H-1223.3

HOUSE BILL 1686

State of Washington 59th Legislature 2005 Regular Session

By Representatives Bailey, Armstrong, Hinkle, Skinner, Clements, Shabro, Roach, Kristiansen, Newhouse, Talcott, Pearson, Strow, Woods, Schindler, Serben, Buck, Ahern and McCune

Read first time 02/02/2005. Referred to Committee on Health Care.

AN ACT Relating to cost reduction and consumer choice in the health care system; amending RCW 48.21.045, 48.44.023, 48.46.066, 41.05.065, 4.56.250, 7.70.020, 7.70.070, 7.70.100, 4.16.350, 7.70.080, 74.34.200, 4.22.070, and 4.22.015; adding a new section to chapter 48.43 RCW; adding a new section to chapter 4.56 RCW; adding a new section to chapter 7.04 RCW; adding new sections to chapter 7.70 RCW; and creating new sections.

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

NEW SECTION. **Sec. 1.** (1) The legislature finds that:

(a) The cost of health care, along with the number of uninsured persons, is continuing to rise;

(b) Many individuals are uninsured because employers are not given adequate health insurance options that they and their employees can afford;

(c) Due to the increasing number of mandated health benefits, willing small employers are financially unable to provide affordable health insurance to their employees that meets the employees' individual needs;

(d) The purchaser and recipient of health care should have more control over the services and products they purchase; and

(e) It is in the best interest of the people of the state of Washington to contain the significantly increasing costs of malpractice insurance for licensed health care professionals and institutions and noninstitutional care providers in order to ensure the continued availability and affordability of health care services in this state by enacting further reforms to the health care tort liability system.

(2) The legislature intends to:

(a) Provide employees with more options in choosing a quality health care plan that meets their individual needs;

(b) Create a moratorium on new mandated health benefits, and require an independent cost-benefit analysis of all current health benefit mandates;

(c) Direct the public employees' benefits board to offer a health savings account option to public employees; and

(d) Enact medical malpractice reforms to stabilize the health care professional liability insurance market, maintain access to affordable quality health care services, and avert the kind of crisis now facing the residents of Washington.

Sec. 2. RCW 48.21.045 and 2004 c 244 s 1 are each amended to read as follows:

(1)((~~(a)~~)) An insurer offering any health benefit plan to a small employer, either directly or through an association or member-governed group formed specifically for the purpose of purchasing health care, may offer and actively market to the small employer ((~~a~~)) no more than one health benefit plan featuring a limited schedule of covered health care services. ((~~Nothing in this subsection shall preclude an insurer from offering, or a small employer from purchasing, other health benefit plans that may have more comprehensive benefits than those included in the product offered under this subsection. An insurer offering a health benefit plan under this subsection shall clearly disclose all covered benefits to the small employer in a brochure filed with the commissioner.~~

~~(b) A health benefit plan offered under this subsection shall provide coverage for hospital expenses and services rendered by a physician licensed under chapter 18.57 or 18.71 RCW but is not subject~~

~~to the requirements of RCW 48.21.130, 48.21.140, 48.21.141, 48.21.142, 48.21.144, 48.21.146, 48.21.160 through 48.21.197, 48.21.200, 48.21.220, 48.21.225, 48.21.230, 48.21.235, 48.21.240, 48.21.244, 48.21.250, 48.21.300, 48.21.310, or 48.21.320.~~

~~(2)~~)) (a) The plan offered under this subsection may be offered with a choice of cost-sharing arrangements, and may, but is not required to, comply with: RCW 48.21.130 through 48.21.240, 48.21.244 through 48.21.280, 48.21.300 through 48.21.320, 48.43.045(1) except as required in (b) of this subsection, 48.43.093, 48.43.115 through 48.43.185, 48.43.515(5), or 48.42.100.

(b) In offering the plan under this subsection, the insurer must offer the small employer the option of permitting every category of health care provider to provide health services or care for conditions covered by the plan pursuant to RCW 48.43.045(1).

(2) An insurer offering the plan under subsection (1) of this section must also offer and actively market to the small employer at least one additional health benefit plan.

(3) Nothing in this section shall prohibit an insurer from offering, or a purchaser from seeking, health benefit plans with benefits in excess of the health benefit plan offered under subsection (1) of this section. All forms, policies, and contracts shall be submitted for approval to the commissioner, and the rates of any plan offered under this section shall be reasonable in relation to the benefits thereto.

((~~(3)~~)) (4) Premium rates for health benefit plans for small employers as defined in this section shall be subject to the following provisions:

(a) The insurer shall develop its rates based on an adjusted community rate and may only vary the adjusted community rate for:

(i) Geographic area;

(ii) Family size;

(iii) Age; and

(iv) Wellness activities.

(b) The adjustment for age in (a)(iii) of this subsection may not use age brackets smaller than five-year increments, which shall begin with age twenty and end with age sixty-five. Employees under the age of twenty shall be treated as those age twenty.

(c) The insurer shall be permitted to develop separate rates for individuals age sixty-five or older for coverage for which medicare is the primary payer and coverage for which medicare is not the primary payer. Both rates shall be subject to the requirements of this subsection ((~~(3)~~)) (4).

(d) The permitted rates for any age group shall be no more than four hundred twenty-five percent of the lowest rate for all age groups on January 1, 1996, four hundred percent on January 1, 1997, and three hundred seventy-five percent on January 1, 2000, and thereafter.

(e) A discount for wellness activities shall be permitted to reflect actuarially justified differences in utilization or cost attributed to such programs.

(f) The rate charged for a health benefit plan offered under this section may not be adjusted more frequently than annually except that the premium may be changed to reflect:

(i) Changes to the enrollment of the small employer;

(ii) Changes to the family composition of the employee;

(iii) Changes to the health benefit plan requested by the small employer; or

(iv) Changes in government requirements affecting the health benefit plan.

(g) Rating factors shall produce premiums for identical groups that differ only by the amounts attributable to plan design, with the exception of discounts for health improvement programs.

(h) For the purposes of this section, a health benefit plan that contains a restricted network provision shall not be considered similar coverage to a health benefit plan that does not contain such a provision, provided that the restrictions of benefits to network providers result in substantial differences in claims costs. A carrier may develop its rates based on claims costs ((~~due to network provider reimbursement schedules or type of network~~)) for a plan. This subsection does not restrict or enhance the portability of benefits as provided in RCW 48.43.015.

(i) Except for small group health benefit plans that qualify as insurance coverage combined with a health savings account as defined by the United States internal revenue service, adjusted community rates established under this section shall pool the medical experience of all small groups purchasing coverage. However, annual rate adjustments for

each small group health benefit plan may vary by up to plus or minus ((~~four~~)) eight percentage points from the overall adjustment of a carrier's entire small group pool((~~, such overall adjustment to be approved by the commissioner, upon a showing by the carrier, certified by a member of the American academy of actuaries that: (i) The variation is a result of deductible leverage, benefit design, or provider network characteristics; and (ii) for a rate renewal period, the projected weighted average of all small group benefit plans will have a revenue neutral effect on the carrier's small group pool. Variations of greater than four percentage points are subject to review by the commissioner, and must be approved or denied within sixty days of submittal~~)) if certified by a member of the American academy of actuaries, that: (i) The variation is a result of deductible leverage, benefit design, claims cost trend for the plan, or provider network characteristics; and (ii) for a rate renewal period, the projected weighted average of all small group benefit plans will have a revenue neutral effect on the carrier's small group pool. Variations of greater than eight percentage points are subject to review by the commissioner, and must be approved or denied within thirty days of submittal. A variation that is not denied within ((~~sixty~~)) thirty days shall be deemed approved. The commissioner must provide to the carrier a detailed actuarial justification for any denial ((~~within thirty days~~)) at the time of the denial.

