SHB 2292 - S COMM AMD
By Committee on Health & Long-Term Care

Strike everything after the enacting clause and insert the following:

"NEW SECTION. **Sec. 1.** The legislature finds that access to safe, affordable health care is one of the most important issues facing the citizens of Washington state. The legislature further finds that the rising cost of medical malpractice insurance has caused some physicians, particularly those in high-risk specialties such as obstetrics and emergency room practice, to be unavailable when and where the citizens need them the most. The answers to these problems are varied and complex, requiring comprehensive solutions that encourage patient safety practices, increase oversight of medical malpractice insurance, and making the civil justice system more understandable, fair, and efficient for all the participants. The legislature finds that neither of the initiatives, Initiative 330 or Initiative 336, contain comprehensive, real solutions to the problems they are attempting to solve, and for this reason, offers the following legislative approach to the citizens of this state.

It is the intent of the legislature to prioritize patient safety and the prevention of medical errors above all other considerations as legal changes are made to address the problem of high malpractice insurance premiums. Thousands of patients are injured each year as a result of medical errors, many of which can be avoided by supporting health care providers, facilities, and carriers in their efforts to reduce the incidence of those mistakes. It is also the legislature's intent to provide incentives to settle cases before resorting to court, and to provide the option of a more fair, efficient, and streamlined alternative to trials for those for whom settlement negotiations do not work. Finally, it is the intent of the legislature to provide the insurance commissioner with the tools and information necessary to

regulate medical malpractice insurance rates and policies so that they are fair to both the insurers and the insured.

PART I - PATIENT SAFETY

Encouraging Patient Safety Through Communications With Patients

Sec. 101. RCW 5.64.010 and 1975-'76 2nd ex.s. c 56 s 3 are each amended to read as follows:

(1) In any civil action against a health care provider for personal injuries which is based upon alleged professional negligence ((~~and which is 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, podiatrist, 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;~~)), or in any arbitration or mediation proceeding related to such civil action, evidence of furnishing or offering or promising to pay medical, hospital, or similar expenses occasioned by an injury is not admissible ((~~to prove liability for the injury~~)).

(2)(a) In a civil action against a health care provider for personal injuries that is based upon alleged professional negligence,

or in any arbitration or mediation proceeding related to such civil action, a statement, affirmation, gesture, or conduct identified in (b) of this subsection is inadmissible as evidence if:

(i) More than twenty days before commencement of trial it was conveyed by a health care provider to the injured person, or to a person specified in RCW 7.70.065(1); and

(ii) It relates to the discomfort, pain, suffering, injury, or death of the injured person as the result of the alleged professional negligence.

(b) (a) of this subsection applies to:

(i) Any statement, affirmation, gesture, or conduct expressing apology, fault, sympathy, commiseration, condolence, compassion, or a general sense of benevolence; or

(ii) Any statement or affirmation regarding remedial actions that may be taken to address the act or omission that is the basis for the allegation of negligence.

Encouraging Reports of Unprofessional Conduct or Lack of Capacity to Practice Safely

Sec. 102. RCW 4.24.260 and 1994 sp.s. c 9 s 701 are each amended to read as follows:

((~~Physicians licensed under chapter 18.71 RCW, dentists licensed under chapter 18.32 RCW, and pharmacists licensed under chapter 18.64 RCW~~)) Any member of a health profession listed under RCW 18.130.040 who, in good faith, makes a report, files charges, or presents evidence against another member of ((~~their~~)) a health profession based on the claimed ((~~incompetency or gross misconduct~~)) unprofessional conduct as provided in RCW 18.130.180 or inability to practice with reasonable skill and safety to consumers by reason of any physical or mental condition as provided in RCW 18.130.170 of such person before the ((~~medical quality assurance commission established under chapter 18.71 RCW, in a proceeding under chapter 18.32 RCW, or to the board of pharmacy under RCW 18.64.160~~)) agency, board, or commission responsible for disciplinary activities for the person's profession under chapter 18.130 RCW, shall be immune from civil action for damages arising out of such activities. A person prevailing upon the good faith defense

provided for in this section is entitled to recover expenses and reasonable attorneys' fees incurred in establishing the defense.

Medical Quality Assurance Commission Consumer Membership

Sec. 103. RCW 18.71.015 and 1999 c 366 s 4 are each amended to read as follows:

The Washington state medical quality assurance commission is established, consisting of thirteen individuals licensed to practice medicine in the state of Washington under this chapter, two individuals who are licensed as physician assistants under chapter 18.71A RCW, and ((~~four~~)) six individuals who are members of the public. At least two of the public members shall not be from the health care industry and shall be representatives of patient advocacy groups or organizations. Each congressional district now existing or hereafter created in the state must be represented by at least one physician member of the commission. The terms of office of members of the commission are not affected by changes in congressional district boundaries. Public members of the commission may not be a member of any other health care licensing board or commission, or have a fiduciary obligation to a facility rendering health services regulated by the commission, or have a material or financial interest in the rendering of health services regulated by the commission.

The members of the commission shall be appointed by the governor. Members of the initial commission may be appointed to staggered terms of one to four years, and thereafter all terms of appointment shall be for four years. The governor shall consider such physician and physician assistant members who are recommended for appointment by the appropriate professional associations in the state. In appointing the initial members of the commission, it is the intent of the legislature that, to the extent possible, the existing members of the board of medical examiners and medical disciplinary board repealed under section 336, chapter 9, Laws of 1994 sp. sess. be appointed to the commission. No member may serve more than two consecutive full terms. Each member shall hold office until a successor is appointed.

Each member of the commission must be a citizen of the United States, must be an actual resident of this state, and, if a physician,

must have been licensed to practice medicine in this state for at least five years.

The commission shall meet as soon as practicable after appointment and elect officers each year. Meetings shall be held at least four times a year and at such place as the commission determines and at such other times and places as the commission deems necessary. A majority of the commission members appointed and serving constitutes a quorum for the transaction of commission business.

The affirmative vote of a majority of a quorum of the commission is required to carry any motion or resolution, to adopt any rule, or to pass any measure. The commission may appoint panels consisting of at least three members. A quorum for the transaction of any business by a panel is a minimum of three members. A majority vote of a quorum of the panel is required to transact business delegated to it by the commission.

Each member of the commission shall be compensated in accordance with RCW 43.03.265 and in addition thereto shall be reimbursed for travel expenses incurred in carrying out the duties of the commission in accordance with RCW 43.03.050 and 43.03.060. Any such expenses shall be paid from funds appropriated to the department of health.

Whenever the governor is satisfied that a member of a commission has been guilty of neglect of duty, misconduct, or malfeasance or misfeasance in office, the governor shall file with the secretary of state a statement of the causes for and the order of removal from office, and the secretary shall forthwith send a certified copy of the statement of causes and order of removal to the last known post office address of the member.

Vacancies in the membership of the commission shall be filled for the unexpired term by appointment by the governor.

The members of the commission are immune from suit in an action, civil or criminal, based on its disciplinary proceedings or other official acts performed in good faith as members of the commission.

Whenever the workload of the commission requires, the commission may request that the secretary appoint pro tempore members of the commission. When serving, pro tempore members of the commission have all of the powers, duties, and immunities, and are entitled to all of the emoluments, including travel expenses, of regularly appointed members of the commission.

Health Care Provider Discipline

Sec. 104. RCW 18.130.160 and 2001 c 195 s 1 are each amended to read as follows:

Upon a finding, after hearing, that a license holder or applicant has committed unprofessional conduct or is unable to practice with reasonable skill and safety due to a physical or mental condition, the disciplining authority may consider the imposition of sanctions, taking into account any prior findings of fact under RCW 18.130.110, any stipulations to informal disposition under RCW 18.130.172, and any action taken by other in-state or out-of-state disciplining authorities, and issue an order providing for one or any combination of the following:

(1) Revocation of the license;

(2) Suspension of the license for a fixed or indefinite term;

(3) Restriction or limitation of the practice;

(4) Requiring the satisfactory completion of a specific program of remedial education or treatment;

(5) The monitoring of the practice by a supervisor approved by the disciplining authority;

(6) Censure or reprimand;

(7) Compliance with conditions of probation for a designated period of time;

(8) Payment of a fine for each violation of this chapter, not to exceed five thousand dollars per violation. Funds received shall be placed in the health professions account;

(9) Denial of the license request;

(10) Corrective action;

(11) Refund of fees billed to and collected from the consumer;

(12) A surrender of the practitioner's license in lieu of other sanctions, which must be reported to the federal data bank.

Except as otherwise provided in section 106 of this act, any of the actions under this section may be totally or partly stayed by the disciplining authority. In determining what action is appropriate, the disciplining authority must first consider what sanctions are necessary to protect or compensate the public. Only after such provisions have been made may the disciplining authority consider and include in the order requirements designed to rehabilitate the license holder or

applicant. All costs associated with compliance with orders issued under this section are the obligation of the license holder or applicant.

