NO. 101300-1

SUPREME COURT OF THE STATE OF WASHINGTON

BETTE BENNETT,

Plaintiff-Appellant,

v.

UNITED STATES OF AMERICA,

Defendant-Appellee.

AMICUS CURIAE BRIEF OF STATE OF WASHINGTON

ROBERT W. FERGUSON
Attorney General

SARA CASSIDEY, WSBA 48646
Assistant Attorney General
PO Box 40126
Olympia, WA 98504-0126
(360) 586-6328
Office ID #91023

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Cases

Statutes

Constitutional Provisions

Other Authorities

I. IDENTITY AND INTEREST OF AMICUS CURIAE

This case concerns the validity, under article I, sections 10 and 12 of the Washington constitution, of the statute of repose applicable in medical malpractice claims. Pursuant to RCW 4.16.350(3), any damages action for injury as a result of health care is time-barred eight years from the date of the act or omission alleged to have caused injury, unless the time for commencing the action is tolled by fraud, concealment, or presence of a non-therapeutic or non-diagnostic foreign body. The State of Washington has a significant interest in the decision to be rendered in this case.

First, when a plaintiff seeks to have a statute declared unconstitutional, the Attorney General is entitled to notice of the action and the opportunity to be heard. RCW 7.24.110; *Pepper v. J.J. Welcome Const. Co*., 73 Wn. App. 523, 549, 871 P.2d 601 (1994); *see also* 28 U.S.C. § 2403(b). The Attorney General is entitled to be heard when constitutionality of a state statute is at issue because "[t]he state as a whole is interested in

the validity of [our state statutes], and it is evident that the legislature desired to protect that interest when it provided for service of the proceedings upon the attorney general." *Camp Fin., LLC v. Brazington*, 133 Wn. App. 156, 160-61, 135 P.3d 946 (2006) (quoting *Parr v. City of Seattle*, 197 Wash. 53, 56, 84 P.2d 375 (1938)).

Second, the statute applies to claims against State agencies that provide health care services. These health care providers have an interest in avoiding having to defend against stale claims when witness memories have faded, records may have been lost or destroyed pursuant to record retention schedules, and the standard of care has likely evolved.

Third, the statute – which applies to claims against all health care providers in the State – reflects a legislative policy choice that followed extensive stakeholder negotiations and a wide-ranging compromise reached between then-Governor Christine Gregoire, Insurance Commissioner Mike Kriedler, the Washington State Medical Association, the Washington State

Hospital Association, the Washington State Trial Lawyers Association (WSTLA),[1] the Washington State Bar Association (WSBA), Physicians Insurance, and others. The State has an interest in this Court upholding an important and consistent part of that extensive negotiation and eventual compromise.

Accordingly, the State offers this brief in defense of the constitutionality of the statute of repose in RCW 4.16.350.

II. LEGISLATIVE HISTORY BACKGROUND OF RCW 4.16.350

A. Original Enactment of and Amendments to RCW 4.16.350

In 1971, the Washington Legislature originally enacted the statute at issue here, RCW 4.16.350. Laws of 1971, ch. 80, § 1. At that time, the Legislature did not include a provision of repose. Instead, the statute provided only that professional negligence claims against health care providers "shall be commenced within (1) three years from the date of the alleged

[1] Now known as the Washington State Association for Justice.

wrongful act, or (2) one year from the time that plaintiff discovers the injury or condition was caused by the wrongful act, whichever period of time expires last." *Id.*

Five years later, the Legislature added the repose provision at issue here: "in no event shall an action be commenced more than eight years after said act or omission." Laws of 1975-76, 2nd Ex. Sess., ch. 56, § 1. At that time, the Legislature did not enact any express findings to support adopting the repose provision. This Court, however, has examined the legislative history and explained that the Legislature enacted the provision "in response to a perceived insurance crisis said to result from the discovery rule and from increased medical malpractice claims, which allegedly created problems in calculating and reserving for exposure on long-tail claims." *DeYoung v. Providence Med. Ctr.*, 136 Wn.2d 136, 147, 960 P.2d 919 (1998). "[T]he Legislature intended to protect insurance companies while 'hopefully not result[ing] in too many individuals not getting compensated.'" *Id.* (quoting House Journal, 44th Legis.

Sess. 318 (1976) (comment by Representative Walt O. Knowles)).

Ten years after adding the repose provision, the Legislature added a tolling exception to the statute, such that "the time for commencement of an action is tolled upon proof of fraud, intentional concealment, or the presence of a foreign body not intended to have a therapeutic purpose or effect." Laws of 1986, ch. 305, § 502. The Legislature made additional amendments to the statute over the next two years related to claims of minors and claims based on childhood sexual abuse. Laws of 1987, ch. 212, § 1401; Laws of 1988, ch. 144, § 2.

Ten years after those additional amendments, the Legislature reenacted RCW 4.16.350 and further amended the tolling provision therein. The revised statute became effective in June 1998. Laws of 1998, ch. 147, § 1.

B. Invalidation of Statute of Repose in RCW 4.16.350(3) in *DeYoung v. Providence Medical Center*

In August 1998, two months after the reenacted RCW 4.16.350 became effective, this Court determined the

statute of repose in subsection (3) violated the privileges and immunities clause in article I, section 12 of the Washington constitution. *DeYoung*, 136 Wn.2d at 139. After determining that an independent state constitutional analysis applying a heightened scrutiny standard was not warranted, the Court examined the statute of repose under a rational basis review. *Id.* at 144. While the Court determined that there are reasonable grounds for the tolling and other provisions which excepted a cause of action from the eight-year time-bar, the Court also concluded that the statute of repose did not bear a rational relationship to its purpose of protecting insurers when materials in the legislative record showed the provision could not rationally be thought to have any chance of actuarially stabilizing the insurance industry. *Id.* at 146-48. Further, although the Court agreed that it was conceivable that the Legislature could have enacted the statute to bar stale claims, (which, the Court agreed, would have been an "appropriate aim") it nonetheless held that the "minuscule" number of claims thought to be barred by the

statue of repose rendered the relationship between the classification and a broad goal of eliminating stale claims too attenuated to survive rational basis review. *Id.* at 150.

C. Reenactment of RCW 4.16.350(3) after Invalidation

In 2005, seven years after this Court struck down the statute of repose, the people of Washington submitted to the Legislature two Initiatives – 330 and 336 – that broadly addressed Washington's health care liability system. App. 4.[2] Whereas I-330 proposed changes to the civil liability system as applied to medical negligence cases, I-336 proposed changes to the medical malpractice insurance system, the health care system's handling of negligence and unanticipated outcomes, and some aspects of the health care liability system. App. 4-5.

---

[2] The State's Appendix includes excerpts of the legislative history and archived legislative files pertaining to Laws of 2006, ch. 8, which reenacted RCW 4.16.350(3). The State asks this Court, in determining the constitutionality of the statute of repose in RCW 4.16.350(3), to take judicial notice of that legislative history. *See DeYoung*, 136 Wn.2d at 147-49 (discussing legislative history of former RCW 4.16.350(3) in analyzing its constitutionality); *Wyman v. Wallace*, 94 Wn.2d 99, 102-03, 615 P.2d 452 (1980) (discussing judicial notice of legislative facts).

In response, the Legislature undertook to propose an alternative to both I-330 and I-336. App. 8. That alternative act, set forth in House Bill (H.B.) 2292 and its companion Senate Bill (S.B.) 6087, addressed patient safety, insurance industry reform, and health care liability reform. App. 8. Under the bill, "[t]he eight-year statute of repose is re-established. Legislative intent and findings regarding the justification for a statute of repose are provided in response to the Washington Supreme Court's decision overturning the statute of repose in *DeYoung v. Providence Medical Center*." App. 22; *see also* H.B. 2292 §§ 301-02 (2005). Specifically, the Legislature expressly stated its purpose to "set[] an outer limit to the operation of the discovery rule," and minimize the defendants compelled to answer stale claims as defined by that limit, "however few." H.B. 2292 § 301.

Other provisions in the bill aimed at health care liability reform included limiting the number of expert witnesses, requiring a certificate of merit, providing for voluntary arbitration, and lifting the restriction on evidence of collateral

source payments. App. 22-24. H.B. 2292, however, left out some of the provisions included in I-330 and I-336, such as limitations on noneconomic damages, limitations on contingent attorney fees, requirements of prior notice before filing suit, a mandatory mediation requirement, and elimination of joint and several liability. App. 16-19.

Numerous stakeholders participated in the initial public hearing on H.B. 2292, held on March 22, 2005, before a joint session of the House and Senate Judiciary, House Health Care, and Senate Health and Long Term Care Committees. App. 31-58. These stakeholders included representatives from the WSBA, the Superior Court Judges Association, the plaintiff and defense bars, medical and hospital associations, Providence Health Care System, insurers, and Insurance Commissioner Kreidler, among many others. App. 31-58. During the hearing, while no testimony outright opposed the re-establishment of a statute of repose, some testimony from the WSBA and Washington State Medical Association noted an uneasiness with doing so. *See* App. 25-29;

Joint Public Hearing, House and Senate Judiciary, House Health Care, and Senate Health & Long Term Care Committees at 0:55:37 and 1:21:35 (Mar. 22, 2005) (Mark Johnson, WSBA Chair of Board of Governors' Legislative Committee, testified that it would be "difficult" for the WSBA to support those provisions that might have already been declared unconstitutional by the Washington Supreme Court; Cliff Webster, Washington State Medical Association, testified that the association believed that reenacting the eight year statute of repose, which he stated the Supreme Court struck down as too long, would suffer the same result when eventually challenged again unless it was shortened), https://www.tvw.org/watch/?eventID=2005031173.

On April 8, 2005, the House passed Substitute House Bill (S.H.B.) 2292, which left the statute of repose provision and supporting legislative findings unchanged, and sent it to the Senate. *See* S.H.B. 2292 §§ 301-02 (2005). Ultimately, on April 24, 2005, the Senate returned S.H.B. 2292 to the House by

resolution. *See* Wash. St. Legis., Bill Information, H.B. 2292, *available at* https://app.leg.wa.gov/billsummary?BillNumber=2292&Chamber=House&Year=2005 (last visited May 3, 2023).[3]

Because the Legislature was unable to pass S.H.B. 2292 during session in 2005, both I-330 and I-336 were submitted to the people in the November 2005 general election without a legislative alternative. App. 76. Both initiatives failed. *Id.*

In 2006, the Legislature returned to its work on S.H.B. 2292. At the public hearing held before the Senate Health and Long-Term Care Committee on February 20, 2006, Governor Gregoire testified in favor of a striking amendment to what was, by then, Second Substitute House Bill (2S.H.B.) 2292. App. 104; Public Hearing, Senate Health & Long-Term Care Committee, at 09:37 (Feb. 20, 2006), *available at* https://www.tvw.org/watch/?eventID=2006021126. Governor

[3] SB 6087, the companion bill, never came to a vote in the Legislature. *See* Wash. St. Legis., Bill Information, S.B. 6087, *available at* https://app.leg.wa.gov/billsummary?BillNumber=6087&Chamber=Senate&Year=2005 (last visited May 3, 2023).

Gregoire explained that representatives from WSTLA, the State hospital and medical associations, Physicians Insurance, WSBA, and her office had come together over several weeks and divided up negotiations as to the three aspects of the bill. *Id.* The Governor and Secretary of Health Mary Selecky had negotiated the patient safety and civil reform aspects of the bill, while Insurance Commissioner Kriedler separately negotiated the insurance reform aspect of the bill. *Id.* Governor Gregoire noted the good faith negotiations had resulted in a better, complete bill, but that not everything that everyone at the negotiating table wanted made it into the bill. *Id.* Governor Gregoire stated that the various stakeholders were united in support of the striker amendment and urged its adoption. *Id.*

Two days after the hearing, the committee did as urged by the Governor and passed the bill, as amended by the striker, out of committee. *See* Wash. St. Legis., Bill Information, H.B. 2292. The Senate then unanimously passed 2S.H.B. 2292; it passed the House by a vote of 82-15. *Id.* Throughout those legislative

proceedings, the statute of repose and its legislative findings remained unchanged. *See* Laws of 2006, ch. 8, §§ 301-02.

The final law included an extensive, general legislative findings and intent section that provided, in relevant part:

> The legislature finds that access to safe, affordable health care is one of the most important issues facing the citizens of Washington state. The legislature further finds that the rising cost of medical malpractice insurance has caused some physicians, particularly those in high-risk specialties such as obstetrics and emergency room practice, to be unavailable when and where the citizens need them the most. *The answers to these problems are varied and complex, requiring comprehensive solutions that encourage patient safety practices, increase oversight of medical malpractice insurance, and making the civil justice system more understandable, fair, and efficient for all the participants.*

Laws of 2006, ch. 8, § 1 (emphasis added). The separate and more specific purpose, findings, and intent section relating to the statute of repose, directly responded to this Court's holding in *DeYoung*:

> The purpose of this section and section 302, chapter 8, Laws of 2006 is to respond to the court's decision in *DeYoung v. Providence Medical Center*, 136

Wn.2d 136 (1998), by expressly stating the legislature's rationale for the eight-year statute of repose in RCW 4.16.350.

The legislature recognizes that the eight-year statute of repose alone may not solve the crisis in the medical insurance industry. However, to the extent that the eight-year statute of repose has an effect on medical malpractice insurance, that effect will tend to reduce rather than increase the cost of malpractice insurance.

Whether or not the statute of repose has the actual effect of reducing insurance costs, the legislature finds it will provide protection against claims, *however few*, that are stale, based on untrustworthy evidence, or that place undue burdens on defendants.

In accordance with the court's opinion in *DeYoung*, the legislature further finds that *compelling even one defendant to answer a stale claim is a substantial wrong, and setting an outer limit to the operation of the discovery rule* is an appropriate aim.

The legislature further finds that an eight-year statute of repose is a reasonable time period in light of the need to balance the interests of injured plaintiffs and the health care industry.

The legislature intends to reenact RCW 4.16.350 with respect to the eight-year statute of repose and specifically set forth for the court the legislature's legitimate rationale for adopting the

> eight-year statute of repose. The legislature further intends that the eight-year statute of repose reenacted by section 302, chapter 8, Laws of 2006 be applied to actions commenced on or after June 7, 2006.

Laws of 2006, ch. 8, § 301 (underlining and italics added).

Throughout the negotiations in 2006, the re-enactment of the statute of repose as supported by those new and express legislative findings, simply was not a controversial piece of the comprehensive legislation under consideration. Other provisions in the act – like protection of apologies, collateral sources, provider discipline, closed claim reporting, adverse event reporting, and voluntary binding arbitration – were. *See* App. 107 (written testimony of Randy Revelle, WSHA Senior Vice President, Feb. 20, 2006).

III. ARGUMENT

Before this Court are two certified questions concerning the facial constitutional validity of RCW 4.16.350(3):

> (1) Does RCW 4.16.350 violate the privileges and immunities clause of the Washington State Constitution, art. 1, sec. 12?

> (2) Does RCW 4.16.350 unconstitutionally restrict a plaintiff's right to access the court in violation of the Washington State Constitution, art. 1, sec. 10?

Order Certifying Questions to the Washington Supreme Court at 2 (Sept. 19, 2022). The answer to both questions should be "no."

This Court reviews constitutional questions and issues involving statutory interpretation de novo. *Davison v. State*, 196 Wn.2d 285, 293, 466 P.3d 231 (2020). In ascertaining and declaring whether legislation is in accordance with, or in contravention of, the provisions of the state constitution, this Court accords a "heavy presumption of constitutionality" to "a legislative act." *Id.* (quoting *Aetna Life Ins. Co. v. Washington Life & Disability Ins. Guaranty Ass'n*, 83 Wn.2d 523, 527, 520 P.2d 162 (1974)). The burden is on the party challenging the statute – here, Bennett – to prove its unconstitutionality "beyond a reasonable doubt." *Island County v. State*, 135 Wn.2d 141, 146, 955 P.2d 377 (1998).

Bennett has not met that heavy burden to show that the statute of repose in RCW 4.16.350(3) is unconstitutional beyond a reasonable doubt under either article I, section 10 or 12 of the Washington constitution. Accordingly, this Court should respect the legislative compromise contained in 2S.H.B. 2292 and refuse to invalidate the statute of repose applicable to medical malpractice actions under either of those constitutional provisions.

A. RCW 4.16.350(3) Does Not Violate the Right of Access to Courts (Answer to Question 2)

Contrary to Bennett's argument before this Court, the statute of repose in RCW 4.16.350(3) does not infringe on her article I, section 10 right of access to courts in her suit against the United States. *See* Petitioner's Opening Br. at 29-37; Reply Br. at 25-26.

First, while there is a constitutional right of access to courts, that right logically exists only where there is a right to a remedy. Where there is no right to a remedy, the right to access courts cannot be implicated.

Second, the Washington constitution "contains no such provision" guaranteeing a remedy or directly limiting the power of the Legislature to abolish rights of action for injury to person, property, or reputation. *Shea v. Olson*, 185 Wash. 143, 160-61, 53 P.2d 615 (1936) (comparing the constitution of Washington to Oregon Constitution, article I, § 10; Delaware Constitution, article I, § 9; Kentucky Constitution, §§ 14, 54, 241; and Connecticut Constitution article I, § 12).

Article I, section 10, of the Washington constitution provides that "[j]ustice in all cases shall be administered openly, and without unnecessary delay." Const. art I, § 10. This Court has recognized that constitutional provision as guaranteeing only open and accessible court proceedings, a public trial, and discovery – *not* a remedy for every wrong. *See State v. Easterling*, 157 Wn.2d 167, 174, 137 P.3d 825 (2006) (the right to open and accessible court proceedings); *Dreiling v. Jain*, 151 Wn.2d 900, 908, 93 P.3d 861 (2004) (the right to a public trial); *Doe v. Puget Sound Blood Center*, 117

Wn.2d 772, 780, 819 P2d 370 (1991) (the concomitant right of discovery).

Indeed, in *1519-1525 Lakeview Blvd. Condo. Ass'n v. Apartment Sales Corp.*, this Court cited to *Shea* and noted that it "had previously held that the state constitution does not contain any guaranty that there shall be a remedy through the courts for every legal injury suffered by a plaintiff." 144 Wn.2d 570, 581, 29 P.3d 1249 (2001). The Court then declined to further determine whether a right to a remedy is contained in article I, section 10. *Id.*

Bennett now essentially invites this Court to find such a guarantee in article I, section 10. *See, e.g.*, Opening Br. at 14 (arguing that article I, section 10 "provides substantive protection for an individual's access to courts" and that "the Legislature may not impose insurmountable obstacles to . . . pursuit of a common law tort"). This Court should decline that invitation.

At Washington's constitutional convention in 1889, the following language for what became article I, section 10 was proposed: "**Section 8.** No court shall be secret but justice shall be administered, openly and without purchase, completely and without delay, *and every person shall have remedy by due course of law for injury done him in his person, property, or reputation.*" The Journal of the Washington State Constitutional Convention 1889 at 51, 499 (B.P. Rosenow ed. 1999) (emphasis added).[4] The framers of the constitution specifically rejected the italicized language, which forms the basis of constitutional remedy provisions in other states. *Cf., e.g.,* Or. Const. art. I, § 10. This Court should not now read that rejected language back into the constitution. *See Washington Water Jet Workers Ass'n v. Yarbrough*, 151 Wn.2d 470, 477, 90 P.3d 42 (2004) (this Court may examine historical context of constitutional provisions for

[4] Journal at 51 is available at https://lib.law.uw.edu/waconst/sources/RosenowJournalJuly4-11.pdf; *Id.* at 499 is available at https://lib.law.uw.edu/waconst/sources/RosenowAnalyticPreamble-ArtII.pdf.

guidance); *State ex rel. Gallwey v. Grimm*, 146 Wn.2d 445, 464-65, 48 P.3d 274 (2002) (considering language rejected by the constitutional convention in determining higher education institutions were not "schools" under article IX, section 4).

Further, even in jurisdictions such as Oregon where there is an express remedy clause, the legislature still has the authority "to adjust, within constitutional limits, the duties and remedies that one person owes another." *See Horton v. Or. Health & Science Univ.*, 359 Or. 168, 224, 376 P.3d 998 (2016). The Oregon Supreme Court in *Horton* undertook an in-depth review of the history and precedent developed under such constitutional remedy clauses throughout the various States. *Id.* at 198-221. Thereafter, the Court identified three principles in its remedy clause jurisprudence that are instructive here.

First, when the legislature has denied *any* remedy to a person injured as a result of the breach of a duty, such a *complete denial* of a remedy violates the remedy clause. *Id.* at 219. Second, the reasons for the legislature's actions can matter. *Id.* And when

the legislature has adjusted a person's rights and remedies as part of a larger statutory scheme extending benefits to some while limiting benefits to others, courts have considered that quid pro quo in determining whether the reduced benefit that the legislature has provided an individual plaintiff is "substantial" in light of the overall statutory scheme so as to comply with the constitutional right to a remedy. *Id.* Third, when the legislature modifies common-law duties and, on occasion, eliminates common-law causes of action where the premises underlying those duties and causes of action have changed, the constitutionality of the legislature's action depends on the reason for the legislative change measured against the extent to which the legislature has departed from the common law. *Id.*

Accordingly, in *Horton*, the Oregon Supreme Court upheld Oregon's statutory damages limits on the tort liability of the state and its employees under Oregon's remedy clause because, in part, the legislature had established a quid pro quo that balanced Oregon's constitutionally recognized interest in

sovereign immunity with the need to indemnify its employees for liability incurred in carrying out state functions. *Id.* at 222-23.

In addition, when examining statutes of repose against Oregon's remedy clause, the Oregon Supreme Court has "considered and rejected the contention that application of a statutory period of ultimate repose before a claim becomes actionable violates the remedy clause of Article I, section 10." *Cannon v. Oregon Dep't of Just.*, 288 Or. App. 793, 800-01, 407 P.3d 883 (2017) (citing *Josephs v. Burns & Bear*, 260 Or. 493, 502, 491 P.2d 203 (1971) (holding that "a statute which purports to extinguish a remedy before the legally protected right becomes actionable" does not violate Article I, section 10)). This Court has previous adopted the view of the Oregon Supreme Court, expressed in *Josephs*, that "'[i]t has always been considered a proper function of legislatures to limit the availability of causes of action by the use of statutes of limitation so long as it is done for the purpose of protecting a recognized public interest.'"

1519-1525 Lakeview Blvd. Condo. Ass'n, 144 Wn.2d at 582 (quoting *Josephs*, 260 Or. at 503).

Here, even if article I, section 10 does encompass a right to a remedy, the eight–year statute of repose in RCW 4.16.350(3) on medical malpractice suits does not violate that right. The 2006 Washington Legislature engaged in extensive negotiations to balance the competing interests of numerous stakeholders with regard to a multitude of proposed civil liability reforms applicable to claims of medical malpractice. *See supra* Part II.C. The reenactment of the statute of repose in RCW 4.16.350(3) was an integral part of the elaborate compromise enacted as 2S.H.B. 2292. The resulting comprehensive scheme affords individuals injured by medical negligence a remedy, but, as found by the legislature, the "eight-year statute of repose is a reasonable time period in light of the need to balance the interests of injured plaintiffs and the health care industry." Laws of 2006, ch. 8, § 301. Such action by the Legislature should not be found offensive to article I, section 10.

Moreover, the statute of repose in RCW 4.16.350(3) comports with the law under Washington's article I, section 10 as it currently exists. Where a statute "unduly burdens" the right of access to courts, it violates article I, section 10. *Putman v. Wenatchee Valley Medical Center, P.S*, 166 Wn.2d 974, 977-78, 985, 216 P.3d 374 (2009). Most recently, in *Martin v. Washington State Department of Corrections*, this Court reaffirmed that, under the federal and state constitutions, accessing the courts "constitutes [t]he very essence of civil liberty and the bedrock foundation upon which rest all the people's rights and obligations." 199 Wn.2d 557, 564, 510 P.3d 321 (2022) (internal citations and quotation marks omitted). This Court additionally reaffirmed that, part of the right to access of the courts, is the right to discovery as authorized in the civil rules. *Id.* Thus, the *Martin* Court, relying on *Putman*, determined that the certificate of merit in RCW 7.70.150, which was part of the 2006 compromise in 2S.H.B. 2292, violated the right of access to courts regardless of whether the defendant is a private entity

or a public one, because the statute could require a plaintiff to obtain evidence otherwise unavailable prior to discovery. *Id.* at 564, 568.

As the United States points out, however, a litigant's right to civil discovery once in court is to be distinguished from the right to an unlimited discovery rule for purposes of claim accrual. *See* Answering Br. of United States at 62. Accordingly, neither *Martin* nor *Putman* on which it was based, controls in this case.

Finally, the article I, section 10 inquiry into an "undue burden" indicates a problem in proportionality. *See State v. Paulson*, 131 Wn. App. 579, 586, 128 P.3d 133 (2006) ("'Undue' means: 'Excessive or unwarranted.'" (Quoting *Black's Law Dictionary* 1563 (8th ed. 16 2004))); CR 26(c) (protective order from discovery may be based on showing an "undue burden"). As Justice Stephens has explained, "we must not be tempted to embrace an interpretation of a fundamental principle such as access to courts without some sense of proportionality and purpose, lest this constitutional right be made to carry the seeds

of its own destruction." Debra Stephens, *The Once and Future Promise of Access to Justice in Washington's Article I, Section 10*, 91 WASH. L. REV. ONLINE 41, 56 (2016) (footnote omitted).

Acceptance of Bennett's argument that the statute of repose in RCW 4.16.350(3) violates article I, section 10 would call into question any number of statutes of limitations and repose enacted by the Legislature, which do not incorporate a discovery of claim provision. Ostensibly, this would mean overruling *1519-1525 Lakeview Blvd. Condo. Ass'n*, which upheld the repose and limitation provisions in RCW 4.16.310 under article I, section 10. *See* 144 Wn.2d at 582. There is no reason for this Court to reconsider its sound reasoning and decision in that case, nor do principles of stare decisis support doing so. *See W.H. v. Olympia Sch. Dist.*, 195 Wn.2d 779, 787, 465 P.3d 322 (2020) (discussing stare decisis principles). Rather, this Court should follow the reasoning in *1519-1525 Lakeview Blvd. Condo. Ass'n*, and uphold the statute of repose in RCW 4.16.350(3).

For all these reasons, this Court should conclude that the statute of repose in RCW 4.16.350(3) has not been shown "beyond a reasonable doubt" to violate article I, section 10 of the Washington constitution. *See Island County*, 135 Wn.2d at 146.