((~~(4)~~)) (5) Nothing in this section shall restrict the right of employees to collectively bargain for insurance providing benefits in excess of those provided herein.

((~~(5)~~)) (6)(a) Except as provided in this subsection, requirements used by an insurer in determining whether to provide coverage to a small employer shall be applied uniformly among all small employers applying for coverage or receiving coverage from the carrier.

(b) An insurer shall not require a minimum participation level greater than:

(i) One hundred percent of eligible employees working for groups with three or less employees; and

(ii) Seventy-five percent of eligible employees working for groups with more than three employees.

(c) In applying minimum participation requirements with respect to

a small employer, a small employer shall not consider employees or dependents who have similar existing coverage in determining whether the applicable percentage of participation is met.

(d) An insurer may not increase any requirement for minimum employee participation or modify any requirement for minimum employer contribution applicable to a small employer at any time after the small employer has been accepted for coverage.

((~~(6)~~)) (7) An insurer must offer coverage to all eligible employees of a small employer and their dependents. An insurer may not offer coverage to only certain individuals or dependents in a small employer group or to only part of the group. An insurer may not modify a health plan with respect to a small employer or any eligible employee or dependent, through riders, endorsements or otherwise, to restrict or exclude coverage or benefits for specific diseases, medical conditions, or services otherwise covered by the plan.

((~~(7)~~)) (8) As used in this section, "health benefit plan," "small employer," "adjusted community rate," and "wellness activities" mean the same as defined in RCW 48.43.005.

Sec. 3. RCW 48.44.023 and 2004 c 244 s 7 are each amended to read as follows:

(1)((~~(a)~~)) A health care services contractor offering any health benefit plan to a small employer, either directly or through an association or member-governed group formed specifically for the purpose of purchasing health care, may offer and actively market to the small employer ((~~a~~)) no more than one health benefit plan featuring a limited schedule of covered health care services. ((~~Nothing in this subsection shall preclude a contractor from offering, or a small employer from purchasing, other health benefit plans that may have more comprehensive benefits than those included in the product offered under this subsection. A contractor offering a health benefit plan under this subsection shall clearly disclose all covered benefits to the small employer in a brochure filed with the commissioner.~~

~~(b) A health benefit plan offered under this subsection shall provide coverage for hospital expenses and services rendered by a physician licensed under chapter 18.57 or 18.71 RCW but is not subject to the requirements of RCW 48.44.225, 48.44.240, 48.44.245, 48.44.290,~~

~~48.44.300, 48.44.310, 48.44.320, 48.44.325, 48.44.330, 48.44.335, 48.44.340, 48.44.344, 48.44.360, 48.44.400, 48.44.440, 48.44.450, and 48.44.460.~~

~~(2)~~)) (a) The plan offered under this subsection may be offered with a choice of cost-sharing arrangements, and may, but is not required to, comply with: RCW 48.44.210, 48.44.212, 48.44.225, 48.44.240 through 48.44.245, 48.44.290 through 48.44.340, 48.44.344, 48.44.360 through 48.44.380, 48.44.400, 48.44.420, 48.44.440 through 48.44.460, 48.44.500, 48.43.045(1) except as required in (b) of this subsection, 48.43.093, 48.43.115 through 48.43.185, 48.43.515(5), or 48.42.100.

(b) In offering the plan under this subsection, the health care service contractor must offer the small employer the option of permitting every category of health care provider to provide health services or care for conditions covered by the plan pursuant to RCW 48.43.045(1).

(2) A health care service contractor offering the plan under subsection (1) of this section must also offer and actively market to the small employer at least one additional health benefit plan.

(3) Nothing in this section shall prohibit a health care service contractor from offering, or a purchaser from seeking, health benefit plans with benefits in excess of the health benefit plan offered under subsection (1) of this section. All forms, policies, and contracts shall be submitted for approval to the commissioner, and the rates of any plan offered under this section shall be reasonable in relation to the benefits thereto.

((~~(3)~~)) (4) Premium rates for health benefit plans for small employers as defined in this section shall be subject to the following provisions:

(a) The contractor shall develop its rates based on an adjusted community rate and may only vary the adjusted community rate for:

(i) Geographic area;

(ii) Family size;

(iii) Age; and

(iv) Wellness activities.

(b) The adjustment for age in (a)(iii) of this subsection may not use age brackets smaller than five-year increments, which shall begin

with age twenty and end with age sixty-five. Employees under the age of twenty shall be treated as those age twenty.

(c) The contractor shall be permitted to develop separate rates for individuals age sixty-five or older for coverage for which medicare is the primary payer and coverage for which medicare is not the primary payer. Both rates shall be subject to the requirements of this subsection ((~~(3)~~)) (4).

(d) The permitted rates for any age group shall be no more than four hundred twenty-five percent of the lowest rate for all age groups on January 1, 1996, four hundred percent on January 1, 1997, and three hundred seventy-five percent on January 1, 2000, and thereafter.

(e) A discount for wellness activities shall be permitted to reflect actuarially justified differences in utilization or cost attributed to such programs.

(f) The rate charged for a health benefit plan offered under this section may not be adjusted more frequently than annually except that the premium may be changed to reflect:

(i) Changes to the enrollment of the small employer;

(ii) Changes to the family composition of the employee;

(iii) Changes to the health benefit plan requested by the small employer; or

(iv) Changes in government requirements affecting the health benefit plan.

(g) Rating factors shall produce premiums for identical groups that differ only by the amounts attributable to plan design, with the exception of discounts for health improvement programs.

(h) For the purposes of this section, a health benefit plan that contains a restricted network provision shall not be considered similar coverage to a health benefit plan that does not contain such a provision, provided that the restrictions of benefits to network providers result in substantial differences in claims costs. A carrier may develop its rates based on claims costs ((~~due to network provider reimbursement schedules or type of network~~)) for a plan. This subsection does not restrict or enhance the portability of benefits as provided in RCW 48.43.015.

(i) Except for small group health benefit plans that qualify as insurance coverage combined with a health savings account as defined by the United States internal revenue service, adjusted community rates

established under this section shall pool the medical experience of all groups purchasing coverage. However, annual rate adjustments for each small group health benefit plan may vary by up to plus or minus ((~~four~~)) eight percentage points from the overall adjustment of a carrier's entire small group pool((~~, such overall adjustment to be approved by the commissioner, upon a showing by the carrier, certified by a member of the American academy of actuaries that: (i) The variation is a result of deductible leverage, benefit design, or provider network characteristics; and (ii) for a rate renewal period, the projected weighted average of all small group benefit plans will have a revenue neutral effect on the carrier's small group pool. Variations of greater than four percentage points are subject to review by the commissioner, and must be approved or denied within sixty days of submittal~~)) if certified by a member of the American academy of actuaries, that: (i) The variation is a result of deductible leverage, benefit design, claims cost trend for the plan, or provider network characteristics; and (ii) for a rate renewal period, the projected weighted average of all small group benefit plans will have a revenue neutral effect on the carrier's small group pool. Variations of greater than eight percentage points are subject to review by the commissioner, and must be approved or denied within thirty days of submittal. A variation that is not denied within ((~~sixty~~)) thirty days shall be deemed approved. The commissioner must provide to the carrier a detailed actuarial justification for any denial ((~~within thirty days~~)) at the time of the denial.

((~~(4)~~)) (5) Nothing in this section shall restrict the right of employees to collectively bargain for insurance providing benefits in excess of those provided herein.

((~~(5)~~)) (6)(a) Except as provided in this subsection, requirements used by a contractor in determining whether to provide coverage to a small employer shall be applied uniformly among all small employers applying for coverage or receiving coverage from the carrier.

(b) A contractor shall not require a minimum participation level greater than:

(i) One hundred percent of eligible employees working for groups with three or less employees; and

(ii) Seventy-five percent of eligible employees working for groups with more than three employees.