The licensee or applicant may enter into a stipulated disposition of charges that includes one or more of the sanctions of this section, but only after a statement of charges has been issued and the licensee has been afforded the opportunity for a hearing and has elected on the record to forego such a hearing. The stipulation shall either contain one or more specific findings of unprofessional conduct or inability to practice, or a statement by the licensee acknowledging that evidence is sufficient to justify one or more specified findings of unprofessional conduct or inability to practice. The stipulation entered into pursuant to this subsection shall be considered formal disciplinary action for all purposes.

Sec. 105. RCW 18.130.172 and 2000 c 171 s 29 are each amended to read as follows:

(1) Except for those acts of unprofessional conduct specified in section 106 of this act, prior to serving a statement of charges under RCW 18.130.090 or 18.130.170, the disciplinary authority may furnish a statement of allegations to the licensee or applicant along with a detailed summary of the evidence relied upon to establish the allegations and a proposed stipulation for informal resolution of the allegations. These documents shall be exempt from public disclosure until such time as the allegations are resolved either by stipulation or otherwise.

(2) The disciplinary authority and the applicant or licensee may stipulate that the allegations may be disposed of informally in accordance with this subsection. The stipulation shall contain a statement of the facts leading to the filing of the complaint; the act or acts of unprofessional conduct alleged to have been committed or the alleged basis for determining that the applicant or licensee is unable to practice with reasonable skill and safety; a statement that the stipulation is not to be construed as a finding of either unprofessional conduct or inability to practice; an acknowledgement that a finding of unprofessional conduct or inability to practice, if proven, constitutes grounds for discipline under this chapter; and an agreement on the part of the licensee or applicant that the sanctions

set forth in RCW 18.130.160, except RCW 18.130.160 (1), (2), (6), and (8), may be imposed as part of the stipulation, except that no fine may be imposed but the licensee or applicant may agree to reimburse the disciplinary authority the costs of investigation and processing the complaint up to an amount not exceeding one thousand dollars per allegation; and an agreement on the part of the disciplinary authority to forego further disciplinary proceedings concerning the allegations. A stipulation entered into pursuant to this subsection shall not be considered formal disciplinary action.

(3) If the licensee or applicant declines to agree to disposition of the charges by means of a stipulation pursuant to subsection (2) of this section, the disciplinary authority may proceed to formal disciplinary action pursuant to RCW 18.130.090 or 18.130.170.

(4) Upon execution of a stipulation under subsection (2) of this section by both the licensee or applicant and the disciplinary authority, the complaint is deemed disposed of and shall become subject to public disclosure on the same basis and to the same extent as other records of the disciplinary authority. Should the licensee or applicant fail to pay any agreed reimbursement within thirty days of the date specified in the stipulation for payment, the disciplinary authority may seek collection of the amount agreed to be paid in the same manner as enforcement of a fine under RCW 18.130.165.

NEW SECTION. **Sec. 106.** A new section is added to chapter 18.130 RCW to read as follows:

(1) The disciplining authority shall revoke the license of a license holder who is found, in three unrelated orders under RCW 18.130.110 in a ten-year period, to have engaged in three separate courses of unprofessional conduct based upon any combination of the following:

(a) Any violation of RCW 18.130.180(4) that causes or substantially contributes to the death of or severe injury to a patient or creates a significant risk of harm to the public;

(b) Any violation of RCW 18.130.180(6) that creates a significant risk of harm to the public;

(c) Any violation of RCW 18.130.180(7) that causes or substantially contributes to the death of or severe injury to a patient or creates a significant risk of harm to the public;

(d) Any violation of RCW 18.130.180(9);

(e) Any violation of RCW 18.130.180(17), except gross misdemeanors;

(f) Any violation of RCW 18.130.180(23) that causes or substantially contributes to the death of or severe injury to a patient or creates a significant risk of harm to the public;

(g) Any violation of RCW 18.130.180(24) based upon an act of abuse to a client or patient; and

(h) Any violation of RCW 18.130.180(24) based upon sexual contact with a client or patient.

(2) For the purposes of subsection (1) of this section, a ten-year period commences upon the completion of all conditions and obligations imposed for the acts identified in subsection (1)(a) through (h) of this section.

(3) An order that includes a finding of mitigating circumstances for an act of unprofessional conduct may be issued and, except for (a) of this subsection, applied one time for any license holder or applicant for a license, and if so, that order does not count as one of the three orders that triggers a license revocation for purposes of this section. A finding of mitigating circumstances under (a) of this subsection may be issued and applied as many times as the license holder meets the criteria for such a finding and does not count as one of the three orders that triggers the revocation of a license for the purposes of this section. Except for (a) of this subsection, after a finding of mitigating circumstances is issued and applied, no subsequent orders under this section may consider any mitigating circumstances. The following mitigating circumstances may be considered:

(a) For subsection (1)(a) of this section, the act involved a high-risk procedure, there was no lower-risk alternative to that procedure, the patient was informed of the risks of the procedure and consented to the procedure anyway, and prior to the institution of disciplinary actions the license holder took appropriate remedial measures;

(b) There is a strong potential for rehabilitation of the license holder; or

(c) There is a strong potential for remedial education and training to prevent future harm to the public.

(4) Nothing in this section limits the ability of the disciplining

authority to impose any sanction, including revocation, for a single violation of any subsection of RCW 18.130.180.

(5) Notwithstanding RCW 9.96A.020(1), revocation of a license under this section is not subject to a petition for reinstatement under RCW 18.130.150.

(6) Revocation of a license under this section is subject to appeal as provided in RCW 18.130.140.

Increasing Patient Safety Through Disclosure and Analysis of Adverse Events

NEW SECTION. **Sec. 107.** The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

(1) "Adverse event" means any of the following events or occurrences:

(a) An unanticipated death or major permanent loss of function, not related to the natural course of a patient's illness or underlying condition;

(b) A patient suicide while the patient was under care in the hospital;

(c) An infant abduction or discharge to the wrong family;

(d) Sexual assault or rape of a patient or staff member while in the hospital;

(e) A hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities;

(f) Surgery performed on the wrong patient or wrong body part;

(g) A failure or major malfunction of a facility system such as the heating, ventilation, fire alarm, fire sprinkler, electrical, electronic information management, or water supply which affects any patient diagnosis, treatment, or care service within the facility; or

(h) A fire which affects any patient diagnosis, treatment, or care area of the facility.

The term does not include an incident.

(2) "Ambulatory surgical facility" means any distinct entity that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization, whether or not the facility is certified under Title XVIII of the federal social security act.

(3) "Childbirth center" means a facility licensed under chapter 18.46 RCW.

(4) "Correctional medical facility" means a part or unit of a correctional facility operated by the department of corrections under chapter 72.10 RCW that provides medical services for lengths of stay in excess of twenty-four hours to offenders.

(5) "Department" means the department of health.

(6) "Health care worker" means an employee, independent contractor, licensee, or other individual who is directly involved in the delivery of health services in a medical facility.

(7) "Hospital" means a facility licensed under chapter 70.41 RCW.

(8) "Incident" means an event, occurrence, or situation involving the clinical care of a patient in a medical facility which:

(a) Results in unanticipated injury to a patient that is less severe than death or major permanent loss of function and is not related to the natural course of the patient's illness or underlying condition; or

(b) Could have injured the patient but did not either cause an unanticipated injury or require the delivery of additional health care services to the patient.

The term does not include an adverse event.

(9) "Medical facility" means an ambulatory surgical facility, childbirth center, hospital, psychiatric hospital, or correctional medical facility.

(10) "Psychiatric hospital" means a hospital facility licensed as a psychiatric hospital under chapter 71.12 RCW.

NEW SECTION. **Sec. 108.** (1) Each medical facility shall report to the department the occurrence of any adverse event. The report must be submitted to the department within forty-five days after occurrence of the event has been confirmed.

(2) The report shall be filed in a format specified by the department after consultation with medical facilities. It shall identify the facility but shall not include any identifying information for any of the health care professionals, facility employees, or patients involved. This provision does not modify the duty of a hospital to make a report to the department of health or a disciplinary

authority if a licensed practitioner has committed unprofessional conduct as defined in RCW 18.130.180.

(3) Any medical facility or health care worker may report an incident to the department. The report shall be filed in a format specified by the department after consultation with medical facilities and shall identify the facility but shall not include any identifying information for any of the health care professionals, facility employees, or patients involved. This provision does not modify the duty of a hospital to make a report to the department of health or a disciplinary authority if a licensed practitioner has committed unprofessional conduct as defined in RCW 18.130.180.

(4) If, in the course of investigating a complaint received from an employee of a licensed medical facility, the department determines that the facility has not undertaken efforts to investigate the occurrence of an adverse event, the department shall direct the facility to undertake an investigation of the event. If a complaint related to a potential adverse event involves care provided in an ambulatory surgical facility, the department shall notify the facility and request that they undertake an investigation of the event. The protections of RCW 43.70.075 apply to complaints related to adverse events or incidents that are submitted in good faith by employees of medical facilities.

