the insured, but also the patients who depend on their insured physicians.

Under current law, the commissioner uses a "file and use" system of rate regulation, where the insurer files rates with the department and those rates become effective either immediately or at some specified date. To ensure that insurance rates are in compliance with regulatory standards, the Committee finds that the Council should require the filing of an application with the insurance commissioner for any rate increase, and prior approval of any rate increases over 7%. Proposed rate increases up to 7% would be deemed approved by the commissioner after 60 days. Proposed increases over 7% would require a hearing and an order "approving, denying, or modifying the proposed change within 90 days after public notice of the proposed change."

The Committee also finds that the insurance commissioner ought to be able to use certain information filed by each insurance provider with the department to determine whether insurance rates are unreasonable. The commissioner could use this information to determine whether the "Total Adjusted Capital", which is the sum of an insurer's statutory, required capital levels and surplus, is excessive. Under this bill, a determination of excessive surplus by the commissioner could trigger a refund to physicians and freezes on rate increases.

The Committee recognizes that this legislation is but one means of addressing what has been characterized as a local national crisis: high medical malpractice insurance rates are driving doctors out of the District.

For the foregoing reasons, the Committee recommends adoption of this legislation by the Council, in addition to a more fulsome discussion of the various approaches available to address the issue of skyrocketing cost of medical malpractice insurance.
IV. PUBLIC HEARING ON BILL 16-334

On March 20, 2006, the Committee on Consumer and Regulatory Affairs held a public hearing on Bill 16-334 in the Council Chamber at 1350 Pennsylvania Avenue, NW (the John A. Wilson Building).

Witness Testimony


Government witnesses included Thomas Hampton of Department of Insurance, Banking and Securities (DISB).

1. Public Testimony

Peter Lavine of the Medical Society of the District of Columbia testified that over two-thirds of the funds raised through malpractice insurance premiums go to legal and administrative costs rather than compensation, and that studies have shown that the extent of injury, rather than the extent of negligence, is the best predictor of the scale of a malpractice award. He challenged the argument that lowered return on investments by insurance companies were largely responsible for the rate increases, citing a GAO study that showed insurance company investments were mostly in fixed-income investments that provided stable returns. He endorsed provisions of Bill 16-283 and Bill 16-418 as likely to stabilize the costs of medical malpractice insurance.

Damian Alagia of the Medical Society of the District of Columbia testified that rising malpractice insurance costs have caused him to stop delivering babies. He testified that the Medical Society of the District of Columbia supports the goal of Bill 16-334, but that the bill would have little impact without patient safety measures and amending the tort process. He also recommended that the proposed linkage of an insurer's total adjusted capital to the approval of its rate increases be deleted from the bill.

Charles Allen of the District of Columbia Primary Care Association testified that the District of Columbia Primary Care Association supports Bill 16-334, but believes it should be merged with Bill 16-418. He cautioned against following the model of California's Proposition 103 too closely, testifying that the California Insurance Commissioner has never rejected a rate increase, but that ensuring disclosure by insurance companies would help keep rate increases under control.

William Burgess of the National Capital Reciprocal Insurance Company testified that the District has the second highest rate of malpractice payments in the country and the highest dollar value of defensive medical costs per capita, malpractice awards per capita and malpractice insurance premiums. He gave examples of several insurers around the country that recently failed after being unable to meet the costs of awards, and cautioned the District against doing anything that would leave insurers undercapitalized.
Lawrence Berman of the District of Columbia Insurance Federation testified that Bill 16-334 would not address the root problem of increasing malpractice insurance rates, which he characterized as the District's failure to adopt changes to the tort process adopted in many states with far lower malpractice premiums. He endorsed Bill 16-283 and Bill 16-418, but criticized Bill 16-334 as irrelevant at best. In particular, he argued that approval of insurance rates should not be tied to total adjusted capital, that information in a rate application may be proprietary and should not be disclosed to the public and that the proposed website of malpractice insurance information would turn the insurance commissioner into a marketer of insurance and undermine the roles of brokers and agents.

Wayne McOwen of WEM Associates testified, on behalf of the Property Casualty Insurance Association of America, that Bill 16-334 is unnecessary, as the problem of increasing malpractice insurance costs is driven by legal costs rather than insurance company profits. He warned that a company's total adjusted capital is not by itself a useful estimate of a company's profitability and a high total adjusted capital should not be taken into account when determining the appropriateness of a proposed rate increase.

Jillian Aldebron of Public Citizen testified that studies that have claimed that high malpractice insurance rates are driven by the costs of legal services and awards have been exposed as misleading or incomplete upon further review. She endorsed Bill 16-334 as a necessary step towards strengthening what she characterized as a weak insurance regulatory regime in the District, and endorsed the proposed website as a useful tool for doctors to "comparison shop" for the best coverage.

John Niles testified that high insurance costs have driven practitioners to leave the District of Columbia or retire early. He argued that a combination of legal reforms and greater transparency would do much to combat increased insurance rates, and so endorsed Bill 16-334 along with Bill 16-283 and Bill 16-418.

Victor Freeman testified that he believes Bill 16-334 would neither help nor hurt by itself, but should be passed because doing so would make clear the extent to which malpractice awards, rather than insurer behavior, have driven insurance costs. He also endorsed Bill 16-283 and Bill 16-418 as good complements for the bill, and expressed interest in the idea, originally raised by Councilmember Catania, of having the District itself act as a re-insurer.

2. Government Testimony

Thomas Hampton of DISB testified that the agency is concerned about increasing premiums for medical malpractice insurance in the District of Columbia, which has caused some physicians to consider scaling back their activities in the city or leaving it altogether. He generally supported the goal of Bill 16-334, but disagreed with linking an insurer's total adjusted capital to the approval of its rate increases, which he felt could lead to undercapitalization of insurers. He also suggested that documentation required for rate increases be made available when it is filed in accordance with the Freedom of Information Act, that the mandatory hearing on rate changes when the resulting rate exceeds 7 percent not apply to rate decreases.
V. FISCAL IMPACT

The fiscal impact statement required by section 602 (c) (3) of the District of Columbia Home Rule Act, approved December 24, 1973 (87 Stat. 813; D.C. Official Code § 1-206.02(c)(3)) is included as Attachment 8 to this report.

VI. SECTION-BY-SECTION ANALYSIS

Section 1 states the short title of the proposed legislation;

Section 2 amends Section 9 of the Risk-Based Capital Act of 1996 to require that the RBC Instructions, RBC Reports, Adjusted RBC Reports, RBC Plans, and Revised RBC Plans shall not be used by the Commissioner for ratemaking or considered or introduced as evidence in any rate proceeding, with the exception that the Commissioner may determine the total adjusted capital of a medical malpractice insurer to be excessive if: the total adjusted capital is greater than the appropriate risk-based capital requirements as determined by the Commissioner for the immediately preceding calendar year; and after a hearing, the Commissioner determines that the surplus is unreasonably large. Additionally, if the Commissioner determines that the total adjusted capital of a medical malpractice insurer is excessive, the Commissioner shall not approve a rate increase sought by the insurer.

Section 3 Amends D.C. Official Code 31-2703 by adding a new paragraph which requires every final rate or premium charge proposed to be used by a medical malpractice insurer to be filed with the Commissioner and to be adequate, not excessive, and not unfairly discriminatory. It defines a medical malpractice rate as excessive if the rate is unreasonably high for the insurance provided. It sets out standards to determine whether rates are adequate, not excessive, and not unfairly discriminatory, by requiring due consideration to be given to past and prospective loss experience within the District; a reasonable margin for underwriting profit and contingencies; dividends, savings, or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members, or subscribers; past and prospective expenses in the District; and all investment income reasonably attributable to medical malpractice insurance in the District.

It also permits the Commissioner to consider experience outside the District if District experience is not credible. It directs the Commissioner to promulgate rules setting forth the extent to which and the circumstances under which an insurer may rely on experience outside the District. When a medical malpractice insurer wishes to change a rate, the insurer must file a complete rate application with the Commissioner. A complete rate application shall include all information, including all actuarial data, projections, and assumptions, which the medical malpractice insurer has relied on in calculating its proposed rates. All such information shall be open to public inspection when filed.
It directs the Commissioner to notify the public of any application by a medical malpractice insurer for a rate change. The application shall be deemed approved 60 days after public notice unless the proposed rate change exceeds 7%. If the proposed rate change exceeds 7%, the Commissioner shall hold a hearing on the proposed change and shall issue an order approving, denying, or modifying the proposed change within 90 days after public notice of the proposed change. Any person shall have a right to challenge a proposed rate change and to participate in the hearing held by the Commissioner. The Commissioner shall promulgate rules governing the participation of the public.

When the Commissioner finds after a hearing that a rate used by a medical malpractice insurer does not comply with this subsection, the Commissioner shall order the insurer to discontinue using the rate and to issue a refund to any policyholder who has paid the rate to the extent that the Commissioner has found it excessive.