(c) In applying minimum participation requirements with respect to a small employer, a small employer shall not consider employees or dependents who have similar existing coverage in determining whether the applicable percentage of participation is met.

(d) A contractor may not increase any requirement for minimum employee participation or modify any requirement for minimum employer contribution applicable to a small employer at any time after the small employer has been accepted for coverage.

((~~(6)~~)) (7) A contractor must offer coverage to all eligible employees of a small employer and their dependents. A contractor may not offer coverage to only certain individuals or dependents in a small employer group or to only part of the group. A contractor may not modify a health plan with respect to a small employer or any eligible employee or dependent, through riders, endorsements or otherwise, to restrict or exclude coverage or benefits for specific diseases, medical conditions, or services otherwise covered by the plan.

Sec. 4. RCW 48.46.066 and 2004 c 244 s 9 are each amended to read as follows:

(1)((~~(a)~~)) A health maintenance organization offering any health benefit plan to a small employer, either directly or through an association or member-governed group formed specifically for the purpose of purchasing health care, may offer and actively market to the small employer ((~~a~~)) no more than one health benefit plan featuring a limited schedule of covered health care services. ((~~Nothing in this subsection shall preclude a health maintenance organization from offering, or a small employer from purchasing, other health benefit plans that may have more comprehensive benefits than those included in the product offered under this subsection. A health maintenance organization offering a health benefit plan under this subsection shall clearly disclose all the covered benefits to the small employer in a brochure filed with the commissioner.~~

~~(b) A health benefit plan offered under this subsection shall provide coverage for hospital expenses and services rendered by a physician licensed under chapter 18.57 or 18.71 RCW but is not subject to the requirements of RCW 48.46.275, 48.46.280, 48.46.285, 48.46.290, 48.46.350, 48.46.355, 48.46.375, 48.46.440, 48.46.480, 48.46.510, 48.46.520, and 48.46.530.~~

~~(2)~~)) (a) The plan offered under this subsection may be offered with a choice of cost-sharing arrangements, and may, but is not required to, comply with: RCW 48.46.250, 48.46.272 through 48.46.290, 48.46.320, 48.46.350, 48.46.375, 48.46.440 through 48.46.460, 48.46.480, 48.46.490, 48.46.510, 48.46.520, 48.46.530, 48.46.565, 48.46.570, 48.46.575, 48.43.045(1) except as required in (b) of this subsection, 48.43.093, 48.43.115 through 48.43.185, 48.43.515(5), or 48.42.100.

(b) In offering the plan under this subsection, the health maintenance organization must offer the small employer the option of permitting every category of health care provider to provide health services or care for conditions covered by the plan pursuant to RCW 48.43.045(1).

(2) A health maintenance organization offering the plan under subsection (1) of this section must also offer and actively market to the small employer at least one additional health benefit plan.

(3) Nothing in this section shall prohibit a health maintenance organization from offering, or a purchaser from seeking, health benefit plans with benefits in excess of the health benefit plan offered under subsection (1) of this section. All forms, policies, and contracts shall be submitted for approval to the commissioner, and the rates of any plan offered under this section shall be reasonable in relation to the benefits thereto.

((~~(3)~~)) (4) Premium rates for health benefit plans for small employers as defined in this section shall be subject to the following provisions:

(a) The health maintenance organization shall develop its rates based on an adjusted community rate and may only vary the adjusted community rate for:

(i) Geographic area;

(ii) Family size;

(iii) Age; and

(iv) Wellness activities.

(b) The adjustment for age in (a)(iii) of this subsection may not use age brackets smaller than five-year increments, which shall begin with age twenty and end with age sixty-five. Employees under the age of twenty shall be treated as those age twenty.

(c) The health maintenance organization shall be permitted to develop separate rates for individuals age sixty-five or older for coverage for which medicare is the primary payer and coverage for which medicare is not the primary payer. Both rates shall be subject to the requirements of this subsection ((~~(3)~~)) (4).

(d) The permitted rates for any age group shall be no more than four hundred twenty-five percent of the lowest rate for all age groups on January 1, 1996, four hundred percent on January 1, 1997, and three hundred seventy-five percent on January 1, 2000, and thereafter.

(e) A discount for wellness activities shall be permitted to reflect actuarially justified differences in utilization or cost attributed to such programs.

(f) The rate charged for a health benefit plan offered under this section may not be adjusted more frequently than annually except that the premium may be changed to reflect:

(i) Changes to the enrollment of the small employer;

(ii) Changes to the family composition of the employee;

(iii) Changes to the health benefit plan requested by the small employer; or

(iv) Changes in government requirements affecting the health benefit plan.

(g) Rating factors shall produce premiums for identical groups that differ only by the amounts attributable to plan design, with the exception of discounts for health improvement programs.

(h) For the purposes of this section, a health benefit plan that contains a restricted network provision shall not be considered similar coverage to a health benefit plan that does not contain such a provision, provided that the restrictions of benefits to network providers result in substantial differences in claims costs. A carrier may develop its rates based on claims costs ((~~due to network provider reimbursement schedules or type of network~~)) for a plan. This subsection does not restrict or enhance the portability of benefits as provided in RCW 48.43.015.

(i) Except for small group health benefit plans that qualify as insurance coverage combined with a health savings account as defined by the United States internal revenue service, adjusted community rates established under this section shall pool the medical experience of all groups purchasing coverage. However, annual rate adjustments for each

small group health benefit plan may vary by up to plus or minus ((~~four~~)) eight percentage points from the overall adjustment of a carrier's entire small group pool((~~, such overall adjustment to be approved by the commissioner, upon a showing by the carrier, certified by a member of the American academy of actuaries that: (i) The variation is a result of deductible leverage, benefit design, or provider network characteristics; and (ii) for a rate renewal period, the projected weighted average of all small group benefit plans will have a revenue neutral effect on the carrier's small group pool. Variations of greater than four percentage points are subject to review by the commissioner, and must be approved or denied within sixty days of submittal~~)) if certified by a member of the American academy of actuaries, that: (i) The variation is a result of deductible leverage, benefit design, claims cost trend for the plan, or provider network characteristics; and (ii) for a rate renewal period, the projected weighted average of all small group benefit plans will have a revenue neutral effect on the health maintenance organization's small group pool. Variations of greater than eight percentage points are subject to review by the commissioner, and must be approved or denied within thirty days of submittal. A variation that is not denied within ((~~sixty~~)) thirty days shall be deemed approved. The commissioner must provide to the carrier a detailed actuarial justification for any denial ((~~within thirty days~~)) at the time of the denial.

((~~(4)~~)) (5) Nothing in this section shall restrict the right of employees to collectively bargain for insurance providing benefits in excess of those provided herein.

((~~(5)~~)) (6)(a) Except as provided in this subsection, requirements used by a health maintenance organization in determining whether to provide coverage to a small employer shall be applied uniformly among all small employers applying for coverage or receiving coverage from the carrier.

(b) A health maintenance organization shall not require a minimum participation level greater than:

(i) One hundred percent of eligible employees working for groups with three or less employees; and

(ii) Seventy-five percent of eligible employees working for groups with more than three employees.

(c) In applying minimum participation requirements with respect to a small employer, a small employer shall not consider employees or dependents who have similar existing coverage in determining whether the applicable percentage of participation is met.

(d) A health maintenance organization may not increase any requirement for minimum employee participation or modify any requirement for minimum employer contribution applicable to a small employer at any time after the small employer has been accepted for coverage.

((~~(6)~~)) (7) A health maintenance organization must offer coverage to all eligible employees of a small employer and their dependents. A health maintenance organization may not offer coverage to only certain individuals or dependents in a small employer group or to only part of the group. A health maintenance organization may not modify a health plan with respect to a small employer or any eligible employee or dependent, through riders, endorsements or otherwise, to restrict or exclude coverage or benefits for specific diseases, medical conditions, or services otherwise covered by the plan.