NEW SECTION. **Sec. 109.** The department shall:

(1) Receive reports of adverse events and incidents under section 108 of this act;

(2) Investigate adverse events;

(3) Establish a system for medical facilities and the health care workers of a medical facility to report adverse events and incidents, which shall be accessible twenty-four hours a day, seven days a week;

(4) Adopt rules as necessary to implement this act;

(5) Directly or by contract:

(a) Collect, analyze, and evaluate data regarding reports of adverse events and incidents, including the identification of performance indicators and patterns in frequency or severity at certain medical facilities or in certain regions of the state;

(b) Develop recommendations for changes in health care practices

and procedures, which may be instituted for the purpose of reducing the number and severity of adverse events and incidents;

(c) Directly advise reporting medical facilities of immediate changes that can be instituted to reduce adverse events and incidents;

(d) Issue recommendations to medical facilities on a facility-specific or on a statewide basis regarding changes, trends, and improvements in health care practices and procedures for the purpose of reducing the number and severity of adverse events and incidents. Prior to issuing recommendations, consideration shall be given to the following factors: Expectation of improved quality care, implementation feasibility, other relevant implementation practices, and the cost impact to patients, payers, and medical facilities. Statewide recommendations shall be issued to medical facilities on a continuing basis and shall be published and posted on the department's publicly accessible web site. The recommendations made to medical facilities under this section shall not be considered mandatory for licensure purposes unless they are adopted by the department as rules pursuant to chapter 34.05 RCW; and

(e) Monitor implementation of reporting systems addressing adverse events or their equivalent in other states and make recommendations to the governor and the legislature as necessary for modifications to this chapter to keep the system as nearly consistent as possible with similar systems in other states;

(6) Report no later than January 1, 2007, and annually thereafter to the governor and the legislature on the department's activities under this act in the preceding year. The report shall include:

(a) The number of adverse events and incidents reported by medical facilities on a geographical basis and their outcomes;

(b) The information derived from the data collected including any recognized trends concerning patient safety; and

(c) Recommendations for statutory or regulatory changes that may help improve patient safety in the state.

The annual report shall be made available for public inspection and shall be posted on the department's web site;

(7) Conduct all activities under this section in a manner that preserves the confidentiality of documents, materials, or information made confidential by section 111 of this act.

NEW SECTION. **Sec. 110.** (1) Medical facilities licensed by the department shall have in place policies to assure that, when appropriate, information about unanticipated outcomes is provided to patients or their families or any surrogate decision makers identified pursuant to RCW 7.70.065. Notifications of unanticipated outcomes under this section do not constitute an acknowledgment or admission of liability, nor can the fact of notification or the content disclosed be introduced as evidence in a civil action.

(2) Beginning January 1, 2006, the department shall, during the survey of a licensed medical facility, ensure that the policy required in subsection (1) of this section is in place.

NEW SECTION. **Sec. 111.** When a report of an adverse event or incident under section 108 of this act is made by or through a coordinated quality improvement program under RCW 43.70.510 or 70.41.200, or by a peer review committee under RCW 4.24.250, information and documents, including complaints and incident reports, created specifically for and collected and maintained by a quality improvement committee for the purpose of preparing a report of an adverse event or incident shall be subject to the confidentiality protections of those laws and RCW 42.17.310(1)(hh).

Coordinated Quality Improvement Programs

Sec. 112. RCW 43.70.510 and 2004 c 145 s 2 are each amended to read as follows:

(1)(a) Health care institutions and medical facilities, other than hospitals, that are licensed by the department, professional societies or organizations, health care service contractors, health maintenance organizations, health carriers approved pursuant to chapter 48.43 RCW, and any other person or entity providing health care coverage under chapter 48.42 RCW that is subject to the jurisdiction and regulation of any state agency or any subdivision thereof may maintain a coordinated quality improvement program for the improvement of the quality of health care services rendered to patients and the identification and prevention of medical malpractice as set forth in RCW 70.41.200.

(b) All such programs shall comply with the requirements of RCW 70.41.200(1) (a), (c), (d), (e), (f), (g), and (h) as modified to

reflect the structural organization of the institution, facility, professional societies or organizations, health care service contractors, health maintenance organizations, health carriers, or any other person or entity providing health care coverage under chapter 48.42 RCW that is subject to the jurisdiction and regulation of any state agency or any subdivision thereof, unless an alternative quality improvement program substantially equivalent to RCW 70.41.200(1)(a) is developed. All such programs, whether complying with the requirement set forth in RCW 70.41.200(1)(a) or in the form of an alternative program, must be approved by the department before the discovery limitations provided in subsections (3) and (4) of this section and the exemption under RCW 42.17.310(1)(hh) and subsection (5) of this section shall apply. In reviewing plans submitted by licensed entities that are associated with physicians' offices, the department shall ensure that the exemption under RCW 42.17.310(1)(hh) and the discovery limitations of this section are applied only to information and documents related specifically to quality improvement activities undertaken by the licensed entity.

(2) Health care provider groups of five or more providers may maintain a coordinated quality improvement program for the improvement of the quality of health care services rendered to patients and the identification and prevention of medical malpractice as set forth in RCW 70.41.200. For purposes of this section, a health care provider group may be a consortium of providers consisting of five or more providers in total. All such programs shall comply with the requirements of RCW 70.41.200(1) (a), (c), (d), (e), (f), (g), and (h) as modified to reflect the structural organization of the health care provider group. All such programs must be approved by the department before the discovery limitations provided in subsections (3) and (4) of this section and the exemption under RCW 42.17.310(1)(hh) and subsection (5) of this section shall apply.

(3) Any person who, in substantial good faith, provides information to further the purposes of the quality improvement and medical malpractice prevention program or who, in substantial good faith, participates on the quality improvement committee shall not be subject to an action for civil damages or other relief as a result of such activity. Any person or entity participating in a coordinated quality improvement program that, in substantial good faith, shares information

or documents with one or more other programs, committees, or boards under subsection (6) of this section is not subject to an action for civil damages or other relief as a result of the activity or its consequences. For the purposes of this section, sharing information is presumed to be in substantial good faith. However, the presumption may be rebutted upon a showing of clear, cogent, and convincing evidence that the information shared was knowingly false or deliberately misleading.

(4) Information and documents, including complaints and incident reports, created specifically for, and collected, and maintained by a quality improvement committee are not subject to discovery or introduction into evidence in any civil action, and no person who was in attendance at a meeting of such committee or who participated in the creation, collection, or maintenance of information or documents specifically for the committee shall be permitted or required to testify in any civil action as to the content of such proceedings or the documents and information prepared specifically for the committee. This subsection does not preclude: (a) In any civil action, the discovery of the identity of persons involved in the medical care that is the basis of the civil action whose involvement was independent of any quality improvement activity; (b) in any civil action, the testimony of any person concerning the facts that form the basis for the institution of such proceedings of which the person had personal knowledge acquired independently of such proceedings; (c) in any civil action by a health care provider regarding the restriction or revocation of that individual's clinical or staff privileges, introduction into evidence information collected and maintained by quality improvement committees regarding such health care provider; (d) in any civil action challenging the termination of a contract by a state agency with any entity maintaining a coordinated quality improvement program under this section if the termination was on the basis of quality of care concerns, introduction into evidence of information created, collected, or maintained by the quality improvement committees of the subject entity, which may be under terms of a protective order as specified by the court; (e) in any civil action, disclosure of the fact that staff privileges were terminated or restricted, including the specific restrictions imposed, if any and the reasons for the restrictions; or (f) in any civil action, discovery and

introduction into evidence of the patient's medical records required by rule of the department of health to be made regarding the care and treatment received.

(5) Information and documents created specifically for, and collected and maintained by a quality improvement committee are exempt from disclosure under chapter 42.17 RCW.

(6) A coordinated quality improvement program may share information and documents, including complaints and incident reports, created specifically for, and collected and maintained by a quality improvement committee or a peer review committee under RCW 4.24.250 with one or more other coordinated quality improvement programs maintained in accordance with this section or with RCW 70.41.200 or a peer review committee under RCW 4.24.250, for the improvement of the quality of health care services rendered to patients and the identification and prevention of medical malpractice. The privacy protections of chapter 70.02 RCW and the federal health insurance portability and accountability act of 1996 and its implementing regulations apply to the sharing of individually identifiable patient information held by a coordinated quality improvement program. Any rules necessary to implement this section shall meet the requirements of applicable federal and state privacy laws. Information and documents disclosed by one coordinated quality improvement program to another coordinated quality improvement program or a peer review committee under RCW 4.24.250 and any information and documents created or maintained as a result of the sharing of information and documents shall not be subject to the discovery process and confidentiality shall be respected as required by subsection (4) of this section and RCW 4.24.250.

(7) The department of health shall adopt rules as are necessary to implement this section.

Prescription Legibility

NEW SECTION. **Sec. 113.** The legislature finds that prescription drug errors occur because the pharmacist or nurse cannot read the prescription from the physician or other provider with prescriptive authority. The legislature further finds that legible prescriptions can prevent these errors.

Sec. 114. RCW 69.41.010 and 2003 c 257 s 2 and 2003 c 140 s 11 are each reenacted and amended to read as follows:

As used in this chapter, the following terms have the meanings indicated unless the context clearly requires otherwise:

(1) "Administer" means the direct application of a legend drug whether by injection, inhalation, ingestion, or any other means, to the body of a patient or research subject by:

(a) A practitioner; or

(b) The patient or research subject at the direction of the practitioner.