B. RCW 4.16.350(3) Does Not Violate the Privileges and Immunities Clause in Article I, Section 12 (Answer to Question 1)

The State joins in the arguments advanced by the United States as to the constitutionality of RCW 4.16.350(3) under the privileges and immunities clause of article I, section 12 of the Washington constitution. *See* Answering Br. of United States at 19-60. For those reasons, this Court should determine that the eight-year statute of repose does not confer a privilege or immunity implicating a fundamental right so as to be subject to reasonable grounds, as opposed to rational basis, review. *See Woods v. Seattle's Union Gospel Mission*, 197 Wn.2d 231, 481 P.3d 1060 (2021) (discussing two-pronged test under article I, section 12). In addition, whether analyzed under rational basis review or the more exacting reasonable grounds test, the statute

of repose passes constitutional muster given (1) the new and express legislative findings supporting the statute's reenactment in 2006, and (2) that this very case is evidence, not speculation, that the statute's application would achieve the legislative goal of barring stale claims. *Compare Martinez-Cuevas v. DeRuyter Bros. Dairy, Inc.*, 196 Wn.2d 506, 523, 475 P.3d 164 (2020) (discussing reasonable ground test under which a court will not hypothesize facts to justify a legislative distinction), *with DeYoung*, 136 Wn.2d at 148 (explaining that the rational basis standard may be satisfied where the legislative choice is based on rational speculation unsupported by evidence or empirical data).

IV. CONCLUSION

For all the forgoing reasons, as well as those provided by the United States, this Court should answer both certified questions "no."

This document contains 4,887 words, excluding the parts of the document exempted from the word count by RAP 18.17.

RESPECTFULLY SUBMITTED this 5th day of May, 2023.

ROBERT W. FERGUSON
Attorney General

s/ Sara Cassidey
SARA CASSIDEY, WSBA 48646
Assistant Attorney General
PO Box 40126
Olympia, WA 98504-0126
(360) 586-6328
Office ID #91023

CERTIFICATE OF SERVICE

I certify that on the date below I electronically filed the AMICUS CURIAE BRIEF OF THE STATE OF WASHINGTON with the Clerk of the Court using the electronic filing system which caused it to be served on the following electronic filing system participants as follows:

Darrin E. Bailey
BAILEY ONSAGER PC
600 University St., Ste. 1020
Seattle, WA 98101
dbailey@baileyonsager.com
Counsel for Plaintiff

Kristen R. Vogel
Teal L. Miller
US Attorney's Office
700 Stewart St., Ste. 5220
Seattle, WA 98101-1271
kristen.vogel@usdoj.com
teal.miller@usdoj.gov
Counsel for Defendant

Christine L. Stanley
2001 E. Madison Street
Seattle, WA 98122
Christine.Stanley@ppgnhaik.org
Counsel for Amicus Curiae Planned Parenthood Great Northwest, Hawai`i, Alaska, Indiana, and Kentucky

Gregory M. Miller
Carney Badley Spellman, P.S.
701 Fifth Ave., Ste. 3600
Seattle, WA 98104
miller@carneylaw.com
Counsel for Amicus Curiae Planned Parenthood Great Northwest, Hawai`i, Alaska, Indiana, and Kentucky

I certify under penalty of perjury under the laws of the State of Washington that the foregoing is true and correct.

EXECUTED this 5th day of May, at Olympia, Washington.

s/ Beverly Cox
BEVERLY COX
Paralegla

APPENDIX

APPENDIX
TABLE OF CONTENTS

11	Written Testimony in Support of SHB 2292, Randy Revelle (Feb. 20, 2006) (*Senate archive file – note, no other written testimony from this date in file)*	106-107
12	Senate Committee Services, Chart of Constituent Positions Regarding SHB 2292 (Feb. 20, 2006) (*Senate archive file*)	108-113
13	Final Bill Report on 2SHB 2292, 59th Leg., Reg. Sess. (Wash. 2006)	114-123

Exhibit 1

Analysis of HB 2292 & Companion SB 6087, 59th Leg., Reg. Sess.
(Wash. 2005)

Washington State
House of Representatives
Office of Program Research

BILL ANALYSIS

Judiciary Committee

HB 2292 & SB 6087

Title: An act relating to improving health care by increasing patient safety, reducing medical errors, reforming medical malpractice insurance, and resolving medical malpractice claims fairly without imposing mandatory limits on damage awards or fees.

Brief Description: Addressing health care liability reform.

Sponsors: Representatives Lantz, Cody, Campbell, Kirby, Flannigan, Williams, Linville, Springer, Clibborn, Wood, Fromhold, Morrell, Hunt, Moeller, Green, Kilmer, Conway, O'Brien, Sells, Kenney, Kessler, Chase, Upthegrove, Ormsby, Lovick, McCoy and Santos.

Brief Summary of Bill

- Proposes an alternative measure to both Initiatives 330 and 336 that deals with changes in health care system practices and discipline, the medical liability insurance industry, and the health care liability system.

Hearing Date: 3/22/05

Staff: Edie Adams (786-7180).

Background:

The Washington Constitution gives the people the power to legislate through the initiative process, either by initiative directly to the people or by initiative to the Legislature. Under the Constitution, the Legislature may deal with an initiative to the Legislature in one of the following ways: (1) enact the initiative during the regular session; (2) reject the initiative or take no action on it, in which case the measure is submitted to a vote of the people at the next general election; or (3) reject or take no action on the measure and propose a different measure dealing with the same subject, in which case both the initiative and the legislative alternative are submitted to a vote of the people.

The people have submitted two initiatives to the Legislature, Initiatives 330 and 336, which both deal broadly with the health care liability system. Initiative 330 proposes changes to the civil liability system as applied to medical negligence cases. Initiative 336 proposes changes to the

medical malpractice insurance system, the health care system's handling of negligence and unanticipated outcomes, and some aspects of the health care liability system.

INITIATIVE 330

Limitations on Non-Economic Damages: A $350,000 cap on a claimant's non-economic damages award is established, regardless of the number of health care professionals or health care institutions or entities involved. An additional $350,000 award for non-economic damages is allowed against a health care institution that is liable for acts of persons other than health care professionals, up to a maximum of $700,000 combined for all institutions.

If the limitation on non-economic damages is ruled unconstitutional, it will take effect after a state constitutional amendment is passed that empowers the Legislature to place limits on non-economic damages in civil actions or after passage of a federal law allowing such limitations.

Attorneys' Contingency Fees: An attorneys' contingency fee for handling a medical negligence case is limited to no more than: 40 percent of the first $50,000 recovered; 33.33 percent of the next $50,000; 25 percent of the next $500,000; and 15 percent of any amount in which the recovery exceeds $600,000. These limits apply to recoveries received in any manner, including by judgment, settlement, or alternative dispute resolution.

Prior Notice and Mandatory Mediation: A plaintiff in a medical negligence action must provide a defendant with 90-days prior notice of the intention to file a lawsuit. All medical negligence actions are subject to mandatory mediation without exception, unless the action is subject to binding arbitration.

Statute of Limitations: A medical negligence action must be commenced within the *earlier* of three years from the act or omission, or one year from the time the patient discovered or reasonably should have discovered that the injury was caused by the act or omission. An action may be brought after the three year statute of limitations period only under the following circumstances:

- for fraud, intentional concealment, or a foreign item left in the body -- the patient has one year from actual discovery;
- if a minor patient's parent or guardian and the defendant colluded in failing to bring an action -- the patient has one year from actual knowledge of the collusion, or one year from the minor's 18th birthday, whichever is longer;
- for an injured minor under the age of 6 -- the minor must commence the action within three years, or prior to the minor's 8th birthday, whichever is longer.

Tolling of the statute of limitations for minority, incompetency, disability, or imprisonment is eliminated.

Collateral Sources: Evidence of any collateral source payment made or to be made in the future may be introduced into evidence. The party receiving the collateral payments may present evidence of amounts paid to secure the right to the compensation. The ability of the plaintiff to

show an obligation to repay the collateral source payment is removed. Rights of subrogation or reimbursement from a plaintiff's tort judgment are prohibited unless required under superseding federal law.

Arbitration Clauses: A binding arbitration clause in a health care services contract must be the first provision of the contract and must be expressed in language provided in the act. A disclosure concerning binding arbitration must be provided in bold type immediately preceding the signature line in the contract. A binding arbitration clause that complies with these requirements is declared not to be a contract of adhesion, unconscionable or otherwise improper.

Periodic Payment of Damages: An award of future economic and non-economic damages of $50,000 or more must be paid by periodic payments at the request of any party. A judgment debtor who is not adequately insured must post security adequate to satisfy the judgment. The periodic payment judgment may be modified upon the death of the judgment creditor to eliminate payments for future medical treatment, care or custody, loss of bodily function, or pain and suffering. Money damages for loss of future earnings may not be reduced or terminated upon the judgment creditor's death, but must be paid to persons to whom the judgment creditor owed a duty of support.

If the debtor has a continuing pattern of failing to make payments, the court must find the debtor in contempt of court and order the debtor to pay damages suffered as a result of the failure to make timely payments, including court costs and attorneys' fees.

Ostensible Agency: A hospital is not vicariously liable for the negligence of a health care provider who is granted privileges to provide care at the hospital unless the provider is an agent or employee of the hospital and was acting within the course and scope of the provider's agency or employment with the hospital. A health care provider is not vicariously liable for the negligence of another provider unless the other provider is an actual agent or employee acting under the provider's direct supervision and control.

Vulnerable Adults: In civil actions involving abuse, exploitation, or neglect of a vulnerable adult being cared for in a facility or by a home health, hospice, or home care agency, the ability of a prevailing plaintiff to recover reasonable attorneys' fees and expert costs is removed.

Joint and Several Liability: Joint and several liability is eliminated in medical negligence actions, and each defendant is responsible for only his or her proportionate share of the damages, except where the defendants acted in concert or one party acted as the agent or under the direct supervision and control of another party.

INITIATIVE 336

Malpractice Insurance Rate Notification: The Office of the Insurance Commissioner (Commissioner) must notify the public of any medical malpractice insurance rate filing where the rate change is less than 15 percent, and any consumer may request a public hearing on the rate filing. The Commissioner must order a public hearing on a rate filing of 15 percent or more. Rate filings are not effective until approved by the Commissioner after the public hearing. If no public hearing was held on the rate filing, the filing is approved 45 days after public notice.

Supplemental Malpractice Insurance Program: A supplemental malpractice insurance program is established to provide excess liability coverage to health care facilities and providers who either self-insure or purchase liability insurance in amounts equal to specified retained limit requirements. The program will pay claims and related defense costs in excess of the retained limits up to the policy limits of the program. The program is operated by an appointed board and is funded by annual premiums and potential capital calls.

Claims Reporting: Insuring entities and self-insurers must report monthly to the Commissioner any medical malpractice claim that resulted in a final judgment, settlement, or disposition with no indemnity payment. Facilities and providers must report the claim if the insurer does not. Insurers who fail to report are subject to a fine of $250 per case up to a maximum of $10,000. Facilities and providers who fail to report are subject to a fine or disciplinary action by the Department of Health (Department).

The Commissioner must use the data to prepare aggregate statistical summaries and an annual report summarizing and analyzing the data for trends in the types, frequency, and severity of claims and the status of the medical malpractice market.

Health Care Provider Discipline: The Department must investigate a health care professional who has three paid claims within the most recent five-year period where the indemnity payment for each claim was $50,000 or more.

A person who has committed three incidents of medical malpractice, found through final court judgments, can't be licensed or continue to be licensed to practice medicine. Mitigating circumstances may be found where there is a strong potential for rehabilitation or for remedial education or training that will prevent future harm to the public.

Medical Quality Assurance Commission (MQAC): The public membership component of the MQAC is increased from four to six members, and at least two of the public members must be representatives of patient advocacy groups.

Patient Disclosure: A health care provider's failure to disclose the provider's experience with a treatment at the patient's request is a violation of the duty to secure informed consent.

Upon written request of a patient or immediate family member of a disabled or deceased patient, a health care facility or provider must make available for examination and copying any records made or received by the facility or provider relating to any adverse medical incident. The identity of a patient and any information protected by privacy restrictions under federal law may not be disclosed in providing the access. "Adverse incident" means negligence, intentional misconduct, and any other act or omission that caused or could have caused injury or death to a patient.

Court Reports of Settlements or Verdicts: The court clerk must report to the Department any medical malpractice action verdict or settlement that exceeds $100,000.

Expert Limits: In a medical malpractice action, each side is entitled to only two experts on an

issue except on a showing of necessity. If there are multiple parties on a side who are unable to agree on the experts, the court may allow additional experts on an issue to be called upon a showing of necessity.

Attorney Certification and Certificate of Merit: An attorney who files an action, counterclaim, cross claim, or a defense certifies by his or her signature and filing that, to the best of the attorney's knowledge and belief formed after reasonable inquiry, it is not frivolous. A violation is punishable by sanctions, which may include costs and reasonable attorneys' fees incurred by the other party in response to the frivolous claim, counterclaim, cross claim, or defense.

Within 120 days after filing suit, an attorney or plaintiff must file a certificate of merit that states that a qualified expert has been consulted and the expert believes that it is more probable than not that the claim satisfies a basis for recovery.

Summary of Bill:

The Legislature finds that addressing the issues of consumer access to health care and the increasing costs of medical malpractice insurance requires comprehensive solutions that encourage patient safety, increase oversight of medical malpractice insurance, and make the civil justice system more understandable, fair, and efficient. The Legislature finds that neither Initiative 330 nor Initiative 336 offer the necessary comprehensive solution to these problems.

The Legislature proposes this act as an alternative to both Initiatives 330 and 336. The act contains a variety of changes designated under the following headings: Patient Safety; Insurance Industry Reform, and Health Care Liability Reform.

PATIENT SAFETY

Statements of Apology: In a medical negligence action, a statement of fault, apology or sympathy, or a statement of remedial actions that may be taken, is not admissible as evidence if the statement was conveyed by a health care provider to the injured person more than 20 days before the suit was filed and it relates to the person's discomfort, pain, or injury. A statement of fault may be admissible for impeachment purposes through an in-camera review process if the court finds by clear and convincing evidence that the witness has directly contradicted the previous statement of fault on an issue of fact material to the proceeding.

Reports of Unprofessional Conduct: A health care professional who makes a good faith report, files charges, or presents evidence to a disciplining authority against another member of a health profession relating to unprofessional conduct or inability to practice safely due to a physical or mental condition is immune in a civil action for damages resulting from such good faith activities. A health care professional who prevails in a civil action on the good faith defense is entitled to recover expenses and reasonable attorneys' fees incurred in establishing the defense.

Medical Quality Assurance Commission: The public membership component of the MQAC is increased from four to six members, and at least two of the public members must be representatives of patient advocacy groups.

Health Care Provider Discipline: When imposing a sanction, a health profession disciplining authority may consider prior findings of unprofessional conduct, stipulations to informal disposition, and the actions of other state disciplining authorities.

Any combination of three unrelated orders for the following acts of unprofessional conduct within a 10-year period results in the permanent revocation of a health care professional's license:

- violations of orders or stipulations of the disciplining authority;
- violations of prescribing practices that create a significant risk to the public;
- certain convictions related to the practice of the profession in question;
- abuse of a patient or client;
- sexual contact with a patient or client; or
- where death, severe injury, or a significant risk to the public results from (1) negligence, incompetence, or malpractice; (2) violation of laws regulating the profession in question; or (3) current substance abuse.

A one-time finding of specified mitigating circumstance may be issued to excuse a violation if there is either strong potential for rehabilitation or strong potential that remedial education and training will prevent future harm to the public. A finding of mitigating circumstances may be issued as many times as the disciplining authority determines that the act at issue involved a high-risk procedure without any lower-risk alternatives, the patient was aware of the procedure's risks, and the health care provider took remedial steps prior to the disciplinary action.

Disclosure of Adverse Events: A medical facility must report the occurrence of an "adverse event" to the Department within 45 days of its occurrence. A medical facility or health care worker may report the occurrence of an "incident" to the Department. "Adverse events" are defined as: unanticipated deaths or major permanent losses of function; patient suicides; infant abductions or discharges to the wrong family; sexual assault or rape; transfusions with major blood incompatibilities; surgery performed on the wrong patient or site; major facility system malfunctions; or fires affecting patient care or treatment. An "incident" is defined as an event involving clinical care that could have injured the patient or that resulted in an unanticipated injury less severe than death or a major permanent loss of function.

Reports of adverse events and incidents must identify the facility, but may not identify any health care professionals, employees, or patients involved in the event or incident. Medical facilities must provide written notification to patients who may have been affected by the adverse event.

The Department is responsible for investigating reports of adverse events and establishing a system for medical facilities and health care workers to report adverse events and incidents. In addition, the Department must evaluate the data to identify patterns of adverse events and incidents and recommend ways to reduce adverse events and incidents and improve health care practices and procedures.

Coordinated Quality Improvement Programs: The types of programs that may apply to the Department to become coordinated quality improvement programs are expanded to include consortiums of health care providers that consist of at least five health care providers.

Prescription Legibility: Prescriptions for legend drugs must either be hand-printed, typewritten, or generated electronically.

INSURANCE INDUSTRY REFORM

Medical Malpractice Closed Claim Reporting: Self-insurers and insuring entities that write medical malpractice insurance are required to report any closed claim resulting in a judgment, settlement, or no payment to the Commissioner within 60 days after the claim is closed. The reports must contain specified data relating to: the type of health care provider, specialty, and facility involved; the dates when the event occurred, the claim was reported to the insurer, and the suit was filed; the claimant's age and sex; and information about the settlement, judgement, or other disposition of the claim, including an itemization of damages and litigation expenses.

If an insurer does not report to the Commissioner because of a policy limitation, the provider or facility must report a claim to the Commissioner. The Commissioner may impose a fine against insuring entities who fail to report of up to $250 per day up to a total of $10,000. The Department may impose a fine against a facility or provider that fails to report of up to $250 per day up to a total of $10,000.

A claimant or the claimant's attorney in a medical malpractice action must report to the Commissioner the amount of court costs, attorneys' fees, or expert witness costs incurred in the action.

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

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

Underwriting Standards: Medical malpractice insurers must file their underwriting standards at least 30 days before the standards become effective. The filing must identify and explain: the class, type, and extent of coverage provided by the insurer; any changes that have occurred to the underwriting standards; and how underwriting changes are expected to affect future losses. The information is subject to public disclosure. "Underwrite" is defined as the process of selecting, rejecting, or pricing a risk.

When an insurer takes an adverse action against an insured, such as cancellation of coverage or an unfavorable change in coverage, the insurer may consider the following factors only in combination with other substantive underwriting factors: (1) that an inquiry was made about the nature or scope of coverage; (2) that a notification was made about a potential claim which did not result in the filing of a claim; or (3) that a claim was closed without payment.

Cancellation or Non-Renewal of Liability Insurance Policies: The mandatory notice period for cancellation or non-renewal of medical malpractice liability insurance policies is increased from 45 days to 90 days. An insurer must actually deliver or mail to the insured a written notice of cancellation of a medical malpractice liability insurance policy. For policies the insurer will not renew, the notice must state that the insurer will not renew the policy upon its expiration date.

Prior Approval of Medical Malpractice Insurance Rates: Medical malpractice rate filings and form filings are changed from the current "use and file" system to a prior approval system. An insurer must, prior to issuing a medical malpractice policy, file the policy rate and forms with the Commissioner. The Commissioner must review the filing, which cannot become effective until 30 days after its filing.

HEALTH CARE LIABILITY REFORM

Statutes of Limitations and Repose: Tolling of the statute of limitations during minority is eliminated.

The eight-year statute of repose is re-established. Legislative intent and findings regarding the justification for a statute of repose are provided in response to the Washington Supreme Court's decision overturning the statute of repose in *DeYoung v. Providence Medical Center*.

Expert Witnesses: An expert witness in a medical malpractice action must meet the following qualifications: (1) have expertise in the medical condition at issue in the action; and (2) was engaged in active practice or teaching in the same or similar area of practice or specialty as the defendant at the time of the incident, or at the time of retirement for a provider who retired no more than five years prior to suit. The court may waive these requirements under specified circumstances.

An expert opinion provided during the course of a medical malpractice action must be corroborated by admissible evidence, such as treatment or practice protocols or guidelines, objective academic research, or clinical trials.

The number of expert witnesses allowed in a medical negligence action is limited to two per party on an issue, except upon a showing of good cause. All parties to a medical malpractice action must file a pretrial expert report that discloses the identity of all expert witnesses and states the nature of the testimony the experts will present at trial. Further depositions of the experts are prohibited. The testimony presented by an expert at trial is limited in nature to the opinions presented in the pretrial report.

Certificate of Merit: In medical negligence actions involving a claim of a breach of the standard of care, the plaintiff must file a certificate of merit at the time of commencing the action, or no later than 45 days after filing the action if the action is filed within 45 days of the running of the statute of limitations. The certificate of merit must be executed by a qualified expert and state that there is a reasonable probability that the defendant's conduct did not meet the required standard of care based on the information known at the time. The court for good cause may grant up to a 90-day extension for filing the certificate of merit.

Failure to file a certificate of merit that complies with these requirements results in dismissal of the case. If a case is dismissed for failure to comply with the certificate of merit requirements, the filing of the claim may not be used against the health care provider in liability insurance rate setting, personal credit history, or professional licensing or credentialing.

Offers of Settlement: An offer of settlement provision is created for medical malpractice actions. In an action where a party made an offer of settlement that is not accepted by the opposing party, the court may, in its discretion, award prevailing party attorneys' fees. "Prevailing party" means a party who makes an offer of settlement that is not accepted by the opposing party and who improves his or her position at trial relative to his or her offer of settlement.

In the case of a defendant, the offer of settlement provision applies only if the defendant previously made a disclosure to the claimant within seven days of learning that the claimant suffered an unanticipated outcome. The disclosure must have included: disclosure of the unanticipated outcome; an apology or expression of sympathy; and assurances that steps would be taken to prevent similar occurrences in the future.

When determining whether an award of attorneys' fees should be made to a prevailing party, the court may consider: (1) whether the party who rejected the offer of settlement was substantially justified in bringing the case to trial; (2) the extent to which additional relevant and material facts became known after the offer was rejected; (3) whether the offer of settlement was made in good faith; (4) the closeness of questions of fact and law at issue in the case; (5) whether a party engaged in conduct that unreasonably delayed the proceedings; (6) whether the circumstances make an award unjust; and (7) any other factor the court deems appropriate.

Voluntary Arbitration: A new voluntary arbitration system is established for disputes involving alleged professional negligence in the provision of health care. The voluntary arbitration system may be used only where all parties have agreed to submit the dispute to voluntary arbitration once the suit is filed, either through the initial complaint and answer, or after the commencement of the suit upon stipulation by all parties.

The maximum award an arbitrator can make is limited to $1,000,000 for both economic and non-economic damages. In addition, the arbitrator may not make an award of damages based on the "ostensible agency" theory of vicarious liability.

The arbitrator is selected by agreement of the parties and the parties may agree to more than one arbitrator. If the parties are unable to agree to an arbitrator, the court must select an arbitrator from names submitted by each side. A dispute submitted to the voluntary arbitration system must follow specified time periods that will result in the commencement of the arbitration no later than 10 months after the parties agreed to submit to voluntary arbitration.

The number of experts allowed for each side is generally limited to two experts on the issue of liability, two experts on the issue of damages, and one rebuttal expert. In addition, the parties are generally entitled to only limited discovery. Depositions of parties and expert witnesses are limited to four hours per deposition and the total number of additional depositions of other witnesses is limited to five per side, for no more than two hours per deposition.

There is no right to a trial de novo on an appeal of the arbitrator's decision. An appeal is limited to the bases for appeal provided under the current arbitration statute for vacation of an award under circumstances where there was corruption or misconduct, or for modification or correction of an award to correct evident mistakes.

Collateral Sources: The collateral source payment statute is amended to remove the restriction on presenting evidence of collateral source payments that come from insurance purchased by the plaintiff. The plaintiff, however, may introduce evidence of amounts paid to secure the right to the collateral source payments (e.g., premiums), in addition to introducing evidence of an obligation to repay the collateral source compensation.

MISCELLANEOUS

The Secretary of State is directed to place this act on the ballot in conjunction with Initiative 330 and in conjunction with Initiative 336 at the next regular general election.

Appropriation: None.

Fiscal Note: Not requested.

Effective Date: The bill takes effect if approved by the people.

Exhibit 2

House Bill Report, HB 2292, 59th Leg., Reg. Sess. (Wash. 2005))

HOUSE BILL REPORT
HB 2292

As Reported by House Committee On:
Judiciary
Appropriations

Title: An act relating to improving health care by increasing patient safety, reducing medical errors, reforming medical malpractice insurance, and resolving medical malpractice claims fairly without imposing mandatory limits on damage awards or fees.

Brief Description: Addressing health care liability reform.

Sponsors: Representatives Lantz, Cody, Campbell, Kirby, Flannigan, Williams, Linville, Springer, Clibborn, Wood, Fromhold, Morrell, Hunt, Moeller, Green, Kilmer, Conway, O'Brien, Sells, Kenney, Kessler, Chase, Upthegrove, Ormsby, Lovick, McCoy and Santos.

Brief History:
Committee Activity:
Judiciary: 3/22/05, 3/25/05 [DPS];
Appropriations: 3/29/05, 3/31/05 [DPS(JUDI)].

Brief Summary of Substitute Bill

- Proposes an alternative measure to both Initiatives 330 and 336 that deals with changes in health care system practices and discipline, the medical liability insurance industry, and the health care liability system.

HOUSE COMMITTEE ON JUDICIARY

Majority Report: The substitute bill be substituted therefor and the substitute bill do pass. Signed by 6 members: Representatives Lantz, Chair; Flannigan, Vice Chair; Williams, Vice Chair; Kirby, Springer and Wood.

Minority Report: Do not pass. Signed by 3 members: Representatives Priest, Ranking Minority Member; Rodne, Assistant Ranking Minority Member; and Serben.

Staff: Edie Adams (786-7180).

Background:

The Washington Constitution gives the people the power to legislate through the initiative process, either by initiative directly to the people or by initiative to the Legislature. Under the Constitution, the Legislature may deal with an initiative to the Legislature in one of the following ways: (1) enact the initiative during the regular session; (2) reject the initiative or

take no action on it, in which case the measure is submitted to a vote of the people at the next general election; or (3) reject or take no action on the measure and propose a different measure dealing with the same subject, in which case both the initiative and the legislative alternative are submitted to a vote of the people.

The people have submitted two initiatives to the Legislature, Initiatives 330 and 336, which both deal broadly with the health care liability system. Initiative 330 proposes changes to the civil liability system as applied to medical negligence cases. Initiative 336 proposes changes to the medical malpractice insurance system, the health care system's handling of negligence and unanticipated outcomes, and some aspects of the health care liability system.

INITIATIVE 330

Limitations on Non-Economic Damages: A $350,000 cap on a claimant's non-economic damages award is established, regardless of the number of health care professionals or health care institutions or entities involved. An additional $350,000 award for non-economic damages is allowed against a health care institution that is liable for acts of persons other than health care professionals, up to a maximum of $700,000 combined for all institutions.

If the limitation on non-economic damages is ruled unconstitutional, it will take effect after a state constitutional amendment is passed that empowers the Legislature to place limits on non-economic damages in civil actions or after passage of a federal law allowing such limitations.

Attorneys' Contingency Fees: An attorney's contingency fee for handling a medical negligence case is limited to no more than: 40 percent of the first $50,000 recovered; 33.33 percent of the next $50,000; 25 percent of the next $500,000; and 15 percent of any amount in which the recovery exceeds $600,000. These limits apply to recoveries received in any manner, including by judgment, settlement, or alternative dispute resolution.