The bill amends Section D.C. Official Code § 31-2704 to require the Commissioner after an investigation of the rates, and before ordering an adjustment, to hold a hearing upon not less than 10 days' written notice specifying the matters to be considered at the hearing, to every company and rating organization which filed the rates. It exempts the Commissioner from holding the hearing if he or she is advised by every such company and rating organization that they do not desire the hearing. If, after the hearing, the Commissioner determines that any or all of the rates are excessive or inadequate, the Commissioner shall order an adjustment. Pending the investigation and order of the Commissioner, the rates shall be deemed to have been made in accordance with the terms of this act.

Additionally, the bill requires that an order of adjustment shall not affect any contract or policy made or issued prior to the effective date of the order unless the adjustment is substantial and exceeds the cost to the companies of making the adjustment; the order is made after the prescribed investigation and hearing and within 30 days after the filing of rates affected; and and requires that an order of adjustment shall not affect an existing contract or policy other than a medical malpractice, workmen's compensation, or automobile liability insurance policy required by law, order, rule, or regulation of a public authority; or a contract or policy of any type as to which the rates are not, by general custom of the business or because of rarity and peculiar characteristics, written according to normal classification or rating procedure.

Section 4 states that the Council adopts the fiscal impact statement in the committee report as the fiscal impact statement required by section 602(c)(3) of the District of Columbia Home Rule Act (D.C. Official Code § 1-206.02(c)(3)); and
Section 5 states that this act shall take effect following approval by the Mayor (or in the event of veto by the Mayor, action by the Council to override the veto), a 30-day period of Congressional review as provided in section 602(c)(I) of the District of Columbia Home Rule Act, approved December 24, 1973 (87 Stat. 813; D.C. Official Code § 1-206.02(c)(I)), and publication in the District of Columbia Register.

VII. IMPACT ON EXISTING LAW

Bill 16-334 would amend the Risk-Based Capital Act of 1996 to authorize the Commissioner to consider a malpractice insurer's surplus in ratemaking if the surplus is unreasonably large; and it would provide for regulation of certain insurance rates in the District of Columbia, and for other purposes to require prior approval of rate increases exceeding 7%, to authorize refunds to physicians who have paid excessive rates, to enable physicians and consumers to challenge rate increases, and make rate filings public information.

VIII. COMMITTEE ACTION

On December 4, 2006, at 10:30 a.m., the Committee on Consumer and Regulatory Affairs held an additional meeting of the Committee to consider and markup the Committee print and accompanying report on Bill 16-334, in Room 123 at 1350 Pennsylvania Avenue, NW.

With Chairperson Graham and Chairman Linda Cropp and Councilmember David Catania present, Chairperson Graham convened a quorum.

After brief opening remarks, Chairperson Graham moved the Committee print, and the accompanying report, on Bill 16-334, with leave for staff and the General Counsel to make technical and conforming amendments.

Councilmember Catania moved an amendment to the committee print, which incorporated the committee prints from the Committee on Health and The Committee on the Judiciary on Bill 16-418, the "Medical Malpractice Reform Act of 2005."

The Medical Malpractice Reform Act of 2005 was introduced by Councilmember Catania on October 5, 2006. Titles I, and II were referred to the Committee on Health. Titles III, IV and V were referred to the Committee on the Judiciary. Titles IV, VII, VII and DC were referred to the Committee on Consumer and Regulatory Affairs.

The Committee on Health met and marked up Titles I and II on May 17, 2006. The Committee on the Judiciary marked up Titles III, IV and V on April 28, 2006. The substance of those committee prints has been incorporated, by amendment, into the Committee print of Bill 16-334. The committee reports for Titles I and II and Titles III, IV and V of the Medical Malpractice Reform Act of 2005, as reported by the relevant committees, are therefore incorporated by reference and attached to this report.

TITLE I improves the performance of the Board of Medicine by requiring the Mayor to dedicate sufficient staff to the Board of Medicine. This title also requires the Board of Medicine to conduct an independent investigation when notified that a complaint has been
Title I also requires the Board of Medicine to maintain a website where information about licensees, including any disciplinary action, shall be made public.

Title II provides for the creation of a centralized database for the collection of de-identified and anonymous information on adverse medical events in order to reduce medical errors and improve health care delivery. This title requires health care institutions to report adverse medical events to the centralized database on a bi-annual basis.

Title III requires a 90-day notice of intent to file a medical malpractice suit. This title also requires the parties in a medical malpractice action to engage in mandatory mediation within 30 days of the initial scheduling conference. Title III also makes benevolent gestures of health care providers to victims of alleged medical malpractice inadmissible as evidence in civil and administrative proceedings.

Title IV requires the Mayor to submit legislation to the Council to create a database of OB/GYN claims for the purpose of identifying trends and best practices.

After brief discussion, including a statement from Chairman Linda Cropp on the importance of this legislation, Chairperson Graham, Chairman Cropp and Councilmember Catania voted unanimously in favor of the committee print of Bill 16-334, as amended, and the report thereto, with leave for staff and the General Counsel to make technical and conforming amendments.

Chairperson Graham then moved to table Titles VI, VII, VIII, and IX of Bill 16-418, which were referred to this committee. A majority of the members present voted in favor of the table motion, with Councilmember Catania voting "no".

IX. COMMITTEE RECOMMENDATION

The Committee on Consumer and Regulatory Affairs, to which Bill 16-334 "Medical Malpractice Insurance Reform Amendment Act of 2005" (renamed by the Committee the "Medical Malpractice Insurance Reform Amendment Act of 2006") was referred, reports favorably on the proposed Committee print, as amended, and recommends that the Council vote favorably on the Committee print of Bill 16-334.

X. ATTACHMENTS

1. Bill 16-334 as introduced with referral
2. Notice of March 20, 2006 public hearing
3. March 20, 2006 Public Hearing Agenda and Witness List
4. Selected written testimony and materials submitted for the record
5. Reports of the Committee on the Judiciary and Committee on Health for Titles I and II and Titles III, IV and V of the Medical Malpractice Reform Act of 2005.
6. Committee print of Bill 16-334 (including technical and conforming amendments)
7. Fiscal impact statement
Memorandum

To: Members of the Council

From: Phyllis Jones, Secretary to the Council

Date: June 8, 2005

Subject: Referral of Proposed Legislation

Notice is given that the attached proposed legislation was introduced in the Legislative Meeting on June 7, 2005. Copies are available in Room 10, the Legislative Services.

TITLE: "Medical Malpractice Insurance Reform Amendment Act of 2005", Bill 16-334

INTRODUCED BY: Chairman Cropp and Councilmembers Brown, Fenty, Barry, and Graham

CO-SPONSORED BY: Councilmember Evans, Catania, Orange, Ambrose, Gray, and Mendelson

The Chairman is referring this legislation to the Committee on Consumer and Regulatory Affairs.

cc: General Counsel
    Legislative Services
A BILL

IN THE COUNCIL OF THE DISTRICT OF COLUMBIA

To amend the Risk-Based Capital Act of 1996 to authorize the Commissioner to consider a malpractice insurer's surplus in ratemaking if the surplus is unreasonably large; and to amend AN ACT To provide for regulation of certain insurance rates in the District of Columbia, and for other purposes to require prior approval of rate increases exceeding 7%, to authorize refunds to physicians who have paid excessive rates, to enable physicians and consumers to challenge rate increases, to make rate filings public information, and to enable physicians to obtain insurance quotations from multiple medical malpractice insurers.

BE IT ENACTED BY THE COUNCIL OF THE DISTRICT OF COLUMBIA, That this act may be cited as the "Medical Malpractice Insurance Reform Amendment Act of 2005".

Sec. 2. Section 9 of the Risk-Based Capital Act of 1996, effective April 9, 1997 (D.C. Law 11-233; D.C. Official Code § 31-2008), is amended as follows:

(a) Subsection (c) is amended to read as follows:

"(c) Except as provided in subsection (d) of this subsection, the RBC Instructions, RBC
Reports, Adjusted RBC Reports, RBC Plans, and Revised RBC Plans shall not be used by the Commissioner for ratemaking or considered or introduced as evidence in any rate proceeding.

(b) A new subsection (d) is added to read as follows:

"(d)(1) The Commissioner may determine the total adjusted capital of a medical malpractice insurer to be excessive if:

"(A) The total adjusted capital is greater than the appropriate risk-based capital requirements as determined by the Commissioner for the immediately preceding calendar year; and

"(B) After a hearing, the Commissioner determines that the surplus is unreasonably large.

"(2) If the Commissioner has determined that the total adjusted capital of a medical malpractice insurer is excessive, the Commissioner shall not approve a rate increase sought by the insurer until he or she determines that the total adjusted capital of the insurer is no longer excessive."