(2) "Community-based care settings" include: Community residential programs for the developmentally disabled, certified by the department of social and health services under chapter 71A.12 RCW; adult family homes licensed under chapter 70.128 RCW; and boarding homes licensed under chapter 18.20 RCW. Community-based care settings do not include acute care or skilled nursing facilities.

(3) "Deliver" or "delivery" means the actual, constructive, or attempted transfer from one person to another of a legend drug, whether or not there is an agency relationship.

(4) "Department" means the department of health.

(5) "Dispense" means the interpretation of a prescription or order for a legend drug and, pursuant to that prescription or order, the proper selection, measuring, compounding, labeling, or packaging necessary to prepare that prescription or order for delivery.

(6) "Dispenser" means a practitioner who dispenses.

(7) "Distribute" means to deliver other than by administering or dispensing a legend drug.

(8) "Distributor" means a person who distributes.

(9) "Drug" means:

(a) Substances recognized as drugs in the official United States pharmacopoeia, official homeopathic pharmacopoeia of the United States, or official national formulary, or any supplement to any of them;

(b) Substances intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease in man or animals;

(c) Substances (other than food, minerals or vitamins) intended to affect the structure or any function of the body of man or animals; and

(d) Substances intended for use as a component of any article

specified in (a), (b), or (c) of this subsection. It does not include devices or their components, parts, or accessories.

(10) "Electronic communication of prescription information" means the communication of prescription information by computer, or the transmission of an exact visual image of a prescription by facsimile, or other electronic means for original prescription information or prescription refill information for a legend drug between an authorized practitioner and a pharmacy or the transfer of prescription information for a legend drug from one pharmacy to another pharmacy.

(11) "In-home care settings" include an individual's place of temporary and permanent residence, but does not include acute care or skilled nursing facilities, and does not include community-based care settings.

(12) "Legend drugs" means any drugs which are required by state law or regulation of the state board of pharmacy to be dispensed on prescription only or are restricted to use by practitioners only.

(13) "Legible prescription" means a prescription or medication order issued by a practitioner that is capable of being read and understood by the pharmacist filling the prescription or the nurse or other practitioner implementing the medication order. A prescription must be hand printed, typewritten, or electronically generated.

(14) "Medication assistance" means assistance rendered by a nonpractitioner to an individual residing in a community-based care setting or in-home care setting to facilitate the individual's self-administration of a legend drug or controlled substance. It includes reminding or coaching the individual, handing the medication container to the individual, opening the individual's medication container, using an enabler, or placing the medication in the individual's hand, and such other means of medication assistance as defined by rule adopted by the department. A nonpractitioner may help in the preparation of legend drugs or controlled substances for self-administration where a practitioner has determined and communicated orally or by written direction that such medication preparation assistance is necessary and appropriate. Medication assistance shall not include assistance with intravenous medications or injectable medications, except prefilled insulin syringes.

(15) "Person" means individual, corporation, government or

governmental subdivision or agency, business trust, estate, trust, partnership or association, or any other legal entity.

(16) "Practitioner" means:

(a) A physician under chapter 18.71 RCW, an osteopathic physician or an osteopathic physician and surgeon under chapter 18.57 RCW, a dentist under chapter 18.32 RCW, a podiatric physician and surgeon under chapter 18.22 RCW, a veterinarian under chapter 18.92 RCW, a registered nurse, advanced registered nurse practitioner, or licensed practical nurse under chapter 18.79 RCW, an optometrist under chapter 18.53 RCW who is certified by the optometry board under RCW 18.53.010, an osteopathic physician assistant under chapter 18.57A RCW, a physician assistant under chapter 18.71A RCW, a naturopath licensed under chapter 18.36A RCW, a pharmacist under chapter 18.64 RCW, or, when acting under the required supervision of a dentist licensed under chapter 18.32 RCW, a dental hygienist licensed under chapter 18.29 RCW;

(b) A pharmacy, hospital, or other institution licensed, registered, or otherwise permitted to distribute, dispense, conduct research with respect to, or to administer a legend drug in the course of professional practice or research in this state; and

(c) A physician licensed to practice medicine and surgery or a physician licensed to practice osteopathic medicine and surgery in any state, or province of Canada, which shares a common border with the state of Washington.

(17) "Secretary" means the secretary of health or the secretary's designee.

Medical Malpractice Premium Assistance

NEW SECTION. **Sec. 115.** The department of health shall develop, in consultation with the department of revenue, 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 and shall submit proposed legislation to the legislature by November 15, 2006. The program must relate the amount of any tax credit to the extent to which a provider serves uninsured, medicare, and medicaid patients, such that providers who serve the greatest number of uninsured, medicare, and medicaid patients

receive the greatest tax credit. The program also should recommend a minimum threshold of uninsured, medicare, or medicaid patients that a provider must serve in order to qualify for the tax credit.

PART II - INSURANCE INDUSTRY REFORM

Medical Malpractice Closed Claim Reporting

NEW SECTION. **Sec. 201.** The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

(1) "Claim" means a demand for payment of a loss caused by medical malpractice.

(a) Two or more claims, or a single claim naming multiple health care providers or facilities, arising out of a single injury or incident of medical malpractice is one claim.

(b) A series of related incidents of medical malpractice is one claim.

(2) "Claimant" means a person filing a claim against a health care provider or health care facility.

(3) "Closed claim" means a claim concluded with or without payment and for which all administrative activity has been finalized by the insuring entity or self-insurer.

(4) "Commissioner" means the insurance commissioner.

(5) "Health care facility" or "facility" means a clinic, diagnostic center, hospital, laboratory, mental health center, nursing home, office, surgical facility, treatment facility, or similar place where a health care provider provides health care to patients.

(6) "Health care provider" or "provider" means a physician licensed under chapter 18.71 RCW, an osteopathic physician licensed under chapter 18.57 RCW, a podiatric physician licensed under chapter 18.22 RCW, a dentist licensed under chapter 18.32 RCW, a chiropractor licensed under chapter 18.25 RCW, an advance registered nurse practitioner licensed under chapter 18.79 RCW, a physician assistant licensed under chapter 18.71A RCW, and a naturopath licensed under chapter 18.36A RCW.

(7) "Insuring entity" means:

(a) An insurer;

(b) A joint underwriting association;

(c) A risk retention group; or

(d) An unauthorized insurer that provides surplus lines coverage.

(8) "Medical malpractice" means a negligent act, error, or omission in providing or failing to provide professional health care services that is actionable under chapter 7.70 RCW.

(9) "Self-insurer" means any health care provider, facility, or other individual or entity that assumes operational or financial risk for claims of medical malpractice.

NEW SECTION. **Sec. 202.** (1) Beginning January 1, 2007, every self-insurer or insuring entity that provides medical malpractice insurance to any facility or provider in Washington state must report to the commissioner any closed claim related to medical malpractice, if the claim resulted in a final:

(a) Judgment in any amount;

(b) Settlement or payment in any amount; or

(c) Disposition of a medical malpractice claim resulting in no indemnity payment on behalf of an insured.

(2) If a closed claim is not required to be reported by an insuring entity or self-insurer and is not covered by insurance, the facility or provider named in the claim must report the closed claim to the commissioner if the claim resulted in a final:

(a) Judgment in any amount;

(b) Settlement or payment in any amount; or

(c) Disposition of a medical malpractice claim resulting in no payment by the health care facility or health care provider.

(3) Reports under this section must be filed with the commissioner within sixty days after the claim is closed by the insuring entity or self-insurer.

(4)(a) The commissioner may impose a fine of up to two hundred fifty dollars per day per case against any insuring entity that violates the requirements of this section. The total fine per case may not exceed ten thousand dollars.

(b) The department of health may impose a fine of up to two hundred fifty dollars per day per case against any facility or provider that violates the requirements of this section. The total fine per case may not exceed ten thousand dollars.

NEW SECTION. **Sec. 203.** The reports required under section 202 of this act must contain the following data in a form and with coding prescribed by the commissioner for each claim:

(1) A unique number assigned to the claim by the insuring entity or self-insurer to serve as an identifier for the claim;

(2) The type of health care provider, including the provider's medical specialty; the type of facility, if any, and the location within the facility where the injury occurred;

(3) The date of the event that resulted in the claim;

(4) The county or counties in which the event that resulted in the claim occurred;

(5) The date the claim was reported to the insuring entity, self-insurer, facility, or provider;

(6) The date of suit, if filed;

(7) The claimant's age and sex;

(8) Specific information about the judgment or settlement including:

(a) The date and amount of any judgment or settlement;

(b) Whether the settlement:

(i) Was the result of a judgment, arbitration, or mediation; and

(ii) Occurred before or after trial;

(c) For claims that result in a verdict or judgment that itemizes damages:

(i) Economic damages, such as incurred and anticipated medical expense and lost wages;

(ii) Noneconomic damages; and

(iii) Allocated loss adjustment expense, including but not limited to court costs, attorneys' fees, and costs of expert witnesses;

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

(i) Total damages; and

(ii) Allocated loss adjustment expense, including but not limited to court costs, attorneys' fees, and costs of expert witnesses; and

(e) If there is no judgment or settlement:

(i) The date and reason for final disposition; and

(ii) The date the claim was closed; and

(9) The reason for the medical malpractice claim. The commissioner shall use the same coding of reasons for malpractice claims as those

used for mandatory reporting to the national practitioner data bank, in the federal department of health and human services, as provided in 42 U.S.C. Secs. 11131 and 11134, as amended.