Prior Notice and Mandatory Mediation: A plaintiff in a medical negligence action must provide a defendant with 90-days prior notice of the intention to file a lawsuit. All medical negligence actions are subject to mandatory mediation without exception, unless the action is subject to binding arbitration.

Statute of Limitations: A medical negligence action must be commenced within the *earlier* of three years from the act or omission, or one year from the time the patient discovered or reasonably should have discovered that the injury was caused by the act or omission. An action may be brought after the three-year statute of limitations period only under the following circumstances:

- for fraud, intentional concealment, or a foreign item left in the body, the patient has one year from actual discovery;
- if a minor patient's parent or guardian and the defendant colluded in failing to bring an action, the patient has one year from actual knowledge of the collusion, or one year from the minor's 18th birthday, whichever is longer;

- for an injured minor under the age of 6, the minor must commence the action within three years, or prior to the minor's 8th birthday, whichever is longer.

Tolling of the statute of limitations for minority, incompetency, disability, or imprisonment is eliminated.

Collateral Sources: Evidence of any collateral source payment made or to be made in the future may be introduced into evidence. The party receiving the collateral payments may present evidence of amounts paid to secure the right to the compensation. The ability of the plaintiff to show an obligation to repay the collateral source payment is removed. Rights of subrogation or reimbursement from a plaintiff's tort judgment are prohibited unless required under superseding federal law.

Arbitration Clauses: A binding arbitration clause in a health care services contract must be the first provision of the contract and must be expressed in language provided in the act. A disclosure concerning binding arbitration must be provided in bold type immediately preceding the signature line in the contract. A binding arbitration clause that complies with these requirements is declared not to be a contract of adhesion, unconscionable or otherwise improper.

Periodic Payment of Damages: An award of future economic and non-economic damages of $50,000 or more must be paid by periodic payments at the request of any party. A judgment debtor who is not adequately insured must post security adequate to satisfy the judgment. The periodic payment judgment may be modified upon the death of the judgment creditor to eliminate payments for future medical treatment, care or custody, loss of bodily function, or pain and suffering. Money damages for loss of future earnings may not be reduced or terminated upon the judgment creditor's death, but must be paid to persons to whom the judgment creditor owed a duty of support.

If the debtor has a continuing pattern of failing to make payments, the court must find the debtor in contempt of court and order the debtor to pay damages suffered as a result of the failure to make timely payments, including court costs and attorneys' fees.

Ostensible Agency: A hospital is not vicariously liable for the negligence of a health care provider who is granted privileges to provide care at the hospital unless the provider is an agent or employee of the hospital and was acting within the course and scope of the provider's agency or employment with the hospital. A health care provider is not vicariously liable for the negligence of another provider unless the other provider is an actual agent or employee acting under the provider's direct supervision and control.

Vulnerable Adults: In civil actions involving abuse, exploitation, or neglect of a vulnerable adult being cared for in a facility or by a home health, hospice, or home care agency, the ability of a prevailing plaintiff to recover reasonable attorneys' fees and expert costs is removed.

Joint and Several Liability: Joint and several liability is eliminated in medical negligence actions, and each defendant is responsible for only his or her proportionate share of the

damages, except where the defendants acted in concert or one party acted as the agent or under the direct supervision and control of another party.

INITIATIVE 336

Malpractice Insurance Rate Notification: The Office of the Insurance Commissioner (Commissioner) must notify the public of any medical malpractice insurance rate filing where the rate change is less than 15 percent, and any consumer may request a public hearing on the rate filing. The Commissioner must order a public hearing on a rate filing of 15 percent or more. Rate filings are not effective until approved by the Commissioner after the public hearing. If no public hearing was held on the rate filing, the filing is approved 45 days after public notice.

Supplemental Malpractice Insurance Program: A supplemental malpractice insurance program is established to provide excess liability coverage to health care facilities and providers who either self-insure or purchase liability insurance in amounts equal to specified retained limit requirements. The program will pay claims and related defense costs in excess of the retained limits up to the policy limits of the program. The program is operated by an appointed board and is funded by annual premiums and potential capital calls.

Claims Reporting: Insuring entities and self-insurers must report monthly to the Commissioner any medical malpractice claim that resulted in a final judgment, settlement, or disposition with no indemnity payment. Facilities and providers must report the claim if the insurer does not. Insurers who fail to report are subject to a fine of $250 per case up to a maximum of $10,000. Facilities and providers who fail to report are subject to a fine or disciplinary action by the Department of Health (Department).

The Commissioner must use the data to prepare aggregate statistical summaries and an annual report summarizing and analyzing the data for trends in the types, frequency, and severity of claims and the status of the medical malpractice market.

Health Care Provider Discipline: The Department must investigate a health care professional who has three paid claims within the most recent five-year period where the indemnity payment for each claim was $50,000 or more.

A person who has committed three incidents of medical malpractice, found through final court judgments, can't be licensed or continue to be licensed to practice medicine. Mitigating circumstances may be found where there is a strong potential for rehabilitation or for remedial education or training that will prevent future harm to the public.

Medical Quality Assurance Commission (MQAC): The public membership component of the MQAC is increased from four to six members, and at least two of the public members must be representatives of patient advocacy groups.

Patient Disclosure: A health care provider's failure to disclose the provider's experience with a treatment at the patient's request is a violation of the duty to secure informed consent.

Upon written request of a patient or immediate family member of a disabled or deceased patient, a health care facility or provider must make available for examination and copying any records made or received by the facility or provider relating to any adverse medical incident. The identity of a patient and any information protected by privacy restrictions under federal law may not be disclosed in providing the access. "Adverse incident" means negligence, intentional misconduct, and any other act or omission that caused or could have caused injury or death to a patient.

Court Reports of Settlements or Verdicts: The court clerk must report to the Department any medical malpractice action verdict or settlement that exceeds $100,000.

Expert Limits: In a medical malpractice action, each side is entitled to only two experts on an issue except on a showing of necessity. If there are multiple parties on a side who are unable to agree on the experts, the court may allow additional experts on an issue to be called upon a showing of necessity.

Attorney Certification and Certificate of Merit: An attorney who files an action, counterclaim, cross claim, or a defense certifies by his or her signature and filing that, to the best of the attorney's knowledge and belief formed after reasonable inquiry, it is not frivolous. A violation is punishable by sanctions, which may include costs and reasonable attorneys' fees incurred by the other party in response to the frivolous claim, counterclaim, cross claim, or defense.

Within 120 days after filing suit, an attorney or plaintiff must file a certificate of merit that states that a qualified expert has been consulted and the expert believes that it is more probable than not that the claim satisfies a basis for recovery.

Summary of Substitute Bill:

The Legislature finds that addressing the issues of consumer access to health care and the increasing costs of medical malpractice insurance requires comprehensive solutions that encourage patient safety, increase oversight of medical malpractice insurance, and make the civil justice system more understandable, fair, and efficient. The Legislature finds that neither Initiative 330 nor Initiative 336 offer the necessary comprehensive solution to these problems.

The Legislature proposes this act as an alternative to both Initiatives 330 and 336. The act contains a variety of changes designated under the following headings: Patient Safety, Insurance Industry Reform, and Health Care Liability Reform.

PATIENT SAFETY

Statements of Apology: In a medical negligence action, a statement of fault, apology, or sympathy, or a statement of remedial actions that may be taken, is not admissible as evidence if the statement was conveyed by a health care provider to the injured person or certain family members more than 20 days before the suit was filed and it relates to the person's discomfort, pain, or injury.

Reports of Unprofessional Conduct: A health care professional who makes a good faith report, files charges, or presents evidence to a disciplining authority against another member of a health profession relating to unprofessional conduct or inability to practice safely due to a physical or mental condition is immune in a civil action for damages resulting from such good faith activities. A health care professional who prevails in a civil action on the good faith defense is entitled to recover expenses and reasonable attorneys' fees incurred in establishing the defense.

Medical Quality Assurance Commission: The public membership component of the MQAC is increased from four to six members, and at least two of the public members must be representatives of patient advocacy groups.

Health Care Provider Discipline: When imposing a sanction, a health profession disciplining authority may consider prior findings of unprofessional conduct, stipulations to informal disposition, and the actions of other Washington or out-of-state disciplining authorities.

Any combination of three unrelated orders for the following acts of unprofessional conduct within a 10-year period results in the permanent revocation of a health care professional's license:

- violations of orders or stipulations of the disciplining authority;
- violations of prescribing practices that create a significant risk to the public;
- certain convictions related to the practice of the profession in question;
- abuse of a patient or client;
- sexual contact with a patient or client; or
- where death, severe injury, or a significant risk to the public results from (1) negligence, incompetence, or malpractice; (2) violation of laws regulating the profession in question; or (3) current substance abuse.

A one-time finding of specified mitigating circumstances may be issued to excuse a violation if there is either strong potential for rehabilitation or strong potential that remedial education and training will prevent future harm to the public. A finding of mitigating circumstances may be issued as many times as the disciplining authority determines that the act at issue involved a high-risk procedure without any lower-risk alternatives, the patient was aware of the procedure's risks, and the health care provider took remedial steps prior to the disciplinary action.

Burden of Proof for License Suspension or Revocation: A new standard of proof of "substantial and significant evidence" applies to the suspension or revocation of a physician's license or a physician's assistant's license. This standard is higher than a preponderance of the evidence and lower than clear and convincing evidence.

Disclosure of Adverse Events: A medical facility must report the occurrence of an "adverse event" to the Department within 45 days of its occurrence. A medical facility or health care worker may report the occurrence of an "incident" to the Department. "Adverse events" are defined as: unanticipated deaths or major permanent losses of function; patient suicides; infant abductions or discharges to the wrong family; sexual assault or rape; transfusions with

major blood incompatibilities; surgery performed on the wrong patient or site; major facility system malfunctions; or fires affecting patient care or treatment. An "incident" is defined as an event involving clinical care that could have injured the patient or that resulted in an unanticipated injury less severe than death or a major permanent loss of function.

Reports of adverse events and incidents must identify the facility, but may not identify any health care professionals, employees, or patients involved in the event or incident. Medical facilities must provide written notification to patients who may have been affected by the adverse event.

The Department is responsible for investigating reports of adverse events and establishing a system for medical facilities and health care workers to report adverse events and incidents. In addition, the Department must evaluate the data to identify patterns of adverse events and incidents and recommend ways to reduce adverse events and incidents and improve health care practices and procedures.

Coordinated Quality Improvement Programs: The types of programs that may apply to the Department to become coordinated quality improvement programs are expanded to include consortiums of health care providers that consist of at least five health care providers.

Prescription Legibility: Prescriptions for legend drugs must either be hand-printed, typewritten, or generated electronically.

Medical Malpractice Premium Assistance: The Department must develop a program to provide business and occupation tax credits for physicians who serve uninsured, Medicare, and Medicaid patients in a private practice or a reduced fee access program for the uninsured.

INSURANCE INDUSTRY REFORM

Medical Malpractice Closed Claim Reporting: Self-insurers and insuring entities that write medical malpractice insurance are required to report any closed claim resulting in a judgment, settlement, or no payment to the Commissioner within 60 days after the claim is closed. The reports must contain specified data relating to: the type of health care provider, specialty, and facility involved; the dates when the event occurred, the claim was reported to the insurer, and the suit was filed; the claimant's age and sex; and information about the settlement, judgement, or other disposition of the claim, including an itemization of damages and litigation expenses.

If an insuring entity or self-insurer does not report the claim to the Commissioner, the provider or facility must report the claim to the Commissioner. The Commissioner may impose a fine against insuring entities who fail to report of up to $250 per day up to a total of $10,000. The Department may impose a fine against a facility or provider that fails to report of up to $250 per day up to a total of $10,000.

A claimant or the claimant's attorney in a medical malpractice action must report to the Commissioner the amount of court costs, attorneys' fees, or expert witness costs incurred in the action.

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

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

Underwriting Standards: Medical malpractice insurers must file their underwriting standards at least 30 days before the standards become effective. The filing must identify and explain: the class, type, and extent of coverage provided by the insurer; any changes that have occurred to the underwriting standards; and how underwriting changes are expected to affect future losses. The information is subject to public disclosure. "Underwrite" is defined as the process of selecting, rejecting, or pricing a risk.

When an insurer takes an adverse action against an insured, such as cancellation of coverage or an unfavorable change in coverage, the insurer may consider the following factors only in combination with other substantive underwriting factors: (1) that an inquiry was made about the nature or scope of coverage; (2) that a notification was made about a potential claim which did not result in the filing of a claim; or (3) that a claim was closed without payment.

Cancellation or Non-Renewal of Liability Insurance Policies: The mandatory notice period for cancellation or non-renewal of medical malpractice liability insurance policies is increased from 45 days to 90 days. An insurer must actually deliver or mail to the insured a written notice of cancellation of a medical malpractice liability insurance policy. For policies the insurer will not renew, the notice must state that the insurer will not renew the policy upon its expiration date.

Prior Approval of Medical Malpractice Insurance Rates: Medical malpractice rate filings and form filings are changed from the current "use and file" system to a prior approval system. An insurer must, prior to issuing a medical malpractice policy, file the policy rate and forms with the Commissioner. The Commissioner must review the filing, which cannot become effective until 30 days after its filing.

HEALTH CARE LIABILITY REFORM

Statutes of Limitations and Repose: Tolling of the statute of limitations during minority is eliminated.

The eight-year statute of repose is re-established. Legislative intent and findings regarding the justification for a statute of repose are provided in response to the Washington Supreme Court's decision overturning the statute of repose in *DeYoung v. Providence Medical Center.*

Expert Witnesses: An expert witness in a medical malpractice action must meet the following qualifications: (1) have expertise in the condition at issue in the action; and (2) was engaged in active practice or teaching in the same or similar area of practice or specialty as the defendant at the time of the incident, or at the time of retirement for a provider who retired no more than five years prior to suit. The court may waive these requirements under specified circumstances.

An expert opinion provided during the course of a medical malpractice action must be corroborated by admissible evidence, such as treatment or practice protocols or guidelines, objective academic research, or clinical trials.

The number of expert witnesses allowed in a medical negligence action is limited to two per side on an issue, except upon a showing of good cause. If there are multiple parties on a side and they are unable to agree on the experts, the court may allow additional experts for good cause. All parties to a medical malpractice action must file a pretrial expert report that discloses the identity of all expert witnesses and states the nature of the testimony the experts will present at trial. Further depositions of the experts are prohibited. The testimony presented by an expert at trial is limited in nature to the opinions presented in the pretrial report.

Certificate of Merit: In medical negligence actions involving a claim of a breach of the standard of care, the plaintiff must file a certificate of merit at the time of commencing the action, or no later than 45 days after filing the action if the action is filed 45 days prior to the running of the statute of limitations. The certificate of merit must be executed by a qualified expert and state that there is a reasonable probability that the defendant's conduct did not meet the required standard of care based on the information known at the time. The court for good cause may grant up to a 90-day extension for filing the certificate of merit.

Failure to file a certificate of merit that complies with these requirements results in dismissal of the case. If a case is dismissed for failure to comply with the certificate of merit requirements, the filing of the claim may not be used against the health care provider in liability insurance rate setting, personal credit history, or professional licensing or credentialing.

Offers of Settlement: An offer of settlement provision is created for medical malpractice actions. In an action where a party made an offer of settlement that is not accepted by the opposing party, the court may, in its discretion, award prevailing party attorneys' fees. "Prevailing party" means a party who makes an offer of settlement that is not accepted by the opposing party and who improves his or her position at trial relative to his or her offer of settlement.

In the case of a defendant, the offer of settlement provision applies only if the defendant previously made a disclosure to the claimant within seven days of learning that the claimant suffered an unanticipated outcome. The disclosure must have included: disclosure of the unanticipated outcome; an apology or expression of sympathy; and assurances that steps would be taken to prevent similar occurrences in the future.

When determining whether an award of attorneys' fees should be made to a prevailing party, the court may consider: (1) whether the party who rejected the offer of settlement was substantially justified in bringing the case to trial; (2) the extent to which additional relevant and material facts became known after the offer was rejected; (3) whether the offer of settlement was made in good faith; (4) the closeness of questions of fact and law at issue in the case; (5) whether a party engaged in conduct that unreasonably delayed the proceedings; (6) whether the circumstances make an award unjust; and (7) any other factor the court deems appropriate.

Voluntary Arbitration: A new voluntary arbitration system is established for disputes involving alleged professional negligence in the provision of health care. The voluntary arbitration system may be used only where all parties have agreed to submit the dispute to voluntary arbitration once the suit is filed, either through the initial complaint and answer, or after the commencement of the suit upon stipulation by all parties.

The maximum award an arbitrator can make is limited to $1,000,000 for both economic and non-economic damages. In addition, the arbitrator may not make an award of damages based on the "ostensible agency" theory of vicarious liability.

The arbitrator is selected by agreement of the parties, and the parties may agree to more than one arbitrator. If the parties are unable to agree to an arbitrator, the court must select an arbitrator from names submitted by each side. A dispute submitted to the voluntary arbitration system must follow specified time periods that will result in the commencement of the arbitration no later than 10 months after the parties agreed to submit to voluntary arbitration.

The number of experts allowed for each side is generally limited to two experts on the issue of liability, two experts on the issue of damages, and one rebuttal expert. In addition, the parties are generally entitled to only limited discovery. Depositions of parties and expert witnesses are limited to four hours per deposition and the total number of additional depositions of other witnesses is limited to five per side, for no more than two hours per deposition.

There is no right to a trial de novo on an appeal of the arbitrator's decision. An appeal is limited to the bases for appeal provided under the current arbitration statute for vacation of an award under circumstances where there was corruption or misconduct, or for modification or correction of an award to correct evident mistakes.

Collateral Sources: The collateral source payment statute is amended to remove the restriction on presenting evidence of collateral source payments that come from insurance purchased by the plaintiff. The plaintiff, however, may introduce evidence of amounts paid to secure the right to the collateral source payments (e.g., premiums), in addition to introducing evidence of an obligation to repay the collateral source compensation.

Frivolous Lawsuits: When signing and filing a claim, counterclaim, cross claim, or defense, an attorney certifies that the claim or defense is not frivolous. An attorney who signs a filing in violation of this section is subject to sanctions, including an order to pay reasonable expenses and reasonable attorneys' fees incurred by the other party.

MISCELLANEOUS

The Secretary of State is directed to place this act on the ballot in conjunction with Initiative 330 and in conjunction with Initiative 336 at the next regular general election. A "concise description" is designated for the ballot title. The concise description states that the alternative would "improve health care by increasing patient safety, reducing medical errors, reforming medical malpractice insurance, and resolving malpractice claims fairly."

Substitute Bill Compared to Original Bill:

The original bill did not contain the following provisions: (1) the creation of a new burden of proof of "substantial and significant evidence" for the suspension or revocation of the license of a physician or physician's assistant; (2) the Department of Health program to provide business and occupation tax credits for physicians serving uninsured, Medicaid, or Medicare patients; (3) the frivolous lawsuit section subjecting an attorney to sanctions for filing a frivolous suit; and (4) the designation of a "concise description" of the alternative for the ballot title.

With respect to statements of apology or fault made by a provider to an injured person, the original bill allowed a statement of fault to be introduced into evidence under limited circumstances for impeachment purposes. In addition, the original bill allowed the apology or statement of fault to be made to a family member of the injured person only if the person was incompetent.

With respect to closed claim reporting, the substitute bill made the following changes: (1) extended the dates for commencement of reporting and for the Commissioner to issue the statistical summaries and annual reports; (2) gave the Commissioner specific rule-making authority to identify who has the primary obligation to report a claim when more than one entity is providing coverage and to specify methodology for the reporting; and (3) clarified when a facility or provider must report a claim when the insuring entity or self-insurer does not.

With respect to expert witnesses, the substitute bill changed the limitation on the number of experts to two per *side* (instead of two per *party*) and also changed references to "medical" in the expert qualifications provision to references to "health profession" or "health care."

In addition, the substitute bill clarified that a disciplining authority's ability to consider prior findings applies to findings of both in-state and out-of-state disciplining authorities.

Appropriation: None.

Fiscal Note: Requested on March 25, 2005.

Effective Date of Substitute Bill: The bill takes effect if approved by the people.

Testimony For: Both Initiatives 330 and 336 are flawed, and it is the Legislature's duty to come up with an alternative that deals with patient safety, insurance reform, and tort reform.

The insurance market has improved and liability insurance is more affordable and accessible, but you still need to makes changes to improve the system and help get through the future hard markets. The alternative focuses on patient safety which provides a very positive focus. The alternative also has the purpose of avoiding litigation and improving the insurance industry. The public has been led to believe that rates are tied to an exploding tort system when the reality is that the real problem is with insurance industry cycles.

The insurance reform contained in the alternative is important. The data reporting component will help us evaluate what is happening in the market. Insurance companies should submit their rates and policies to the Insurance Commissioner before they start using them, and the 90-day cancellation requirement will provide more time for providers to find replacement policies. The alternative should go farther and also address the issue of capacity by establishing a supplemental malpractice insurance program similar to what is contained in Initiative 336.

This alternative will make a real practical improvement to the system and will allow resolution of disputes with less cost and without abolishing fundamental rights. It represents reasonableness over extremism, patient safety over special interests, and the best interest of people over political expediency. There is one small concern with eliminating expert depositions. Depositions are a cost effective way to frame the issues and help cases get resolved earlier.

(With concerns) It has become clear that the claims made a few years ago that an explosion in lawsuits and payouts were causing the malpractice premium crisis are just not true. The number of lawsuits when adjusted for population growth are down 15 percent in the last 10 years. Premiums are also down 7.7 percent, and Washington ranks 35th lowest in terms of average premiums for physicians. It is important to focus on patient safety. Data show that 195,000 people a year die from medical errors. The cost of this is more than six times the cost of the total medical malpractice liability system.

There are many good patient safety measures in the alternative, including adding two consumer members to the Medical Quality Assurance Commission. However, we need to make sure that complaints to that body are thoroughly investigated. In addition, the alternative is missing the very important piece of public access to this information and disclosure to individual patients. There should be language in the alternative prohibiting confidentiality restrictions in settlements, as contained in Initiative 336. It is important that this information be available to patients so they can make informed decisions about the doctors they chose.

On the insurance side, the alternative is missing the important component of public participation in insurance rate increases. Surplus lines carriers are concerned about being included in the closed claim reporting requirement.

The establishment of expert qualifications and limitations on the number of experts and expert depositions all interfere with the judges' ability to effectively manage trials and get to the truth. These limitations may unnecessarily increase costs and protract litigation. The expert

qualifications should relate to the issue in the case rather than to the defendant's particular practice and, as drafted, only allow physicians to be experts. The expert limits should be two per side rather than allowing the stacking of multiple experts on one side. There are also concerns with the statute of limitations running on minors.

The voluntary arbitration piece will provide a simpler, quicker, and less expensive way to handle the majority of disputes. It will benefit doctors, hospitals, and claimants and should take most of the cases out of the court system. The system should also include a reporting mechanism for the arbitrator to report attorneys who file frivolous claims and doctors who are found to have caused significant harm through their negligence.

The Washington Defense Trial Lawyers Association was reported to be involved in crafting or reviewing this legislation, but this was not the case.

Testimony Against: Many physicians in this state are either leaving the state, leaving practice, or significantly limiting their practice. Washington residents are suffering as a result. Between 2000 and 2004, 14 percent of obstetrician-gynecologists stopped delivering babies, and 39 percent of family practitioners stopped delivery babies. This represents a combined 29 percent of physicians who have stopped delivering babies during that four-year period.

After two years of trying to get meaningful reform adopted by the Legislature and after significant frustrations, the medical association decided to pursue an initiative. Initiative 330 contains the key features for liability reform contained in the California MICRA law, including a cap on non-economic damages, sliding scale cap on attorneys' fees, elimination of the collateral source rule, periodic payment of future damages, and joint and several liability reform.

Optimal reform must contain reasonable reform of the litigation system. The alternative does not contain meaningful medical litigation reform. It represents a missed opportunity. The voluntary arbitration provisions does nothing since voluntary arbitration is already a part of the law. The alternative does not contain a cap on non-economic damages nor a sliding scale cap on attorneys' fees. In addition, it does not contain joint and several liability reform, elimination of the collateral source rule, or expansion of periodic payment of damages. All of these features are necessary. The only successful approach is to enact meaningful liability reform as contained in Initiative 330. A study of the California MICRA law found that law does not reduce access to the court system as people have claimed.

The insurance industry has concerns with changing from a "use and file" to a prior approval system. It is important for the industry to be able to develop products and introduce them in a timely fashion in order to create and maintain a competitive marketplace. A prior approval system is more appropriate for the less sophisticated segment of the insurance market.

Persons Testifying: (In support) Representative Lantz, prime sponsor; Senator Keiser; Senator Kline; Mike Kreidler, Insurance Commissioner; Bill Daley, Washington Citizens Action; and Mark Johnson and Ron Ward, Washington State Bar Association.

(With concerns) Martha Harden Cesar, Superior Court Judges' Association; Emilia Sweeney, Washington Defense Trial Lawyers; Lauri Gearllach, Cheryl Marshall, Candi Taylor, and Dolores Christiano, Citizens for Better Safer Healthcare; Larry Shannon and Joel Cunningham, Washington State Trial Lawyers' Association; Will Parry, Puget Sound Alliance for Retired Americans; and Tom Parker, Surplus Line Association.

(Opposed) Cliff Webster, Washington State Medical Association; Randy Revelle, Washington State Hospital Association; Kris Tefft, Association of Washington Business; and Mel Sorensen, Property Casualty Insurance Association.

Persons Signed In To Testify But Not Testifying: None.

HOUSE COMMITTEE ON APPROPRIATIONS

Majority Report: The substitute bill by Committee on Judiciary be substituted therefor and the substitute bill do pass. Signed by 16 members: Representatives Sommers, Chair; Fromhold, Vice Chair; Cody, Conway, Darneille, Dunshee, Grant, Haigh, Hunter, Kagi, Kenney, Kessler, Linville, McDermott, McIntire and Miloscia.

Minority Report: Do not pass. Signed by 12 members: Representatives Alexander, Ranking Minority Member; Anderson, Assistant Ranking Minority Member; McDonald, Assistant Ranking Minority Member; Bailey, Buri, Clements, Hinkle, Pearson, Priest, Schual-Berke, Talcott and Walsh.

Staff: Amy Hanson (786-7118).

Summary of Recommendation of Committee On Appropriations Compared to Recommendation of Committee On Judiciary:

No new changes were recommended.

Appropriation: None.

Fiscal Note: Available.

Effective Date of Substitute Bill: The bill takes effect if approved by the people.

Testimony For: (With concerns) The good faith effort that has been put into this bill and the thought process that has occurred on this subject reflects an evolution on the issue of medical malpractice and medical safety. The fact that this bill is so heavily reflective of a patient-centered and a patient safety-centered process really tells us where we need to go in this debate and discussion. As far as the fiscal issues, what is being encouraged by some of the policy in this bill is what we should be encouraging in our health care system.

