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: None.
Persons Testifying: None.

Persons Signed In To Testify But Not Testifying: None.