NEW SECTION. **Sec. 204.** The commissioner must prepare aggregate statistical summaries of closed claims based on calendar year data submitted under section 202 of this act.

(1) At a minimum, data must be sorted by calendar year and calendar incident year. The commissioner may also decide to display data in other ways.

(2) The summaries must be available by April 30th of each year.

(3) Information included in an individual closed claim report submitted by an insurer or self-insurer under this chapter is confidential, is exempt from public disclosure, and may not be made available by the commissioner to the public.

NEW SECTION. **Sec. 205.** Beginning in 2008, the commissioner must prepare an annual report by June 30th that summarizes and analyzes the closed claim reports for medical malpractice filed under section 202 of this act and the annual financial reports filed by insurers writing medical malpractice insurance in this state. The report must include:

(1) An analysis of closed claim reports of prior years for which data are collected and show:

(a) Trends in the frequency and severity of claims payments;

(b) An itemization of economic and noneconomic damages;

(c) An itemization of allocated loss adjustment expenses;

(d) The types of medical malpractice for which claims have been paid; and

(e) Any other information the commissioner determines illustrates trends in closed claims;

(2) An analysis of the medical malpractice insurance market in Washington state, including:

(a) An analysis of the financial reports of the insurers with a combined market share of at least ninety percent of net written medical malpractice premium in Washington state for the prior calendar year;

(b) A loss ratio analysis of medical malpractice insurance written in Washington state; and

(c) A profitability analysis of each insurer writing medical malpractice insurance;

(3) A comparison of loss ratios and the profitability of medical malpractice insurance in Washington state to other states based on financial reports filed with the national association of insurance commissioners and any other source of information the commissioner deems relevant;

(4) A summary of the rate filings for medical malpractice that have been approved by the commissioner for the prior calendar year, including an analysis of the trend of direct and incurred losses as compared to prior years;

(5) The commissioner must post reports required by this section on the internet no later than thirty days after they are due; and

(6) The commissioner may adopt rules that require insuring entities and self-insurers required to report under section 202(1) of this act to report data related to:

(a) The frequency and severity of open claims for the reporting period;

(b) The aggregate amounts reserved for incurred claims;

(c) Changes in reserves from the previous reporting period; and

(d) Any other information that helps the commissioner monitor losses and claims development in the Washington state medical malpractice insurance market.

NEW SECTION. **Sec. 206.** The commissioner shall adopt all rules needed to implement this chapter. The rules shall identify which insuring entity or self-insurer has the primary obligation to report a closed claim when more than one insuring entity or self-insurer is providing medical malpractice liability coverage to a single health care provider or a single health care facility that has been named in a claim. The rules may also specify standards and methodology for the reporting by the insuring entities and self-insurers. To ensure that claimants, health care providers, health care facilities, and self-insurers cannot be individually identified when data is disclosed to the public, the commissioner shall adopt rules that require the protection of information that, in combination, could result in the ability to identify the claimant, health care provider, health care

facility, or self-insurer in a particular claim or collection of claims.

NEW SECTION. **Sec. 207.** A new section is added to chapter 7.70 RCW to read as follows:

In any action filed under this chapter that results in a final:

(1) Judgment in any amount;

(2) Settlement or payment in any amount; or

(3) Disposition resulting in no indemnity payment,

the claimant or his or her attorney shall report to the office of the insurance commissioner on forms provided by the commissioner any court costs, attorneys' fees, or costs of expert witnesses incurred in pursuing the action.

NEW SECTION. **Sec. 208.** If the national association of insurance commissioners adopts model medical malpractice reporting standards, the insurance commissioner must analyze the model standards and report to the legislature on or before the December 1st subsequent to the adoption of the model standards. The report must include an analysis of any differences between the model standards and sections 201 through 206 of this act and make recommendations, if any, regarding possible legislative changes. The report must be made to the house of representatives committees on health care; financial institutions and insurance; and judiciary and the senate committees on health and long-term care; financial institutions, housing and consumer protection; and judiciary.

NEW SECTION. **Sec. 209.** A new section is added to chapter 42.17 RCW to read as follows:

Information in a closed claim report filed under section 203 of this act that alone or in combination could result in the ability to identify a claimant, health care provider, health care facility, or self-insurer involved in a particular claim is exempt from disclosure under this chapter.

Underwriting Standards

NEW SECTION. **Sec. 210.** A new section is added to chapter 48.19 RCW to read as follows:

(1) For the purposes of this section, "underwrite" means the process of selecting, rejecting, or pricing a risk, and includes each of these processes:

(a) Evaluation, selection, and classification of risk;

(b) Application of rates, rating rules, and classification plans to risks that are accepted; and

(c) Determining eligibility for:

(i) Coverage provisions;

(ii) Providing or limiting the amount of coverage or policy limits; or

(iii) Premium payment plans.

(2) Each medical malpractice insurer must file its underwriting rules, guidelines, criteria, standards, or other information the insurer uses to underwrite medical malpractice coverage. However, an insurer is excluded from this requirement if the insurer is ordered into rehabilitation under chapter 48.31 or 48.99 RCW.

(a) Every filing of underwriting information must identify and explain:

(i) The class, type, and extent of coverage provided by the insurer;

(ii) Any changes that have occurred to the underwriting standards; and

(iii) How underwriting changes are expected to affect future losses.

(b) The information under (a) of this subsection must be filed with the commissioner at least thirty days before it becomes effective and is subject to public disclosure upon receipt by the commissioner.

NEW SECTION. **Sec. 211.** A new section is added to chapter 48.18 RCW to read as follows:

(1) For the purposes of this section:

(a) "Adverse action" includes, but is not limited to, the following:

(i) Cancellation, denial, or nonrenewal of medical malpractice insurance coverage;

(ii) Charging a higher insurance premium for medical malpractice insurance than would have been charged, whether the charge is by any of the following:

(A) Application of a rating rule;

(B) Assignment to a rating tier that does not have the lowest available rates; or

(C) Placement with an affiliate company that does not offer the lowest rates available to the insured within the affiliate group of insurance companies; or

(iii) Any reduction or adverse or unfavorable change in the terms of coverage or amount of any medical malpractice insurance, including, but not limited to, the following: Coverage provided to the insured health care provider is not as broad in scope as coverage requested by the insured health care provider but is available to other insured health care providers of the insurer or any affiliate.

(b) "Affiliate" has the same meaning as in RCW 48.31B.005(1).

(c) "Claim" means a demand for payment by an allegedly injured third party under the terms and conditions of an insurance contract.

(d) "Tier" has the same meaning as in RCW 48.18.545(1)(h).

(2) When an insurer takes adverse action against an insured, the insurer may consider the following factors only in combination with other substantive underwriting factors:

(a) An insured has inquired about the nature or scope of coverage under a medical malpractice insurance policy;

(b) An insured has notified the insurer, pursuant to the provisions of the insurance contract, about a potential claim, which did not ultimately result in the filing of a claim; or

(c) A claim was closed without payment.

Cancellation or Nonrenewal of Liability Insurance Policies

Sec. 212. RCW 48.18.290 and 1997 c 85 s 1 are each amended to read as follows:

(1) Cancellation by the insurer of any policy which by its terms is cancellable at the option of the insurer, or of any binder based on such policy which does not contain a clearly stated expiration date, may be effected as to any interest only upon compliance with the following:

(a)(i) For policies other than medical malpractice liability insurance: Written notice of such cancellation, accompanied by the actual reason therefor, must be actually delivered or mailed to the named insured not less than forty-five days prior to the effective date of the cancellation ((~~except for cancellation of insurance policies for~~));

(ii) For policies that provide medical malpractice liability insurance: Written notice of such cancellation, accompanied by the actual reason therefore, must be actually delivered or mailed to the named insured not less than ninety days prior to the effective date of the cancellation;

(iii) For policies canceled due to nonpayment of premiums, ((~~which~~)) written notice ((~~shall be~~)) must be actually delivered or mailed to the named insured not less than ten days prior to ((~~such date and except for cancellation of fire insurance policies~~)) the effective date of the cancellation; and

(iv) For fire insurance policies canceled under chapter 48.53 RCW, ((~~which~~)) written notice ((~~shall not be~~)) must be actually delivered or mailed to the named insured not less than five days prior to ((~~such date~~)) the effective date of the cancellation;

(b) Like notice must also be so delivered or mailed to each mortgagee, pledgee, or other person shown by the policy to have an interest in any loss which may occur thereunder. For purposes of this subsection (1)(b), "delivered" includes electronic transmittal, facsimile, or personal delivery.

(2) The mailing of any such notice shall be effected by depositing it in a sealed envelope, directed to the addressee at his or her last address as known to the insurer or as shown by the insurer's records, with proper prepaid postage affixed, in a letter depository of the United States post office. The insurer shall retain in its records any such item so mailed, together with its envelope, which was returned by the post office upon failure to find, or deliver the mailing to, the addressee.

(3) The affidavit of the individual making or supervising such a mailing, shall constitute prima facie evidence of such facts of the mailing as are therein affirmed.