Sec. 3. AN ACT To provide for regulation of certain insurance rates in the District of Columbia, and for other purposes, approved May 20, 1968 (62 Stat. 242; D.C. Official Code §31-2701 et seq.), is amended as follows:

(a) Section 3 (D.C. Official Code §31-2703) is amended by adding a new subsection (f-1) to read as follows:

"(f-1)(1)(A) Every final rate or premium charge proposed to be used by a medical malpractice insurer shall be filed with the Commissioner and shall be adequate, not excessive, and not unfairly discriminatory. A medical malpractice rate shall be excessive if the rate is
unreasonably high for the insurance provided. In determining whether rates are adequate, not excessive, and not unfairly discriminatory, due consideration shall be given to:

- "(i) Past and prospective loss experience within the District;
- "(ii) A reasonable margin for underwriting profit and contingencies;
- "(iii) Dividends, savings, or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members, or subscribers;
- "(iv) Past and prospective expenses in the District;
- "(v) All investment income reasonably attributable to medical malpractice insurance in the District.

"(B) If District experience is not credible, the Commissioner may consider experience outside the District. The Commissioner shall promulgate rules setting forth the extent to which and the circumstances under which an insurer may rely on experience outside the District. 

"(2) If a medical malpractice insurer wishes to change a rate, it shall file a complete rate application with the Commissioner. A complete rate application shall include all information, including all actuarial data, projections, and assumptions, that the medical malpractice insurer has relied on in calculating its proposed rates. All such information shall be open to public inspection as soon as filed.

"(3) The Commissioner shall notify the public of any application by a medical malpractice insurer for a rate change. The application shall be deemed approved 60 days after public notice unless the proposed rate change exceeds 7%. If the proposed rate change exceeds 7%, the Commissioner shall hold a hearing on the proposed change and shall issue an order
approving, denying, or modifying the proposed change within 90 days after public notice of the proposed change. Any person shall have a right to challenge a proposed rate change and to participate in the hearing held by the Commissioner. The Commissioner shall promulgate rules governing the participation of the public.

"(4) If the Commissioner finds, after a hearing, that a rate used by a medical malpractice insurer does not comply with this subsection, he shall order the insurer to discontinue using the rate and to issue a refund to any policyholder who has paid the rate to the extent that the Commissioner has found it excessive."

(b) Section 3(c) (D.C. Official Code § 31-2704 (c)) is amended to read as follows:

"(c)(l) After an investigation of the rates, the Commissioner shall, before ordering an adjustment, hold a hearing upon not less than 10 days' written notice specifying the matters to be considered at the hearing, to every company and rating organization which filed the rates; provided, that the Commissioner shall not be required to hold the hearing if he or she is advised by every such company and rating organization that they do not desire the hearing. If, after the hearing, the Commissioner determines that any or all of the rates are excessive or inadequate, he shall order an adjustment. Pending the investigation and order of the Commissioner, the rates shall be deemed to have been made in accordance with the terms of this act.

"(2)(A) An order of adjustment shall not affect any contract or policy made or issued prior to the effective date of the order unless:

"(i) The adjustment is substantial and exceeds the cost to the companies of making the adjustment; and

"(ii) The order is made after the prescribed investigation and
hearing and within 30 days after the filing of rates affected; and

"(B) An order of adjustment shall not affect an existing contract or policy other than:

"(i) A medical malpractice, workmen's compensation, or automobile liability insurance policy required by law, order, rule, or regulation of a public authority; or

"(ii) A contract or policy of any type as to which the rates are not, by general custom of the business or because of rarity and peculiar characteristics, written according to normal classification or rating procedure.

(c) A new section 15 is added to read as follows:

"Sec. 15. Medical malpractice insurance quotation service.

"(a) Not later than October 1, 2005, and after consultation with medical malpractice insurers, the Commissioner shall establish an interactive website which shall enable any physician licensed in the District to obtain a quote from each insurer licensed to write the medical malpractice insurance coverage sought by the physician ("medical malpractice insurer").

"(b) The website established by the Commissioner shall enable physicians to complete an online form which requires information sufficient for an insurer to provide a quotation for the medical malpractice insurance coverage sought by the physician. The online form shall require, at a minimum, the following information:

"(1) The medical specialty of the physician;

"(2) The number of years the physician has been in practice;

"(3) The claims experience of the physician;"
"(4) The policy limits sought by the physician; and  

"(5) Such other information regarding factors that the Commissioner determines will have a material effect on the medical malpractice insurance premiums of physicians.  

"(c) After a physician has completed the online form, the website shall display quotations for the physician for the coverage from each medical malpractice insurer.  

"(d) Quotations provided by the website shall at all times be accurate. Whenever the Commissioner approves any rate change for a medical malpractice insurer, the Commissioner shall implement the change at the website as soon as practicable, but not later than 10 days after the change has been approved.  

"(e) The Commissioner shall design the website to incorporate user-friendly formats and self-help guidance materials and shall develop a user-friendly internet user-interface.  

"(f) The website shall provide contact information for each medical malpractice insurer. The contact information shall consist of address, telephone number, fax number, e-mail address, and any additional information that the Commissioner may require. The website shall also display the name, address, and telephone number of each agent that each medical malpractice insurer has appointed in the District.".

Sec. 4. Fiscal impact statement.

The Council adopts the fiscal impact statement in the committee report as the fiscal impact statement required by section 602(c)(3) of the District of Columbia Home Rule Act, approved December 24, 1973 (87 Stat. 813; D.C. Official Code § 1-206.02(c)(3)).

Sec. 5. Effective date.

This act shall take effect following approval by the Mayor (or in the event of veto by the
Mayor, action by the Council to override the veto), a 30-day period of Congressional review as provided in section 602(c)(1) of the District of Columbia Home Rule Act, approved December 24, 1973 (87 Stat. 813; D.C. Official Code § 1-206.02(c)(l)), and publication in the District of Columbia Register.
Attachment E:

Bill 16-418 Committee Print
A BILL

16-418

IN THE COUNCIL OF THE DISTRICT OF COLUMBIA

To amend the District of Columbia Health Occupations and Revision Act of 1985 to establish reporting requirements for physicians found liable for medical malpractice and for health care providers who discipline a physician employed by the health care provider, to authorize the Board of Medicine to establish a new physician licensure fee, and to improve the performance of the Board of Medicine by requiring the Mayor to dedicate a minimum number of full-time employees whose sole responsibility shall be to support the Board of Medicine; and to require the creation of a centralized database for the collection of information for the analysis of adverse medical events to reduce medical errors and improve health care delivery, to require individuals who intend to file suit alleging medical malpractice to file with potential defendants a 90-day notice of intent to file suit in the District of Columbia Superior Court, to require parties to the suit to engage in mediation early in the litigation process, to make inadmissible as an admission of medical malpractice liability certain benevolent gestures made by the defendant, to examine all closed liability claims against Obstetricians/Gynecologists in order to identify ways to improve health care delivery and share best practices, to require the current rates charged by medical malpractice insurers be made public, to require all information filed with the Commissioner of Insurance, Securities and Banking regarding rate changes for medical malpractice policies to be made public, and to require all insurance companies and self-insurers that offer medical malpractice insurance to disclose on a quarterly basis certain information about claims, settlements, and judgments related to medical malpractice, with all information being de-identified and anonymous.

BE IT ENACTED BY THE COUNCIL OF THE DISTRICT OF COLUMBIA, That this act may be cited as the "Medical Malpractice Reform Act of 2006".

TITLE I. IMPROVED PERFORMANCE BY THE BOARD OF MEDICINE.

Sec. 101. The District of Columbia Health Occupations and Revision Act of 1985,
effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code § 3-1201.01 etseq.), is amended as follows:

(a) Section 203(a)(7) (D.C. Official Code § 3-1202.03(a)(7)) is amended as follows:

1. Designate the existing text as subparagraph (A).

2. Add a new subparagraph (B) to read as follows:

"(B) By January 1, 2007, in addition to the executive director, the Mayor shall require, at a minimum, that an investigator, an attorney, and 2 clerical support staff be hired, who shall be full-time employees of the District and whose work shall be limited solely to administering and implementing the orders of the Board in accordance with this act and rules and regulations issued pursuant to this act. The mandatory minimum number of employees hereby established shall not restrict the Mayor's ability to authorize additional staff.

(b) Section 409 (D.C. Official Code § 3-1204.09) is amended by striking the phrase "implement this section." and inserting the phrase "implement this section; except, that the fee for the issuance of a medical license shall be set by the Board of Medicine; provided, that the fee shall be no less than $500 and shall be sufficient to fund the programmatic needs of the Board." in its place.

(c) Add a new section 513a to read as follows:

"Sec. 513a. Physician and health care provider notice requirements, penalty for noncompliance; settlement agreement not a bar to filing a complaint or testifying.