Testimony Against: There is a crisis in this state and there is a difference in opinion on the solutions to this problem. This bill is a compromise and it falls short of providing the necessary reforms that we think will stem the liability reform crisis. In particular, there are three components that are missing: sliding scale cap on attorney fees; a cap on non-economic

damages; and elimination of joint and severable liability. These are proven reforms that have been seen in other states such as California and Texas. We urge the Legislature to put the two initiatives, and just those two initiatives, before the voters in November.

Persons Testifying: (With concerns) Larry Shannon, Washington State Trial Lawyers Association.

(Opposed) Dana Childers, Liability Reform Coalition.

Persons Signed In To Testify But Not Testifying: None.

Exhibit 3

House Testimony/Attendance Roster - HB 2292 and SB 6087, March 22, 2005
Public Hearing (House archive file)

TESTIMONY/ATTENDANCE ROSTER

Committee: House & Senate Judiciary, House Health Care, Senate Health & Long-Term Care

Date/Time: Tues, March 22, 2005 6:00 PM

Bill No.: HB 2292 & SB 6087

Short Title: Addressing health care liability reform.

Name	Wish to Testify? (Yes/No)	If so, Indicate Pro/Con	Organization	Mailing Address (Fill out completely) Do Not Say "On File"	Telephone
Please Print Mark Johnson	Yes	Pro	WSBA	Street 2101 4th Ave City, Zip Seattle e-mail	360 943-9971
Please Print RON Ward	Yes	Pro	WSBA	Street 2101 4th Ave City, Zip Seattle e-mail	360 943 9971
Please Print BILL DALEY	YES	PRO	WASHINGTON CITIZEN ACTION	Street 323 FOOTE ST NW City, Zip OLYMPIA 98502 e-mail	943-0138
Please Print Mike Kreidler	Yes	Pro	INSURANCE Commissioner	Street City, Zip e-mail	
Please Print Martha Harden Cesar	Yes	Concerns	Superior Court Judges Assn	Street 821 Sixth Ave N City Sea 98109 Zip	206 963-0748
Please Print Emilia L. Sweeney	YES	concerns	Washington Defense Trial Lawyers	Street 9221 24th Ave. N.W. City, Zip Seattle WA 98117 e-mail	206-223-7087
Please Print Melanie Stewart	NO	CON	Wa Osteopathic Med. Assoc	Street 6035 Tyee Dr SE City, Zip Olympia WA e-mail	943-3806
Please Print Vicki Austin	NO	CON	Providence Health System	Street City, Zip e-mail	485-2026

(1)

TESTIMONY/ATTENDANCE ROSTER

Committee: House & Senate Judiciary, House Health Care, Senate Health & Long-Term Care

Bill No.: HB 2292 & SB 6087

Date/Time: Tues, March 22, 2005 6:00 PM

Short Title: Addressing health care liability reform.

Name	Wish to Testify? (Yes/No)	If so, Indicate Pro/Con	Organization	Mailing Address (Fill out completely) Do Not Say "On File"	Telephone
Please Print Bill Daley			Washington Citizen Action	Street City, Zip e-mail	
Please Print Will Parm	Yes	w/ concerns	Puget Sound Alliance for Retired Americans	Street City, Zip e-mail	
Please Print Cheryl Marshall	Yes	concerns	Citizens for Better Safer Healthcare	Street City, Zip e-mail P.O. Box 2806 Seattle, WA 98107	
Please Print Candi Taylor	Yes	concerns	"	Street City, Zip e-mail P.O. Box 2806 Seattle, WA 98107	
Please Print Dolores Christiano	Yes	concerns	"	Street City Zip "	
Please Print Larry Shannon	Yes	w/ concerns	WSTLA 1511 State Ave NE Oly WA	Street City, Zip e-mail	
Please Print Joel Cunningham	Yes	"	"	Street City, Zip e-mail	
Please Print Angela Kerwin	NO	CON	Greater Seattle Chamber of Comm	Street 1301 5th Ave Ste 2500 City, Zip Seattle, WA 98101 e-mail angelak@seattlechamber.com	206-419-0371

(3)

TESTIMONY/ATTENDANCE ROSTER

Committee: House & Senate Judiciary, House Health Care, Senate Health & Long-Term Care

Date/Time: Tues, March 22, 2005 6:00 PM

Bill No.: HB 2292 & SB 6087

Short Title: Addressing health care liability reform.

Name	Wish to Testify? (Yes/No)	If so, Indicate Pro/Con	Organization	Mailing Address (Fill out completely) Do Not Say "On File"	Telephone
Please Print Lauri Gearllach	Yes	w/ concerns	Citizens for Better Safer Healthcare	Street P.O. Box 2806 City, Zip Seattle, WA 98101 e-mail	206. 250. 274L
Please Print Mel Sorensen	Yes	Con	Property Casualty Insurers Assoc.	Street 400 5th Ave. #5800 City, Zip Seattle e-mail	206 607-4152
Please Print Jim Irish	No	?	Family	Street 10508 Palatine Av. North City, Zip seattle, WA 98133-8725 e-mail BF777@msn.com	206-838-1238
Please Print Cliff Webster	Yes	Con	WA State Medical Assn.	Street 700-5th Ave, # 5800 City, Zip Seattle WA 98104 e-mail	(206) 622-8020
Please Print KRIS TEFFT	Yes	Con	Assoc. Wash. Business	Street PO Box 658 City Olympia Zip WA 98507	360 943 1600
Please Print Tim Layton	No	Con	American Insurance Assn.	Street 206 - 11th Ave SE, # 2 City, Zip Olympia 98501 e-mail	(360) 357-6500
Please Print				Street City, Zip e-mail	
Please Print Randy Revelle	Yes	Con	Washington State Hospital Assn.	Street 300 Elliott Ave. West City, Zip Seattle, WA 98119 e-mail randyr@wsha.org	206) 216-2515

(2)

TESTIMONY/ATTENDANCE ROSTER

Committee: House & Senate Judiciary, House Health Care, Senate Health & Long-Term Care

Date/Time: Tues, March 22, 2005 6:00 PM

Bill No.: HB 2292 & SB 6087

Short Title: Addressing health care liability reform.

Name	Wish to Testify? (Yes/No)	If so, Indicate Pro/Con	Organization	Mailing Address (Fill out completely) Do Not Say "On File"	Telephone
Please Print Dana Childers	No	Con	Liability Reform Coalition	Street 2033 - 6th Ave City, Zip Seattle 98053 e-mail	(425) 868-2698
Please Print Sydney Smith Zvara	No	Con	Assoc. of WA Healthcare Plans	Street City, Zip e-mail	425 - 396 - 5375
Please Print				Street City, Zip e-mail	
Please Print				Street City, Zip e-mail	
Please Print				Street City Zip	
Please Print				Street City, Zip e-mail	
Please Print				Street City, Zip e-mail	
Please Print				Street City, Zip e-mail	

(4)

TESTIMONY/ATTENDANCE ROSTER

Committee: House & Senate Judiciary, House Health Care, Senate Health & Long-Term Care

Date/Time: Tues, March 22, 2005 6:00 PM

Bill No.: HB 2292 & SB 6087

Short Title: Addressing health care liability reform.

Name	Wish to Testify? (Yes/No)	If so, Indicate Pro/Con	Organization	Mailing Address (Fill out completely) Do Not Say "On File"	Telephone
Please Print Carolyn Logue	No	Con	NFIB	Street 4160 6th Ave SE #201 City, Zip Lacey WA 98516 e-mail	786-8675
Please Print Gary Smith	No	Con	Ind Bus. Assoc	Street City, Zip e-mail	425-453-8671
Please Print Tom Parker	Yes	concerns	Surplus Lines	Street 717 17th SW City, Zip Olympia e-mail	206-935-4819
Please Print				Street City, Zip e-mail	
Please Print				Street City Zip	
Please Print				Street City, Zip e-mail	
Please Print				Street City, Zip e-mail	
Please Print				Street City, Zip e-mail	

(5)

Exhibit 4

Letters of Testimony on HB 2292/SB 6087; March 22, 2005
Public Hearing (House archive file)

TO: Members, Washington State Legislature
FR: Larry Shannon, WSTLA Government Affairs Director
RE: WSTLA Position on HB 2292/SB 6087
DT: March 22, 2005

Thank you for allowing me the opportunity to present testimony on HB 2292/SB 6087, the proposed alternatives to Initiatives 330 and 336. We greatly appreciate the thoughtful effort and consideration that has gone into this carefully crafted product. While we do have concerns about some elements of these twin measures, we also believe there are some very positive and innovative ideas that are contained here.

Before we get into the specifics of the measure, I would like to take this opportunity to present some context of how we got to where we are presently on this issue.

Background:

For the last three years proponents of measures aimed at attacking the legal and constitutional rights of Washington's citizens have launched a campaign of disinformation on our liability system. We now know its disinformation. Proponents have screamed that the number of lawsuits exploded, runaway juries hand out damage awards to anyone who asks, and "lottery seeking" litigants were flocking in search of "jackpot justice" and payouts in settlements have skyrocketed upwards. None of these claims are true, and now we have the data to prove it. The facts are as follows.

Medical liability:

1) When adjusted for inflation, lawsuits are down, not up, in Washington, by almost 15% over the last ten years.

2) In the last two years, we believe there was a grand total of TWO plaintiff verdicts in medical mal practice cases in the state of Washington. Over the last eight years, the grand total is thirty-four, or an average of about four per year.

3) Last week's ten year closed claim report released by OIC provide significant data for us. Closed claims settlements, paid by insurers, have increased by about four percent, per year, like clockwork. No explosion, no spikes, no drama. As the Office of the Insurance Commissioner remarked at the recent hearing, "the results were remarkable for how unremarkable they are."

4) This closed claim result is not limited to Washington State. In the last four weeks, studies in Texas, Missouri and Florida all showed the exact same phenomenon.

5) On insurance premiums, OIC also released a study showing that, when adjusted for inflation, medical liability premiums in Washington state were higher in 1985 than they are today.

6) Also worth noting is that just this month, our state's largest medical insurer was forced to refund $1.3 million in overcharges, and a $90,000 civil penalty, after also posting there most profitable year in history.

7) Five years ago, the Institute of Medicine release a report, "To Error is Human," that claimed over 99,000 Americans die of preventable medical errors in hospitals every year. This year, in updating that figure IOM estimates that 195,000 people die needlessly every year.

8) The total cost of this rate of injury to our health care system is nearly six times the total cost of the medical malpractice system.

Given these facts and figures, there is no question that any solution must involve a primary focus on patient safety and injury prevention, as well as a strong insurance reform platform. Improvements to the liability system can and should be made, but we need to focus on making the system fairer for everyone.

HB 2292 and SB 6057 retain these principles, which are the bedrock of I-336, and for that we commend you. We do have concerns about specific elements, which we are happy to continue working on. We are optimistic that we can reach the best possible solution for all the citizens of our state.

Thank you for the opportunity to present tonight. We look forward to working with you on this important policy goal.

To: Members of the Senate Judiciary Committee, House Judiciary Committee, Senate Health and Long Term Care Committee, and House Health Care Committee
From: Cheryl Marshall
33825 133rd Ave SE
Auburn, WA 98092
253.653.7495

RE: Initiative 336 and Plan B

Good evening.

My name is Cheryl Marshall, and I am from Auburn.

During the first two years after my son, Lucas Hollingsworth, was born we had many questions concerning what had happened at Enumclaw Community Memorial Hospital on the night he was born.

During an assessment meeting when Lucas was about two years old, doctors at Children's Orthopedic Hospital remained silent as they shuffled their feet upon the floor not wanting to make eye contact. They were intentionally protecting the attending Physician, Dr. Delvin E. Littell, who now practices in Tennessee. I was told to bring Lucas back in two more years when they thought they could be more conclusive. I was warned he would be slightly behind his peers.

It wasn't until Lucas was four years old that I finally learned the truth about my son's birth injuries while trying to place him in a Special Education class. I was outraged that I was left without a diagnosis and the causation thereof for so many years.

We were able to obtain an attorney solely because the case was taken for a mere $100 contingency fee. The case had merit and was not frivolous. Four years and more than 9,000 legal hours were spent to bring the case to a jury.

Lucas sustained a permanent injury to his brain which was life altering and continues to affect every aspect of our lives each and every day.

The doctor's and hospital's insurance company wanted me to hire a campfire girl to provide Lucas' care for $2 hour. They waged a war of attrition against us by making meager out of court settlement offers. They wanted him placed in an institution such as Rainier School. I believe that home and community placement provides a far better quality of life in a less restrictive setting.

It is specifically the non-economic damages awarded that give my son a quality of life. When I hear people comment that an award such as Lucas' is a "jackpot", I cringe because it surely was not. The award money is put back into our economy by paying fees to a fiduciary and advisors;

- Lucas Pays taxes on the interest earned, transportation and real estate held;
- He is an employer to an RN and a Special Education Teacher;
- He purchases ongoing healthcare, specialized equipment, education and therapies.

Additional surgeries have arisen from the initial injury and these surgeries will continue well into the future.

Because of Lucas' non-economic damages we are able to maximize his inclusion in our community as well as take a trip to Disneyland each year - something that Lucas has to look forward to. This allows Lucas new experiences and something that normalizes his life.

Thankfully, we are not dependent upon the state of Washington to provide and care for him. I believe that the care he is getting has been what has kept him alive and thriving instead of dying in an institutional setting.

I had sincerely hoped that when our case went to trial, it would prevent another mother and/or family such as the Malone's from having to live with the heartache of watching their child or relative's health and future be flushed down the drain along with

their own. Patients need to be able to hold accountable those responsible for substandard care. I have been fighting this issue for almost thirty years.

I am glad that I-336 and the Legislative "Plan B" begin to thoughtfully address issues of patient safety.

The State of Washington must outlaw the secrecy which we encountered when Lucas was born that currently allows bad doctors to hide their record of wrongdoing from consumers. I-336 will expose them. Any alternative considered by the Legislature should do the same.

I-336 is finally a real solution that I can stand behind because of the protection it puts in place to hold everyone accountable - that's why I am one of it's sponsors. **Capping or limiting non economic damages allows companies and bad doctors to treat liability as a cost of doing business, which will weaken the deterrent impact that lawsuits presently have. That is not right, fair, just or good business.**

It is time that the State of Washington put patients first.

March 22, 2005

Dear Members of the Senate & House Judiciary Committees,

My name is Amanda Carmier Cichanski, I am President of the Puget Sound Chapter of American Association of Legal Nurse Consultants, and on behalf of the Chapter, I am submitting written testimony in support of Plan B.

Our organization endorsed Initiative 336, and is pleased to see the legislature develop a plan that is comprehensive, and addresses patient safety.

Legal nurse consultants are licensed registered nurses who perform key analysis of health care issues and outcomes for law firms, government offices, insurance companies, healthcare entities, and others. Legal nurse consultants have a strong education and experiential background and thus are competent to assess linkage to standards of health care practice as it applies to nursing and health care.

As nurses working in clinical settings, members of our organization have seen situations where a patient has sustained catastrophic damage to life and limb. There is nothing more difficult than seeing someone suffer through a preventable injury.

Plan B and I-336 are sound policy because they provide a core solution to the problem - not just a band-aid. We support measures that would hold EVERYONE accountable: Doctors, Lawyers, nurses and the Insurance Industry.

We are most supportive of the patient safety measures proposed in both I-336 and Plan B. Patient safety measures are a key to preventing life altering injures and minimizing injuries and deaths caused by the 5% of "bad doctors" that cause 50% of the malpractice.

However, the patient safety section of Plan B could benefit from the addition of some of the measures contained in I-336. Specifically, the Legal Nurse Consultants encourage you to consider the provision that eliminates secrecy agreements that are use when settling cases. This hides medical negligent histories making it difficult for others to know if they are in the hands of an incompetent healthcare provider. It also prevents the creation of appropriate measures to prevent future injuries.

We also support the provision that gives patients the right to know his or her doctor's malpractice history. This information gives the patients the right to decide to proceed with the doctor or to look for another provider. This

information is essential to helping patients choose the best care for themselves and their families.

Members of the Committees, the Legal Nurse Consultants are supportive of Plan B, but we urge you to include these important safety measures in I-336 in Plan B before deciding to send it to the people.

Thank you for your time.

Sincerely,

Amanda Carmier Cichanski MN, RN, LNCC
President , Puget Sound Chapter American Association Legal Nurse Consultant
4655 Lighthouse Dr. NE
Tacoma, WA 98422

Good Evening Chairman and members of the Committee:

My name is Candi Taylor. I live in Kent , and my husband was killed by medical negligence and a bad hospital system.

Although I support Initiative 336, I would like to start by thanking you for including numerous patient safety measures in Plan B.

On March 12, 1999, my husband and best friend, Bob Taylor, had surgery on a ruptured disk in his neck. The surgery went well, and after Bob emerged from the recovery room, we were both relieved that he was no longer experiencing pain.

That night, Bob began complaining that his throat and neck felt funny. He kept asking me if it looked like his neck was swelling. When we told nurses of Bob's discomfort, they adjusted his morphine drip. They did not explore his discomfort further, or call a doctor, even when he needed oxygen later that evening.

At about 1:20 a.m., a nurse called me at home. The nurse said Bob was having breathing problems and I was urgently needed at the hospital.

When I arrived, Bob was in a coma on life support. Three days after the surgery, Bob passed away. Last week marked the sixth anniversary of my husband's death.

Many of the patient safety measures in both Initiative 336 and Plan B could prevent other families from enduring the tragedy of losing a husband and father.

In plan B, I appreciate the addition of Representative Cody's apology bill. I wish the hospital had told me what happened, rather than covering up the truth. When something so catastrophic and so tragic happens to a family member, you really just want to know what happened - what his last moments were like.

Instead, victims of medical malpractice and their families usually face a huge wall of silence.

An apology would help other families in situations similar to my own. While Bob was in a coma and knowing that the end was near, friends in the health care field advised me to request an autopsy - something that is very unusual when a death occurs within hospital walls. It was through the autopsy that we actually begin to unravel the details of what happened to Bob.

In Plan B, I also applaud Representative Tami Green's bill requiring health care facilities to report unanticipated serious injuries or deaths, as well as "near misses" to the department of Health. The department could then develop recommendations to improve patient safety.

Our family ultimately learned that Bob's death occurred not from the tremendous swelling in his neck, but because doctors did not have the correct size tube available to fit down Bob's constricted airway. As his throat swelled, Bob had difficulty breathing because his airway was reduced tot he size of a pinhole. He basically suffocated.

Doctors needed to fit a tube down his airway to get oxygen into Bob's lungs. They called the emergency room to find a tube used for infants - one that would fit through Bob's restricted airway. It took a long time for the emergency room to find the correct tube - and by the time a usable tube arrived, Bob had been without oxygen for half an hour.

I would hope that reporting of incidents like this to the Department of Health could result in recommendations to hospitals that will make health care safer for all patients - like advising hospitals to equip a wings with infant-sized tubes, not just pediatrics or the ER.

Since Bob died, I have wanted the hospital to tell me the truth, and I want healthcare providers to know they need to listen to their patients. If Bob's concerns about discomfort, trouble breathing, and swelling in his neck had been addressed earlier in the evening, I might not be here testifying tonight.

I encourage you to make these additions, but before Plan B is passed, I would encourage you to add provisions that allow the public access to information that could protect them.

By telling my story, I hope other patients and their families will recognize the need to advocate for family members when they're in the hospital - because doctors and nurses don't always listen to their patients.

Thank you.

Candi Taylor
28012 188th Avenue SE
Kent, WA 98042
(253) 631-7961

March 22, 2005

Good Evening Members of the Committees:

My name is Dolores Christiano, and I am from Spokane.

I appreciate the opportunity to speak to you tonight regarding a subject that I knew little to nothing about until it affected my family.

In 1999, the Institute of Medicine reported that nearly 100,000 Americans die each year from preventable medical injuries. Then, last summer, HealthGrades released a report that raised that number to nearly 200,000.

These are staggering figures, but do not even begin to estimate the number of people who suffer debilitating, life altering injuries at the hands of negligent doctors.

In 1997, my husband Joe became one of those statistics in Washington State.

That year, he experienced a great deal of worsening lower back pain. An orthopedic surgeon assured him that the problem could be corrected with a relatively routine surgical procedure.

Although the surgery was successful, an infection developed at the surgical site and was allowed to go undiagnosed for several weeks. Two visits to the orthopedic surgeon's office and a visit to the emergency room led to

painkillers, but never any further exploration to find the source of the pain or possible post-operative infection.

Deterioration of the lower spine was so extensive that vertebrae fusion was required. This resulted in life threatening reconstructive surgery performed by a neurosurgeon, extensive physical therapy and several life-long disabilities.

I filed a formal written complaint, along with supporting documentation, with the Medical Quality Assurance Commission. Through my correspondence with this agency, I am convinced that their agenda is focused on preserving a doctor's reputation rather than investigating malpractice complaints and working with patients to avoid impending problems. Since my complaint was filed, two additional lawsuits have been filed against this same orthopedic surgeon. At least one of these cases resulted in a secret settlement. To my knowledge this surgeon is still practicing without any disciplinary action having been taken against him.

Our medical disciplinary system is broken. As someone who has been affected by medical malpractice, I can tell you that the patient safety measures in Initiative 336 – some of which are also contained in Plan B – are vitally important to the health and well-being of the citizens of this state.

When MQAC closed the investigation of my husband's case without ever interviewing us, I did some further research into this commission. What I found left me with little surprise at MQAC's apathetic response: the commission is overwhelmingly comprised of physicians.

Adding two consumer members to MQAC may not be enough to ensure thorough that investigations and fair hearings are conducted, but it is a tremendous step in the right direction. This is one of the most important provisions in Initiative 336 – and also in Plan B. Afterall, if MQAC doesn't protect the public, who will? When a patient files a complaint against a doctor, the citizens of Washington State are owed a thorough and sound investigation – at the very least.

Three strikes for health care providers is also important. Families who have experienced injury or loss caused by a negligent doctor will tell you that three strikes is too many chances. If action had been taken by MQAC against the orthopedic surgeon who failed to properly treat Joe, perhaps the two additional patients would not have been injured.

From a citizen perspective, one key component is missing from Plan B: providing public access to this information. Improving MQAC and requiring action against repeat offenders won't benefit patients if that information is concealed and hidden from the public.

Initiative 336 gives patients the right to know their doctor's malpractice history. I'm sure if people in Spokane could know the malpractice history of Joe's orthopedic surgeon, they could make sound decisions before undergoing surgery or treatment with this incompetent doctor. Changes to our medical disciplinary system will keep all patients safer by eliminating the most negligent physicians in our state.

While I didn't get anywhere with MQAC, Joe and I didn't get anywhere with our lawsuit either. A panel of three appellate judges gave us a new trial. In their decision they stated that the presiding judge at the first trial had abused his discretion. We began getting ready for a new trial.

However, the surgeon's malpractice insurance carrier threw the full weight of their endless resources at us. They gave us a list of 20 expert witnesses they planned to depose before going to a new trial – each at a cost of $2,000 a day. The law required that we also depose each of their 20 expert witnesses. Joe and I were not working on a contingency fee basis, and therefore could not afford to continue with the trial at this enormous expense.

Limiting the number of expert witnesses in medical malpractice cases to two per side per issue will certainly level the playing field. Right now, insurance companies can use their deep pockets to force plaintiffs to settle legitimate cases for less than the economic cost of the injury. Limiting the number of expert witnesses is good policy, and an important piece of both Initiative 336 and Plan B.

It is impossible for any uninvolved individual to understand the depth of depression that overwhelms a person when they are witness to a spouse languishing in unrelenting pain. It is an experience that never completely leaves you. I sincerely hope that you, or any of your loved ones, never encounter what my husband and I have gone through physically, emotionally, psychologically and financially over the last several years – all

of which could have been so easily avoided with a week of oral anti-biotics prescribed by a competent doctor.

Whether or not Plan B passes, I thank you for proposing comprehensive and responsible legislation that will help protect patients without taking away their rights. I hope you will give serious consideration to allowing public access to information about doctors that could help save lives.

Thank you.

Dolores Christiano
12707 E. 24th Avenue
Spokane, WA 99216
(509) 927-0320

TESTIMONY ON I-330, I-336 AND PLAN B

My name is Will Parry. I am president of the Puget Sound Alliance for Retired Americans, one of 31 Washington State retiree organizations affiliated with the national Alliance for Retired Americans. We represent approximately 60,000 members in Washington State.

We've heard a lot about tort reform, medical malpractice, doctors and lawyers.

We who are neither doctors nor lawyers also have a stake in the outcome of this debate. That's why we have endorsed Initiative 336 and why we oppose Initiative 330.

On the proposal to cap non-economic damages: Unlike younger working people with a steady income, most seniors would incur little or no *economic* damages. For that reason, to cap *non*-economic damages would be to deny us meaningful compensation – no matter how grievous our loss.

Caps are not the only problem with I-330. That initiative would grant immunity to nursing homes, pharmaceutical companies and HMOs. For seniors, this is a frightening prospect. Nursing homes *do* neglect and abuse residents. Pharmaceutical products *do* sometimes cause irreparable damage. HMOs *do* sometimes make callous bottom-line decisions that leave our health in ruins.

I certainly do not want to have to waive my right to a jury trial and fair compensation as a condition of receiving medical care or entering a nursing home. I-330 would require me to waive these fundamental rights.

The older we get, the more we rely on doctors and hospitals. Seniors especially need to know that basic safety measures are in place – such as being able to learn a doctor's malpractice history, or knowing that the public is represented in our state's medical disciplinary board.

These are simple and sensible changes. We should be able to research a doctor before placing ourselves in his hands the way we research a vehicle before opening its doors to our loved ones.

We thank you for the insurance and legal reforms set forth in Plan B. These measures will help good doctors maintain reasonable premiums without jeopardizing the wellbeing of patients. We respectfully urge you to incorporate the patient safety measures found in I-336. Above all, please prevent the enactment of those provisions of I-330 that would destroy accountability in our health care system.

Thank you.

Will Parry
President, Puget Sound Alliance for Retired Americans
2800 First Avenue, #262
Seattle, WA 98121
(206) 448-9646

Members of the Committees:

My name is Ashley Bucy, and I am from Gig Harbor.

As someone whose entire life was changed by medical negligence, I am thankful that the Legislature is considering many patient safety measures this year. I support Initiative 336, but I also support measures in the Legislature's Plan B.

However, I am here tonight because I do have concerns. Plan B is missing a major component of patient safety. While Plan B would do a tremendous amount of good, it does not include any provisions that allow the public to learn who is causing the majority of malpractice in this state.

Two years ago, I visited a Pierce County hospital emergency room complaining of a sore throat. I was told that my condition was viral – to go home and rest. Over the next week, I was repeatedly denied a $10 throat culture that would have diagnosed my step throat.

Without antibiotics or a correct diagnosis, the infection spread into my blood stream and poisoned my body. Saving my life required amputation of both my legs and all of my fingertips. Skin graphs saved my arms, but left my body permanently damaged and scarred.

The doctors who sent me home to die have been held accountable, but only because I was able to file a lawsuit. My case settled last fall, finally giving me a second chance at life.