Sec. 5. RCW 41.05.065 and 2003 c 158 s 2 are each amended to read as follows:

(1) The board shall study all matters connected with the provision of health care coverage, life insurance, liability insurance, accidental death and dismemberment insurance, and disability income insurance or any of, or a combination of, the enumerated types of insurance for employees and their dependents on the best basis possible with relation both to the welfare of the employees and to the state. However, liability insurance shall not be made available to dependents.

(2) The board shall develop employee benefit plans that include comprehensive health care benefits for all employees. In developing these plans, the board shall consider the following elements:

(a) Methods of maximizing cost containment while ensuring access to quality health care;

(b) Development of provider arrangements that encourage cost containment and ensure access to quality care, including but not limited to prepaid delivery systems and prospective payment methods;

(c) Wellness incentives that focus on proven strategies, such as smoking cessation, injury and accident prevention, reduction of alcohol

misuse, appropriate weight reduction, exercise, automobile and motorcycle safety, blood cholesterol reduction, and nutrition education;

(d) Utilization review procedures including, but not limited to a cost-efficient method for prior authorization of services, hospital inpatient length of stay review, requirements for use of outpatient surgeries and second opinions for surgeries, review of invoices or claims submitted by service providers, and performance audit of providers;

(e) Effective coordination of benefits;

(f) Minimum standards for insuring entities; and

(g) Minimum scope and content of public employee benefit plans to be offered to enrollees participating in the employee health benefit plans. To maintain the comprehensive nature of employee health care benefits, employee eligibility criteria related to the number of hours worked and the benefits provided to employees shall be substantially equivalent to the state employees' health benefits plan and eligibility criteria in effect on January 1, 1993. Nothing in this subsection (2)(g) shall prohibit changes or increases in employee point-of-service payments or employee premium payments for benefits.

(3) The board shall design benefits and determine the terms and conditions of employee participation and coverage, including establishment of eligibility criteria. The same terms and conditions of participation and coverage, including eligibility criteria, shall apply to state employees and to school district employees and educational service district employees.

(4) The board may authorize premium contributions for an employee and the employee's dependents in a manner that encourages the use of cost-efficient managed health care systems. The board shall require participating school district and educational service district employees to pay at least the same employee premiums by plan and family size as state employees pay.

(5) <u>The board shall develop a health savings account option for employees that conforms to section 223, Part VII of subchapter B of chapter 1 of the internal revenue code of 1986. The board shall comply with all applicable federal standards related to the establishment of health savings accounts.</u>

(6) Employees shall choose participation in one of the health care benefit plans developed by the board and may be permitted to waive coverage under terms and conditions established by the board.

((~~(6)~~)) (7) The board shall review plans proposed by insuring entities that desire to offer property insurance and/or accident and casualty insurance to state employees through payroll deduction. The board may approve any such plan for payroll deduction by insuring entities holding a valid certificate of authority in the state of Washington and which the board determines to be in the best interests of employees and the state. The board shall promulgate rules setting forth criteria by which it shall evaluate the plans.

((~~(7)~~)) (8) Before January 1, 1998, the public employees' benefits board shall make available one or more fully insured long-term care insurance plans that comply with the requirements of chapter 48.84 RCW. Such programs shall be made available to eligible employees, retired employees, and retired school employees as well as eligible dependents which, for the purpose of this section, includes the parents of the employee or retiree and the parents of the spouse of the employee or retiree. Employees of local governments and employees of political subdivisions not otherwise enrolled in the public employees' benefits board sponsored medical programs may enroll under terms and conditions established by the administrator, if it does not jeopardize the financial viability of the public employees' benefits board's long-term care offering.

(a) Participation of eligible employees or retired employees and retired school employees in any long-term care insurance plan made available by the public employees' benefits board is voluntary and shall not be subject to binding arbitration under chapter 41.56 RCW. Participation is subject to reasonable underwriting guidelines and eligibility rules established by the public employees' benefits board and the health care authority.

(b) The employee, retired employee, and retired school employee are solely responsible for the payment of the premium rates developed by the health care authority. The health care authority is authorized to charge a reasonable administrative fee in addition to the premium charged by the long-term care insurer, which shall include the health care authority's cost of administration, marketing, and consumer

education materials prepared by the health care authority and the office of the insurance commissioner.

(c) To the extent administratively possible, the state shall establish an automatic payroll or pension deduction system for the payment of the long-term care insurance premiums.

(d) The public employees' benefits board and the health care authority shall establish a technical advisory committee to provide advice in the development of the benefit design and establishment of underwriting guidelines and eligibility rules. The committee shall also advise the board and authority on effective and cost-effective ways to market and distribute the long-term care product. The technical advisory committee shall be comprised, at a minimum, of representatives of the office of the insurance commissioner, providers of long-term care services, licensed insurance agents with expertise in long-term care insurance, employees, retired employees, retired school employees, and other interested parties determined to be appropriate by the board.

(e) The health care authority shall offer employees, retired employees, and retired school employees the option of purchasing long-term care insurance through licensed agents or brokers appointed by the long-term care insurer. The authority, in consultation with the public employees' benefits board, shall establish marketing procedures and may consider all premium components as a part of the contract negotiations with the long-term care insurer.

(f) In developing the long-term care insurance benefit designs, the public employees' benefits board shall include an alternative plan of care benefit, including adult day services, as approved by the office of the insurance commissioner.

(g) The health care authority, with the cooperation of the office of the insurance commissioner, shall develop a consumer education program for the eligible employees, retired employees, and retired school employees designed to provide education on the potential need for long-term care, methods of financing long-term care, and the availability of long-term care insurance products including the products offered by the board.

(h) By December 1998, the health care authority, in consultation with the public employees' benefits board, shall submit a report to the

appropriate committees of the legislature, including an analysis of the marketing and distribution of the long-term care insurance provided under this section.

NEW SECTION. **Sec. 6.** A new section is added to chapter 48.43 RCW to read as follows:

(1) After the effective date of this section, no health carrier may deliver, issue, or renew a health insurance policy that includes any additional coverage mandates, beyond those mandates in effect on the effective date of this section.

(2) The office of the insurance commissioner shall contract for an independent health care actuarial review of all existing health care coverage mandates. The first mandate to be reviewed is the requirement to cover every category of health care provider as required by RCW 48.43.045.

Sec. 7. RCW 4.56.250 and 1986 c 305 s 301 are each amended to read as follows:

(1) As used in this section, the following terms have the meanings indicated unless the context clearly requires otherwise.

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

(b) "Noneconomic damages" means subjective, nonmonetary losses, including((~~,~~)) but not limited to pain, suffering, inconvenience, mental anguish, disability or disfigurement incurred by the injured party, loss of ability to enjoy life, emotional distress, loss of society and companionship, loss of consortium, injury to reputation and humiliation, ((~~and~~)) destruction of the parent-child relationship, and other nonpecuniary damages of any type.

(c) "Bodily injury" means physical injury, sickness, or disease, including death.

(d) "Average annual wage" means the average annual wage in the state of Washington as determined under RCW 50.04.355.

(2) Except as provided in section 8 of this act, in no action seeking damages for personal injury or death may a claimant recover a

judgment for noneconomic damages exceeding an amount determined by multiplying 0.43 by the average annual wage and by the life expectancy of the person incurring noneconomic damages, as the life expectancy is determined by the life expectancy tables adopted by the insurance commissioner. For purposes of determining the maximum amount allowable for noneconomic damages, a claimant's life expectancy shall not be less than fifteen years. The limitation contained in this subsection applies to all claims for noneconomic damages made by a claimant who incurred bodily injury. Claims for loss of consortium, loss of society and companionship, destruction of the parent-child relationship, and all other derivative claims asserted by persons who did not sustain bodily injury are to be included within the limitation on claims for noneconomic damages arising from the same bodily injury.