"(a)(1) A physician licensed by the Board shall report to the Board within 60 days of the occurrence of any of the following:

"(A) Notice of a judgment against a physician named in a medical malpractice suit or notice of a confidential settlement of a medical malpractice claim to be paid by a physician, an insurer, or other entity on behalf of the physician; or

"(B) Disciplinary action taken against the physician by a health care licensing authority of another state."
"(2)(A) A health care provider who employs a physician who is licensed in the District of Columbia shall report to the Board any disciplinary action taken against the physician within 10 days of the action being taken. The resignation of a physician that occurs while the physician is being investigated by the health care provider shall also be reported to the Board by the health care provider within 10 days of the resignation.

"(B) The Board shall impose a fine of not more than $2,500 on a health care provider for failure to comply with the provisions of this paragraph.

"(b) Nothing in a confidential settlement agreement shall operate to prevent the parties to the agreement from filing a complaint with the Board or from testifying in any investigation conducted by the Board."

TITLE II. MANDATORY ADVERSE EVENT REPORTING.
Sec. 201. Definitions.
For the purposes of this title, the term:

(1) "Adverse event" means an event, occurrence, or situation involving the medical care of a patient by a health care provider that results in death or an unanticipated injury to the patient.

(2) "Healthcare provider" means an individual or entity licensed or otherwise authorized under District law to provide healthcare service, including a hospital, health maintenance organization, nursing facility, comprehensive outpatient rehabilitation facility, home health agency, hospice program, renal dialysis facility, ambulatory surgical center, pharmacy, physician or health care practitioner's office, long term care facility, behavior health residential treatment facility, health clinic, clinical laboratory, health center, physician, physician assistant, nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, certified nurse midwife, psychologist, certified social worker, registered dietitian or nutrition professional, physical or occupational therapist, pharmacist, or other individual health care practitioner.

(3) "Medical facility" means a hospital, health maintenance organization, nursing
facility, comprehensive outpatient rehabilitation facility, home health agency, hospice program, renal dialysis facility, ambulatory surgical center, pharmacy, physician or health care practitioner's office, long term care facility, behavior health residential treatment facility, health clinic, clinical laboratory or health center.

(4) "Primary health record" means the record of continuing care maintained by a health professional, group practice, or health care facility or agency containing all diagnostic and therapeutic services rendered to an individual patient by that health professional, group practice, or health care facility, or agency.

Sec. 202. Creation of centralized reporting system.

By July 1, 2007, the Mayor shall establish, within the Department of Health, a centralized system for the collection and analysis of adverse events in the District of Columbia.

Sec. 203. Appointment of system administrator.

The Mayor shall appoint an employee of the Department of Health to administer the system, whose responsibilities shall include:

(1) Collecting, organizing, and storing data on adverse events occurring at medical facilities in the District of Columbia;

(2) Tracking, assessing, and analyzing the incoming reports, findings, and corrective action plans;

(3) Identifying common adverse event patterns or trends;

(4) Recommending methods to reduce systematic adverse events;

(5) Providing technical assistance to healthcare providers and medical facilities on the development and implementation of patient safety plans to prevent adverse events;

(6) Disseminating information and advising healthcare providers and medical facilities in the District of Columbia on medical best practices;

(7) Monitoring national trends in best practices and disseminating relevant information and advice to healthcare providers and medical facilities in the District of Columbia;
and

(8) Publishing an annual report that includes summary data of the number and types of adverse events of the prior calendar year by type of healthcare providers and medical facility, rates of change, and other analyses and communicating recommendations to improve health care delivery in the District of Columbia.

Sec. 204. Mandatory reporting.

(a) Pursuant to this title, healthcare providers and medical facilities providing services in the District of Columbia shall submit biannual reports, on January 1 and July 1 of each calendar year, on adverse events to the system administrator. Each report shall contain, for each adverse event, the patient’s full primary health record; except, that medical information with respect to the patient’s identity shall be de-identified and anonymous.

(b) Failure to submit a report as required by this section shall be punishable by a fine of not less than $500 or more than $2,500.

Sec. 205. Confidentiality of data.

(a) Except as otherwise provided by this section, the files, records, findings, opinions, recommendations, evaluations, and reports of the system administrator, information provided to or obtained by the system administrator, the identity of persons providing information to the system administrator, and reports or information provided pursuant to section 204 shall be confidential, not subject to disclosure pursuant to any other provision of law, and shall be neither discoverable nor admissible into evidence in any civil, criminal, or legislative proceeding; under no circumstances shall the information be disclosed by any person. Nothing in this subsection shall preclude use of reports or information provided under section 204 by a board regulating a health profession or the Mayor in proceedings by the board or the Mayor.

(b) No person who provided information to the system administrator shall be compelled to testify in any civil, criminal, or legislative proceeding with respect to any confidential matter contained in the information provided to the system administrator.
(c) Notwithstanding subsections (a) or (b) of this section, a court may order a system administrator to provide information in a criminal proceeding in which an individual is accused of a felony, if the court determines that disclosure is essential to protect the public interest and that the information being sought can be obtained from no other source. In determining whether disclosure is essential to protect the public interest, the court shall consider the seriousness of the offense with which the individual is charged, the need for disclosure of the party seeking it, and the probative value of the information. If the court orders disclosure, the identity of any patient shall not be disclosed without the consent of the patient or his or her legal representative.

Sec. 206. Funding.

Implementation of title shall be funded through the licensure fees collected by the Board of Medicine.

TITLE X. IMPLEMENTATION.

Sec. 1001. Fiscal impact statement.

The Council adopts the fiscal impact statement in the committee report as the fiscal impact statement required by section 602(c)(3) of the District of Columbia Home Rule Act, approved December 24, 1973 (87 Stat. 813; D.C. Official Code § 1-206.02(c)(3)).

Sec. 1002. Effective date.

This act shall take effect following approval by the Mayor (or in the event of veto by the Mayor, action by the Council to override the veto), a 30-day period of Congressional review as provided in section 602(c)(1) of the District of Columbia Home Rule Act, approved December 24, 1973 (87 Stat. 813; D.C. Official Code § 1-206.02(c)(1)), and publication in the District of Columbia Register.
The Committee on the Judiciary, to which Bill 16-418, the "Medical Malpractice Reform Act of 2006" was referred, reports favorably thereon with amendments, and recommends approval by the Council.

CONTENTS

I. Background and Need ................................................. 1
II. Legislative Chronology .......................................... 2
III. Summary of Testimony ....................................... 2
IV. Impact on Existing Law ....................................... 5
V. Fiscal Impact ..................................................... 5
VI. Section-by-Section Analysis ................................ 5
VII. Committee Action ............................................ 7
VIII. Attachments ..................................................... 7

I. BACKGROUND AND NEED

Bill 16-418, the Medical Malpractice Reform Act of 2006 represents a unique collaborative effort between representatives from the medical profession, hospital field, and patient advocacy. The basis of this legislation was a taskforce on medical malpractice that was organized by Councilmember David Catania, Chairperson of the Committee on Health. In an effort to establish common ground in the area of medical malpractice, Councilmember Catania organized representatives from these typically divergent groups and tasked them with "creating a set of policy recommendations for the Committee on Health." The taskforce responded with a set of recommendations that represent consensus in the areas of civil justice modifications, patient safety initiatives, and insurance regulation initiatives. Some of their recommendations were referred to this committee and form the substance of this committee report.

This bill works to improve legal process in the area of civil justice in three ways. For medical malpractice cases, this bill would: 1) require a 90-day notice of intent to sue; 2) obligate parties to participate in early mandated mediation; and 3) make certain benevolent gestures inadmissible. The 90-day notice requirement and early mandated mediation serve similar purposes. The notice requirement compels the plaintiff to provide the defendant with 90 days notice before filing suit and the mandated mediation requires the parties to engage in mediation before a trial date can be scheduled. These measures encourage early settlements and facilitate
the parties' ability to reach a settlement. Settlements, especially ones accomplished early in the litigation process, lower each party's individual costs (providing cost savings that can be spread to the general public through less costly insurance rates), and promote judicial economy by decreasing the time and money spent by the court on these complicated and contentious issues.

The inadmissibility of certain benevolent gestures would make expressions of sympathy, regret, or apology from healthcare providers to patients inadmissible as an admission of liability for any purpose. Karen Klaus, from the DC Chapter of American College of Nurse-Midwives, testified at the hearing that historically, experts in the field of liability reduction have encouraged healthcare providers to remain silent after unanticipated outcomes occurred. Today, these experts are encouraging practitioners to enter into dialogues with their patients. "Saying one is sorry after an event occurred is very different from admitting one made a mistake." This inadmissibility provision is an acknowledgement of that change in philosophy. A statement of public policy that honest and open communication between the parties will diffuse the adversarial environment oftentimes resorted to in today's litigious society.

Because the origins of this bill stem from a compromise between typically opposing stakeholders in the medical malpractice reform field, the legislation received similar broad support at the public hearing. The Committee recommends approval of Bill 16-418 as amended.