No one should have to endure the nightmare my life became after I nearly died at the negligent hands of a few bad doctors.

Yet, due to a secrecy agreement as a term of settling my case, the doctors who harmed me are allowed to quietly tuck themselves away and hide behind the law. I can never warn anyone about the doctors who mistreated me.

Initiative 336 would change this by requiring that all settlements are reported, including the names of the defendants. I-336 would also give patients the right to know their doctor's malpractice history.

These are two essential pieces of the patient safety section in I-336, and I strongly urge you to add these components to Plan B.

Eliminating secrecy surrounding medical malpractice will literally save lives – and will hold negligent doctors accountable.

What will not hold bad doctors accountable is Initiative 330. I-330 is a brazen attempt to increase the insurance industry's bottom line and ensure bad doctors have a free ride until they kill or injure again.

Caps on damages benefit insurance companies, but nothing in I-330 requires insurance companies to pass those benefits on to physicians. Caps would forever close the courthouse doors to people who have been severely injured by bad doctors. And a closed courthouse door means the cost of the injury is passed on to taxpayers.

When insurance companies are let off the hook, taxpayers pick up the bill. Prior to my settlement, I lived off of $600 a month from DSHS. The government provided me with the bare essentials, but not enough to afford a decent wheelchair or the kind of prosthetics that now allow me to walk.

The only effective way to reduce the cost of malpractice and save taxpayer money is to reduce the amount of malpractice. By allowing the public access to

information about doctors in their communities, you empower patients to make good choices about their healthcare.

Please allow patients that choice. It is too late for many of us, but I hope in the future, my daughters will be able to access malpractice information before choosing a doctor. This would help save my daughters and all Washington residents from the horror of a preventable medical injury or death.

Thank you,

Ashley Bucy
3716 87th Avenue Court NW
Gig Harbor, WA 98335
253-265-3045

The Association of Washington Healthcare Plans

Date: March 22, 2005

To: House Health Care Committee
Senate Health & Long-Term Care Committee
House Judiciary Committee
Senate Judiciary Committee

From: Sydney Smith Zvara, Executive Director, AWHP

Re: Support for Meaningful Liability Reform

The Association of Washington Healthcare Plans continues to stand with our state's physicians and hospitals in support of meaningful liability reform. This is why we urge you to support Initiative 330 and oppose Initiative 336. We also urge you to avoid placing on the ballot either of the recently developed "Plan A" and "Plan B" alternatives, because they --- like I-336, both fall short of real reform.

Although we applaud the focus on patient protection we see in HB 2292 and SB 6087, we can not support those bills as an alternative to I-330. They lack key measures including reasonable caps on non-economic damages and attorney fees, as well as elimination of joint and several liability for healthcare providers.

Limits on attorney contingency fees are important because they help ensure that the injured person receives a greater share of any awarded amount. Also critical, are reasonable caps on non-economic damages because they are the only proven means of lowering trend, while preserving access to courts to injured patients[1]. In states with non-economic damage limits, liability premiums have been lowered by 17%[2].

Another key provision --- the elimination of joint and several liability provisions, serves to discourage plaintiffs from suing multiple defendants in pursuit of "deep pockets".

We are also concerned that placing either or both "Plan A" and "Plan B" on the November ballot, would serve only to clutter the ballot and confuse voters --- thereby furthering the cause of those would seek to oppose meaningful reform in our state.

AWHP member plans provide coverage for over 4 million residents of our state.

---

[1] Californians Allied for Patient Protection, Study, Feb 2005
[2] Thorpe, Health Affairs, Jan. 2004

Washington
State
Hospital
Association

STATEMENT OPPOSING PLAN B
by
Randy Revelle, Vice President
Washington State Hospital Association

Members of the Washington State Senate and House of Representatives,

- I am Randy Revelle, Vice President for Policy and Public Affairs, of the Washington State Hospital Association. I am speaking on behalf of the association and its board of trustees.

- Thank you for the opportunity to testify on Senate Bill 6087 and House Bill 2292 (together known as Plan B), a proposed alternative to both Initiative 330 and Initiative 336.

- The hospital association strongly supports Initiative 330 and strongly opposes Initiative 336.

- Plan B addresses health care liability reform by proposing changes in the areas of patient safety, insurance reform, and civil justice reform. Unfortunately, Plan B omits Initiative 330's key liability reform provisions strongly supported by the hospital association and the medical association, including:

  - ✓ A reasonable cap on non-economic damages;
  - ✓ Elimination of joint and several liability for health care providers;
  - ✓ Limiting the liability of hospitals to their employees and agents (known as "ostensible agency");
  - ✓ Periodic payments on future damages; and
  - ✓ Limits on attorneys' contingency fees.

300 Elliott Avenue West
Suite 300
Seattle, WA 98119-4118
Phone 206-281-7211
Fax 206-283-6122
www.wsha.org

- Last Friday, after extensive discussion, the hospital association's board of trustees voted unanimously to oppose Plan B before the state legislature. We intend to continue our commitment to work with the medical association for the passage of Initiative 330 in November.
- Plan B does not address the liability reform issues that are most important to hospitals. In partnership with the medical association, the hospital association supports the reforms contained in Initiative 330 and omitted from Plan B.
- We respectfully urge you not to enact Plan B as an alternative to both Initiative 330 and Initiative 336.
- Thank you again for the opportunity to testify.

March 22, 2005

Exhibit 5

Senate Testimony/Attendance Roster – SHB 2292, April 12, 2005 Public Hearing (Senate archive file)

Senate Committee Services - Testimony/Attendance Roster

PRO.

Committee: –Senate Health and Long-Term Care **Bill number** SHB 2292

Date: April 12, 2005 **Short Title:** Addressing health care liability reform.

If you are from ou rk the box to the right of your name.

Name	Organization	Mailing Address (No "on file," please)	Phone/E-mail	Testifying? (Yes/No)	If so, Pro[redacted]
Please Print ☐ MIKE KREIDLER	INSURANCE Commissioner	Street City Zip	Phone: E-mail:	Yes	Pro
Please Print ☐ Rush W. Shearer	Retired Toxicologist	Street 1848 Circle Loop SE City Lacey 98503 Zip	Phone: E-mail:	No	Pro
Please Print ☐		Street City Zip	Phone: E-mail:		
Please Print ☐		Street City Zip	Phone: E-mail:		
Please Print ☐		Street City Zip	Phone: E-mail:		
Please Print ☐		Street City Zip	Phone: E-mail:		
Please Print ☐		Street City Zip	Phone: E-mail:		
Please Print ☐		Street City Zip	Phone: E-mail:		
Please Print ☐		Street City Zip	Phone: E-mail:		
Please Print ☐		Street City Zip	Phone: E-mail:		

Senate Committee Services - Testimony/Attendance Roster

CON

Committee: Senate Health and Long-Term Care **Bill number** SHB 2292

Date: April 12, 2005 **Short Title:** Addressing health care liability reform.

If you are from out ☐ *k the box to the right of your name.*

Name	Organization	Mailing Address (No "on file," please)	Phone/E-mail	Testifying? (Yes/No)	If so, Pro/Con
Please Print Cliff Webster ☐	WA State Medical Assn	Street 700 - 5th Ave, #5800 City Seattle Zip 98104	Phone (206) 622-8000 E-mail:	Yes	Con
Please Print LISA THATCHER ☐	WSHA	Street City Zip	Phone: E-mail:	Yes	CON
Please Print JAN GEE ☐	WA FOOD INDUSTRY	Street City Zip	Phone: 253.209.5079 E-mail:	NO	CON
Please Print ☐		Street City Zip	Phone: E-mail:		
Please Print Dana Childers ☐	LRC	Street City Zip Seattle	Phone: E-mail: 206-953-6342	yes	con
Please Print KRIS TEFFT ☐	A.W.B.	Street City Zip Olympia	Phone: E-mail: 360 943 1600	yes	CON
Please Print Tim Layton ☐	~~AAA~~ American Insurance Assn.	Street City Seattle Zip	Phone: E-mail:	No	CON
Please Print Mel Sorensen ☐	Property Casualty Insurers Assoc.	Street 700 5th Ave City Seattle Zip	Phone: E-mail:	No	CON
Please Print Phil Watkins ☐	MultiCare Health System	Street P.O. Box 2315 City Oly Zip 98507	Phone: 360.486.8601 E-mail:	No	Con
Please Print Nancy Waldermath ☐	- Regence Blue Shield - Kaiser - Aetna	Street City Zip	Phone: E-mail:	No	Con

Senate Committee Services - Testimony/Attendance Roster

CON

Committee: Senate Health and Long-Term Care **Bill number** SHB 2292

Date: April 12, 2005 **Short Title:** Addressing health care liability reform.

If you are from out *the box to the right of your name.*

Name	Organization	Mailing Address (No "on file," please)	Phone/E-mail	Testifying? (Yes/No)	If so, [redacted]/Con
Please Print Sydney Smith Zvara ☐	Assoc. of WA Healthcare Plans	Street City Zip	Phone: E-mail:	X/O	CON
Please Print Carolyn Logue ☐	NFIB	Street City Zip	Phone: E-mail: 786-8675	(written) NO	Con
Please Print ☐		Street City Zip	Phone: E-mail:		
Please Print ☐		Street City Zip	Phone: E-mail:		
Please Print ☐		Street City Zip	Phone: E-mail:		
Please Print ☐		Street City Zip	Phone: E-mail:		
Please Print ☐		Street City Zip	Phone: E-mail:		
Please Print ☐		Street City Zip	Phone: E-mail:		
Please Print ☐		Street City Zip	Phone: E-mail:		
Please Print ☐		Street City Zip	Phone: E-mail:		

Senate Committee Services - Testimony/Attendance Roster

Other

Committee: Senate Health and Long-Term Care **Bill number** SHB 2292

Date: April 12, 2005 **Short Title:** Addressing health care liability reform.

If you are from out of *be box to the right of your name.*

Name	Organization	Mailing Address (No "on file," please)	Phone/E-mail	Testifying? (Yes/No)	If so, [redacted]
Please Print Larry Shannon ☐	WSTLA	Street City Zip	Phone: E-mail:	Yes	some concerns
Please Print ☐		Street City Zip	Phone: E-mail:		
Please Print ☐		Street City Zip	Phone: E-mail:		
Please Print Gail Stone ☐	WA State Bar Assn	Street 1001 Eastside City Oly Zip 98501	Phone: 943-9977 E-mail:	NO	Pro with concerns
Please Print ☐		Street City Zip	Phone: E-mail:		
Please Print ☐		Street City Zip	Phone: E-mail:		
Please Print ☐		Street City Zip	Phone: E-mail:		
Please Print ☐		Street City Zip	Phone: E-mail:		
Please Print ☐		Street City Zip	Phone: E-mail:		
Please Print ☐		Street City Zip	Phone: E-mail:		

Exhibit 6

Letters of Testimony from Attendees on SHB 2292
(Senate archive file)

Sydney Zvara
4/12/05
SHB 2292

The Association of Washington Healthcare Plans

Date: March 22, 2005

To: House Health Care Committee
Senate Health & Long-Term Care Committee
House Judiciary Committee
Senate Judiciary Committee

From: Sydney Smith Zvara, Executive Director, AWHP

Re: Support for Meaningful Liability Reform

The Association of Washington Healthcare Plans continues to stand with our state's physicians and hospitals in support of meaningful liability reform. This is why we urge you to support Initiative 330 and oppose Initiative 336. We also urge you to avoid placing on the ballot either of the recently developed "Plan A" and "Plan B" alternatives, because they --- like I-336, both fall short of real reform.

Although we applaud the focus on patient protection we see in HB 2292 and SB 6087, we can not support those bills as an alternative to I-330. They lack key measures including reasonable caps on non-economic damages and attorney fees, as well as elimination of joint and several liability for healthcare providers.

Limits on attorney contingency fees are important because they help ensure that the injured person receives a greater share of any awarded amount. Also critical, are reasonable caps on non-economic damages because they are the only proven means of lowering trend, while preserving access to courts to injured patients[1]. In states with non-economic damage limits, liability premiums have been lowered by 17%[2].

Another key provision --- the elimination of joint and several liability provisions, serves to discourage plaintiffs from suing multiple defendants in pursuit of "deep pockets".

We are also concerned that placing either or both "Plan A" and "Plan B" on the November ballot, would serve only to clutter the ballot and confuse voters --- thereby furthering the cause of those who would seek to oppose meaningful reform in our state.

AWHP member plans provide coverage for over 4 million residents of our state.

---

[1] Californians Allied for Patient Protection, Study, Feb 2005
[2] Thorpe, Health Affairs, Jan. 2004

SHB 2292
Dana Childers
4/12/05

LRC

LIABILITY REFORM COALITION

2033 Sixth Avenue
Suite 1100
Seattle, WA 98121
425 · 868 · 2698
425 · 868 · 8427 Fax
www.walrc.org

Clifford A. Webster
Chair

Dana R. Childers
Executive Director

April 12, 2005

The Honorable Members of the Senate Health and Long-Term Care Committee

Re: Substitute House Bill 2292

Dear Senators:

While the members of the Liability Reform Coalition appreciate the attention the legislature has given to the critical issue of medical liability reform, the Liability Reform Coalition (LRC) cannot support SHB 2292. SHB 2292 does not contain the needed package of proven, substantive liability reforms that have brought the medical liability crisis under control in California and Texas.

Substitute House Bill 2292, like I-336, falls short because it does not include:

- **Cap on non-economic damages**. A cap on non-economic damages is the most effective and only proven way of making the jury system more predictable. Despite statements to the contrary, the actuarial evidence is irrefutable – large, unpredictable jury awards are a key component of this crisis. It is this simple: large jury awards drive-up the cost of medical malpractice settlements, which in turn drive-up the cost of premiums paid by doctors. In order to control premiums one must be able to control jury awards.

- **Limits on attorney contingency fees**. Limiting the amount an attorney may receive on contingency ensures a greater share of the award will go to the injured party, and not their attorney. It is not uncommon for attorneys representing plaintiffs in medical negligence cases to receive a contingency fee of 40 percent or more of the total damages (economic and non-economic) awarded the plaintiff. This is excessive.

- **Elimination of joint and several liability**. Elimination of joint and several liability in cases of medical negligence would discourage plaintiffs from suing multiple defendants in pursuit of a deep pocket defendant, such as a hospital or clinic. Current law encourages this behavior. In cases where the plaintiff is not at fault, the law holds a single party in a multi-party lawsuit jointly and severally liable for 100 percent of all damages. This is true even though even if the defendant (such as the hospital or doctor) were found to be only 1 percent at fault.

Each of these reforms is critical to any meaningful medical liability bill. They go directly to the cost factors driving increased malpractice premiums by focusing on greater predictability and creating less incentive for jackpot jury awards.

A February 2005 study by the Californians Allied for Patient Protection proves that caps on non-economic damages, as required by that state's landmark liability reform measure, was instrumental in holding down health care costs, yet preserving access to courts to injured patients.

SHB 2292 serves only to further clutter the November ballot. Therefore, we respectfully request that you simply send I-330 and I-336 to the ballot, without an alternative.

Best regards,

Dana R. Childers
Executive Director

SHB 2292
Carolyn Logue
4/12/05

NFIB
The Voice of Small Business®

WASHINGTON

March 22, 2005

Dear Members of the Legislature:

On behalf of the 15,000 Washington members of the National Federation of Independent Business, we would like to reiterate our support for Initiative 330 – medical malpractice reform. This initiative is extremely important to small businesses who are desperately fighting to provide health care insurance despite cost increases. While medical malpractice costs are not the only driver of health care costs, they are significant and must be contained.

We do not support HB 2292 proposed as alternatives to I-330. Nor do we support I-336. None of these approaches contains all of the elements that must be in place for small business to support a medical malpractice liability reform proposal. To support a proposal, it must contain the following:

- A cap on non-economic damages that is reasonable and truly works to help limit costs by providing more predictability.
- Limitations on attorney contingency fees.
- Elimination of joint and several liability for health care providers.

These elements are supported by over 85 percent of NFIB's members and are imperative from our perspective to making a medical malpractice proposal work. We urge you to pass I-330 and begin the process of reigning in this segment of our state's health care costs.

Sincerely,

Carolyn Logue
Washington State Director

National Federation of Independent Business – WASHINGTON
4160 6th Ave. SE, Suite 201 • Lacey, WA 98503 • 360-786-8675 • Fax 360-943-2456 • www.NFIB.com

Whatcom Alliance for Healthcare Access

April 11, 2005

Senator Karen Keiser
Chair
Senate Health & Long Term Care Committee

Dear Senator Keiser and Honorable Members:

The Whatcom Alliance for Health Care Access is a community-based group working to improve healthcare access locally and sound health policy at the state and national levels.

One of our priorities is to promote a comprehensive bi-partisan Medical Malpractice Reform solution (Attached is the proposal adopted by our Steering Committee in December 2004.) Representative Linville and Senator Brandland were active participants in the process and we had broad-based community support.

Our proposal is based on the belief that affordable medical malpractice insurance for physicians is a health care access issue for patients and that there is no "silver bullet" solution. No one approach will address the problem and a package of strategies is required to make meaningful change and achieve the support needed to take action.

We want to acknowledge the work that both parties have made in introducing HB 2292 and 2295. We believe they both have the elements that support our goal of a comprehensive bi-partisan proposal.

At this point we would like to encourage your committee to seek enhancements to SHB 2292 that will round-out the proposal and broaden the support. Specifically we would like you to consider adding the following provisions to achieve a more comprehensive package:

1. ***Implementation of joint and several liability reform*** that limits the obligation of the defendant for damages to proportion of award that matches fault.
2. ***A requirement that an injury awards schedule be developed*** and shared as part of the jury instructions at trial.
3. ***Strengthen alternatives to litigation*** including a requirement of mandatory mediation before filing a claim.
4. ***Implementation of a sliding fee scale for attorneys.***

We encourage and support your work toward a comprehensive bi partisan solution.

Thank you,
Victoria Doerper
Chair, Legislative Advocacy Workgroup

PO Box 5641 Bellingham, WA 98227 ~ (360) 671-3349 ~ Whatcomalliance.org

"An alliance of Whatcom County community leaders and healthcare organizations promoting consistent access to core health care services for all members of our community"

Whatcom Alliance for Healthcare Access

Medical Malpractice Liability Reform Proposal
December 14, 2004

Introduction

This paper presents a package of strategies ("the proposal") designed to remedy the problem of prohibitive medical malpractice liability insurance costs. The proposal is presented by the Whatcom Alliance for Healthcare Access ("the Alliance"), a non-partisan community group committed to improving access to health care in Whatcom County.

As the paper explains, the proposal is designed as a comprehensive reform package, with strategies that address four primary subject areas: Medical Malpractice Premium Assistance; Civil Liability Reform; Insurance Industry Regulatory Reform; and Consumer Protection Measures. The Alliance believes strongly that only through such a comprehensive approach can an effective solution be reached and implemented.

The proposal is intended to serve as a guide for elected officials evaluating medical malpractice solutions and will be introduced as a specific piece of legislation if appropriate.

Purpose and Background

One of the many challenges that make it difficult for people to gain access to health care in Whatcom County, the State of Washington, and the entire country is the growing cost of medical malpractice insurance which in some cases is forcing physicians out of practice and further eroding health care access in our communities.

In Whatcom County:

- Local physicians ***with no adverse claims*** have experienced annual rate increases of between 30% and 100% over the last two to three years.
- Since January 2004 over 30% (13) of the county's family doctors have stopped delivering babies because of high insurance costs.

In July 2004 with support from elected officials of the 40th and 42nd districts, The Alliance formed a study group to develop an effective bipartisan medical malpractice solution that would address rising medical malpractice rates affecting healthcare access as well as patient safety concerns.

The study group process included the following:

- Researching of best practices around the country including contact with national experts
- Analyzing past and presently proposed legislation and initiatives to the legislature

- Consulting with representatives from the State Office of Insurance Commissioner (OIC) to better understand the issues and barriers to affordable medical malpractice insurance in this state
- Receiving the support and expertise of Washington State House and Senate non partisan staff assigned to both the Judiciary and Health Care Committees.

Study Group Participants

Whatcom Alliance for Health Care Access members

- Victoria Doerper and Richard Dietz (Northwest Regional Council)
- Chris Phillips (St. Joseph Hospital)
- Chuck Beard, St. Luke's Foundation
- Jeff Graham, M.D. (Whatcom Medical Society)
- Gil Thurston (consumer)
- Dave Lynch, M.D. (Family Care Network)
- Erick Laine, M.D. (Madrona Medical Group)
- Ralph Hill (Interfaith Health Center)
- Linda McCarthy (MBFM)
- Jim Anderson (Business rep)
- Jim Wells, Regence
- Don Rappe, M.D., Group Health
- Sue Sharpe, facilitator

Dale Brandland, State Senator
Kelli Linville, State Representative
State Insurance Commissioner Representative
Edie Adams, non partisan staff from House Judiciary Committee
Hal Thurston, legal rep
Larry Thompson, health care consultant

Principles and Strategy

The group found that conflicting studies abound regarding the effectiveness of approaches designed to help bring down medical malpractice insurance rates. Most special interests promote a "silver bullet" approach that tends to polarize the debate with an exclusive focus on civil liability reform at one of the end of the spectrum or minimizing medical errors at the other end.

In developing a final recommendation the Alliance Medical Malpractice Study Group adopted the following principles:

1. *Addressing medical malpractice insurance premiums is a health care access issue. Controlling medical malpractice rates will improve health care access in our communities.*
2. *No one strategy will address this problem. A package of strategies is required to make meaningful change and to achieve the broad based support needed to take action.*

3. *Medical malpractice issues are different from other liability issues given the inability of health care providers to pass on rising costs due to fixed reimbursements and the impact it has on fundamental consumer issues: health care access and safety. Medical malpractice solutions should be addressed separately and not tied to omnibus or comprehensive tort reform.*
4. *Insurance industry reform or regulation needs to be balanced between benefiting the public good while maintaining an attractive and competitive marketplace for medical malpractice insurance providers doing business in Washington State.*

2005 Legislative Proposal

The following strategies constitute a comprehensive Medical Malpractice Reform package. No one category or strategy can be considered an effective solution without addressing the whole. (A summary chart can be found in Attachment A)

Category #1: Medical Malpractice Premium Assistance

1.1. Expand special needs assistance for high risk specialties and volunteer physicians: High risk specialties would include obstetrics and physicians providing care in emergency settings. Qualifying volunteer physicians would be those providers serving in community clinics supporting underserved populations.

1.2. Implement tax credits (for example B&O tax credits) for qualifying physicians: This strategy would offset rising premium costs for physicians who see a large percentage of fixed (Medicare, Medicaid) or uninsured clients.

1.3 Encourage and support expansion of federal grants to underserved areas: This would include providing premiums assistance for communities who can demonstrate physician shortages through Health Provider Shortage Areas (HPSA) designation or classification as a rural health clinics.

Category #2: Civil Liability Reform

2.1. Implement joint and several liability reform: Limit obligation of defendant for damages to proportion of award that matches fault.

2.2. Implement provisions to encourage full disclosure and apology by provider: A timely disclosure, apology and compensation would be offered before filing of a claim which has been shown to promote a resolution short of litigation in many cases. These efforts need to be protected from admissibility in any subsequent litigation.

2.3. Strengthen measures to reduce frivolous lawsuits: Encourage and strengthen use of existing judicial capacity to discourage or fine plaintiff attorneys for the pursuit of frivolous lawsuits.

2.4. Initiate "caps" on non economic damage awards: Implement measures to cap this element of damages awards in a fashion that protects against exorbitant damage awards while assuring appropriate recovery for injured party.

2.5. Statue of limitation restrictions: Shorten length of time after injury in which claim may be filed, particularly with respect to claims arising from injury to minors. This provision addresses tail coverage requirements that are an additional and burdensome cost of medical malpractice insurance.

2.6. Implement periodic payment of damages feature: Lower the existing threshold, insure payments are guaranteed and that lost wage payments extend beyond the death of the plaintiff.

2.7. Implement alternatives to litigation: This would include mandatory mediation, requirement of certificate of merit before filing a claim and other effective pretrial mechanisms for reducing the number of lawsuits that require trial.

2.8. Certify and limit expert witnesses: Initiate measures to limit use of expert witnesses to reduce the cost of litigation. Measures should include defining qualifications of expert witnesses before allowing testimony and limiting number permitted to testify on a particular issue

2.9. Implement sliding fee scale for attorneys' fees: Implement caps on fees, based on sliding scale which allows lesser percentage of recovery as awards increase in total amounts.

Category #3: Insurance Industry Improvements

3.1. Require OIC public notification of proposed medical liability insurance increases of over 15%

3.2. Improve insurance company reporting requirements for medical malpractice insurance: Require reporting of closed med mal claims data and/or other data which permit more effective analysis and decision making by the Office of the Insurance Commissioner.

Category #4: Consumer Protection

4.1. Implement medical error reporting incentives and protections: Require mandatory reporting of serious adverse events and voluntary reporting of near misses. Sharing this

information is critical to helping practitioners prevent future errors and problems. Only aggregated data is reported publicly and reports must be confidential and inadmissible.

4.2. Provide incentives to health care providers to implement quality improvement practices: This would include tax credits or grants for implementing information systems required to standardize best practices and proven patient safety incentives. Define and monitor performance outcomes and require purchasers to reward performance.

4.3. Strengthen and improve health care provider discipline: Require full DOH/disciplinary board investigation of an excess of three medical malpractice claims (over $50,000) paid within last five years. Provide incentives and protection for health providers making good faith effort reports to a disciplinary entity of suspected unprofessional conduct by a health care provider.

Conclusion

The Whatcom Alliance for Healthcare Access believes strongly that this proposal can form the basis of an achievable solution to the acute problems associated with medical provider liability insurance costs. We urge state legislators to act this session to assure that such a package of reforms is initiated, so that both providers and consumers of healthcare services can look forward to improved access and service delivery as a result.