(4) The portion of any premium paid to the insurer on account of the policy, unearned because of the cancellation and in amount as

computed on the pro rata basis, must be actually paid to the insured or other person entitled thereto as shown by the policy or by any endorsement thereon, or be mailed to the insured or such person as soon as possible, and no later than forty-five days after the date of notice of cancellation to the insured for homeowners', dwelling fire, and private passenger auto. Any such payment may be made by cash, or by check, bank draft, or money order.

(5) This section shall not apply to contracts of life or disability insurance without provision for cancellation prior to the date to which premiums have been paid, or to contracts of insurance procured under the provisions of chapter 48.15 RCW.

Sec. 213. RCW 48.18.2901 and 2002 c 347 s 1 are each amended to read as follows:

(1) Each insurer shall be required to renew any contract of insurance subject to RCW 48.18.290 unless one of the following situations exists:

(a) The insurer gives the named insured at least forty-five or ninety days' notice in writing as provided for in RCW 48.18.290(1)(a)(i) or (ii), that it ((~~proposes to refuse to renew~~)) will not renew the insurance contract upon its expiration date; and sets forth in that writing the actual reason for refusing to renew;

(b) At least twenty days prior to its expiration date, the insurer has communicated, either directly or through its agent, its willingness to renew in writing to the named insured and has included in that writing a statement of the amount of the premium or portion thereof required to be paid by the insured to renew the policy, and the insured fails to discharge when due his or her obligation in connection with the payment of such premium or portion thereof;

(c) The insured has procured equivalent coverage prior to the expiration of the policy period;

(d) The contract is evidenced by a written binder containing a clearly stated expiration date which has expired according to its terms; or

(e) The contract clearly states that it is not renewable, and is for a specific line, subclassification, or type of coverage that is not offered on a renewable basis. This subsection (1)(e) does not restrict the authority of the insurance commissioner under this code.

(2) Any insurer failing to include in the notice required by subsection (1)(b) of this section the amount of any increased premium resulting from a change of rates and an explanation of any change in the contract provisions shall renew the policy if so required by that subsection according to the rates and contract provisions applicable to the expiring policy. However, renewal based on the rates and contract provisions applicable to the expiring policy shall not prevent the insurer from making changes in the rates and/or contract provisions of the policy once during the term of its renewal after at least twenty days' advance notice of such change has been given to the named insured.

(3) Renewal of a policy shall not constitute a waiver or estoppel with respect to grounds for cancellation which existed before the effective date of such renewal, or with respect to cancellation of fire policies under chapter 48.53 RCW.

(4) "Renewal" or "to renew" means the issuance and delivery by an insurer of a contract of insurance replacing at the end of the contract period a contract of insurance previously issued and delivered by the same insurer, or the issuance and delivery of a certificate or notice extending the term of a contract beyond its policy period or term. However, (a) any contract of insurance with a policy period or term of six months or less whether or not made continuous for successive terms upon the payment of additional premiums shall for the purpose of RCW 48.18.290 and 48.18.293 through 48.18.295 be considered as if written for a policy period or term of six months; and (b) any policy written for a term longer than one year or any policy with no fixed expiration date, shall, for the purpose of RCW 48.18.290 and 48.18.293 through 48.18.295, be considered as if written for successive policy periods or terms of one year.

(5) A midterm blanket reduction in rate, approved by the commissioner, for medical malpractice insurance shall not be considered a renewal for purposes of this section.

Prior Approval of Medical Malpractice Insurance Rates

Sec. 214. RCW 48.18.100 and 1997 c 428 s 3 are each amended to read as follows:

(1) No insurance policy form other than surety bond forms, forms

exempt under RCW 48.18.103, or application form where written application is required and is to be attached to the policy, or printed life or disability rider or endorsement form shall be issued, delivered, or used unless it has been filed with and approved by the commissioner. This section shall not apply to policies, riders or endorsements of unique character designed for and used with relation to insurance upon a particular subject.

(2) Every such filing containing a certification, in a form approved by the commissioner, by either the chief executive officer of the insurer or by an actuary who is a member of the American academy of actuaries, attesting that the filing complies with Title 48 RCW and Title 284 of the Washington Administrative Code, may be used by such insurer immediately after filing with the commissioner. The commissioner may order an insurer to cease using a certified form upon the grounds set forth in RCW 48.18.110. This subsection shall not apply to certain types of policy forms designated by the commissioner by rule.

(3) Except as provided in RCW 48.18.103, every filing that does not contain a certification pursuant to subsection (2) of this section shall be made not less than thirty days in advance of any such issuance, delivery, or use. At the expiration of such thirty days the form so filed shall be deemed approved unless prior thereto it has been affirmatively approved or disapproved by order of the commissioner. The commissioner may extend by not more than an additional fifteen days the period within which he or she may so affirmatively approve or disapprove any such form, by giving notice of such extension before expiration of the initial thirty-day period. At the expiration of any such period as so extended, and in the absence of such prior affirmative approval or disapproval, any such form shall be deemed approved. The commissioner may withdraw any such approval at any time for cause. By approval of any such form for immediate use, the commissioner may waive any unexpired portion of such initial thirty-day waiting period.

(4) The commissioner's order disapproving any such form or withdrawing a previous approval shall state the grounds therefor.

(5) No such form shall knowingly be so issued or delivered as to which the commissioner's approval does not then exist.

(6) The commissioner may, by order, exempt from the requirements of this section for so long as he or she deems proper, any insurance document or form or type thereof as specified in such order, to which in his or her opinion this section may not practicably be applied, or the filing and approval of which are, in his or her opinion, not desirable or necessary for the protection of the public.

(7) Every member or subscriber to a rating organization shall adhere to the form filings made on its behalf by the organization. Deviations from such organization are permitted only when filed with the commissioner in accordance with this chapter.

(8) Medical malpractice insurance form filings are subject to the provisions of this section.

Sec. 215. RCW 48.18.103 and 2003 c 248 s 4 are each amended to read as follows:

(1) It is the intent of the legislature to assist the purchasers of commercial property casualty insurance by allowing policies to be issued more expeditiously and provide a more competitive market for forms.

(2) Commercial property casualty policies may be issued prior to filing the forms. All commercial property casualty forms shall be filed with the commissioner within thirty days after an insurer issues any policy using them.

(3) If, within thirty days after a commercial property casualty form has been filed, the commissioner finds that the form does not meet the requirements of this chapter, the commissioner shall disapprove the form and give notice to the insurer or rating organization that made the filing, specifying how the form fails to meet the requirements and stating when, within a reasonable period thereafter, the form shall be deemed no longer effective. The commissioner may extend the time for review another fifteen days by giving notice to the insurer prior to the expiration of the original thirty-day period.

(4) Upon a final determination of a disapproval of a policy form under subsection (3) of this section, the insurer shall amend any previously issued disapproved form by endorsement to comply with the commissioner's disapproval.

(5) For purposes of this section, "commercial property casualty" means insurance pertaining to a business, profession, occupation,

nonprofit organization, or public entity for the lines of property and casualty insurance defined in RCW 48.11.040, 48.11.050, 48.11.060, or 48.11.070, but does not mean medical malpractice insurance.

(6) Except as provided in subsection (4) of this section, the disapproval shall not affect any contract made or issued prior to the expiration of the period set forth in the notice of disapproval.

(7) In the event a hearing is held on the actions of the commissioner under subsection (3) of this section, the burden of proof shall be on the commissioner.

Sec. 216. RCW 48.19.043 and 2003 c 248 s 7 are each amended to read as follows:

(1) It is the intent of the legislature to assist the purchasers of commercial property casualty insurance by allowing policies to be issued more expeditiously and provide a more competitive market for rates.

(2) Notwithstanding the provisions of RCW 48.19.040(1), commercial property casualty policies may be issued prior to filing the rates. All commercial property casualty rates shall be filed with the commissioner within thirty days after an insurer issues any policy using them.

(3) If, within thirty days after a commercial property casualty rate has been filed, the commissioner finds that the rate does not meet the requirements of this chapter, the commissioner shall disapprove the filing and give notice to the insurer or rating organization that made the filing, specifying how the filing fails to meet the requirements and stating when, within a reasonable period thereafter, the filing shall be deemed no longer effective. The commissioner may extend the time for review another fifteen days by giving notice to the insurer prior to the expiration of the original thirty-day period.

(4) Upon a final determination of a disapproval of a rate filing under subsection (3) of this section, the insurer shall issue an endorsement changing the rate to comply with the commissioner's disapproval from the date the rate is no longer effective.

(5) For purposes of this section, "commercial property casualty" means insurance pertaining to a business, profession, occupation, nonprofit organization, or public entity for the lines of property and

casualty insurance defined in RCW 48.11.040, 48.11.050, 48.11.060, or 48.11.070, but does not mean medical malpractice insurance.

(6) Except as provided in subsection (4) of this section, the disapproval shall not affect any contract made or issued prior to the expiration of the period set forth in the notice of disapproval.

(7) In the event a hearing is held on the actions of the commissioner under subsection (3) of this section, the burden of proof is on the commissioner.