II. LEGISLATIVE CHRONOLOGY

September 20, 2005 Bill 16-418, "Medical Malpractice Reform Act of 2006" is introduced by Councilmember Catania and co-sponsored by Councilmembers Patterson and Gray.

October 14, 2005 Notice of Intent to act on Bill 16-418 is published in the D.C. Register. Titles I and II are referred to the Committee on Health, III, IV, and V are referred to the Committee on the Judiciary, and VI, VII, VIII, and IX are referred to the Committee on Consumer and Regulatory Affairs.

November 4, 2005 Notice of Public Hearing on Bill 16-418 is published in the DC Register.

December 1, 2005 Committee on the Judiciary holds a public hearing on Bill 16-418.

April 27, 2006 Committee on the Judiciary marks-up Bill 16-418.

III. SUMMARY OF TESTIMONY

The Committee on the Judiciary held a public hearing on Bills 16-283, the Health Care Reform Act of 2006; and 16-418, the Medical Malpractice Reform Act of 2006 on Thursday, December 1, 2005. The testimony summarized below is from that hearing. Due to the considerable amount of testimony submitted for this hearing, copies of the testimony are not
attached to this report. Copies of the testimony are available from the Council Secretary, Office of Legislative Services.

PUBLIC CITIZEN PANEL

Frank Clemente, Director, Public Citizen's Congress Watch, testified as to his participation on the Medical Malpractice Taskforce

George Mozee, Public Witness, had his testimony read by Jan Mozee. He testified as to his personal injuries and stated that limitations on pain and suffering serve to harm victims of medical malpractice a second time.

Yvonne Ewell Smith, Public Witness, testified regarding the mistreatment her mother received while living at a nursing home.

Jillian Aldebron, Civil Justice Counsel, Public Citizen’s Congress Watch, testified on B16-283.

MEDICAL SOCIETY OF THE DISTRICT OF COLUMBIA PANEL

K. Edward Shanbacker, Executive Vice-President, MSDC, introduced the panel’s presenters.

Damian P. Alagia, MD, President, MSDC, testified on Bill 16-283 and spoke about the decreasing number of practicing OB/gyns in the District and the high premiums for high-risk specialties such as emergency medicine, neurosurgery, and obstetrics.

Peter E. Lavine, MD, Chairman, MSDC, testified on Bill 16-283.

John Herbert Niles, MD, testified on Bill 16-283.

William Brownlee, III, MD, testified on Bill 16-283.

Robert McMillan, Esq., Trustee, American Medical Association, testified that the District’s excessive medical malpractice costs have driven doctors from the District. He expressed that these costs affect African American doctors in particular and as a result affects African American patient access.

Howard Friedman, Senior Vice-President and Chief Underwriting Officer, ProAssurance, testified on B16-283 and the urgent need for action. He stated that claim payments in the District are among the highest in the country and the legal environment is considered to be very volatile.

James Hurley, Consulting Actuary, Towers Perrin-Tillinghast, testified that the rates in the District are relatively high compared to other jurisdictions and that he believes that this is primarily because of higher than average claim costs. He stated that high rates (when prompted by high claim costs) along with a volatile legal environment, and limited market size, make outcomes appear more unpredictable and discourages insurers from doing business in the District.

DISTRICT OF COLUMBIA HOSPITAL ASSOCIATION PANEL

Tonya Vidal Kinlow, Vice-President for Government Relations, DCHA, testified in support of Titles III, IV, and V of Bill 16-418. Ms. Kinlow stated that the 90-day notice requirement could encourage claim resolution outside of the court. The mandatory mediation requirement also serves to resolve cases outside of court, and the cost-sharing requirement will encourage good
faith efforts toward settlement. She also expressed support for making benevolent gestures inadmissible in order to promote open communication between the provider and the patient.

*Larry L. Smith, JD, Vice-President, Risk Management Services, MedStar Health, Inc.*, testified in support of Bill 16-418.

*Jeffrey Elting, MD, DCHA*, testified in support of Bill 16-283.

**TRIAL LAWYERS ASSOCIATION OF METROPOLITAN WASHINGTON DC PANEL**

*James Nathanson, Esq., Legislative Counsel, TLA-DC*, provided comments on B16-418 and testified on Bill 16-283.

*PatMalone, Esq., President, TLA-DC*, testified on Bill 16-283.

*Harvey Rosenfield, Foundation for Taxpayer and Consumer Rights*, testified on Bill 16-283.

*Sandra Robinson, Past-President, TLA-DC*, testified on Title IV of Bill 16-283.

*James Talglieri, Past-President, TLA-DC*, testified on Bill 16-283.

*Jack Olender, Chair, Legislative Committee, TLA-DC*, provided written comments on B16-418.

**GOVERNMENT WITNESSES**

*Dr. Greg Pane, Director, Department of Health*, testified in support of Bill 16-418 in principle; however, he expressed several concerns about requirements in Titles I and II of the bill (referred to the Committee on Health).

*Thomas E. Hampton, Acting Commissioner, Department of Insurance, Securities and Banking*, testified that DISB would have no objection to Bill 16-418. He stated that this bill would have minimal effect, if any, on the regulation of insurance companies.

**PUBLIC WITNESSES**

*Michael Sindram, Public Witness*, testified that Bill 16-418 requires additional clarification.

*Dr. Robert Emery, District of Columbia Dental Society*, testified in favor of Bill 16-418. He stated that the bill would provide for better control over insurance industry practices.

*Charles Allen, Senior Policy Specialist, District of Columbia Primary Care Association*, testified in support of the relevant titles of Bill 16-418. Mr. Allen stated that this was a measure with broad support from all the stakeholders and expressed his belief that there is a need for increased oversight and accountability over the medical liability insurance industry.

*Randall R. Bovbjerg, Public Witness*, testified in support of Bill 16-418. He stated that the bill will likely not influence litigants’ or clinicians’ behavior or affect liability insurance rates but they are modest steps in the right direction.

*Angela Conley, Public Witness*, testified on Bill 16-283 and her personal experience with her injuries resulting from medical malpractice.

*Walter L. Faggett, MD, President, Medico-chirurgical Society (NMA)*, testified in support of Bill 16-418 and its patient safety and quality care measures.

*Allison Kohler, President, Maryland Trial Lawyers Association*, testified on Bill 16-283.


Gwendolyn Bynum-Lawrence, Public Witness, testified on Bill 16-283 and her personal experience with her son's medical malpractice case.

Joyce Betchter, Public Witness, testified on Bill 16-283 and her personal experience with her son's medical malpractice case.

Vivia E. Sherwood, Public Witness, testified on Bill 16-283 and her personal experience with medical malpractice.

Seglinde (aka Linda) Bitterfield, Public Witness, testified on Bill 16-283 and her personal experience with her husband's medical malpractice case.

Karen Klauss, CNM Chapter Chair, DC Chapter of American College of Nurse-Midwives, testified in support of Bill 16-418. With respect to Title IV of the bill she stated that the term "birth centers" should be added to the definition section. Ms. Klauss noted that experts in the field of liability now encourage practitioners to enter into dialogue with patients and therefore they enthusiastically support Title V.

IV. IMPACT ON EXISTING LAW

Bill 16-418, Titles III, IV, and V, would amend title 16 of the D.C. Code by adding a new Chapter 28. The bill would modify existing law by: 1) creating a requirement for a 90 day notice of intent to file suit in medical malpractice cases against healthcare providers and providing for an extension of the statute of limitations when such notice is filed within 90 days of the statute of limitation's expiration date; 2) require parties involved in a medical malpractice suit against a healthcare provider to enter into early mediation; and 3) make inadmissible as an admission of liability certain benevolent gestures made by or on behalf of healthcare providers.

V. FISCAL IMPACT

Attached is a fiscal impact statement from the Council's Budget Director. Funds are sufficient in the budget and financial plan. The bill amends law with regard to civil procedure and therefore takes no direct effect on the cost of government operations.

VI. SECTION BY SECTION ANALYSIS

Title III

Sec. 301. States the short title.

Sec. 302. Amends Title 16 of the District of Columbia Official Code to add a new Chapter 28, "Medical Malpractice".
Subchapter I. Generally.

Sec. 16-2801. Defines the terms "Court" and "Healthcare Provider".

Sec. 16-2802. Provides a 90-day notice requirement for any person who files suit in DC Superior Court alleging medical malpractice against a healthcare provider.

Sec. 16-2803. Provides for a 90-day extension of the statute of limitations if notice of intention to file suit is served within 90-days of the applicable statute of limitation's expiration.

Sec. 16-2804. States that the notice requirement is not applicable when the intended defendant's name is unknown or when the defendant is not licensed at either the time of the alleged occurrence or at the time notice is given. This requirement also shall be inapplicable to claims unknown to the person when filing the claim or to intended defendants who are identified in the notice by a misnomer. This section permits waiver of this requirement by the court upon the finding of a good faith effort or if the interests of justice dictate.

Subchapter II. Mediation.