Whatcom Alliance for Healthcare Access

Medical Malpractice Liability Reform Proposal - - Summary Table

STRATEGIES	EXPLANATIONS
Category #1: Med Mal Prem Assistance	
1.1. Special needs assistance for high risk specialties and volunteer physicians	High risk specialties would include obstetrics and physicians providing care in emergency settings. Qualifying volunteer physicians would be those providers serving in community clinics supporting underserved populations.
1.2. Implement tax credits (for example B&O tax credits) for qualifying physicians	Credit would offset rising premium costs for physicians who see a large percentage of fixed (Medicare, Medicaid) or uninsured clients
1.3 Encourage and support expansion of federal grants to underserved areas	This would include providing premium assistance for communities who can demonstrate physician shortages through Health Provider Shortage Areas (HPSA) designation or classification as a rural health clinics.
Category #2: Civil Liability Reform	
2.1. Implement joint and several liability reform	Limit obligation of defendant for damages to proportion of award that matches fault.
2.2. Implement provisions to encourage full disclosure and apology by provider	A timely disclosure, apology and compensation would be offered before filing of a claim which has been shown to promote a resolution short of litigation in many cases. These efforts need to be protected from admissibility in any subsequent litigation.
2.3. Strengthen measures to reduce frivolous lawsuits	Encourage and strengthen use of existing judicial capacity to discourage or fine plaintiff attorneys for the pursuit of frivolous lawsuits.
2.4. Initiate "caps" on non economic damage awards	Implement measures to cap this element of damages awards in a fashion that protects against exorbitant damage awards while assuring appropriate recovery for injured party.
2.5. Statue of limitation restrictions	Shorten length of time after injury in which claim may be filed, particularly with respect to claims arising from injury to minors. This provision addresses tail coverage requirements that are an additional and burdensome cost of medical malpractice insurance.
2.6. Implement periodic payment of damages feature	Lower the existing threshold, insure payments are guaranteed and that lost wage payments extend beyond the death of the plaintiff.
2.7. Implement alternatives to litigation:	This would include mandatory mediation, requirement of certificate of merit before filing a claim and other effective pretrial mechanisms for reducing the number of lawsuits that require trial.
2.8. Certify and limit expert witnesses	Initiate measures to limit use of expert witnesses to reduce the cost of litigation. Measures should include defining qualifications of expert witnesses before allowing testimony and limiting number permitted to testify on a particular issue
2.9. Implement sliding fee scale for attorneys' fees	Implement caps on fees, based on sliding scale which allows lesser percentage of recovery as awards increase in total amounts.
Category #3: Insurance Industry Improvements	
3.1. Notification of premium increases above 15%	Insurance company requirement to provide advance notice of increases above a certain percentage and the claims data to support it
3.2. Improve insurance company reporting requirements for medical malpractice insurance	Require reporting of closed med mal claims data and/or other data which permit more effective analysis and decision making by the Office of the Insurance Commissioner.
Category #4: Consumer Protection	
4.1. Implement medical error reporting incentives and protections	Require mandatory reporting of serious adverse events and voluntary reporting of near misses. Sharing this information is critical to helping practitioners prevent future errors and problems. Only aggregated data is reported publicly and reports must be confidential and inadmissible.
4.2. Provide incentives to health care providers to implement quality improvement practices	This would include tax credits or grants for implementing information systems required to standardize best practices and proven patient safety incentives. Define and monitor performance outcomes and require purchasers to reward performance.
4.3. Strengthen and improve health care provider discipline	Require full DOH/disciplinary board investigation of an excess of three medical malpractice claims (over $50,000) paid within last five years. Provide incentives and protection for health providers making good faith effort reports to a disciplinary entity of suspected unprofessional conduct by a health care provider.

Exhibit 7

General Election Results, Initiatives 330 & 336 (Nov. 2005, Washington Secretary of State)

Elections Search Results

« Back

November 2005 General

State Totals Proofed · County Totals Proofed

Initiative to the Legislature 330

Yes/No	Votes	Percentage
Yes	783435	43.27%
No	1027117	56.73%

Ballot Title:
Initiative Measure No. 330 concerns claims for personal injury or death arising from health care services. This measure would change laws governing claims for negligent health care, including restricting noneconomic damages to $350,000 (with exception), shortening time limits for filing cases, limiting repayments to insurers and limiting claimants' attorney fees.

Show County Breakdown

Initiative to the Legislature 336

Candidate	Votes	Percentage
Yes	711443	39.78%
No	1076918	60.22%

Ballot Title:
Initiative Measure No. 336 concerns medical malpractice, including insurance, health care provider licensing, and lawsuits. This measure would require notices and hearings on insurance rate increases, establish a supplemental malpractice insurance program, require license revocation proceedings after three malpractice incidents, and limit numbers of expert witnesses in lawsuits.

Show County Breakdown

Initiative to the People 900

Candidate	Votes	Percentage
Yes	994757	56.44%

No	767844	43.56%

Ballot Title:
Initiative Measure No. 900 concerns performance audits of governmental entities. This measure would direct the State Auditor to conduct performance audits of state and local governments, and dedicate 0.16% of the state's portion of sales and use tax collections to fund these audits.

Show County Breakdown

Initiative to the People 901

Candidate	Votes	Percentage
Yes	1153353	63.25%
No	670225	36.75%

Ballot Title:
Initiative Measure No. 901 concerns amending the Clean Indoor Air Act by expanding smoking prohibitions. This measure would prohibit smoking in buildings and vehicles open to the public and places of employment, including areas within 25 feet of doorways and ventilation openings unless a lesser distance is approved.

Show County Breakdown

Initiative to the People 912

Candidate	Votes	Percentage
Yes	823366	45.38%
No	991196	54.62%

Ballot Title:
Initiative Measure No. 912 concerns motor vehicle fuel taxes. This measure would repeal motor vehicle fuel tax increases of 3 cents in 2005 and 2006, 2 cents in 2007, and 1.5 cents per gallon in 2008, enacted in 2005 for transportation purposes.

Show County Breakdown

Senate Joint Resolution 8207

Candidate	Votes	Percentage
Yes	1102192	67.55%
No	529586	32.45%

Ballot Title:
The Legislature has proposed a constitutional amendment on qualifications for service on the Commission on Judicial Conduct. This amendment would permit one member of the Commission on Judicial Conduct to be selected by and from the judges of all courts of limited jurisdiction.

Show County Breakdown

State Representative District #19 Position #2

Candidate	Party	Votes	Percentage
Dean A. Takko	D	21763	60.02%
Dawn Courtney	R	12807	35.32%
Judi Roberts Fiest	L	1687	4.65%

Show County Breakdown

Court of Appeals Division I District #1 Position #2

Candidate	Votes	Percentage
Susan Agid	334402	100%

Show County Breakdown

Court of Appeals Division I District #2 Position #1

Candidate	Votes	Percentage
Stephen J. Dwyer	42639	30.83%
J. Robert Leach	23448	16.95%
David Hulbert	22460	16.24%

Harold B. Field	8508	6.15%
Seth Fine	18576	13.43%
David W. Freese	11198	8.10%
Michael W. Hall	11468	8.29%
Show County Breakdown		

This database of election results is an ongoing project and users are reminded to frequently check for updates.

1900 - 1969 was added in March, 2011. All years, 1900 - 2006, are receiving a final proof, which will be indicated under the election name. Those elections that have received a final proof of state totals will say "State Totals Proofed". Those that received a final proof of the county results will say "County Totals Proofed". County results will be proofed last.

Disclaimer

The Washington Office of Secretary of State is not responsible for any losses caused by reliance on the accuracy, reliability, or timeliness of this information. Portions of such information may be incorrect or not current. Any person or entity who relies on any information obtained from the database does so at his or her own risk.

Exhibit 8

House Bill Report, SHB 2292, 59th Leg., Reg. Sess. (Wash. 2006)

HOUSE BILL REPORT
SHB 2292

As Reported by House Committee On:
Judiciary

Title: An act relating to improving health care by increasing patient safety, reducing medical errors, reforming medical malpractice insurance, and resolving medical malpractice claims fairly without imposing mandatory limits on damage awards or fees.

Brief Description: Addressing health care liability reform.

Brief History:
Committee Activity:
Judiciary: 1/13/06 [DP2S].

Brief Summary of Second Substitute Bill

- Makes a number of changes relating to health care practices and discipline, including protecting apologies and reports of unprofessional conduct, changing health care provider disciplining standards, and requiring disclosure of adverse events.
- Makes a number of changes to the medical malpractice insurance industry, including requiring closed claim reporting, changing requirements relating to underwriting standards and cancellation or non-renewal of policies, and requiring prior approval of rates and forms.
- Makes a number of changes to the health care liability system, including changes in the areas of the statute of limitations, expert witnesses, certificates of merit, offers of settlement, voluntary arbitration, collateral sources, and frivolous suits.

HOUSE COMMITTEE ON JUDICIARY

Majority Report: The second substitute bill be substituted therefor and the second substitute bill do pass. Signed by Representatives Lantz, Chair; Flannigan, Vice Chair; Williams, Vice Chair; Campbell, Kirby, Springer and Wood.

Minority Report: Without recommendation. Signed by Representatives Priest, Ranking Minority Member; Rodne, Assistant Ranking Minority Member and Serben.

Staff: Edie Adams (786-7180).

Background:

PATIENT SAFETY

Statements of Apology: Under both a statute and a court rule, evidence of furnishing or offering to pay medical expenses needed as the result of an injury is not admissible in a civil action to prove liability for the injury. In addition, a court rule provides that evidence of offers of compromise are not admissible to prove liability for a claim. Evidence of conduct or statements made in compromise negotiations are likewise not admissible.

In 2002, the Legislature passed legislation that makes expressions of sympathy relating to the pain, suffering, or death of an injured person inadmissible in a civil trial. A statement of fault, however, is not made inadmissible under this provision.

Reports of Unprofessional Conduct: A provision of law gives immunity specifically to physicians, dentists, and pharmacists who in good faith file charges or present evidence of incompetency or gross misconduct against another member of their profession before the Medical Quality Assurance Commission, the Dental Quality Assurance Commission, or the Board of Pharmacy.

Medical Quality Assurance Commission Membership (MQAC): The MQAC is responsible for the regulation of physicians and physician assistants. This constitutes approximately 23,000 credentialed health care professionals. The MQAC currently has 19 members consisting of 13 licensed physicians, two physician assistants, and four members of the public.

Health Care Provider Discipline: The Uniform Disciplinary Act (UDA) governs disciplinary actions for all 57 categories of credentialed health care providers. The UDA defines acts of unprofessional conduct, establishes sanctions for such acts, and provides general procedures for addressing complaints and taking disciplinary actions against a credentialed health care provider. Responsibilities in the disciplinary process are divided between the Secretary of Health (Secretary) and the 16 health profession boards and commissions according to the profession that the health care provider is a member of and the relevant step in the disciplinary process.

Upon a finding of an act of unprofessional conduct, the Secretary or the board or commission decides which sanctions should be ordered. These sanctions include: revocation of a license, suspension of a license, restriction of the practice, mandatory remedial education or treatment, monitoring of the practice, censure or reprimand, conditions of probation, payment of a fine, and surrender of the license. In the selection of a sanction the first consideration is what is necessary to protect or compensate the public, and the second consideration is what

may rehabilitate the license holder or applicant.

Disclosure of Adverse Events: A hospital is required to inform the Department of Health when certain events occur in its facility. These events include: unanticipated deaths or major permanent losses of function; patient suicides; infant abductions or discharges to the wrong family; sexual assault or rape; transfusions with major blood incompatibilities; surgery performed on the wrong patient or site; major facility system malfunctions; or fires affecting patient care or treatment. Hospitals must report this information within two business days of the hospital leaders learning of the event.

Coordinated Quality Improvement Programs: Hospitals maintain quality improvement committees to improve the quality of health care services and prevent medical malpractice. Quality improvement proceedings review medical staff privileges and employee competency, collect information related to negative health care outcomes, and conduct safety improvement activities. Provider groups and medical facilities other than hospitals are encouraged to conduct similar activities.

INSURANCE INDUSTRY REFORM

Medical Malpractice Closed Claim Reporting: The Insurance Commissioner (Commissioner) is responsible for the licensing and regulation of insurance companies doing business in this state. This includes insurers offering coverage for medical malpractice. There is no statutory requirement for insurers to report to the Commissioner information about medical malpractice claims, judgments, or settlements.

Underwriting Standards: Underwriting standards are used by insurers to evaluate and classify risks, assign rates and rate plans, and determine eligibility for coverage or coverage limitations. Insurers, including medical malpractice insurers, are not required to file their underwriting standards with the Commissioner.

Cancellation or Non-Renewal of Liability Insurance Policies: With certain exceptions, state insurance law requires insurance policies to be renewable. An insurer is exempt from this requirement if the insurer provides the insured with a cancellation notice that is delivered or mailed to the insured no fewer than 45 days before the effective date of the cancellation. Shorter notice periods apply for cancellation based on nonpayment of premiums (10 days) and for cancellation of fire insurance policies under certain circumstances (five days). The written notice must state the actual reason for cancellation of the insurance policy.

Prior Approval of Medical Malpractice Insurance Rates: The forms and rates of medical malpractice polices are "use and file." After issuing any policy, an insurer must file the forms and rates with the Commissioner within 30 days. Rates and forms are subject to public disclosure when the filing becomes effective. Actuarial formulas, statistics, and assumptions submitted in support of the filing are not subject to public disclosure.

HEALTH CARE LIABILITY REFORM

Statutes of Limitations and Repose: A medical malpractice action must be brought within time limits specified in statute, called the statute of limitations. Generally, a medical malpractice action must be brought within three years of the act or omission or within one year of when the claimant discovered or reasonably should have discovered that the injury was caused by the act or omission, *whichever period is longer.*

The statute of limitations is tolled during minority. This means that the three-year period does not begin to run until the minor reaches the age of 18. An injured minor will therefore always have until at least the age of 21 to bring a medical malpractice action.

The statute also provides that a medical malpractice action may never be commenced more than eight years after the act or omission. This eight-year outside time limit for bringing an action is called a "statute of repose." In the 1998 Washington Supreme Court decision *DeYoung v. Providence Medical Center*, the eight-year statute of repose was held unconstitutional on equal protection grounds.

Expert Witnesses: Expert witnesses are generally required in a medical malpractice action to establish the standard of care of a reasonably prudent health care provider and to prove that the failure to exercise that standard of care was the proximate cause of the patient's injury.

Statutory law dealing with medical malpractice actions does not establish qualifications for expert witnesses. However, court rule provides requirements for the use of expert witnesses in any trial, including medical malpractice cases. Under Evidence Rule 702, a person may be an expert if qualified by "knowledge, skill, experience, training, or education." The trial court judge has broad discretion under this rule to determine whether a witness is qualified to give an expert opinion.

Prior to trial, each party is entitled to what is known as "discovery" of facts and information from the other party that may be relevant to the case. A specific court rule deals with discovery of expert witnesses. A party may use interrogatories to require another party to disclose the identity of potential expert witnesses, the subject matter on which the expert intends to testify, the substance of the facts and opinions the expert plans to testify about, and a summary of the grounds for the expert's opinions. In addition, a party may depose any expert that another party intends to call as an expert witness at trial.

Certificate of Merit: A lawsuit is commenced either by filing a complaint or service of summons and a copy of the complaint on the defendant. The complaint is the plaintiff's statement of his or her claim against the defendant. The plaintiff is generally not required to plead detailed facts in the complaint; rather, the complaint may contain a short and plain statement that sets forth the basic nature of the claim and shows that the plaintiff is entitled to

relief.

There is no requirement that a plaintiff instituting a civil action file an affidavit or other document stating that the action has merit. However, a court rule requires that the pleadings in a case be made in good faith (Civil Rule 11). An attorney or party signing the pleading certifies that he or she has objectively reasonable grounds for asserting the facts and law. The court may assess attorneys' fees and costs against a party if the court finds that the pleading was made in bad faith, or to harass or cause unnecessary delay or needless expense.

Offers of Settlement: An offer of settlement statute is a mechanism to encourage the parties to a civil lawsuit to reach a settlement and avoid a lengthy and costly trial. An existing offer of settlement statute applies to actions in district court where the amount pleaded is $10,000 or less. This statute provides that the prevailing party who has made an offer of settlement is entitled to payment of reasonable attorneys' fees. Prevailing party means a party who makes an offer of settlement and who receives a judgment in the trial that is greater than his or her offer of settlement.

Voluntary Arbitration: Parties to a dispute may voluntarily agree in writing to enter into binding arbitration to resolve the dispute. A procedural framework for conducting the arbitration proceeding is provided in statute, including provisions relating to appointment of an arbitrator, attorney representation, witnesses, depositions, and awards. The arbitrator's decision is final and binding on the parties and there is no right of appeal. A court's review of an arbitration decision is limited to correction of an award or vacation of an award under limited circumstances.

Collateral Sources: In the context of tort actions, "collateral sources" are sources of payments or benefits available to the injured person that are totally independent of the tortfeasor. Examples of collateral sources are health insurance coverage, disability insurance, or sick leave. Under the common law "collateral source rule," a defendant is barred from introducing evidence that the plaintiff has received collateral source compensation for the injury.

The traditional collateral source rule has been modified in medical malpractice actions. In a medical malpractice action, any party may introduce evidence that the plaintiff has received compensation for the injury from collateral sources, except those purchased with the plaintiff's assets (e.g., insurance plan payments). The plaintiff may present evidence of an obligation to repay the collateral source compensation.

Summary of Second Substitute Bill:

The Legislature finds that addressing the issues of consumer access to health care and the increasing costs of medical malpractice insurance requires comprehensive solutions that

encourage patient safety, increase oversight of medical malpractice insurance, and make the civil justice system more understandable, fair, and efficient.

PATIENT SAFETY

Statements of Apology: In a medical negligence action, a statement of fault, apology, or sympathy, or a statement of remedial actions that may be taken, is not admissible as evidence if the statement was conveyed by a health care provider to the injured person or certain family members more than 20 days before the suit was filed and it relates to the person's discomfort, pain, or injury.

Reports of Unprofessional Conduct: A health care professional who makes a good faith report, files charges, or presents evidence to a disciplining authority against another member of a health profession relating to unprofessional conduct or inability to practice safely due to a physical or mental condition is immune in a civil action for damages resulting from such good faith activities. A health care professional who prevails in a civil action on the good faith defense is entitled to recover expenses and reasonable attorneys' fees incurred in establishing the defense.

Medical Quality Assurance Commission (MQAC): The public membership component of the MQAC is increased from four to six members, and at least two of the public members must be representatives of patient advocacy groups.

Health Care Provider Discipline: When imposing a sanction, a health profession disciplining authority may consider prior findings of unprofessional conduct, stipulations to informal disposition, and the actions of other Washington or out-of-state disciplining authorities.

Any combination of three unrelated orders for the following acts of unprofessional conduct within a 10-year period results in the permanent revocation of a health care professional's license:

- violations of orders or stipulations of the disciplining authority;
- violations of prescribing practices that create a significant risk to the public;
- certain convictions related to the practice of the profession in question;
- abuse of a patient or client;
- sexual contact with a patient or client; or
- where death, severe injury, or a significant risk to the public results from: (1) negligence, incompetence, or malpractice; (2) violation of laws regulating the profession in question; or (3) current substance abuse.

A one-time finding of specified mitigating circumstances may be issued to excuse a violation if there is either strong potential for rehabilitation or strong potential that remedial education and training will prevent future harm to the public. A finding of mitigating circumstances may be issued as many times as the disciplining authority determines that the act at issue

involved a high-risk procedure without any lower-risk alternatives, the patient was aware of the procedure's risks, and the health care provider took remedial steps prior to the disciplinary action.

Burden of Proof for License Suspension or Revocation: A new standard of proof of "substantial and significant evidence" applies to the suspension or revocation of a physician's license or a physician's assistant's license. This standard is higher than a preponderance of the evidence and lower than clear and convincing evidence.

Disclosure of Adverse Events: A medical facility must report the occurrence of an "adverse event" to the Department of Health (Department) within 45 days of its occurrence and may report the occurrence of an "incident." "Adverse events" are defined as: unanticipated deaths or major permanent losses of function; patient suicides; infant abductions or discharges to the wrong family; sexual assault or rape; transfusions with major blood incompatibilities; surgery performed on the wrong patient or site; major facility system malfunctions; or fires affecting patient care or treatment. An "incident" is defined as an event involving clinical care that could have injured the patient or that resulted in an unanticipated injury less severe than death or a major permanent loss of function.

Reports of adverse events and incidents must identify the facility, but may not identify any health care professionals, employees, or patients involved in the event or incident. Medical facilities must provide written notification to patients who may have been affected by the adverse event.

The Department is responsible for investigating reports of adverse events and establishing a system for medical facilities and health care workers to report adverse events and incidents. In addition, the Department must evaluate the data to identify patterns of adverse events and incidents and recommend ways to reduce adverse events and incidents and improve health care practices and procedures.

Coordinated Quality Improvement Programs: The types of programs that may apply to the Department to become coordinated quality improvement programs are expanded to include consortiums of health care providers that consist of at least five health care providers.

Prescription Legibility: Prescriptions for legend drugs must either be hand-printed, typewritten, or generated electronically.

Medical Malpractice Premium Assistance: The Department must develop a program to provide business and occupation tax credits for physicians who serve uninsured, Medicare, and Medicaid patients in a private practice or a reduced fee access program for the uninsured.

INSURANCE INDUSTRY REFORM

Medical Malpractice Closed Claim Reporting: Self-insurers and insuring entities that write medical malpractice insurance are required to report any closed claim resulting in a judgment, settlement, or no payment to the Office of the Insurance Commissioner (Commissioner) within 60 days after the claim is closed. The reports must contain specified data relating to: the type of health care provider, specialty, and facility involved; the dates when the event occurred, the claim was reported to the insurer, and the suit was filed; the claimant's age and sex; and information about the settlement, judgement, or other disposition of the claim, including an itemization of damages and litigation expenses.

If an insuring entity or self-insurer does not report the claim to the Commissioner, the provider or facility must report the claim to the Commissioner. The Commissioner may impose a fine against insuring entities who fail to report of up to $250 per day up to a total of $10,000. The Department may impose a fine against a facility or provider that fails to report of up to $250 per day up to a total of $10,000.

A claimant or the claimant's attorney in a medical malpractice action must report to the Commissioner the amount of court costs, attorneys' fees, or expert witness costs incurred in the action.

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

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

Underwriting Standards: Medical malpractice insurers must file their underwriting standards at least 30 days before the standards become effective. The filing must identify and explain: the class, type, and extent of coverage provided by the insurer; any changes that have occurred to the underwriting standards; and how underwriting changes are expected to affect future losses. The information is subject to public disclosure. "Underwrite" is defined as the process of selecting, rejecting, or pricing a risk.

When an insurer takes an adverse action against an insured, such as cancellation of coverage or an unfavorable change in coverage, the insurer may consider the following factors only in combination with other substantive underwriting factors: (1) that an inquiry was made about the nature or scope of coverage; (2) that a notification was made about a potential claim which did not result in the filing of a claim; or (3) that a claim was closed without payment.

Cancellation or Non-Renewal of Liability Insurance Policies: The mandatory notice period for cancellation or non-renewal of medical malpractice liability insurance policies is increased from 45 days to 90 days. An insurer must actually deliver or mail to the insured a written notice of cancellation of a medical malpractice liability insurance policy. For policies the insurer will not renew, the notice must state that the insurer will not renew the policy upon its expiration date.

Prior Approval of Medical Malpractice Insurance Rates: Medical malpractice rate filings and form filings are changed from the current "use and file" system to a prior approval system. An insurer must, prior to issuing a medical malpractice policy, file the policy rate and forms with the Commissioner. The Commissioner must review the filing, which cannot become effective until 30 days after its filing.

HEALTH CARE LIABILITY REFORM

Statutes of Limitations and Repose: Tolling of the statute of limitations during minority is eliminated.

The eight-year statute of repose is re-established. Legislative intent and findings regarding the justification for a statute of repose are provided in response to the Washington Supreme Court's decision overturning the statute of repose in *DeYoung v. Providence Medical Center*.

Expert Witnesses: An expert witness in a medical malpractice action must meet the following qualifications: (1) have expertise in the condition at issue in the action; and (2) was engaged in active practice or teaching in the same or similar area of practice or specialty as the defendant at the time of the incident, or at the time of retirement for a provider who retired no more than five years prior to suit. The court may waive these requirements under specified circumstances.

The number of expert witnesses allowed in a medical negligence action is limited to two per side on an issue, except upon a showing of good cause. If there are multiple parties on a side and they are unable to agree on the experts, the court may allow additional experts for good cause. All parties to a medical malpractice action must file a pretrial expert report that discloses the identity of all expert witnesses and states the nature of the testimony the experts will present at trial. Further depositions of the experts are prohibited. The testimony presented by an expert at trial is limited in nature to the opinions presented in the pretrial report.

Certificate of Merit: In medical negligence actions involving a claim of a breach of the standard of care, the plaintiff must file a certificate of merit at the time of commencing the action, or no later than 45 days after filing the action if the action is filed 45 days prior to the running of the statute of limitations. The certificate of merit must be executed by a qualified

expert and state that there is a reasonable probability that the defendant's conduct did not meet the required standard of care based on the information known at the time. The court for good cause may grant up to a 90-day extension for filing the certificate of merit.

Failure to file a certificate of merit that complies with these requirements results in dismissal of the case. If a case is dismissed for failure to comply with the certificate of merit requirements, the filing of the claim may not be used against the health care provider in liability insurance rate setting, personal credit history, or professional licensing or credentialing.

Offers of Settlement: An offer of settlement provision is created for medical malpractice actions. In an action where a party made an offer of settlement that is not accepted by the opposing party, the court may, in its discretion, award prevailing party attorneys' fees. "Prevailing party" means a party who makes an offer of settlement that is not accepted by the opposing party and who improves his or her position at trial relative to his or her offer of settlement.

In the case of a defendant, the offer of settlement provision applies only if the defendant previously made a disclosure to the claimant within seven days of learning that the claimant suffered an unanticipated outcome. The disclosure must have included: disclosure of the unanticipated outcome; an apology or expression of sympathy; and assurances that steps would be taken to prevent similar occurrences in the future.

When determining whether an award of attorneys' fees should be made to a prevailing party, the court may consider: (1) whether the party who rejected the offer of settlement was substantially justified in bringing the case to trial; (2) the extent to which additional relevant and material facts became known after the offer was rejected; (3) whether the offer of settlement was made in good faith; (4) the closeness of questions of fact and law at issue in the case; (5) whether a party engaged in conduct that unreasonably delayed the proceedings; (6) whether the circumstances make an award unjust; and (7) any other factor the court deems appropriate.

Voluntary Arbitration: A new voluntary arbitration system is established for disputes involving alleged professional negligence in the provision of health care. The voluntary arbitration system may be used only where all parties have agreed to submit the dispute to voluntary arbitration once the suit is filed, either through the initial complaint and answer, or after the commencement of the suit upon stipulation by all parties.

The maximum award an arbitrator can make is limited to $1 million for both economic and non-economic damages. In addition, the arbitrator may not make an award of damages based on the "ostensible agency" theory of vicarious liability.

The arbitrator is selected by agreement of the parties, and the parties may agree to more than

one arbitrator. If the parties are unable to agree to an arbitrator, the court must select an arbitrator from names submitted by each side. A dispute submitted to the voluntary arbitration system must follow specified time periods that will result in the commencement of the arbitration no later than 10 months after the parties agreed to submit to voluntary arbitration.

The number of experts allowed for each side is generally limited to two experts on the issue of liability, two experts on the issue of damages, and one rebuttal expert. In addition, the parties are generally entitled to only limited discovery. Depositions of parties and expert witnesses are limited to four hours per deposition and the total number of additional depositions of other witnesses is limited to five per side, for no more than two hours per deposition.

There is no right to a trial de novo on an appeal of the arbitrator's decision. An appeal is limited to the bases for appeal provided under the current arbitration statute for vacation of an award under circumstances where there was corruption or misconduct, or for modification or correction of an award to correct evident mistakes.