Sec. 217. RCW 48.19.060 and 1997 c 428 s 4 are each amended to read as follows:

(1) The commissioner shall review a filing as soon as reasonably possible after made, to determine whether it meets the requirements of this chapter.

(2) Except as provided in RCW 48.19.070 and 48.19.043:

(a) No such filing shall become effective within thirty days after the date of filing with the commissioner, which period may be extended by the commissioner for an additional period not to exceed fifteen days if he or she gives notice within such waiting period to the insurer or rating organization which made the filing that he or she needs such additional time for the consideration of the filing. The commissioner may, upon application and for cause shown, waive such waiting period or part thereof as to a filing that he or she has not disapproved.

(b) A filing shall be deemed to meet the requirements of this chapter unless disapproved by the commissioner within the waiting period or any extension thereof.

(3) Medical malpractice insurance rate filings are subject to the provisions of this section.

PART III - HEALTH CARE LIABILITY REFORM

Statutes of Limitations and Repose

NEW SECTION. **Sec. 301.** The purpose of this section and section 302 of this act is to respond to the court's decision in *DeYoung v. Providence Medical Center*, 136 Wn.2d 136 (1998), by expressly stating the legislature's rationale for the eight-year statute of repose in RCW 4.16.350.

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

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

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

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

The legislature intends to reenact RCW 4.16.350 with respect to the eight-year statute of repose and specifically set forth for the court the legislature's legitimate rationale for adopting the eight-year statute of repose. The legislature further intends that the eight-year statute of repose reenacted by section 302 of this act be applied to actions commenced on or after the effective date of this act.

Sec. 302. RCW 4.16.350 and 1998 c 147 s 1 are each reenacted to read as follows:

Any civil action for damages for injury occurring as a result of health care 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; based upon alleged professional negligence shall be commenced within three years of the act or omission alleged to have caused the injury or condition, or one year of the time the patient or his representative discovered or reasonably should have discovered that the injury 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.

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).

Sec. 303. RCW 4.16.190 and 1993 c 232 s 1 are each amended to read as follows:

(1) Unless otherwise provided in this section, if a person entitled to bring an action mentioned in this chapter, except for a penalty or forfeiture, or against a sheriff or other officer, for an escape, be at the time the cause of action accrued either under the age of eighteen years, or incompetent or disabled to such a degree that he or she cannot understand the nature of the proceedings, such incompetency or disability as determined according to chapter 11.88 RCW, or imprisoned on a criminal charge prior to sentencing, the time of such disability shall not be a part of the time limited for the commencement of action.

(2) Subsection (1) of this section with respect to a person under the age of eighteen years does not apply to the time limited for the commencement of an action under RCW 4.16.350.

Expert Witnesses

NEW SECTION. **Sec. 304.** A new section is added to chapter 7.70 RCW to read as follows:

(1) In an action against a health care provider under this chapter, a health care professional expert may not provide testimony at trial unless the health care professional expert meets the following criteria:

(a) Has expertise in the condition at issue in the action; and

(b) At the time of the occurrence of the incident at issue in the action, or at the time of retirement in the case of an expert who retired no sooner than five years prior to the time the action is commenced, was either:

(i) Engaged in active practice in the same or similar area of practice or specialty as the defendant or is qualified to be an expert witness by virtue of having training, experience, and knowledge in the standard of care pertinent to the procedure or treatment in dispute; or

(ii) Teaching at an accredited health professions school or an accredited or affiliated academic or clinical training program in the same or similar area of practice or specialty as the defendant, including instruction regarding the particular condition at issue.

(2) Upon motion of a party, the court may waive the requirements of

subsection (1) of this section and allow a health care professional expert who does not meet those requirements to testify at trial if the court finds that:

(a) Extensive efforts were made by the party to locate an expert who meets the criteria under subsection (1) of this section, but none was willing and available to testify; and

(b) The proposed expert is qualified to be an expert witness by virtue of the person's training, experience, and knowledge.

NEW SECTION. **Sec. 305.** A new section is added to chapter 7.70 RCW to read as follows:

An expert opinion provided in the course of an action against a health care provider under this chapter must be corroborated by admissible evidence, such as, but not limited to, treatment or practice protocols or guidelines developed by health care specialty organizations, objective academic research, clinical trials or studies, widely accepted clinical practices, or evidence deemed sufficient by the court.

NEW SECTION. **Sec. 306.** A new section is added to chapter 7.70 RCW to read as follows:

In any action under this chapter, each side shall presumptively be entitled to only two independent experts on an issue, except upon a showing of good cause. Where there are multiple parties on a side and the parties cannot agree as to which independent experts will be called on an issue, the court, upon a showing of good cause, shall allow additional experts on an issue to be called as the court deems appropriate.

Certificate of Merit

NEW SECTION. **Sec. 307.** A new section is added to chapter 7.70 RCW to read as follows:

(1) In an action against an individual health care provider under this chapter for personal injury or wrongful death in which the injury is alleged to have been caused by an act or omission that violates the accepted standard of care, the plaintiff must file a certificate of merit at the time of commencing the action. If the action is commenced

within forty-five days prior to the expiration of the applicable statute of limitations, the plaintiff must file the certificate of merit no later than forty-five days after commencing the action.

(2) The certificate of merit must be executed by a health care provider who meets the qualifications of an expert under this chapter. If there is more than one defendant in the action, the person commencing the action must file a certificate of merit for each defendant.

(3) The certificate of merit must contain a statement that the person executing the certificate of merit believes, based on the information known at the time of executing the certificate of merit, that there is a reasonable probability that the defendant's conduct did not follow the accepted standard of care required to be exercised by the defendant.

(4) Upon motion of the plaintiff, the court may grant an additional period of time to file the certificate of merit, not to exceed ninety days, if the court finds there is good cause for the extension.

(5)(a) Failure to file a certificate of merit that complies with the requirements of this section is grounds for dismissal of the case.

(b) If a case is dismissed for failure to file a certificate of merit that complies with the requirements of this section, the filing of the claim against the health care provider shall not be used against the health care provider in professional liability insurance rate setting, personal credit history, or professional licensing and credentialing.

Affidavits of Noninvolvement

NEW SECTION. **Sec. 308.** A new section is added to chapter 7.70 RCW to read as follows:

(1) A health care provider named as a defendant in a medical malpractice action may cause the action against that provider to be dismissed upon the filing of an affidavit of noninvolvement with the court. The affidavit of noninvolvement shall set forth, with particularity, the facts that demonstrate that the provider was misidentified or otherwise not involved, individually or through its servants or employees, in the care and treatment of the claimant, and was not obligated, either individually or through its servants or

employees, to provide for the care and treatment of the claimant, and could not have caused the alleged malpractice, either individually or through its servants or employees, in any way.

(2) A codefendant or claimant shall have the right to challenge an affidavit of noninvolvement by filing a motion and submitting an affidavit that contradicts the assertions of noninvolvement made by the health care provider in the affidavit of noninvolvement.

(3) If the court determines that a health care provider named as a defendant falsely files or makes false or inaccurate statements in an affidavit of noninvolvement, the court, upon motion or upon its own initiative, shall immediately reinstate the claim against that provider. Reinstatement of a party pursuant to this subsection shall not be barred by any statute of limitations defense that was not valid at the time the original action was filed.

In any action in which the health care provider is found by the court to have knowingly filed a false or inaccurate affidavit of noninvolvement, the court shall impose upon the person who signed the affidavit or represented the party, or both, an appropriate sanction, including, but not limited to, at the discretion of the court, reasonable expenses incurred as a result of the filing of the false or inaccurate affidavit, including reasonable attorneys' fees.

(4) If the court determines that a plaintiff falsely objected to a health care provider's affidavit of noninvolvement, or knowingly provided an inaccurate statement regarding a health care provider's affidavit, the court shall impose upon the plaintiff or the plaintiff's counsel, or both, an appropriate sanction, including, but not limited to, an order to pay to the other party or parties the amount of the reasonable expenses incurred as a result of the submission of the false objection or inaccurate statement, including reasonable attorneys' fees.

(5) If, as a matter of law, a health care provider is dismissed as a result of an affidavit of noninvolvement from an action alleging medical malpractice, no fault may be allocated to that person. In addition, any such defendant may not have his or her status as a defendant in the action used against him or her for purposes of establishing insurance rates, to deny hospital privileges, or for the purposes of credit scoring or credit applications.

Voluntary Arbitration

NEW SECTION. **Sec. 309.** This chapter applies to any cause of action for damages for personal injury or wrongful death based on alleged professional negligence in the provision of health care where all parties to the action have agreed to submit the dispute to arbitration under this chapter in accordance with the requirements of section 310 of this act. Any contract or other agreement entered into prior to the commencement of an action that purports to require a party to elect arbitration under this chapter is void and unenforceable.

NEW SECTION. **Sec. 310.** (1) Parties in an action covered under section 309 of this act may elect to submit the dispute to arbitration under this chapter only in accordance with the requirements in this section.

(a) A claimant may elect to submit the dispute to arbitration under this chapter by including such election in the complaint filed at the commencement of the action. A defendant may elect to submit the dispute to arbitration under this chapter by including such election in the defendant's answer to the complaint. The dispute will be submitted to arbitration under this chapter only if all parties to the action elect to submit the dispute to arbitration.