Sec. 16-2821. Provides that the Court shall require parties to enter into mediation after filing suit in the DC Superior Court against a healthcare provider when alleging medical malpractice. This section states: that there shall be no discovery, unless otherwise agreed upon by the parties; mediation must take place before any further litigation; requires that the mediation schedule shall be included in the scheduling conference order; and provides that any stay in discovery shall not be more than 30 days past the Initial Scheduling and Settlement Conference (ISSC).

Sec. 16-2822. Provides that, unless otherwise agreed to, the parties will equally share any mediation costs.

Sec. 16-2823. Requires DC Superior Court to assign parties to court-provided mediation and provide a roster of medical malpractice mediators. This section establishes the minimum requirements for a mediator to be eligible for such a roster. Upon agreement by the parties, they can hire an individual outside the roster.

Sec. 16-2824. Defines what parties are required to attend mediation sessions.

Sec. 16-2825. Requires parties to submit confidential mediation statements to the mediator no later than 10 days prior to the initial mediation session. This section details the content required for the mediation statement and clarifies that such statements are intended as a tool for facilitating mediation and shall not be filed with the court.
Sec. 16-2826. States the content required in the mediator's report and requires that such a report be filed with the court no later than 10 days after the mediation has terminated.

Sec. 16-2827. Clarifies that mediation communications shall be confidential. No party is bound to any obligations resulting from mediation unless a settlement is reached. This section provides that mediators cannot be compelled to provide evidence of mediation communication in any subsequent trial.

Subchapter III. Evidence.

Sec. 16-2841. Provides that certain benevolent gestures by the healthcare provider will be inadmissible as an admission of liability. A statement of regret (e.g., saying one is sorry or "I'm sorry it happened") after an event occurred is very different from admitting one made a mistake. But saying one is sorry, "I made a mistake," would still be admissible.

VII. COMMITTEE ACTION

On Friday, April 28, 2006, the Committee on the Judiciary met to consider Bill 16-418, the "Medical Malpractice Reform Act of 2006". The meeting was called to order at 4:17 p.m., and Bill 16-418 was number 5 on the agenda. Chairman Mendelson presented the committee print and report. After opportunity for discussion, Chairman Mendelson moved the committee print and report for a vote with leave for staff to make technical and editorial changes. The committee print and report were approved by unanimous vote of the Committee. (Chairman Mendelson, and Councilmembers Ambrose, Brown, Catania, and Patterson voting aye.)

VIII. ATTACHMENTS

1. Bill 16-418 as introduced.
3. Fiscal impact statement by the Council's Budget Director.
4. Committee Print for Bill 16-418 (only those titles referred to this Committee).
A BILL

16-334

IN THE COUNCIL OF THE DISTRICT OF COLUMBIA

To amend the Risk-Based Capital Act of 1996 to authorize the Commissioner to consider a malpractice insurer's surplus in ratemaking if the surplus is unreasonably large; to amend AN ACT To provide for regulation of certain insurance rates in the District of Columbia, and for other purposes to require prior approval of rate increases exceeding 7%, to authorize refunds to physicians who have paid excessive rates, to enable physicians and consumers to challenge rate increases, and to make rate filings public information; to amend the District of Columbia Health Occupations and Revision Act of 1985 to establish reporting requirements for physicians found liable for medical malpractice and for health care providers who discipline a physician employed by the health care provider, to authorize the Board of Medicine to establish a new physician licensure fee, and to improve the performance of the Board of Medicine by requiring the Mayor to dedicate a minimum number of full-time employees whose sole responsibility shall be to support the Board of Medicine; to require the creation of a centralized database for the collection of information for the analysis of adverse medical events to reduce medical errors and improve health care delivery; to require individuals who intend to file suit alleging medical malpractice to file with potential defendants a 90-day notice of intent to file suit in the District of Columbia Superior Court; to require parties to the suit to engage in mediation early in the litigation process; to make inadmissible as an admission of medical malpractice liability certain benevolent gestures made by the defendant; and to examine all closed liability claims against Obstetricians/Gynecologists in order to identify ways to improve health care delivery and share best practices.

BE IT ENACTED BY THE COUNCIL OF THE DISTRICT OF COLUMBIA, That this act may be cited as the "Medical Malpractice Amendment Act of 2006".

Sec. 2. Section 9 of the Risk-Based Capital Act of 1996, effective April 9, 1997 (D.C. Law 11-233; D.C. Official Code § 31-2008), is amended as follows:

(a) Subsection (c) is amended to read as follows:

"(c) Except as provided in subsection (d) of this subsection, the RBC Instructions, RBC Reports, Adjusted RBC Reports, RBC Plans, and Revised RBC Plans shall not be used by the
Commissioner for ratemaking or considered or introduced as evidence in any rate proceeding.

(b) A new subsection (d) is added to read as follows:

"(d)(1) The Commissioner may determine the total adjusted capital of a medical malpractice insurer to be excessive if:

"(A) The total adjusted capital is greater than the appropriate risk-based capital requirements as determined by the Commissioner for the immediately preceding calendar year; and

"(B) After a hearing, the Commissioner determines that the surplus is unreasonably large.

"(2) If the Commissioner has determined that the total adjusted capital of a medical malpractice insurer is excessive, the Commissioner shall not approve a rate increase sought by the insurer."

Sec. 3. AN ACT To provide for regulation of certain insurance rates in the District of Columbia, and for other purposes, approved May 20, 1968 (62 Stat. 242; D.C. Official Code § 31-2701 et seq.), is amended as follows:

(a) Section 1 (D.C. Official Code §31-2701) is amended by adding a new paragraph to read as follows:

"Medical malpractice insurer" means an insurer licensed to underwrite medical malpractice insurance."

(b) Section 3 (D.C. Official Code § 31-2703) is amended by adding a new subsection (f-1) to read as follows:

"(f-1)(1)(A) Every final rate or premium charge proposed to be used by a medical malpractice insurer shall be filed with the Commissioner and shall be adequate, not excessive,
and not unfairly discriminatory. A medical malpractice rate shall be excessive if the rate is unreasonably high for the insurance provided. In determining whether rates are adequate, not excessive, and not unfairly discriminatory, due consideration shall be given to:

"(i) Past and prospective loss experience within the District;

"(ii) A reasonable margin for underwriting profit and contingencies;

"(iii) Dividends, savings, or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members, or subscribers;

"(iv) Past and prospective expenses in the District;

"(v) All investment income reasonably attributable to medical malpractice insurance in the District.

"(B) If District experience is not credible, the Commissioner may consider experience outside the District. The Commissioner shall promulgate rules setting forth the extent to which and the circumstances under which an insurer may rely on experience outside the District.

"(2) If a medical malpractice insurer wishes to change a rate, it shall file a complete rate application with the Commissioner. A complete rate application shall include all information, including all actuarial data, projections, and assumptions, that the medical malpractice insurer has relied on in calculating its proposed rates. All such information shall be made available when filed in accordance with the Freedom of Information Act.

"(3) The Commissioner shall notify the public of any application by a medical malpractice insurer for a rate change increase. The application shall be deemed approved 60 days after public notice unless the proposed rate change increase exceeds 7%. If the proposed
rate change increase exceeds 7%, the Commissioner shall hold a hearing on the proposed change and shall issue an order approving, denying, or modifying the proposed change within 90 days after public notice of the proposed change. Any person shall have a right to challenge a proposed rate change increase and to participate in the hearing held by the Commissioner. The Commissioner shall promulgate rules governing the participation of the public.

"(4) If the Commissioner finds, after a hearing, that a rate used by a medical malpractice insurer does not comply with this subsection, the Commissioner shall order the insurer to discontinue using the rate and to issue a refund to any policyholder who has paid the rate to the extent that the Commissioner has found it excessive."

(c) Section 4(c) (D.C. Official Code § 31-2704(c)) is amended to read as follows:

"(c)(1) After an investigation of the rates, the Commissioner shall, before ordering an adjustment, hold a hearing upon not less than 10 days' written notice specifying the matters to be considered at the hearing, to every company and rating organization which filed the rates; provided, that the Commissioner shall not be required to hold the hearing if he or she is advised by every such company and rating organization that they do not desire the hearing. The cost of the hearing shall be borne by the insurance company requesting the rate increase. If, after the hearing, the Commissioner determines that any or all of the rates are excessive or inadequate, he or she shall order an adjustment. Pending the investigation and order of the Commissioner, the rates shall be deemed to have been made in accordance with the terms of this act.

"(2)(A) An order of adjustment shall not affect any contract or policy made or issued prior to the effective date of the order unless:

"(i) The adjustment is substantial and exceeds the cost to the companies of making the adjustment; and
"(ii) The order is made after the prescribed investigation and hearing and within 30 days after the filing of rates affected; and

"(B) An order of adjustment shall not affect an existing contract or policy other than:

"(i) A medical malpractice, workmen's compensation, or automobile liability insurance policy required by law, order, rule, or regulation of a public authority; or

"(ii) A contract or policy of any type as to which the rates are not, by general custom of the business or because of rarity and peculiar characteristics, written according to normal classification or rating procedure.”.