Collateral Sources: The collateral source payment statute is amended to remove the restriction on presenting evidence of collateral source payments that come from insurance purchased by the plaintiff. The plaintiff, however, may introduce evidence of amounts paid to secure the right to the collateral source payments (e.g., premiums), in addition to introducing evidence of an obligation to repay the collateral source compensation.

Frivolous Lawsuits: When signing and filing a claim, counterclaim, cross claim, or defense, an attorney certifies that the claim or defense is not frivolous. An attorney who signs a filing in violation of this section is subject to sanctions, including an order to pay reasonable expenses and reasonable attorneys' fees incurred by the other party.

Second Substitute Bill Compared to Substitute Bill:

The second substitute made a number of technical changes, including removing all references to Initiatives 330 and 336 in the intent section and removing the provisions designating the bill as an alternative to the Initiatives; removing a section of the bill that was passed in the 2005 session in another bill; updating a date from 2005 to 2006; and changing references for internal consistency.

Appropriation: None.

Fiscal Note: Available.

Effective Date of Second Substitute Bill: The bill takes effect 90 days after adjournment of

session in which bill is passed.

Testimony For: (In support) Both Initiatives 330 and 336 are flawed, and it is the Legislature's duty to come up with an alternative that deals with patient safety, insurance reform, and tort reform. The insurance market has improved and liability insurance is more affordable and accessible, but you still need to makes changes to improve the system and help get through the future hard markets. The alternative focuses on patient safety which provides a very positive focus. The alternative also has the purpose of avoiding litigation and improving the insurance industry. The public has been led to believe that rates are tied to an exploding tort system when the reality is that the real problem is with insurance industry cycles.

The insurance reform contained in the alternative is important. The data reporting component will help us evaluate what is happening in the market. Insurance companies should submit their rates and policies to the Insurance Commissioner before they start using them, and the 90-day cancellation requirement will provide more time for providers to find replacement policies. The alternative should go farther and also address the issue of capacity by establishing a supplemental malpractice insurance program similar to what is contained in Initiative 336.

This alternative will make a real practical improvement to the system and will allow resolution of disputes with less cost and without abolishing fundamental rights. It represents reasonableness over extremism, patient safety over special interests, and the best interest of people over political expediency. There is one small concern with eliminating expert depositions. Depositions are a cost effective way to frame the issues and help cases get resolved earlier.

(With concerns) It has become clear that the claims made a few years ago that an explosion in lawsuits and payouts were causing the malpractice premium crisis are just not true. The number of lawsuits when adjusted for population growth are down 15 percent in the last 10 years. Premiums are also down 7.7 percent, and Washington ranks 35th lowest in terms of average premiums for physicians. It is important to focus on patient safety. Data show that 195,000 people a year die from medical errors. The cost of this is more than six times the cost of the total medical malpractice liability system.

There are many good patient safety measures in the alternative, including adding two consumer members to the Medical Quality Assurance Commission. However, we need to make sure that complaints to that body are thoroughly investigated. In addition, the alternative is missing the very important piece of public access to this information and disclosure to individual patients. There should be language in the alternative prohibiting confidentiality restrictions in settlements, as contained in Initiative 336. It is important that this information be available to patients so they can make informed decisions about the doctors they chose.

On the insurance side, the alternative is missing the important component of public participation in insurance rate increases. Surplus lines carriers are concerned about being included in the closed claim reporting requirement.

The establishment of expert qualifications and limitations on the number of experts and expert depositions all interfere with the judges' ability to effectively manage trials and get to the truth. These limitations may unnecessarily increase costs and protract litigation. The expert qualifications should relate to the issue in the case rather than to the defendant's particular practice and, as drafted, only allow physicians to be experts. The expert limits should be two per side rather than allowing the stacking of multiple experts on one side. There are also concerns with the statute of limitations running on minors.

The voluntary arbitration piece will provide a simpler, quicker, and less expensive way to handle the majority of disputes. It will benefit doctors, hospitals, and claimants and should take most of the cases out of the court system. The system should also include a reporting mechanism for the arbitrator to report attorneys who file frivolous claims and doctors who are found to have caused significant harm through their negligence.

The Washington Defense Trial Lawyers Association was reported to be involved in crafting or reviewing this legislation, but this was not the case.

Testimony Against: Many physicians in this state are either leaving the state, leaving practice, or significantly limiting their practice. Washington residents are suffering as a result. Between 2000 and 2004, 14 percent of obstetrician-gynecologists stopped delivering babies, and 39 percent of family practitioners stopped delivery babies. This represents a combined 29 percent of physicians who have stopped delivering babies during that four-year period.

After two years of trying to get meaningful reform adopted by the Legislature and after significant frustrations, the medical association decided to pursue an initiative. Initiative 330 contains the key features for liability reform contained in the California Medical Injury Compensation Reform Act (MICRA) law, including a cap on non-economic damages, sliding scale cap on attorneys' fees, elimination of the collateral source rule, periodic payment of future damages, and joint and several liability reform.

Optimal reform must contain reasonable reform of the litigation system. The alternative does not contain meaningful medical litigation reform. It represents a missed opportunity. The voluntary arbitration provisions does nothing since voluntary arbitration is already a part of the law. The alternative does not contain a cap on non-economic damages nor a sliding scale cap on attorneys' fees. In addition, it does not contain joint and several liability reform, elimination of the collateral source rule, or expansion of periodic payment of damages. All of these features are necessary. The only successful approach is to enact meaningful liability

reform as contained in Initiative 330. A study of the California MICRA law found that law does not reduce access to the court system as people have claimed.

The insurance industry has concerns with changing from a "use and file" to a prior approval system. It is important for the industry to be able to develop products and introduce them in a timely fashion in order to create and maintain a competitive marketplace. A prior approval system is more appropriate for the less sophisticated segment of the insurance market.

Persons Testifying: (In support) Representative Lantz, prime sponsor; Senator Keiser; Senator Kline; Mike Kreidler, Insurance Commissioner; Bill Daley, Washington Citizens Action; and Mark Johnson and Ron Ward, Washington State Bar Association.

(With concerns) Martha Harden Cesar, Superior Court Judges' Association; Emilia Sweeney, Washington Defense Trial Lawyers; Lauri Gearllach, Cheryl Marshall, Candi Taylor, and Dolores Christiano, Citizens for Better Safer Healthcare; Larry Shannon and Joel Cunningham, Washington State Trial Lawyers' Association; Will Parry, Puget Sound Alliance for Retired Americans; and Tom Parker, Surplus Line Association.

(Opposed) Cliff Webster, Washington State Medical Association; Randy Revelle, Washington State Hospital Association; Kris Tefft, Association of Washington Business; and Mel Sorensen, Property Casualty Insurance Association.

Persons Signed In To Testify But Not Testifying: None.

Exhibit 9

Senate Bill Report, 2SB 6087, 59th Leg., Reg. Sess. (Wash. 2006)

SENATE BILL REPORT
2SHB 2292

As Reported By Senate Committee On:
Health & Long-Term Care, February 22, 2006

Title: An act relating to improving health care by increasing patient safety, reducing medical errors, reforming medical malpractice insurance, and resolving medical malpractice claims fairly without imposing mandatory limits on damage awards or fees.

Brief Description: Addressing health care liability reform.

Sponsors: House Committee on Judiciary (originally sponsored by Representatives Lantz, Cody, Campbell, Kirby, Flannigan, Williams, Linville, Springer, Clibborn, Wood, Fromhold, Morrell, Hunt, Moeller, Green, Kilmer, Conway, O'Brien, Sells, Kenney, Kessler, Chase, Upthegrove, Ormsby, Lovick, McCoy and Santos).

Brief History: Passed House: 1/23/06, 54-43.
Committee Activity: Health & Long-Term Care: 2/20/06, 2/22/06 [DPA].

SENATE COMMITTEE ON HEALTH & LONG-TERM CARE

Majority Report: Do pass as amended.
Signed by Senators Keiser, Chair; Thibaudeau, Vice Chair; Deccio, Ranking Minority Member; Benson, Brandland, Johnson, Kastama, Kline, Parlette and Poulsen.

Staff: Edith Rice (786-7444)

Background: Patient Safety

Statements of Apology: Under both a statute and a court rule, evidence of furnishing or offering to pay medical expenses needed as the result of an injury is not admissible in a civil action to prove liability for the injury. In addition, a court rule provides that evidence of offers of compromise are not admissible to prove liability for a claim. Evidence of conduct or statements made in compromise negotiations are likewise not admissible.

In 2002, the Legislature passed legislation that makes expressions of sympathy relating to the pain, suffering, or death of an injured person inadmissible in a civil trial. A statement of fault, however, is not made inadmissible under this provision.

Reports of Unprofessional Conduct: A provision of law gives immunity specifically to physicians, dentists, and pharmacists who in good faith file charges or present evidence of incompetency or gross misconduct against another member of their profession before the Medical Quality Assurance Commission, the Dental Quality Assurance Commission, or the Board of Pharmacy.

Medical Quality Assurance Commission Membership (MQAC): The MQAC is responsible for the regulation of physicians and physician assistants. This constitutes approximately 23,000

credentialed health care professionals. The MQAC currently has 19 members consisting of 13 licensed physicians, two physician assistants, and four members of the public.

Health Care Provider Discipline: The Uniform Disciplinary Act (UDA) governs disciplinary actions for all 57 categories of credentialed health care providers. The UDA defines acts of unprofessional conduct, establishes sanctions for such acts, and provides general procedures for addressing complaints and taking disciplinary actions against a credentialed health care provider. Responsibilities in the disciplinary process are divided between the Secretary of Health (Secretary) and the 16 health profession boards and commissions according to the profession that the health care provider is a member of and the relevant step in the disciplinary process.

Upon a finding of an act of unprofessional conduct, the Secretary or the board or commission decides which sanctions should be ordered. These sanctions include: revocation of a license, suspension of a license, restriction of the practice, mandatory remedial education or treatment, monitoring of the practice, censure or reprimand, conditions of probation, payment of a fine, and surrender of the license. In the selection of a sanction the first consideration is what is necessary to protect or compensate the public, and the second consideration is what may rehabilitate the license holder or applicant.

Disclosure of Adverse Events: A hospital is required to inform the Department of Health when certain events occur in its facility. These events include: unanticipated deaths or major permanent losses of function; patient suicides; infant abductions or discharges to the wrong family; sexual assault or rape; transfusions with major blood incompatibilities; surgery performed on the wrong patient or site; major facility system malfunctions; or fires affecting patient care or treatment. Hospitals must report this information within two business days of the hospital leaders learning of the event.

Coordinated Quality Improvement Programs: Hospitals maintain quality improvement committees to improve the quality of health care services and prevent medical malpractice. Quality improvement proceedings review medical staff privileges and employee competency, collect information related to negative health care outcomes, and conduct safety improvement activities. Provider groups and medical facilities other than hospitals are encouraged to conduct similar activities.

Insurance Industry Reform

Medical Malpractice Closed Claim Reporting: The Insurance Commissioner (Commissioner) is responsible for the licensing and regulation of insurance companies doing business in this state. This includes insurers offering coverage for medical malpractice. There is no statutory requirement for insurers to report to the Commissioner information about medical malpractice claims, judgments, or settlements.

Cancellation or Non-Renewal of Liability Insurance Policies: With certain exceptions, state insurance law requires insurance policies to be renewable. An insurer is exempt from this requirement if the insurer provides the insured with a cancellation notice that is delivered or mailed to the insured no fewer than 45 days before the effective date of the cancellation. Shorter notice periods apply for cancellation based on nonpayment of premiums (10 days) and for cancellation of fire insurance policies under certain circumstances (five days). The written notice must state the actual reason for cancellation of the insurance policy.

Prior Approval of Medical Malpractice Insurance Rates: The forms and rates of medical malpractice polices are "use and file." After issuing any policy, an insurer must file the forms and rates with the Commissioner within 30 days. Rates and forms are subject to public disclosure when the filing becomes effective. Actuarial formulas, statistics, and assumptions submitted in support of the filing are not subject to public disclosure.

Health Care Liability Reform

Statutes of Limitations and Repose: A medical malpractice action must be brought within time limits specified in statute, called the statute of limitations. Generally, a medical malpractice action must be brought within three years of the act or omission or within one year of when the claimant discovered or reasonably should have discovered that the injury was caused by the act or omission, whichever period is longer.

The statute of limitations is tolled during minority. This means that the three-year period does not begin to run until the minor reaches the age of 18. An injured minor will therefore always have until at least the age of 21 to bring a medical malpractice action.

The statute also provides that a medical malpractice action may never be commenced more than eight years after the act or omission. This eight-year outside time limit for bringing an action is called a "statute of repose." In the 1998 Washington Supreme Court decision *DeYoung v. Providence Medical Center*, the eight-year statute of repose was held unconstitutional on equal protection grounds.

Certificate of Merit: A lawsuit is commenced either by filing a complaint or service of summons and a copy of the complaint on the defendant. The complaint is the plaintiff's statement of his or her claim against the defendant. The plaintiff is generally not required to plead detailed facts in the complaint; rather, the complaint may contain a short and plain statement that sets forth the basic nature of the claim and shows that the plaintiff is entitled to relief.

There is no requirement that a plaintiff instituting a civil action file an affidavit or other document stating that the action has merit. However, a court rule requires that the pleadings in a case be made in good faith (Civil Rule 11). An attorney or party signing the pleading certifies that he or she has objectively reasonable grounds for asserting the facts and law. The court may assess attorneys' fees and costs against a party if the court finds that the pleading was made in bad faith, or to harass or cause unnecessary delay or needless expense.

Voluntary Arbitration: Parties to a dispute may voluntarily agree in writing to enter into binding arbitration to resolve the dispute. A procedural framework for conducting the arbitration proceeding is provided in statute, including provisions relating to appointment of an arbitrator, attorney representation, witnesses, depositions, and awards. The arbitrator's decision is final and binding on the parties and there is no right of appeal. A court's review of an arbitration decision is limited to correction of an award or vacation of an award under limited circumstances.

Collateral Sources: In the context of tort actions, "collateral sources" are sources of payments or benefits available to the injured person that are totally independent of the tortfeasor. Examples of collateral sources are health insurance coverage, disability insurance, or sick

leave. Under the common law "collateral source rule," a defendant is barred from introducing evidence that the plaintiff has received collateral source compensation for the injury.

The traditional collateral source rule has been modified in medical malpractice actions. In a medical malpractice action, any party may introduce evidence that the plaintiff has received compensation for the injury from collateral sources, except those purchased with the plaintiff's assets (e.g., insurance plan payments). The plaintiff may present evidence of an obligation to repay the collateral source compensation.

Summary of Amended Bill: The Legislature finds that addressing the issues of consumer access to health care and the increasing costs of medical malpractice insurance requires comprehensive solutions that encourage patient safety, increase oversight of medical malpractice insurance, and making the civil justice system more understandable, fair, and efficient. The Legislature intends to prioritize patient safety and the prevention of medical errors, to provide incentives to settle cases prior to going to court, and to provide the insurance commissioner with tools and information necessary to regulate medical malpractice insurance rates and policies so they are fair to insurers and the insured.

Part I

PATIENT SAFETY

Statements of Apology: In a medical negligence action, a statement of fault, apology, or sympathy, or a statement of remedial actions that may be taken, is not admissible as evidence if the statement was conveyed by a health care provider to the injured person or certain family members within 30 days of the act or within 30 days of the time the health care provider discovered the act, whichever is longer.

Reports of Unprofessional Conduct: A health care professional who makes a good faith report, files charges, or presents evidence to a disciplining authority against another member of a health profession relating to unprofessional conduct or inability to practice safely due to a physical or mental condition is immune in a civil action for damages resulting from such good faith activities. A health care professional who prevails in a civil action on the good faith defense is entitled to recover expenses and reasonable attorneys' fees incurred in establishing the defense.

Medical Quality Assurance Commission (MQAC): The public membership component of the MQAC is increased from four to six members, and at least two of the public members must not be from the health care industry.

Health Care Provider Discipline: When imposing a sanction, a health profession disciplining authority may consider prior findings of unprofessional conduct, stipulations to informal disposition, and the actions of other Washington or out-of-state disciplining authorities.

Adverse health event : "Adverse event" is defined as the list of serious reportable events adopted by the national quality forum in 2002. "Incident" is defined as a situation involving patient care which results in an unanticipated injury not part of the patient's illness, or a situation which could result in injury or require additional health care services but did not. Other definitions are provided.

Adverse Event Notification: Medical facilities must notify the Department of Health (DOH) within 48 hours of confirmation that an adverse event has occurred. A report must be submitted to the DOH within 45 days after confirmation that an adverse event has occurred. If DOH determines that an adverse event has not been reported or investigated, DOH will direct the facility to report or investigate it.

Independent entity to receive notification of adverse events and incidents: DOH will contract with an independent entity to develop an internet based system for reporting adverse events by facilities immediately available to DOH. The system will protect confidentiality, and the independent entity will develop recommendations for changes in health care practices for the purpose of reducing the number and severity of adverse events.

Whistleblower protection: An adverse event or incidents are specifically mentioned as information for which whistleblowers are protected if reported to DOH in good faith.

Confidentiality: Notification or reports of adverse events or are subject to the confidentiality provisions in current law and are exempt from public disclosure.

Prescription Legibility: Prescriptions for legend drugs must either be hand-printed, typewritten, or generated electronically.

Part II

INSURANCE INDUSTRY REFORM

Medical Malpractice Closed Claim Reporting: Self-insurers and insuring entities that write medical malpractice insurance are required to report any closed claim to the Office of the Insurance Commissioner (OIC). OIC may fine those who violate this requirement, up to $250 per day. The reports must contain specified data that is (to the extent possible) consistent with the format for data reported to the national practitioner data bank.

The Office of the Commissioner is required to prepare aggregate statistical summaries of closed claims based on the data submitted, while protecting the confidentiality of the underlying data.

OIC must prepare an annual report starting in 2010 which should include an analysis of closed claim information and any information the Commissioner finds is relevant to trends in medical malpractice. OIC will monitor losses and claim development patterns in the Washington state medical malpractice insurance market.

If the National Association of Insurance Commissioners adopts revised model statistical reporting standards for medica malpractice insurance, the OIC must analyze them and report any changes and recommendations to the Legislature by December 1, the year after they are adopted.

Written notice of a medical malpractice policy non-renewal must be delivered or mailed to the named insured at least 90 days before policy expiration and must include the actual reason for refusing to renew.

Medical malpractice policy forms or application forms are subject to the requirements under current law which must be filed with and approved by the OIC unless exempted from doing so by rule.

Part III

HEALTH CARE LIABILITY REFORM

Statutes of Limitations and Repose:
The eight-year statute of repose is re-established. Legislative intent and findings regarding the justification for a statute of repose are provided in response to the Washington Supreme Court's decision overturning the statute of repose in DeYoung v. Providence Medical Center. This means that a civil action for injury from health care must be commenced within three years of the act causing injury or within one year of the time that the patient discovered the injury or should have discovered the injury, whichever is later. However, this cannot be more than eight years after the original act causing the injury.
There are exceptions for fraud or intentional concealment until the date the patient has actual knowledge of the act of fraud or concealment, then they have one year from knowledge of the fraud or concealment. Knowledge of a custodial parent or guardian is imputed to a minor (person under 18 years of age). This means that tolling of the statute of limitations during minority is eliminated. Any actions not meeting these requirements are barred.

Certificate of Merit: In medical negligence actions involving a claim of a breach of the standard of care, the plaintiff must file a certificate of merit at the time of commencing the action (or no later than 45 days after filing the action if the action is filed 45 days prior to the running of the statute of limitations). If there is more than one defendant, a certificate of merit must be filed for each defendant. The person executing the certificate of merit must state that there is reasonable probability that the defendant's conduct did not follow the accepted standard of care required.

Failure to file a certificate of merit that complies with these requirements results in dismissal of the case. If a case is dismissed for failure to comply with the certificate of merit requirements, the filing of the claim may not be used against the health care provider in liability insurance rate settings, personal credit history, or professional licensing or credentialing.

Voluntary Arbitration: A voluntary arbitration system is established for disputes involving alleged professional negligence in the provision of health care. The voluntary arbitration system may be used only where all parties have agreed to submit the dispute to voluntary arbitration once the suit is filed, either through the initial complaint and answer, or after the commencement of the suit upon stipulation by all parties.

Arbitration award: The maximum award an arbitrator can make is limited to $1 million for both economic and non-economic damages. In addition, the arbitrator may not make an award of damages based on the "ostensible agency" theory of vicarious liability (an agency created by operation of law - a principle's actions would reasonably lead a third party to conclude that an agency relationship existed). Fees and expenses shall be paid by the non-prevailing party.

Appeal: There is no right to a trial de novo on an appeal of the arbitrator's decision. An appeal is limited to the bases for appeal provided under the current arbitration statute for vacation of an award under circumstances where there was corruption or misconduct, or for modification or correction of an award to correct evident mistakes.

Notice: Ninety days notice of intent to file a lawsuit is required if the lawsuit is based on a health care provider's professional negligence. Mandatory mediation does not apply to parties who have agreed to arbitration.

Collateral Sources: The collateral source payment statute is amended to remove the restriction on presenting evidence of collateral source payments that come from insurance purchased by the plaintiff. The plaintiff, however, may introduce evidence of amounts paid to secure the right to the collateral source payments (e.g., premiums).

Frivolous Lawsuits: When signing and filing a claim, counterclaim, cross claim, or defense, an attorney must certify that the claim or defense is not frivolous. An attorney who signs a filing in violation of this section is subject to sanctions, including an order to pay reasonable expenses and reasonable attorneys' fees incurred by the other party.

Amended Bill Compared to Second Substitute Bill: The amended bill provides that statements of fault or apology are not admissible if conveyed within 30 days of the act, no longer contains a reference to mandatory revocation of a health care professional license. Adverse events are defined and reporting requirements for adverse events are described. The amended bill removes the reference to burden of proof for license suspension or revocation, and deletes the reference to business and occupation tax credits for physicians treating the uninsured. Reference to filing underwriting standards is removed, the limitation on number of expert witnesses is deleted, as is the reference to offers of settlement. A 90 day notice of intent to file a medical malpractice lawsuit is required.

Appropriation: None.

Fiscal Note: Available.

Committee/Commission/Task Force Created: No.

Effective Date: Ninety days after adjournment of session in which bill is passed.

Testimony For: This bill is an improvement, but not necessarily everything everyone wanted. There is more work to be done in the future, but this is a good start. This bill has appropriate trade-offs. This bill will allow us to be better prepared for future changes. Real data will allow us to make meaningful changes in the future. This is an important first step. We fully support the striking amendment. This is an important step towards comprehensive reform. We have agreed to continue the dialogue started with this striking amendment. We have concerns about the additional data required. This will add cost, and we have concerns about the penalties in this bill.

Testimony Against: None.

Who Testified: PRO: Governor Christine Gregoire; Insurance Commissioner Mike Kreidler; Representative Pat Lantz, Prime sponser; Randy Revelle, Washington State Hospital Association; Peter Dunbar, MD, Washington State Medical Association; John Budlong, Washington State Trail Lawyers Association; Mary Selecky, Secretary, Department of Health; Gary Morse, Physicians Insurance; S. Brooke Taylor, Washington State Bar Association; Tom Parker, Surplus Lines; Mike Kapplohn, Farmers Insurance.

Exhibit 10

Senate Testimony/Attendance Roster – 2SHB 2292, February 20, 2006 Public Hearing

Senate Committee Services - Testimony/Attendance Roster

PRO

Committee: HEA **Bill number** 2SHB 2292 Addressing health care liability reform.

Date: 2/20/04 **Short Title:**

If you are from out of town and wish to testify, please mark the box to the right of your name.

Name	Organization	Mailing Address	Phone/E-mail	Testifying? (Yes/No)	If so, Pro/Con
Please Print ~~RANDY REVELLE~~ ☐	Washington State Hospital Association	Street 300 Elliott West Suite 300 City Seattle Zip 98119-4118	Phone: 206/216-2515 E-mail: randyr@wsha.org	YES	PRO
Please Print ~~S. BROOKE TAYLOR~~ ☐	WASH. STATE BAR ASSOC.	Street 1001 Eastside City Olympia Zip 98501	Phone: E-mail: 360-943-9977	YES	PRO
Please Print Barbara Flye ☐	WASH. Network for Civil Justice & Accountability	Street PO Box 422 City Zip Seattle WA 98111	Phone: 206-697-4744 E-mail:	NO	Pro
Please Print Insurance Commissioner ~~Mike Kreidler~~ ☐	Ins Commissioner	Street P.O Box 40255 City Olympia WA Zip	Phone: 725-7103 E-mail:	yes	Pro
Please Print ~~Peter Dunbar, MD~~ ☐	WSMA	Street City Zip	Phone: 441-9762 E-mail:	yes	PRO
Please Print ~~Gary Morse~~ ☐	Physicians Insurance	Street City Zip	Phone: 343-7300 E-mail:	yes	PRO
Please Print ~~NICK PETERSEN~~ ☐	MIDWIVES ASS'N OF WASHINGTON STATE	Street 2927 Cloverfield DR. SE City Olympia Zip 98501	Phone: 360-481-1936 E-mail:	NO	PRO
Please Print ~~John Budlong~~ ☐	WSTLA	Street 100 2nd Ave S City Edmonds WA Zip 98020	Phone: 425 673-1944 E-mail:	yes	PRO
Please Print Governor Gregoire ☐	Governors office	Street City Zip	Phone: E-mail:	Yes	Pro
Please Print ~~Mary Selecky~~ ☐	Dept. of Health	Street City Zip	Phone: E-mail:	Yes	Pro

Lacey

PRO

Senate Committee Services - Testimony/Attendance Roster

PRO

Committee: HEALTH & LONG TERM CARE COMMITTEE **Bill number** 2SHB 2292 Addressing health care liability reform.

Date: 2/20/06 **Short Title:**

If you are from out of town and wish to testify, please mark the box to the right of your name.

Name	Organization	Mailing Address (No "on file," please)	Phone/E-mail	Testifying? (Yes/No)	If so, Pro/Con
Please Print Lacey Shannon ☐	WSTLA	Street City Zip	Phone: E-mail:	Yes	PRO
Please Print Tom Parker ☐	Surplus Lines	Street City Zip tparker011@comcast.net	Phone: E-mail:	Yes	concerns
Please Print Mike Kappelman ☐	Farmers Ins	Street City Zip	Phone: E-mail:	YES	Concerns
Please Print ☐		Street City Zip	Phone: E-mail:		
Please Print ☐		Street City Zip	Phone: E-mail:		
Please Print ☐		Street City Zip	Phone: E-mail:		
Please Print ☐		Street City Zip	Phone: E-mail:		
Please Print ☐		Street City Zip	Phone: E-mail:		
Please Print ☐		Street City Zip	Phone: E-mail:		
Please Print ☐		Street City Zip	Phone: E-mail:		

Exhibit 11

Written Testimony in Support of SHB 2292, Randy Revelle
(Feb. 20, 2006)

R Revelle
2292
2/20/06

February 20, 2006

TESTIMONY IN SUPPORT OF SHB 2292
Randy Revelle, WSHA Senior Vice President

- Thank you for the opportunity to testify on House Bill 2292. I am Randy Revelle, Senior Vice President of the Washington State Hospital Association.