(3) If a case is tried to a jury, the jury shall not be informed of the limitation contained in subsection (2) of this section.

NEW SECTION. **Sec. 8.** A new section is added to chapter 4.56 RCW to read as follows:

(1) In any action or arbitration for damages for injury or death occurring as a result of health care or related services, or the arranging for the provision of health care or related services, whether brought under chapter 7.70 RCW, RCW 4.20.010, 4.20.020, 4.20.046, 4.20.060, 4.24.010, or 48.43.545(1), any other applicable law, or any combination thereof, that is based upon the alleged wrongful acts or omissions of one or more health care professionals, whether or not those health care professionals are named as defendants, the total combined civil liability for noneconomic damages for all health care professionals, all persons, entities, and health care institutions for whose conduct the health care professionals could be held liable, and all persons, entities, and health care institutions that could be held liable for the conduct of any health care professionals, shall not exceed three hundred fifty thousand dollars for each claimant, regardless of the number of health care professionals, health care providers, or health care institutions against whom the claim for injury or death is or could have been asserted or the number of separate causes of action on which the claim is based.

(2) Any and all health care institutions against whom liability is imposed based upon a wrongful act or omission of any health care

professional are specifically included within the limitation on liability for noneconomic damages contained in subsection (1) of this section, even if the health care institution also is or could be held liable for a wrongful act or omission of a person other than a health care professional, another health care institution, or a related entity, facility, or institution.

(3) If, in an action or arbitration for injury or death occurring as a result of health care or related services, or the arranging for health care or related services, whether brought under chapter 7.70 RCW, RCW 4.20.010, 4.20.020, 4.20.046, 4.20.060, 4.24.010, or 48.43.545(1), any other applicable law, or any combination thereof, one or more health care institutions are liable for any wrongful acts or omissions of persons other than health care professionals, but are not liable for any alleged wrongful act or omission of any health care professional, the total civil liability for noneconomic damages for each such health care institution, including all persons, entities, and other health care institutions for whose conduct the health care institution could be liable, shall not exceed three hundred fifty thousand dollars for each claimant, and the total combined limit of civil liability for noneconomic damages for all health care institutions, including all persons, entities, and other health care institutions for whose conduct the health care institutions could be held liable, shall not exceed seven hundred thousand dollars for each claimant, regardless of the number of health care institutions, health care professionals, or health care providers against whom the claim for damages for injury or death is or could have been asserted or the number of separate causes of action on which the claim is based.

(4) A claimant shall not be permitted to obtain more than one recovery of noneconomic damages by splitting his or her claim or cause of action for damages for injury or death occurring as a result of health care or related services, or the arranging for the provision of health care or related services, or by bringing separate actions for such injury or death against more than one health care professional or health care institution. A claimant who has recovered noneconomic damages in one action for damages for injury or death occurring as a result of health care or related services, or the arranging for the provision of health care or related services, shall be precluded from

seeking or recovering additional noneconomic damages for the injury or death in any other action.

(5) If the jury's assessment of noneconomic damages exceeds the limitations contained in subsection (1), (2), or (3) of this section, nothing in RCW 4.44.450 precludes the court from entering a judgment that limits the total amount of noneconomic damages to those limits provided in subsections (1), (2), and (3) of this section.

(6) If a case is tried to a jury, the jury shall not be informed of the limitations on noneconomic damages contained in subsections (1), (2), and (3) of this section.

(7) The definitions in this subsection apply throughout this section unless the context clearly requires otherwise.

(a) "Claimant" means a person, including a decedent's estate, seeking or who has sought recovery of damages in an action or arbitration for injury or death occurring as a result of health care or related services, or the arranging for the provision of health care or related services. All persons claiming to have sustained damages as a result of the injury or death of a single person are considered a single claimant, and the limitations on noneconomic damages specified in subsections (1), (2), and (3) of this section shall include all noneconomic damages claimed by or on behalf of the person whose injury or death occurred as a result of health care or related services, or the arranging for the provision of health care or related services, as well as all claims for noneconomic damages asserted by or on behalf of others arising from the same injury or death.

(b) "Economic damages" has the meaning set forth in RCW 4.56.250(1)(a).

(c) "Health care institution" means any entity, whether or not incorporated, facility, or institution that is licensed, registered, or certified by this state to provide health care or related services or to arrange for the provision of health care or related services, including, but not limited to, an ambulatory diagnostic, treatment, or surgical facility, an adult family home, an ambulance, aid, or emergency medical service, a blood bank or blood center, a boarding home, a community health center, a community mental health center, a comprehensive community health center, a disability insurer, a drug and alcohol treatment center, an extended care facility, a group home, a health carrier, a health care service contractor, a health maintenance

organization, a home health agency, a hospice, a hospice care center, a hospital, an independent clinical laboratory, an in-home services agency, an intermediate care facility, a kidney disease treatment facility, a long-term care facility, a migrant health center, a nursing home, a pharmacy, a psychiatric hospital, a psychiatric, neuropsychiatric, or mental health facility, a rehabilitation facility, a renal dialysis center, a rural health care facility, a skilled nursing facility, a soldiers or veterans home, a sperm bank, a tissue bank, a tribal clinic, or a visiting nurse service, including any related entity, facility, or institution owned or operated by the health care institution, and any officer, director, employee, agent, or apparent agent of the health care institution or such related entity, facility, or institution, acting in the course and scope of his or her employment or agency, including in the event such officer, director, employee, or agent is deceased, his or her estate or personal representative.

(d) "Health care professional" means:

(i) Any health care provider described in RCW 7.70.020 (1) and (2);

(ii) Any clinic, corporation, limited liability company, partnership, or limited liability partnership comprised of one or more of the health care providers described in RCW 7.70.020(1), and any officer, director, employee, agent, or apparent agent thereof acting within the scope of his or her employment or agency, including in the event such officer, director, employee, agent, or apparent agent is deceased, his or her estate or personal representative; or

(iii) Any entity, facility, or institution that is owned or operated by a health care provider described in RCW 7.70.020(1), or by a clinic, corporation, limited liability company, partnership, or limited liability partnership comprised of one or more of the health care providers described in RCW 7.70.020(1), and any officer, director, employee, agent, or apparent agent thereof acting in the course and scope of his or her employment or agency, including in the event such officer, director, employee, agent, or apparent agent is deceased, his or her estate or personal representative.

(e) "Health care provider" means any person or entity described in RCW 7.70.020.

(f) "Noneconomic damages" has the meaning set forth in RCW 4.56.250(1)(b).

Sec. 9. RCW 7.70.020 and 1995 c 323 s 3 are each amended to read as follows:

As used in this chapter "health care provider" means either:

(1) A person licensed, registered, or certified by this state to provide health care or related services, including, but not limited to, a licensed acupuncturist, a physician, an osteopathic physician, a dentist, a nurse, an optometrist, a podiatric physician and surgeon, a chiropractor, a physical therapist, a psychologist, a pharmacist, an optician, a physician's assistant, a midwife, an osteopathic physician's assistant, an advanced registered nurse practitioner, a drugless healer, a naturopath, a dental hygienist, a denturist, an ocularist, an occupational therapist, a pharmacy assistant, a radiologic technologist, a nursing assistant, a respiratory care practitioner, a health care assistant, a dietician, a nutritionist, a surgical technologist, a mental health counselor, a marriage and family therapist, a social worker, or a physician's trained mobile intensive care paramedic, including, in the event such person is deceased, his or her estate or personal representative;

(2) An employee or agent of a person described in ((~~part~~)) subsection (1) ((~~above~~)) of this section, acting in the course and scope of his or her employment or agency, including, in the event such employee or agent is deceased, his or her estate or personal representative; or

(3) An entity, whether or not incorporated, facility, or institution employing one or more persons described in ((~~part~~)) subsection (1) ((~~above~~)) of this section, including, but not limited to, a hospital, clinic, health maintenance organization, or nursing home; or an officer, director, employee, or agent thereof acting in the course and scope of his or her employment or agency, including in the event such officer, director, employee, or agent is deceased, his or her estate or personal representative.