Sec. 4. Improved performance by the board of medicine.

(a) The District of Columbia Health Occupations and Revision Act of 1985, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code § 3-1201.01 et seq.), is amended as follows:

(1) Section 203(a)(7) (D.C. Official Code § 3-1202.03(a)(7)) is amended as follows:

(A) Designate the existing text as subparagraph (A).

(B) Add a new subparagraph (B) to read as follows:

"(B) By January 1, 2007, in addition to the executive director, the Mayor shall require, at a minimum, that an investigator, an attorney, and 2 clerical support staff be hired, who shall be full-time employees of the District and whose work shall be limited solely to administering and implementing the orders of the Board in accordance with this act and rules and regulations issued pursuant to this act. The mandatory minimum number of employees hereby established shall not restrict the Mayor's ability to authorize additional staff."
(2) Section 409 (D.C. Official Code § 3-1204.09) is amended by striking the phrase "implement this section." and inserting the phrase "implement this section; except, that the fee for the issuance of a medical license shall be set by the Board of Medicine; provided, that the fee shall be no less than $500 and shall be sufficient to fund the programmatic needs of the Board." in its place.

(3) Add a new section 513a to read as follows:

"Sec. 513a. Physician and health care provider notice requirements, penalty for noncompliance; settlement agreement not a bar to filing a complaint or testifying.

"(a)(1) A physician licensed by the Board shall report to the Board within 60 days of the occurrence of any of the following:

"(A) Notice of a judgment against a physician named in a medical malpractice suit or notice of a confidential settlement of a medical malpractice claim to be paid by a physician, an insurer, or other entity on behalf of the physician; or

"(B) Disciplinary action taken against the physician by a health care licensing authority of another state.

"(2)(A) A health care provider who employs a physician who is licensed in the District of Columbia shall report to the Board any disciplinary action taken against the physician within 10 days of the action being taken. The resignation of a physician that occurs while the physician is being investigated by the health care provider shall also be reported to the Board by the health care provider within 10 days of the resignation.

"(B) The Board shall impose a fine of not more than $2,500 on a health care provider for failure to comply with the provisions of this paragraph.

"(b) Nothing in a confidential settlement agreement shall operate to prevent the
parties to the agreement from filing a complaint with the Board or from testifying in any investigation conducted by the Board."

Sec. 5. Mandatory adverse event reporting.

(a) For the purposes of this section, the term:

(1) "Adverse event" means an event, occurrence, or situation involving the medical care of a patient by a health care provider that results in death or an unanticipated injury to the patient.

(2) "Healthcare provider" means an individual or entity licensed or otherwise authorized under District law to provide healthcare service, including a hospital, health maintenance organization, nursing facility, comprehensive outpatient rehabilitation facility, home health agency, hospice program, renal dialysis facility, ambulatory surgical center, pharmacy, physician or health care practitioner's office, long term care facility, behavior health residential treatment facility, health clinic, clinical laboratory, health center, physician, physician assistant, nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, certified nurse midwife, psychologist, certified social worker, registered dietitian or nutrition professional, physical or occupational therapist, pharmacist, or other individual health care practitioner.

(3) "Medical facility" means a hospital, health maintenance organization, nursing facility, comprehensive outpatient rehabilitation facility, home health agency, hospice program, renal dialysis facility, ambulatory surgical center, pharmacy, physician or health care practitioner's office, long term care facility, behavior health residential treatment facility, health clinic, clinical laboratory or health center.

(4) "Primary health record" means the record of continuing care maintained by a health professional, group practice, or health care facility or agency containing all diagnostic and
therapeutic services rendered to an individual patient by that health professional, group practice,
or health care facility, or agency.

(b) By July 1, 2007, the Mayor shall establish, within the Department of Health, a
centralized system for the collection and analysis of adverse events in the District of Columbia.
(c) The Mayor shall appoint an employee of the Department of Health to administer the
system, whose responsibilities shall include:

(1) Collecting, organizing, and storing data on adverse events occurring at medical
facilities in the District of Columbia;

(2) Tracking, assessing, and analyzing the incoming reports, findings, and
corrective action plans;

(3) Identifying common adverse event patterns or trends;

(4) Recommending methods to reduce systematic adverse events;

(5) Providing technical assistance to healthcare providers and medical facilities on
the development and implementation of patient safety plans to prevent adverse events;

(6) Disseminating information and advising healthcare providers and medical
facilities in the District of Columbia on medical best practices;

(7) Monitoring national trends in best practices and disseminating relevant
information and advice to healthcare providers and medical facilities in the District of Columbia;
and

(8) Publishing an annual report that includes summary data of the number and
types of adverse events of the prior calendar year by type of healthcare providers and medical
facility, rates of change, and other analyses and communicating recommendations to improve
health care delivery in the District of Columbia.
(d)(1) Pursuant to this section, healthcare providers and medical facilities providing services in the District of Columbia shall submit biannual reports, on January 1 and July 1 of each calendar year, on adverse events to the system administrator. Each report shall contain, for each adverse event, the patient's full primary health record; except, that medical information with respect to the patient's identity shall be de-identified and anonymous.

(2) Failure to submit a report as required by this section shall be punishable by a fine of not less than $500 or more than $2,500.

(e)(1) Except as otherwise provided by this section, the files, records, findings, opinions, recommendations, evaluations, and reports of the system administrator, information provided to or obtained by the system administrator, the identity of persons providing information to the system administrator, and reports or information provided pursuant to section 204 shall be confidential, not subject to disclosure pursuant to any other provision of law, and shall be neither discoverable nor admissible into evidence in any civil, criminal, or legislative proceeding; under no circumstances shall the information be disclosed by any person. Nothing in this subsection shall preclude use of reports or information provided under section 204 by a board regulating a health profession or the Mayor in proceedings by the board or the Mayor.

(2) No person who provided information to the system administrator shall be compelled to testify in any civil, criminal, or legislative proceeding with respect to any confidential matter contained in the information provided to the system administrator.

(3) Notwithstanding subsections (a) or (b) of this section, a court may order a system administrator to provide information in a criminal proceeding in which an individual is accused of a felony, if the court determines that disclosure is essential to protect the public interest and that the information being sought can be obtained from no other source.
determining whether disclosure is essential to protect the public interest, the court shall consider the seriousness of the offense with which the individual is charged, the need for disclosure of the party seeking it, and the probative value of the information. If the court orders disclosure, the identity of any patient shall not be disclosed without the consent of the patient or his or her legal representative.

(f) Implementation of this title shall be funded through the licensure fees collected by the Board of Medicine.

Sec. 6. 90 day notice of intent to file suit; early mandated mediation; inadmissibility of benevolent gestures.

(a) Short title.

This section may be cited as the "Medical Malpractice Proceedings Act of 2006".

(b) Title 16 of the District of Columbia Official Code is amended as follows:

(1) The table of contents is amended by adding the phrase "28. Medical Malpractice ...." after the phrase "27. Negligence Causing Death ....".

(2) A new Chapter 28 is added to read as follows:

"Chapter 28

"Medical Malpractice.

"Subchapter I. Generally.

"Section

"16-2801. Definitions.

" 16-2802. Notice of intention to file suit.

" 16-2803. Extension of statute of limitations.

"16-2804. Unknown defendant."
"Subchapter II. Mediation

16-2821. Requirement for mediation.

16-2822. Mediation costs.

16-2823. Mediators.

16-2824. Attendance at mediation session.

16-2825. Mediation statements.

16-2826. Mediator's report.

16-2827. Confidentiality.

"Subchapter III. Evidence.

16-2841. Inadmissibility of benevolent gestures.

"Subchapter I. Generally.

§ 16-2801. Definitions.

"For the purposes of this chapter, the term:

"(1) "Court" means the Superior Court of the District of Columbia.

"(2) "Healthcare provider" means an individual or entity licensed or otherwise authorized under District law to provide healthcare service, including a hospital, health maintenance organization, nursing facility, comprehensive outpatient rehabilitation facility, home health agency, hospice program, renal dialysis facility, ambulatory surgical center, pharmacy, physician or health care practitioner's office, long term care facility, behavior health residential treatment facility, health clinic, birth center, clinical laboratory, health center, physician, physician assistant, nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, certified nurse midwife, psychologist, certified social worker, registered dietitian or nutrition professional, physical or occupational therapist, pharmacist, or other individual health
"§ 16-2802. Notice of intention to file suit.

(a) Any person who intends to file suit in the Superior Court of the District of Columbia alleging medical malpractice against a healthcare provider shall notify the intended defendant of his or her suit no fewer than 90 days prior to filing the suit. Notice may be accomplished by service on an intended defendant's last known address registered with the appropriate licensing authority. Upon a showing of a good faith effort to give the required notice, the court shall have the authority to excuse the failure to give notice within the time prescribed.