- The hospital association supports the version of House Bill 2292 negotiated by Governor Gregoire and agreed to by the Washington State Medical Association, the Washington State Trial Lawyers Association, and Physicians Insurance.

- We respectfully urge you to enact the negotiated version of House Bill 2292 without amendments.

- We reached agreement on a number of controversial provisions: protection of apologies, collateral sources, provider discipline, closed claim reporting, adverse event reporting, and voluntary binding arbitration.

- We agreed to recommend omitting provisions on expert witnesses, early offers of settlement, and mandating license revocation.

- While we are pleased with the negotiated improvements to House Bill 2292, we are very disappointed we were unable to reach agreement on our highest priority reforms to the ***current*** medical liability system – several liability for non-economic damages, elimination of ostensible agency, and a revised burden of proof for emergency services.

- Much more needs to be done to reform the state's medical liability system. We hope we can achieve fundamental, comprehensive reform by developing a ***new system*** with the following three goals: (1) reduce preventable injuries and promote patient safety; (2) fairly compensate injured patients; and (3) significantly reduce the legal and administrative costs of the system.

- In closing, I want to emphasize that Governor Gregoire put in a significant amount of time, effort, and skill to negotiate a workable compromise regarding House Bill 2292. Her leadership made the difference in achieving this important first step towards effective reform of the medical liability system.

Exhibit 12

Senate Committee Services, Chart of Constituent Positions Regarding SHB 2292, (Feb. 20, 2006)

CIVIL JUSTICE REFORM			
ISSUE(Sections from proposed striker	**DESCRIPTION**		**STRIKER PROVISIONS AND POSITIONS**
	Current	**2292**	
Certificate of Merit *(Sec. 304)*	No current requirement except Rule 11	• Requires a certificate of merit to state there is a reasonable probability conduct did not meet standard of care • Attorney must certify that claim is not frivolous and is subject to sanctions for a violation	All agree to this section (WSHA/WSMA/WSTLA)
Collateral Sources *(Sec. 315)*	No admissibility of collateral source payments (RCW 7.70.080)	Provides that evidence of any collateral source payment is admissible, but plaintiff may show evidence of an obligation to repay the payments and amounts paid to secure the rights to the payments.	All parties agree to proposed language, but WSHA/WSMA would prefer to include future payments; WSTLA does not agree to this
Expert Witness (Deleted)	No current statute; federal rules limit experts, as does state court discretion	• Establishes expert qualifications/requires corroboration • Limits the number of experts to ***two per side*** • Requires pre-trial expert reports; prohibits expert depositions	All parties agree these should be stricken (WSHA/WSMA/WSTLA)
Offers of Settlement (Deleted)	There is no applicable statutory provision	• Allows a court to award attorneys' fees to a prevailing party where the party made an offer of settlement that is not accepted by the opposing party • Applies to a defendant only if the defendant previously disclosed the unanticipated outcome that is at issue in the suit and made an apology and assurances that remedial steps would be taken	All parties oppose Sec. 309 as drafted – strike (WSHA, WSMA/WSTLA) (No agreement on an attorney fees limit)

2/20/2006 10:10 AM
SCS Staff

CIVIL JUSTICE REFORM (continued)			
ISSUE(Sections from proposed striker)	**DESCRIPTION**		**STRIKER PROVISIONS AND POSITIONS**
	Current	**2292**	
Statute of Limitations/Statute of Repose *(Sec. 301- 303)*	RCW 4.16.350 (invalidated in *DeYoung*)	Reenacts the eight-year statute of repose. Makes no change to the time limit in the statute of limitations. In a med. mal. action, eliminates the ability to toll the statute of limitations due to minority	All parties agree to these sections as drafted (WSHA/WSMA/WSTLA)
Voluntary Binding Arbitration *(Sec. 305- 313)*	Parties can now agree to arbitration/mediation	Establishes a **voluntary** binding arbitration system available where all parties to the suit agree to arbitration after the suit is filed. Limits discovery and ostensible agency recovery	Parties agree to language worked out between WSTLA and Physicians Insurance
Mandatory Mediation (Sec. 314)	None	Prefiling mandatory mediation required; statute of limits tolled	
Preventing Frivilous Lawsuits (Sec. 316)	Rule 11	Attorney must certify non-frivolous and is subject to sanctions	

COMPARISON/POSITIONS: MEDICAL MALPRACTICE – 2SHB 2292

PATIENT SAFETY			
ISSUE (Sections from proposed striker)	**DESCRIPTION**		**STRIKER PROVISIONS AND POSITIONS**
	Current	**2292**	
Adverse Events Reporting *(Sec. 105- 112)*	Not presently in law	• Requires facilities to report serious "adverse events;" allows reports of less serious "incidents" • Requires the DOH to investigate	All support subject to resolution of costs imposed on hospitals and confidentiality and inadmissibility provisions. (WSHA/WSMA/WSTLA/DOH)
Coordinated Quality Improvement Programs *(Sec. 113)*	In current law (43.70.510), this is an expansion	Expands the providers that can establish coordinated quality improvement programs	All agree on this provision (WSHA/WSMA/WSTLA/DOH)
Medical Malpractice Premium Assistance (Deleted)	In a budget proviso last session	Requires DOH to develop a program to provide B&O credits for M.D.s who serve uninsured/Medicaid/Medicare	All agree this can be deleted; taken care of in 2005 by budget proviso (WSHA/WSMA/WSTLA)
Prescription Legibility *(Sec.114-115)*	Not presently in law	Requires prescriptions to be hand printed, typewritten, or generated electronically	All agree on this section as drafted (WSHA/WSMA/WSTLA)
Protection of Apologies *(Sec. 101)*	Not presently in law	Provides that a health care provider's statements of apology, fault, or remedial acts that will be taken are inadmissible as evidence in a civil action	All support revised language making inadmissible apologies, statements of regret, including fault 30 days from discovery (WSHA/WSMA/WSTLA) (Revised, agreed language sent by Barbara Shickich – 2/13/06)

PROVIDER DISCIPLINE			
ISSUE(Sections from proposed striker)	**DESCRIPTION**		**STRIKER PROVISIONS AND POSITIONS**
	Current	**2292**	
Health Care Discipline Burden of Proof (Deleted)	• Current case law: clear cogent • Case #2 argued 10/05	• Specifies that generally the burden of proof applicable in health care professional disciplinary proceedings is a "preponderance of the evidence" • Creates a new burden of proof of "substantial and significant"	All agree this section can be deleted and left to court decisions expected soon
Mandatory License Revocation (3 strikes) (Deleted)	Not in current law	Requires automatic revocation, three strikes, within ten years	All agree this section can be deleted; Commission has authority to act (WSHA/WSMA/WSTLA/DOH)
Medical Quality Assurance Commission *(Sec. 103-104)*	Amends current law	Increases public membership from four to six members; requires two new public members represent patient "advocacy" groups	All agree to addition of two additional public members, strike "advocacy" groups language, leave to appointing authority (WSHA/WSMA/WSTLA/DOH)
Reports of Unprofessional Conducts *(Sec. 102)*	Immunity in RCW 18.130.180 and 18.170.193; this adds immunity and attorney fees	Provides immunity for health care professionals who, in good faith, report another's unprofessional conduct or impairment and attorney fees if have an action to defend "good faith"	All agree to this section (WSHA/WSMA/WSTLA/DOH)

INSURANCE REFORM[1]			
ISSUE(Sections from proposed striker	**DESCRIPTION**		**STRIKER PROVISIONS AND POSITIONS**
	Current	**2292**	
Closed Claim Reporting *(Sec. 201-210)*		• Requires insurers, self-insurers, and claimants to report certain data regarding med. mal. closed claims • Requires OIC to prepare reports analyzing trends in malpractice area • Provides fines • Revised language delays implementation to 2008 and extends confidentiality to providers and facilities	All parties and OIC in agreement on revised language as long as language does not include the $250/day fine Section 204(4) problem for DOH as well; definition of health care facility too broad; gives fining authority both to OIC and DOH
Cancellation or Non-renewal of Insurance Policies *(Sec. 212-213)*		Requires 90 days prior notice for cancellation or non-renewal of a med. mal. policy and reasons	All parties and OIC in agreement on slightly revised language
Underwriting Standards *(Sec.211)*		• Requires med. mal. insurers to file their underwriting standards at least 30 days before they become effective • Prohibits an adverse action against an insured solely on the basis that the insured notified the insurer about a potential claim or had a claim closed with no payment	Alls parties and OIC in agreement on revised language
Prior Approval of Rates and Forms *(Sec. 214)*		Changes med. mal. insurance from "file and use" to "prior approval"	

2/20/2006 10:10 AM

Exhibit 13

Final Bill Report on 2SHB 2292, 59th Leg., Reg. Sess. (Wash. 2006)

FINAL BILL REPORT
2SHB 2292

C 8 L 06
Synopsis as Enacted

Brief Description: Addressing health care liability reform.

Sponsors: By House Committee on Judiciary (originally sponsored by Representatives Lantz, Cody, Campbell, Kirby, Flannigan, Williams, Linville, Springer, Clibborn, Wood, Fromhold, Morrell, Hunt, Moeller, Green, Kilmer, Conway, O'Brien, Sells, Kenney, Kessler, Chase, Upthegrove, Ormsby, Lovick, McCoy and Santos).

House Committee on Judiciary
Senate Committee on Health & Long-Term Care
Background:

The Legislature has considered a number of legislative proposals relating to medical malpractice over the past several years. These proposals have included a wide variety of issues that fall into three main areas designated as "patient safety," "insurance industry reform," and "civil liability reform."

PATIENT SAFETY

Statements of Apology. Under both a statute and a court rule, evidence of furnishing or offering to pay medical expenses needed as the result of an injury is not admissible in a civil action to prove liability for the injury. In addition, a court rule provides that evidence of offers of compromise are not admissible to prove liability for a claim. Evidence of conduct or statements made in compromise negotiations are likewise not admissible.

In 2002, the Legislature passed legislation that provides that an expression of sympathy relating to the pain, suffering, or death of an injured person is inadmissible in a civil trial. A statement of fault, however, is not made inadmissible under this provision.

Reports of Unprofessional Conduct. The Uniform Disciplinary Act (UDA) gives immunity to any person who, in good faith, either submits a written complaint to a disciplining authority charging a health care professional with unprofessional conduct or reports information to a disciplining authority indicating that a provider may not be able to practice his or her profession with reasonable skill and safety because of a mental or physical condition.

Another provision of law gives immunity specifically to physicians, dentists, and pharmacists who in good faith file charges or present evidence of incompetency or gross misconduct against another member of their profession before the Medical Quality Assurance Commission, the Dental Quality Assurance Commission, or the Board of Pharmacy.

Medical Quality Assurance Commission Membership (MQAC). The MQAC is responsible for the regulation of physicians and physician assistants. This constitutes approximately

23,000 credentialed health care professionals. The MQAC has 19 members consisting of 13 licensed physicians, two physician assistants, and four members of the public.

Health Care Provider Discipline. The UDA governs disciplinary actions for all 57 categories of credentialed health care providers. The UDA defines acts of unprofessional conduct, establishes sanctions for such acts, and provides general procedures for addressing complaints and taking disciplinary actions against a credentialed health care provider. Responsibilities in the disciplinary process are divided between the Secretary of Health and the 16 health profession boards and commissions according to the health care provider's profession and the relevant step in the disciplinary process.

Upon a finding of an act of unprofessional conduct, the Secretary or the board or commission decides which sanctions should be ordered. These sanctions include: revocation of a license, suspension of a license, restriction of the practice, mandatory remedial education or treatment, monitoring of the practice, censure or reprimand, conditions of probation, payment of a fine, denial of a license request, corrective action, refund of billings, and surrender of the license.

Disclosure of Adverse Events. A hospital is required to inform the Department of Health (DOH) when certain events occur in its facility. These events include: unanticipated deaths or major permanent losses of function; patient suicides; infant abductions or discharges to the wrong family; sexual assault or rape; transfusions with major blood incompatibilities; surgery performed on the wrong patient or site; major facility system malfunctions; or fires affecting patient care or treatment. A hospital must report this information within two business days of learning of the event.

Coordinated Quality Improvement Programs. Hospitals are required to maintain quality improvement programs to improve the quality of health care services and prevent medical malpractice. Quality improvement programs review medical staff privileges and employee competency, collect information related to negative health care outcomes, and conduct safety improvement activities. Medical facilities other than hospitals, and health care provider groups consisting of five or more providers, also may maintain quality improvement programs approved by the DOH.

INSURANCE INDUSTRY REFORM

Medical Malpractice Closed Claim Reporting. The Insurance Commissioner (Commissioner) is responsible for the licensing and regulation of insurance companies doing business in this state. This includes insurers offering coverage for medical malpractice. There is no statutory requirement for insurers to report to the Commissioner information about medical malpractice claims, judgments, or settlements.

Underwriting Standards. Underwriting standards are used by insurers to evaluate and classify risks, assign rates and rate plans, and determine eligibility for coverage or coverage limitations. Insurers, including medical malpractice insurers, are not required to file their underwriting standards with the Commissioner nor to notify an insured of the significant risk factors that lead to an underwriting action.

Cancellation or Non-Renewal of Liability Insurance Policies. With certain exceptions, state insurance law requires insurance policies to be renewable. An insurer is exempt from this requirement if the insurer provides the insured with a cancellation notice that is delivered or mailed to the insured no fewer than 45 days before the effective date of the cancellation. Shorter notice periods apply for cancellation based on nonpayment of premiums (10 days) and for cancellation of fire insurance policies under certain circumstances (five days). The written notice must state the actual reason for cancellation of the insurance policy.

Prior Approval of Medical Malpractice Insurance Rates. The forms and rates of medical malpractice polices are "use and file." After issuing any policy, an insurer must file the forms and rates with the Commissioner within 30 days. Rates and forms are subject to public disclosure when the filing becomes effective. Actuarial formulas, statistics, and assumptions submitted in support of the filing are not subject to public disclosure.

HEALTH CARE LIABILITY REFORM

Statutes of Limitations and Repose. A medical malpractice action must be brought within time limits specified in statute, called the statute of limitations. Generally, a medical malpractice action must be brought within three years of the act or omission or within one year of when the claimant discovered or reasonably should have discovered that the injury was caused by the act or omission, *whichever period is longer.*

The statute of limitations is tolled during minority. This means that the three-year period does not begin to run until the minor reaches the age of 18. An injured minor will therefore always have until at least the age of 21 to bring a medical malpractice action.

The statute also provides that a medical malpractice action may never be commenced more than eight years after the act or omission. This eight-year outside time limit for bringing an action is called a "statute of repose." In 1998 the Washington Supreme Court held the eight-year statute of repose unconstitutional on equal protection grounds.

Certificate of Merit. A lawsuit is commenced either by filing a complaint or by service of summons and a copy of the complaint on the defendant. The complaint is the plaintiff's statement of his or her claim against the defendant. The plaintiff is generally not required to plead detailed facts in the complaint; rather, the complaint may contain a short and plain statement that sets forth the basic nature of the claim and shows that the plaintiff is entitled to relief.

There is no requirement that a plaintiff instituting a civil action file an affidavit or other document stating that the action has merit. However, a court rule requires that the pleadings in a case be made in good faith. An attorney or party signing the pleading certifies that he or she has objectively reasonable grounds for asserting the facts and law. The court may assess attorneys' fees and costs against a party if the court finds that the pleading was made in bad faith or to harass or cause unnecessary delay or needless expense.

Voluntary Arbitration. Parties to a dispute may voluntarily agree in writing to enter into binding arbitration to resolve the dispute. A procedural framework for conducting the

arbitration proceeding is provided in statute, including provisions relating to appointment of an arbitrator, attorney representation, witnesses, depositions, and awards. The arbitrator's decision is final and binding on the parties, and there is no right of appeal. A court's review of an arbitration decision is limited to correction of an award or vacation of an award under limited circumstances.

Pre-Suit Notice and Mandatory Mediation. Generally, a plaintiff does not have to provide a defendant with prior notice of his or her intent to institute a civil suit. In suits against the state or a local government, however, a plaintiff must first file a claim with the governmental entity that provides notice of specified information relating to the claim. The plaintiff may not file suit until 60 days after the claim is filed with the governmental entity.

Medical malpractice claims are subject to mandatory mediation in accordance with court rules adopted by the Washington Supreme Court. The court rule provides deadlines for commencing mediation proceedings, the process for appointing a mediator, and the procedure for conducting mediation proceedings. The rule allows mandatory mediation to be waived upon petition of any party that mediation is not appropriate.

Collateral Sources. In the context of tort actions, "collateral sources" are sources of payments or benefits available to the injured person that are totally independent of the tortfeasor. Examples of collateral sources are health insurance coverage, disability insurance, or sick leave. Under the common law "collateral source rule," a defendant is barred from introducing evidence that the plaintiff has received collateral source compensation for the injury.

The traditional collateral source rule has been modified in medical malpractice actions. In a medical malpractice action, any party may introduce evidence that the plaintiff has received compensation for the injury from collateral sources, except those purchased with the plaintiff's assets (e.g., insurance plan payments). The plaintiff may present evidence of an obligation to repay the collateral source compensation.

Frivolous Lawsuits. Under both statute and court rule, the court may sanction a party or attorney for bringing a frivolous suit or asserting a frivolous claim or defense. Under the statute, which applies to all civil actions, if the court finds that the action, or any claim or defense asserted in the action, was frivolous and advanced without reasonable cause, the court may require the non-prevailing party to pay the prevailing party reasonable expenses and attorneys' fees incurred in defending the claim or defense.

Summary:

The Legislature finds that addressing the issues of consumer access to health care and the increasing costs of medical malpractice insurance requires comprehensive solutions that encourage patient safety, increase oversight of medical malpractice insurance, and make the civil justice system more understandable, fair, and efficient.

PATIENT SAFETY

Statements of Apology. In a medical negligence action, a statement of fault, apology, or sympathy, or a statement of remedial actions that may be taken, is not admissible as evidence in a civil action if the statement was conveyed by a health care provider to the injured person or certain family members within 30 days of the act or omission, or the discovery of the act or omission, that is the basis for the claim.

Reports of Unprofessional Conduct. The statute granting immunity to a physician, dentist, or pharmacist who files charges or presents evidence about the incompetence or misconduct of another physician, dentist, or pharmacist is expanded to apply to any health care professional subject to the Uniform Disciplinary Act and to apply to reports or evidence relating to unprofessional conduct or the inability to practice with reasonable skill and safety because of a physical or mental condition. A health care professional who prevails in a civil action on the good faith defense provided in this immunity statute is entitled to recover expenses and reasonable attorneys' fees incurred in establishing the defense.

Medical Quality Assurance Commission (MQAC). The public membership component of the MQAC is increased from four to six members, and at least two of the public members must not be representatives of the health care industry.

Health Care Provider Discipline. When imposing a sanction against a health care provider, a health profession disciplining authority may consider prior findings of unprofessional conduct, stipulations to informal disposition, and the actions of other Washington or out-of-state disciplining authorities.

Disclosure of Adverse Events. A medical facility must notify the Department of Health (DOH) within 48 hours of confirmation that an adverse event has occurred. The medical facility must submit a subsequent report of the adverse event to the DOH within 45 days. The report must include a root cause analysis of the adverse event and a corrective action plan, or an explanation of the reasons for not taking corrective action. Facilities and health care workers may report the occurrence of "incidents." "Adverse event" is defined as the list of serious reportable events adopted by the National Quality Forum in 2002. "Incident" is defined as an event involving clinical care that could have injured the patient or that resulted in an unanticipated injury that does not rise to the level of an adverse event.

The DOH must contract with an independent entity to develop a secure internet-based system for the reporting of adverse events and incidents. The independent entity is responsible for receiving and analyzing the notifications and reports and developing recommendations for changes in health care practices for the purpose of reducing the number and severity of adverse events. The independent entity must report to the Legislature and the Governor on an annual basis regarding the number of adverse events and incidents reported and the information derived from the reports.

Coordinated Quality Improvement Programs. The types of programs that may apply to the DOH to become coordinated quality improvement programs are expanded to include consortiums of health care providers that consist of at least five health care providers.

Prescription Legibility. Prescriptions for legend drugs must either be hand-printed, typewritten, or generated electronically.

INSURANCE INDUSTRY REFORM

Medical Malpractice Closed Claim Reporting. Self-insurers and insuring entities that write medical malpractice insurance are required to report medical malpractice closed claims that are closed after January 1, 2008, to the Office of the Insurance Commissioner (Commissioner). Closed claims reports must be filed annually by March 1, and must include data for closed claims for the preceding year. The reports must contain specified data relating to: the type of health care provider, specialty, and facility involved; the reason for the claim and the severity of the injury; the dates when the event occurred, the claim was reported to the insurer, and the suit was filed; the injured person's age and sex; and information about the settlement, judgment, or other disposition of the claim, including an itemization of damages and litigation expenses.

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

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

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

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

Underwriting Standards. During the underwriting process, an insurer may consider the following factors only in combination with other substantive underwriting factors: (1) that an inquiry was made about the nature or scope of coverage; (2) that a notification was made about a potential claim that did not result in the filing of a claim; or (3) that a claim was closed without payment. If an underwriting activity results in a higher premium or reduced coverage, the insurer must provide written notice to the insured describing the significant risk factors that led to the underwriting action.

Cancellation or Non-Renewal of Liability Insurance Policies. The mandatory notice period for cancellation or non-renewal of medical malpractice liability insurance policies is increased from 45 days to 90 days. An insurer must actually deliver or mail to the insured a written notice of the cancellation or non-renewal of the policy, which must include the actual reason for the cancellation or non-renewal and the significant risk factors that led to the action. For policies the insurer will not renew, the notice must state that the insurer will not renew the policy upon its expiration date.

Prior Approval of Medical Malpractice Insurance Rates. Medical malpractice rate filings and form filings are changed from the current "use and file" system to a prior approval system. An insurer must, prior to issuing a medical malpractice policy, file the policy rate and forms with the Commissioner. The Commissioner must review the filing, which cannot become effective until 30 days after its filing.

HEALTH CARE LIABILITY REFORM

Statutes of Limitations and Repose. Tolling of the statute of limitations during minority is eliminated.

The eight-year statute of repose is re-established. Legislative intent and findings regarding the justification for a statute of repose are provided in response to the Washington Supreme Court's decision overturning the statute of repose.

Certificate of Merit. In medical negligence actions involving a claim of a breach of the standard of care, the plaintiff must file a certificate of merit at the time of commencing the action, or no later than 45 days after filing the action if the action is filed 45 days prior to the running of the statute of limitations. The certificate of merit must be executed by a qualified expert and state that there is a reasonable probability that the defendant's conduct did not meet the required standard of care based on the information known at the time. The court for good cause may grant up to a 90-day extension for filing the certificate of merit.

Failure to file a certificate of merit that complies with these requirements results in dismissal of the case. If a case is dismissed for failure to comply with the certificate of merit requirements, the filing of the claim may not be used against the health care provider in liability insurance rate setting, personal credit history, or professional licensing or credentialing.

Voluntary Arbitration. A new voluntary arbitration system is established for disputes involving alleged professional negligence in the provision of health care. The voluntary arbitration system may be used only where all parties have agreed to submit the dispute to voluntary arbitration once the suit is filed, either through the initial complaint and answer, or after the commencement of the suit upon stipulation by all parties.

The maximum award an arbitrator may make is limited to $1 million for both economic and non-economic damages. In addition, the arbitrator may not make an award of damages based on the "ostensible agency" theory of vicarious liability.

The arbitrator is selected by agreement of the parties, and the parties may agree to more than one arbitrator. If the parties are unable to agree to an arbitrator, the court must select an arbitrator from names submitted by each side. A dispute submitted to the voluntary arbitration system must follow specified time periods that will result in the commencement of the arbitration no later than 12 months after the parties agreed to submit to voluntary arbitration.

The number of experts allowed for each side is generally limited to two experts on the issue of liability, two experts on the issue of damages, and one rebuttal expert. In addition, the parties are generally entitled to only limited discovery. Depositions of parties and expert witnesses are limited to four hours per deposition and the total number of additional depositions of other witnesses is limited to five per side, for no more than two hours per deposition.

There is no right to a trial de novo on an appeal of the arbitrator's decision. An appeal is limited to the bases for appeal provided under the current arbitration statute for vacation of an award under circumstances where there was corruption or misconduct, or for modification or correction of an award to correct evident mistakes.

Pre-Suit Notice and Mandatory Mediation. A medical malpractice action may not be commenced unless the plaintiff has provided the defendant with 90 days prior notice of the intention to file a suit. The 90-day notice requirement does not apply if the defendant's name is unknown at the time of filing the complaint.

The mandatory mediation statute is amended to require mandatory mediation of medical malpractice claims unless the claim is subject to either mandatory or voluntary arbitration. Implementation of the mediation requirement contemplates the adoption of a rule by the Supreme Court establishing a procedure for the parties to certify the manner of mediation used by the parties.

Collateral Sources. The collateral source payment statute is amended to remove the restriction on presenting evidence of collateral source payments that come from insurance purchased by the plaintiff. The plaintiff, however, may introduce evidence of amounts paid to secure the right to the collateral source payments (e.g., premiums), in addition to introducing evidence of an obligation to repay the collateral source compensation.

Frivolous Lawsuits. An attorney in a medical malpractice action, by signing and filing a claim, counterclaim, cross claim, or defense, certifies that the claim or defense is not frivolous. An attorney who signs a filing in violation of this section is subject to sanctions, including an order to pay reasonable expenses and reasonable attorneys' fees incurred by the other party.

Votes on Final Passage:

House	54	43	
Senate	48	0	(Senate amended)
House	82	15	(House concurred)

Effective: June 7, 2006

July 1, 2006 (Sections 112 and 210)

ATTORNEY GENERAL'S OFFICE, TORTS DIVISION

May 05, 2023 - 4:30 PM

Transmittal Information

Filed with Court:	Supreme Court
Appellate Court Case Number:	101,300-1
Appellate Court Case Title:	Bette Bennett v. United States

The following documents have been uploaded:

- 1013001_Briefs_20230505162820SC629551_6438.pdf
  This File Contains:
  Briefs - Amicus Curiae
  The Original File Name was Amicus_FINAL.pdf
- 1013001_Motion_20230505162820SC629551_0246.pdf
  This File Contains:
  Motion 1 - Other
  The Original File Name was Mot_LeaveAmicus_FINAL.pdf

A copy of the uploaded files will be sent to:

- Christine.Stanley@ppgnhaik.org
- dbailey@baileyonsager.com
- kristen.vogel@usdoj.gov
- miller@carneylaw.com
- prevost@carneylaw.com
- teal.miller@usdoj.gov

Comments:

Sender Name: Beverly Cox - Email: beverly.cox@atg.wa.gov
Filing on Behalf of: Sara Avet Cassidey - Email: sara.cassidey@atg.wa.gov (Alternate Email: TORTTAP@atg.wa.gov)

Address:
PO Box 40126
Olympia, WA, 98504-0126
Phone: (360) 586-6300

Note: The Filing Id is 20230505162820SC629551