Sec. 10. RCW 7.70.070 and 1975-'76 2nd ex.s. c 56 s 12 are each amended to read as follows:

(1) Except as set forth in subsection (2) of this section, the

court shall, in any action under this chapter, determine the reasonableness of each party's attorneys' fees. The court shall take into consideration the following:

((~~(1)~~)) (a) The time and labor required, the novelty and difficulty of the questions involved, and the skill requisite to perform the legal service properly;

((~~(2)~~)) (b) The likelihood, if apparent to the client, that the acceptance of the particular employment will preclude other employment by the lawyer;

((~~(3)~~)) (c) The fee customarily charged in the locality for similar legal services;

((~~(4)~~)) (d) The amount involved and the results obtained;

((~~(5)~~)) (e) The time limitations imposed by the client or by the circumstances;

((~~(6)~~)) (f) The nature and length of the professional relationship with the client;

((~~(7)~~)) (g) The experience, reputation, and ability of the lawyer or lawyers performing the services;

((~~(8)~~)) (h) Whether the fee is fixed or contingent.

(2)(a) An attorney may not contract for or collect a contingency fee for representing a person in connection with an action for damages for injury or death occurring as a result of health care or related services, or the arranging for the provision of health care or related services, in excess of the following limits:

(i) Forty percent of the first fifty thousand dollars recovered;

(ii) Thirty-three and one-third percent of the next fifty thousand dollars recovered;

(iii) Twenty-five percent of the next five hundred thousand dollars recovered;

(iv) Fifteen percent of any amount in which the recovery exceeds six hundred thousand dollars.

(b) The limitations in this section apply regardless of whether the recovery is by judgment, settlement, arbitration, mediation, or other form of alternative dispute resolution.

(c) If periodic payments are awarded to the plaintiff, the court shall place a total value on these payments and include this amount in computing the total award from which attorneys' fees are calculated under this subsection.

(d) For purposes of this subsection, "recovered" means the net sum recovered after deducting any disbursements or costs incurred in connection with the arbitration, litigation, or settlement of the claim. Costs of medical care incurred by the plaintiff and the attorney's office overhead costs or charges are not deductible disbursements or costs for such purposes.

(3) Subsection (2) of this section applies to all contingency fee arrangements or agreements, including any modification of the amount of any contingency fee, entered into after the effective date of this section.

Sec. 11. RCW 7.70.100 and 1993 c 492 s 419 are each amended to read as follows:

(1) No action for damages for injury or death occurring as a result of health care or related services, or the arranging for the provision of health care or related services, may be commenced unless the defendant has been given at least ninety days' notice of the intention to commence the action. If the notice is served within ninety days before the expiration of the applicable statute of limitations, the time for the commencement of the action must be extended ninety days from the service of the notice.

(2) The provisions of subsection (1) of this section are not applicable with respect to any defendant whose name is unknown to the plaintiff at the time of filing the complaint and who is identified therein by a fictitious name.

(3) After the filing of the ninety-day presuit notice, and before a superior court trial, all causes of action, whether based in tort, contract, or otherwise, for damages ((~~arising from~~)) for injury or death occurring as a result of health care or related services, or the arranging for the provision of health care or related services, provided after July 1, 1993, shall be subject to mandatory mediation prior to trial.

((~~(2)~~)) (4) The supreme court shall by rule adopt procedures to implement mandatory mediation of actions under this chapter. The rules shall require mandatory mediation without exception and address, at a minimum:

(a) Procedures for the appointment of, and qualifications of, mediators. A mediator shall have experience or expertise related to

actions arising from injury occurring as a result of health care, and be a member of the state bar association who has been admitted to the bar for a minimum of five years or who is a retired judge. The parties may stipulate to a nonlawyer mediator. The court may prescribe additional qualifications of mediators;

(b) Appropriate limits on the amount or manner of compensation of mediators;

(c) The number of days following the filing of a claim ((~~under this chapter~~)) within which a mediator must be selected;

(d) The method by which a mediator is selected. The rule shall provide for designation of a mediator by the superior court if the parties are unable to agree upon a mediator;

(e) The number of days following the selection of a mediator within which a mediation conference must be held;

(f) A means by which mediation of an action ((~~under this chapter~~)) may be waived by a mediator who has determined that the claim is not appropriate for mediation; and

(g) Any other matters deemed necessary by the court.

((~~(3)~~)) (5) Mediators shall not impose discovery schedules upon the parties.

(6) The supreme court shall by rule also adopt procedures for the parties to certify to the court the manner of mediation used by the parties to comply with this section.

Sec. 12. RCW 4.16.350 and 1998 c 147 s 1 are each amended to read as follows:

(1) Any civil action or arbitration for damages for injury or death occurring as a result of health care or related services, or the arranging for the provision of health care or related services, which is provided after June 25, 1976, against((~~:~~

~~(1) A person licensed by this state to provide health care or related services, including, but not limited to, a physician, osteopathic physician, dentist, nurse, optometrist, podiatric physician and surgeon, chiropractor, physical therapist, psychologist, pharmacist, optician, physician's assistant, osteopathic physician's assistant, nurse practitioner, or physician's trained mobile intensive care paramedic, including, in the event such person is deceased, his estate or personal representative;~~

~~(2) An employee or agent of a person described in subsection (1) of this section, acting in the course and scope of his employment, including, in the event such employee or agent is deceased, his estate or personal representative; or~~

~~(3) An entity, whether or not incorporated, facility, or institution employing one or more persons described in subsection (1) of this section, including, but not limited to, a hospital, clinic, health maintenance organization, or nursing home; or an officer, director, employee, or agent thereof acting in the course and scope of his employment, including, in the event such officer, director, employee, or agent is deceased, his estate or personal representative;~~)) a health care provider as defined in RCW 7.70.020, or a health care institution as defined in section 8(7)(c) of this act, based upon alleged professional negligence shall be commenced within three years of the act or omission alleged to have caused the injury, death, or condition, or within one year of the time the patient or his or her representative or custodial parent or guardian discovered or reasonably should have discovered that the injury, death, or condition was caused by said act or omission, whichever period ((~~expires later, except that in no event shall an action be commenced more than eight years after said act or omission: PROVIDED, 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 or diagnostic purpose or effect, until the date the patient or the patient's representative has actual knowledge of the act of fraud or concealment, or of the presence of the foreign body; the patient or the patient's representative has one year from the date of the actual knowledge in which to commence a civil action for damages.~~

~~For purposes of this section, notwithstanding RCW 4.16.190, the knowledge of a custodial parent or guardian shall be imputed to a person under the age of eighteen years, and such imputed knowledge shall operate to bar the claim of such minor to the same extent that the claim of an adult would be barred under this section. Any action not commenced in accordance with this section shall be barred.~~

~~For purposes of this section, with respect to care provided after June 25, 1976, and before August 1, 1986, the knowledge of a custodial parent or guardian shall be imputed as of April 29, 1987, to persons under the age of eighteen years~~)) occurs first.

(2) In no event may an action be commenced more than three years after the act or omission alleged to have caused the injury or condition except:

(a) Upon proof of fraud, intentional concealment, or the presence of a foreign body not intended to have a therapeutic or diagnostic purpose or effect, in which case the patient or the patient's representative has one year from the date the patient or the patient's representative or custodial parent or guardian has actual knowledge of the act of fraud or concealment or of the presence of the foreign body within which to commence a civil action for damages.