(b) The notice required in subsection (a) of this section shall include sufficient information to put the defendant on notice of the legal basis for the claim and the type and extent of the loss sustained, including information regarding the injuries suffered. Nothing herein shall preclude the person giving notice from adding additional theories of liability based upon information obtained in court-conducted discovery or adding injuries or loss which become known at a later time.

(c) No legal action alleging medical malpractice may be commenced in the Superior Court of the District of Columbia unless the requirements of this section have been satisfied.

"§16-2803. Extension of statute of limitations.

If the notice required under § 16-2802 is served within 90 days of the expiration of the applicable statute of limitations, the time for the commencement of the action shall be extended 90 days from the date of the service of the notice.

"§16-2804. Unknown defendant or unlicensed defendant.

The requirements of § 16-2802 are not applicable with respect to any intended defendant whose name is unknown or who was not licensed at the time of the alleged occurrence or is
unlicensed at the time notice is given; or to any claim that is unknown to the person at the time of filing his or her notice or to any intended defendant who is identified in the notice by a misnomer. Nothing indicated herein shall prevent the court from waiving the requirements of section 16-2802 upon a showing of good faith effort to comply or if the interests of justice dictate.

"Subchapter II. Mediation.

"§16-2821. Requirement for mediation.

"After filing a suit in the Superior Court of the District of Columbia against a healthcare provider alleging medical malpractice, the Court shall require the parties to enter into mediation, without discovery or, if all parties agree with only limited discovery that will not interfere with the completion of mediation within 30 days of the Initial Scheduling and Settlement Conference (ISSC), prior to any further litigation in an effort to reach a settlement agreement. The mediation schedule shall be included in the scheduling conference order following the ISSC. In no event shall the stay of discovery be more than 30 days beyond the ISSC, unless all parties agree.

"§ 16-2822. Mediation costs.

Unless otherwise agreed by the parties, the costs of mediation, if any, shall be equally shared by the parties.

"§ 16-2823. Mediators.

"(a) The Court shall assign the parties to court-provided mediation and provide a roster of medical malpractice mediators from which the parties may hire an eligible medical malpractice mediator. In the alternative, all parties can agree to hire another individual outside the roster. To be eligible for inclusion in the roster of medical malpractice mediators, an individual shall be a
judge or lawyer with at least 10 years of significant experience in medical malpractice litigation.

"(b) If the parties cannot agree on the selection of a mediator, the Court shall appoint one.

"§16-2824. Attendance at mediation session.

"(a) For the purposes of this section, the term "a representative with settlement authority" means an individual with control of the financial settlement resources for the case, and the authority to pledge those resources to settle the case on behalf of a party.

"(b) All parties shall personally attend mediation sessions.

"(c) If a party is not a natural person, a representative with settlement authority for the party shall attend the mediation session.

"(d) In cases involving an insurance company, a representative of the company with settlement authority shall attend the mediation session.

"(e) Attorneys representing each party with primary responsibility for the case shall attend the mediation session.

"§ 16-2825. Mediation statements.

"(a) Each party shall submit a confidential mediation statement to the mediator no later than 10 days prior to the initial mediation session. The parties shall not send copies of the mediation statement to the clerk, the assigned judge, or the other parties.

"(b) Unless not already stated in the complaint and answer, the mediation statement shall:

"(1) Include a brief summary of facts;

"(2) Identify the issues of law and fact in dispute and summarize the party's position on those issues;

"(3) Discuss whether there are issues of law or fact the early resolution of which could facilitate early settlement or narrow the scope of the dispute;
"(4) Identify the attorney who will represent the party at the mediation session and the person with settlement authority who will attend the mediation session;

"(5) Include any documents or materials relevant to the case which may assist the mediator and advance the purposes of the mediation session; and

"(6) Present any other matters that may assist the mediator and facilitate the mediation.

"(c) Mediation statements are intended solely to facilitate the mediation and shall not be filed with the court.

"§ 16-2826. Mediator's report.

"(a) A mediator's report shall be filed with the court no later than 10 days after the mediation has terminated, informing the court regarding:

"(1) Attendance;

"(2) Whether a settlement was reached; or

"(3) If a settlement was not reached, any agreements to narrow the scope of the dispute, limit discovery, facilitate future settlement, hold another mediation session, or otherwise reduce the cost and time of trial preparation.

"§ 16-2827. Confidentiality.

"(a) The mediation session is confidential. All proceedings at the mediation, including any statement made by any party, attorney, or other participant, are privileged. They may not be construed as an admission against interest and nothing said at such sessions may be used in court in connection with the case or any other litigation. No party is bound by anything said or done at the mediation unless a settlement is reached.

"(b) A mediator shall not be compelled to provide evidence of a mediation
communication in any subsequent trial.

"Subchapter III. Evidence.

§16-2841. Inadmissibility of benevolent gestures.

"For the purpose of any civil action or administrative proceeding alleging medical malpractice against a healthcare provider, an expression of sympathy or regret made in writing, orally, or by conduct made by or on behalf of the healthcare provider to a victim of the alleged medical malpractice, any member of the victim's family, or any individual who claims damages by or through that victim is inadmissible as an admission of liability. Nothing herein shall preclude the court from permitting the introduction of an admission of liability into evidence."

Sec. 7. Analysis of closed obstetrician/gynecologist claims.

(a) Short title.

This title may be cited as the "Medical Malpractice Analysis of Closed Obstetrician/Gynecologist Claims Act of 2005".

(b) Closed claim analysis.

(1) Within 180 days of the enactment of this title, the Mayor shall submit legislation to the Council for the establishment of a database of closed Obstetrician/Gynecologist malpractice claims reports to be submitted by providers of medical malpractice insurance.

(2) The plan shall:

(A) Contain provisions to identify trends and develop recommendations for preventative action for adverse Obstetrician/Gynecologist events;

(B) Ensure dissemination of best practices among Obstetrician/Gynecologist practitioners and facilities and shall include provisions for ensuring the implementation of these practices; and
(C) Include provisions to study recommendations based on closed Obstetrician/Gynecologist malpractice claims in other jurisdictions.

Sec. 8. Fiscal impact statement.

The Council adopts the fiscal impact statement in the committee report as the fiscal impact statement required by section 602(c)(3) of the District of Columbia Home Rule Act, approved December 24, 1973 (87 Stat. 813; D.C. Official Code § 1-206.02(c)(3)).

Sec. 9. Effective date.

This act shall take effect following approval by the Mayor (or in the event of veto by the Mayor, action by the Council to override the veto), a 30-day period of Congressional review as provided in section 602(c)(1) of the District of Columbia Home Rule Act, approved December 24, 1973 (87 Stat. 813; D.C. Official Code § 1-206.02(c)(1)), and publication in the District of Columbia Register.
**Subject/Short Title:** The "Medical Malpractice Insurance Reform Amendment Act of 2006"

### Part I. Summary of the Fiscal Estimates of the Bill

1. It will impact spending. (If "Yes," complete Section 1 in the Fiscal Estimate Worksheet).
   - a) It will affect local expenditures. (X)
   - b) It will affect federal expenditures. (X)
   - c) It will affect private/other expenditures.
   - d) It will affect intra-District expenditures.

2. It will impact revenue. (If "Yes," complete Section 2 in the Fiscal Estimate Worksheet).
   - a) It will impact local revenue. (X)
   - b) It will impact federal revenue.
   - c) It will impact private/other revenue.
   - d) It will impact intra-District revenue.

3. The bill will have NO or little fiscal impact on spending or revenue. (If "Yes," explain below). (X)

Explanatio or NO fiscal impact:

This legislation would authorize the Commissioner of the Department of Insurance, Securities and Banking to consider an insurer’s surplus in ratemaking decisions for malpractice insurance, require prior approval for malpractice insurance rate increases of 7% or greater, authorize refunds for physicians who have paid excessive insurance rates, enable physicians and consumers to challenge rate increases, and make rate filings public information. The insurer commissio n currently institutes national “best practices” for rate increases, which include a review of the increase to avoid excessiveness, and hearings over certain rate increases prior to the increase taking effect. An increased costs or savings would be borne by or credited to insurers or physicians; no expenditure of District money is required.

### Part II. Other Impact of the Bill

If you check "Yes" for each question, please explain on separate sheet.

1. It will affect an agency and/or agencies in the District. (X)
2. Will there be performance measures/output for this bill? (X)
3. Will it have results/outcome, i.e., what would happen if this bill is enacted or not enacted? (X)
4. Will the budget and Financial Plan be affected by this bill? (X)
5. The bill will have NO performance or outcome impact. (X)

### Sources of Information:

Councilmember: Jim Graham

Staff Person & Tel: Steve Hernandez, 20:1JZ, 8230

Reviewed by Budget Director: (X) Vv

Budget Office Tel: 202-724-8139