(b) In the case of a minor, upon proof that the minor's custodial parent or guardian and the defendant or the defendant's insurer have committed fraud or collusion in the failure to bring an action on behalf of the minor, in which case the patient or the patient's representative has one year from the date the patient or the patient's representative other than the custodial parent or guardian who committed the fraud or collusion has actual knowledge of the fraud or collusion, or one year from the date of the minor's eighteenth birthday, whichever provides a longer period.

(c) In the case of a minor under the full age of six years, in which case the action on behalf of the minor must be commenced within three years, or prior to the minor's eighth birthday, whichever provides a longer period.

(3) For purposes of this section, the tolling provisions of RCW 4.16.190 do not apply.

(4) This section does not apply to a civil action based on intentional conduct brought against those individuals or entities specified in this section by a person for recovery of damages for injury occurring as a result of childhood sexual abuse as defined in RCW 4.16.340(5).

(5) This section applies to all causes of action for injury or death occurring as a result of health care or related services, or the arranging for the provision of health care or related services, filed on or after the effective date of this section. However, any action which, if filed on or after the effective date of this section, would have been timely under former law, but now would be barred under the chapter . . ., Laws of 2005 amendments contained in this section, may

be brought within one year following the effective date of this section.

(6) Any action not commenced in accordance with this section is barred.

Sec. 13. RCW 7.70.080 and 1975-'76 2nd ex.s. c 56 s 13 are each amended to read as follows:

(1) Any party may present evidence to the trier of fact that the patient or claimant has already been, or will be, compensated for the injury complained of from ((~~any source except the assets of the patient, his representative, or his immediate family, or insurance purchased with such assets. In the event such evidence is admitted, the plaintiff may present evidence of an obligation to repay such compensation. Insurance bargained for or provided on behalf of an employee shall be considered insurance purchased with the assets of the employee~~)) a collateral source. In the event the evidence is admitted, the other party may present evidence of any amount that was paid or contributed to secure the right to any compensation. Compensation as used in this section shall mean payment of money or other property to or on behalf of the patient or claimant, rendering of services to the patient free of charge to the patient or claimant, or indemnification of expenses incurred by or on behalf of the patient or claimant. Notwithstanding this section, evidence of compensation by a defendant health care provider may be offered only by that provider.

(2) Unless otherwise provided by superseding federal law, there is no right of subrogation or reimbursement from the patient's or claimant's tort recovery with respect to compensation covered in subsection (1) of this section.

NEW SECTION. **Sec. 14.** A new section is added to chapter 7.04 RCW to read as follows:

(1) A contract for health care or related services that contains a provision for arbitration of a dispute as to professional negligence of a health care provider as defined in RCW 7.70.020, whether brought under chapter 7.70 RCW, RCW 4.20.010, 4.20.020, 4.20.046, 4.20.060, or 4.24.010, any other applicable law, or any combination thereof, must have the provision as the first article of the contract and the provision must be expressed in the following language:

"It is understood that any dispute as to medical malpractice that is as to whether any health care or related services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by Washington law, and not by a lawsuit or resort to court process except as Washington law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have such a dispute decided in a court of law before a jury, and instead are accepting the use of arbitration."

(2) Immediately before the signature line provided for the individual contracting for the health care or related services, there must appear the following in at least ten-point bold red type:

"NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE ONE OF THIS CONTRACT."

(3) Once signed, such a contract governs all subsequent open-book account transactions for health care or related services for which the contract was signed until or unless rescinded by written notice within thirty days of signature. Written notice of such rescission may be given by a guardian or other legal representative of the patient if the patient is incapacitated or a minor.

(4) Where the contract is one for health care or related services to a minor, it may not be disaffirmed if signed by the minor's parent or legal guardian.

(5) A contract for the provision of health care or related services that contains a provision for arbitration of a dispute as to professional negligence of a health care provider shall not be deemed a contract of adhesion, or unconscionable, or otherwise improper, where it complies with subsections (1) through (3) of this section.

(6) Subsections (1) through (3) of this section do not apply to any health benefit plan contract offered by an organization regulated under Title 48 RCW that has been negotiated to contain an arbitration agreement with subscribers and enrollees under such a contract.

NEW SECTION. **Sec. 15.** A new section is added to chapter 7.70 RCW to read as follows:

RCW 7.70.100, 7.70.110, 7.70.120, and 7.70.130 do not apply if there is a contract for binding arbitration under section 14 of this act.

NEW SECTION. **Sec. 16.** A new section is added to chapter 7.70 RCW to read as follows:

(1) The definitions in this subsection apply throughout this section unless the context clearly requires otherwise.

(a) "Future damages" includes damages for future health care or related services, care or custody, loss of future earnings, loss of bodily function, or future pain and suffering of the judgment creditor.

(b) "Periodic payments" means the payment of money or delivery of other property to the judgment creditor at regular intervals.

(2) In any action for damages for injury occurring as a result of health care or related services, or for the arranging for the provision of health care or related services, the court shall, at the request of either party, enter a judgment ordering that money damages or its equivalent for future damages of the judgment creditor be paid in whole or in part by periodic payments rather than by a lump-sum payment if the award equals or exceeds fifty thousand dollars in future damages. In entering a judgment ordering the payment of future damages by periodic payments, the court shall make a specific finding as to the dollar amount of periodic payments which will compensate the judgment creditor for such future damages. As a condition to authorizing periodic payments of future damages, the court shall require the judgment debtor who is not adequately insured to post security adequate to ensure full payment of such damages awarded by the judgment. Upon termination of periodic payments of future damages, the court shall order the return of this security, or so much as remains, to the judgment debtor.

(3)(a) The judgment ordering the payment of future damages by periodic payments must specify the recipient or recipients of the payments, the dollar amount of the payments, the interval between payments, and the number of payments or the period of time over which payments must be made. The payments are only subject to modification in the event of the death of the judgment creditor.

(b) In the event that the court finds that the judgment debtor has exhibited a continuing pattern of failing to make the payments, as

specified in (a) of this subsection, the court shall find the judgment debtor in contempt of court and, in addition to the required periodic payments, shall order the judgment debtor to pay the judgment creditor all damages caused by the failure to make such periodic payments, including court costs and attorneys' fees.

(4) In the event of the death of the judgment creditor, the court, upon petition of any party in interest, shall modify the judgment to eliminate future periodic payments of damages awarded for future medical treatment, care or custody, loss of bodily function, or future pain and suffering of the judgment creditor. However, money damages awarded for loss of future earnings may not be reduced or payments terminated by reason of the death of the judgment creditor, but must be paid to persons to whom the judgment creditor owed a duty of support, as provided by law, immediately prior to his or her death. In such cases, the court that rendered the original judgment may, upon petition of any party in interest, modify the judgment to award and apportion the unpaid future damages in accordance with this subsection (4).

(5) Following the occurrence or expiration of all obligations specified in the periodic payment judgment, any obligation of the judgment debtor to make further payments ceases and any security given under subsection (2) of this section reverts to the judgment debtor.

(6) For purposes of this section, the provisions of RCW 4.56.250 do not apply.

(7) It is intended in enacting this section to authorize, in actions for damages for injury occurring as a result of health care or related services, or the arranging for the provision of health care or related services, the entry of judgments that provide for the payment of future damages through periodic payments rather than lump-sum payments. By authorizing periodic payment judgments, it is further intended that the courts will utilize such judgments to provide compensation sufficient to meet the needs of an injured plaintiff and those persons who are dependent on the plaintiff for whatever period is necessary while eliminating the potential windfall from a lump-sum recovery that was intended to provide for the care of an injured plaintiff over an extended period who then dies shortly after the judgment is paid, leaving the balance of the judgment award to persons and purposes for which it was not intended. It is also intended that all elements of the periodic payment program be specified with

certainty in the judgment ordering such payments and that the judgment not be subject to modification at some future time that might alter the specifications of the original judgment, except in the event of the death of the judgment creditor.

NEW SECTION. **Sec. 17.** It is intended in enacting sections 18 and 19 of this act that health care providers should remain personally liable for their own negligent or wrongful acts or omissions in connection with the provision of health care services, but that their vicarious liability for the negligent or wrongful acts or omissions of others should be curtailed. To that end, it is intended that *Adamski v. Tacoma General Hospital,* 20 Wn. App. 98, 579 P.2d 970 (1978), and its holding that hospitals may be held liable for a physician's acts or omissions under so-called "apparent agency" or "ostensible agency" theories should be reversed, so that hospitals will not be liable for the act or omission of a health care provider granted hospital privileges unless the health care provider is an actual agent or employee of the hospital. It is further intended that, notwithstanding any generally applicable principle of vicarious liability to the contrary, individual health care professionals will not be liable for the negligent or wrongful acts of others, except those who were acting under their direct supervision and control.

NEW SECTION. **Sec. 18.** A new section is added to chapter 7.70 RCW to read as follows:

A public or private hospital shall be liable for an act or omission of a health care provider granted privileges to provide health care at the hospital only if the health care provider is an actual agent or employee of the hospital and the act or omission of the health care provider occurred while the health care provider was acting within the course and scope of the health care provider's agency or employment with the hospital.

NEW SECTION. **Sec. 19.** A new section is added to chapter 7.70 RCW to read as follows:

A person who is a health care provider under RCW 7.70.020 (1) or (2) shall not be personally liable for any act or omission of any other

health care provider who was not the person's actual agent or employee or who was not acting under the person's direct supervision and control at the time of the act or omission.

Sec. 20. RCW 74.34.200 and 1999 c 176 s 15 are each amended to read as follows:

(1) In addition to other remedies available under the law, a vulnerable adult who has been subjected to abandonment, abuse, financial exploitation, or neglect either while residing in a facility or in the case of a person residing at home who receives care from a home health, hospice, or home care agency, or an individual provider, shall have a cause of action for damages on account of his or her injuries, pain and suffering, and loss of property sustained thereby. This action shall be available where the defendant is or was a corporation, trust, unincorporated association, partnership, administrator, employee, agent, officer, partner, or director of a facility, or of a home health, hospice, or home care agency licensed or required to be licensed under chapter 70.127 RCW, as now or subsequently designated, or an individual provider.

(2) It is the intent of the legislature, however, that where there is a dispute about the care or treatment of a vulnerable adult, the parties should use the least formal means available to try to resolve the dispute. Where feasible, parties are encouraged but not mandated to employ direct discussion with the health care provider, use of the long-term care ombudsman or other intermediaries, and, when necessary, recourse through licensing or other regulatory authorities.

(3) In an action brought under this section, a prevailing plaintiff shall be awarded his or her actual damages, together with the costs of the suit((~~, including a reasonable attorney's fee~~)). The term "costs" includes((~~, but is not limited to,~~)) the reasonable fees for a guardian((~~,~~)) and guardian ad litem, ((~~and experts,~~)) if any, that ((~~may be~~)) were necessary to the litigation of a claim brought under this section.

NEW SECTION. **Sec. 21.** In the event that the Washington state supreme court or other court of competent jurisdiction rules or affirms that section 8 of this act is unconstitutional, then the prescribed limitations on noneconomic damages set forth in section 8 of this act

take effect upon the ratification of a state constitutional amendment that empowers the legislature to enact limits on the amount of noneconomic damages recoverable in any or all civil causes of action or upon the enactment by the United States congress of a law permitting such limitations on noneconomic damages, whichever occurs first.

Sec. 22. RCW 4.22.070 and 1993 c 496 s 1 are each amended to read as follows:

(1) In all actions involving fault of more than one entity, the trier of fact shall determine the percentage of the total fault which is attributable to every entity which caused the claimant's damages except entities immune from liability to the claimant under Title 51 RCW. The sum of the percentages of the total fault attributed to at-fault entities shall equal one hundred percent. The entities whose fault shall be determined include the claimant or person suffering personal injury or incurring property damage, defendants, third-party defendants, entities ((~~released by~~)) who have entered into a release, covenant not to sue, covenant not to enforce judgment, or similar agreement with the claimant, entities with any other individual defense against the claimant, and entities immune from liability to the claimant, but shall not include those entities immune from liability to the claimant under Title 51 RCW. Judgment shall be entered against each defendant except those entities who have ((~~been released by~~)) entered into a release, covenant not to sue, covenant not to enforce judgment, or similar agreement with the claimant or are immune from liability to the claimant or have prevailed on any other individual defense against the claimant in an amount which represents that party's proportionate share of the claimant's total damages. The liability of each defendant shall be several only and shall not be joint except:

(a) A party shall be responsible for the fault of another person or for payment of the proportionate share of another party where both were acting in concert or when a person was acting as an agent or servant of the party.

(b) If the trier of fact determines that the claimant or party suffering bodily injury or incurring property damages was not at fault, the defendants against whom judgment is entered shall be jointly and severally liable for the sum of their proportionate shares of the ((~~claimants [claimant's]~~)) claimant's total damages.

(2) Notwithstanding the provisions of subsection (1)(a) and (b) of this section, in an action for damages for injury or death occurring as a result of health care or related services, or the arranging for the provision of health care or related services, whether brought under chapter 7.70 RCW, RCW 4.20.010, 4.20.020, 4.20.046, 4.24.010, or 48.43.545(1), any other applicable law, or any combination thereof, the liability of each health care provider, health care professional, and health care institution, as those terms are defined in section 8(7) of this act, shall be several only except that a party shall be responsible for the fault of another person or for payment of the proportionate share of another party where both were acting in concert or when a person was acting as the actual agent or servant of the party or was acting under the party's direct supervision and control.

(3) If a defendant is jointly and severally liable under one of the exceptions listed in subsection((~~s~~)) (1)(a) ((~~or (1)~~)), (b), or (2) of this section, such defendant's rights to contribution against another jointly and severally liable defendant, and the effect of settlement by either such defendant, shall be determined under RCW 4.22.040, 4.22.050, and 4.22.060.

((~~(3)~~)) (4)(a) Nothing in this section affects any cause of action relating to hazardous wastes or substances or solid waste disposal sites.

(b) Nothing in this section shall affect a cause of action arising from the tortious interference with contracts or business relations.

(c) Nothing in this section shall affect any cause of action arising from the manufacture or marketing of a fungible product in a generic form which contains no clearly identifiable shape, color, or marking.

Sec. 23. RCW 4.22.015 and 1981 c 27 s 9 are each amended to read as follows:

"Fault" includes acts or omissions, including misuse of a product, that are in any measure negligent or reckless toward the person or property of the actor or others, or that subject a person to strict tort liability or liability on a product liability claim. The term also includes breach of warranty, unreasonable assumption of risk, and unreasonable failure to avoid an injury or to mitigate damages. Legal

requirements of causal relation apply both to fault as the basis for liability and to contributory fault.

A comparison of fault for any purpose under RCW 4.22.005 through ((~~4.22.060~~)) 4.22.070 shall involve consideration of both the nature of the conduct of the parties to the action and the extent of the causal relation between such conduct and the damages.

NEW SECTION. **Sec. 24.** If any provision of this act or its application to any person or circumstance is held invalid, the remainder of the act or the application of the provision to other persons or circumstances is not affected.

NEW SECTION. **Sec. 25.** Sections 7 through 9, 13, 16 through 20, 22, and 23 of this act apply to all causes of action, whether filed or not, that the parties have not settled or in which judgment has not been entered before the effective date of this section.

NEW SECTION. **Sec. 26.** Sections 11, 14, and 15 of this act apply to all causes of action filed on or after the effective date of this section.

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