(b) If the parties do not initially elect to submit the dispute to arbitration in accordance with (a) of this subsection, the parties may make such an election at any time during the pendency of the action by filing a stipulation with the court in which all parties to the action agree to submit the dispute to arbitration under this chapter.

(2) A party that does not initially elect to submit a dispute to arbitration under this chapter must file a declaration with the court that meets the following requirements:

(a) In the case of a claimant, the declaration must be filed at the time of commencing the action and must state that the attorney representing the claimant presented the claimant with a copy of the provisions of this chapter before commencing the action and that the claimant elected not to submit the dispute to arbitration under this chapter; and

(b) In the case of a defendant, the declaration must be filed at the time of filing the answer and must state that the attorney

representing the defendant presented the defendant with a copy of the provisions of this chapter before filing the defendant's answer and that the defendant elected not to submit the dispute to arbitration under this chapter.

NEW SECTION. **Sec. 311.** (1) An arbitrator shall be selected by agreement of the parties no later than forty-five days after: (a) The date all defendants elected arbitration in the answer where the parties elected arbitration in the initial complaint and answer; or (b) the date of the stipulation where the parties agreed to enter into arbitration after the commencement of the action through a stipulation filed with the court. The parties may agree to select more than one arbitrator to conduct the arbitration.

(2) If the parties are unable to agree to an arbitrator by the time specified in subsection (1) of this section, each side may submit the names of three arbitrators to the court, and the court shall select an arbitrator from among the submitted names within fifteen days of being notified that the parties are unable to agree to an arbitrator. If none of the parties submit any names of potential arbitrators, the court shall select an arbitrator.

NEW SECTION. **Sec. 312.** The arbitrator may conduct the arbitration in such manner as the arbitrator considers appropriate so as to aid in the fair and expeditious disposition of the proceeding subject to the requirements of this section and section 313 of this act.

(1)(a) Except as provided in (b) of this subsection, each side is entitled to two experts on the issue of liability, two experts on the issue of damages, and one rebuttal expert.

(b) Where there are multiple parties on one side, the arbitrator shall determine the number of experts that are allowed based on the minimum number of experts necessary to ensure a fair and economic resolution of the action.

(2)(a) Unless the arbitrator determines that exceptional circumstances require additional discovery, each party is entitled to the following discovery from any other party:

(i) Twenty-five interrogatories, including subparts;

(ii) Ten requests for admission; and

(iii) In accordance with applicable court rules:

(A) Requests for production of documents and things, and for entry upon land for inspection and other purposes; and

(B) Requests for physical and mental examinations of persons.

(b) The parties shall be entitled to the following depositions:

(i) Depositions of parties and any expert that a party expects to call as a witness. Except by order of the arbitrator for good cause shown, the length of the deposition of a party or an expert witness shall be limited to four hours.

(ii) Depositions of other witnesses. Unless the arbitrator determines that exceptional circumstances require additional depositions, the total number of depositions of persons who are not parties or expert witnesses is limited to five depositions per side, each of which may last no longer than two hours in length. In the deposition of a fact witness, each side is entitled to examine for one hour of the deposition.

(3) An arbitrator may issue a subpoena for the attendance of a witness and for the production of records and other evidence at any hearing and may administer oaths. A subpoena must be served in the manner for service of subpoenas in a civil action and, upon motion to the court by a party to the arbitration proceeding or the arbitrator, enforced in the manner for enforcement of subpoenas in a civil action.

NEW SECTION. **Sec. 313.** (1) An arbitration under this chapter shall be conducted according to the time frames specified in this section. The time frames provided in this section run from the date all defendants have agreed to arbitration in their answers where the parties elected arbitration in the initial complaint and answer, and from the date of the execution of the stipulation where the parties agreed to enter into arbitration after the commencement of the action through a stipulation filed with the court. The arbitrator shall issue a case scheduling order in every case specifying the dates by which the requirements of (b) through (g) of this subsection must be completed.

(a) Within forty-five days, the claimant shall provide stipulations for all relevant medical records to the defendants.

(b) Within one hundred twenty days, the claimant shall disclose to the defendants the names and curriculum vitae or other documentation of qualifications of any expert the claimant expects to call as a witness.

(c) Within one hundred forty days, each defendant shall disclose to the claimants the names and curriculum vitae or other documentation of qualifications of any expert the defendant expects to call as a witness.

(d) Within one hundred sixty days, each party shall disclose to the other parties the name and curriculum vitae or other documentation of qualifications of any rebuttal expert the party expects to call as a witness.

(e) Within two hundred forty days, all discovery shall be completed.

(f) Within two hundred fifty days, mandatory mediation as required by RCW 7.70.100 shall be completed. The arbitrator for the dispute may not serve as the mediator in the mediation.

(g) Within two hundred seventy days, the arbitration hearing shall commence.

(2) It is the express public policy of the legislature that arbitration hearings under this chapter be commenced no later than ten months after the parties elect to submit the dispute to arbitration. The arbitrator may grant a continuance of the commencement of the arbitration hearing only where a party shows that exceptional circumstances create an undue and unavoidable hardship on the party.

NEW SECTION. **Sec. 314.** (1) The arbitrator shall issue a decision in writing and signed by the arbitrator within fourteen days after the completion of the arbitration hearing and shall promptly deliver a copy of the decision to each of the parties or their attorneys.

(2) The arbitrator may not make an award of damages under this chapter that exceeds one million dollars for both economic and noneconomic damages.

(3) The arbitrator may not make an award of damages under this chapter under a theory of ostensible agency liability.

(4) The arbitrator shall make a finding as to whether a claim, counterclaim, cross-claim, or defense advanced by a party was frivolous as defined in RCW 4.84.185.

(5) If the arbitrator makes an award of damages to the claimant, the arbitrator shall make a finding as to whether the claimant suffered serious mental or physical injury as a result of the professional negligence of the defendant or defendants.

(6) The arbitrator shall review the reasonableness of each party's attorneys' fees under the provisions of RCW 4.24.005.

(7) The fees and expenses of the arbitrator shall be paid by the nonprevailing parties.

NEW SECTION. **Sec. 315.** After a party to the arbitration proceeding receives notice of a decision, the party may file a motion with the court for a judgment in accordance with the decision, at which time the court shall issue such a judgment unless the decision is modified, corrected, or vacated as provided in section 318 of this act.

NEW SECTION. **Sec. 316.** There is no right to a trial de novo on an appeal of the arbitrator's decision. An appeal of the arbitrator's decision is limited to the bases for appeal provided in RCW 7.--.---(1) (a) through (d) and 7.--.--- (sections 23(1) (a) through (d) and 24, chapter . . . (Substitute House Bill No. 1054), Laws of 2005).

NEW SECTION. **Sec. 317.** The provisions of chapter 7.-- RCW (sections 1 through 32, chapter . . . (Substitute House Bill No. 1054), Laws of 2005) do not apply to arbitrations conducted under this chapter except to the extent specifically provided in this chapter.

NEW SECTION. **Sec. 318.** There is no right to a trial de novo on an appeal of the arbitrator's decision. An appeal of the arbitrator's decision is limited to the bases for appeal provided in RCW 7.04.160 (1) through (4) and 7.04.170, or equivalent provisions in a successor statute.

NEW SECTION. **Sec. 319.** The provisions of chapter 7.04 RCW do not apply to arbitrations conducted under this chapter except to the extent specifically provided in this chapter.

Sec. 320. RCW 7.04.010 and 1947 c 209 s 1 are each amended to read as follows:

Two or more parties may agree in writing to submit to arbitration, in conformity with the provisions of this chapter, any controversy which may be the subject of an action existing between them at the time of the agreement to submit, or they may include in a written agreement

a provision to settle by arbitration any controversy thereafter arising between them out of or in relation to such agreement. Such agreement shall be valid, enforceable and irrevocable save upon such grounds as exist in law or equity for the revocation of any agreement.

The provisions of this chapter shall not apply to any arbitration agreement between employers and employees or between employers and associations of employees, and as to any such agreement the parties thereto may provide for any method and procedure for the settlement of existing or future disputes and controversies, and such procedure shall be valid, enforceable and irrevocable save upon such grounds as exist in law or equity for the revocation of any agreement.

The provisions of this chapter do not apply to arbitrations under chapter 7.-- RCW (sections 309 through 319 of this act) except to the extent provided in that chapter.

Sec. 321. RCW 7.--.--- and 2005 c ... (SHB 1054) s 3 are each amended to read as follows:

(1) Before July 1, 2006, this chapter governs agreements to arbitrate entered into:

(a) On or after the effective date of chapter . . . (Substitute House Bill No. 1054), Laws of 2005; and

(b) Before the effective date of chapter . . . (Substitute House Bill No. 1054), Laws of 2005, if all parties to the agreement to arbitrate or to arbitration proceedings agree in a record to be governed by this chapter.

(2) On or after July 1, 2006, this chapter governs agreements to arbitrate even if the arbitration agreement was entered into before the effective date of chapter . . . (Substitute House Bill No. 1054), Laws of 2005.

(3) This chapter does not apply to any arbitration governed by chapter 7.06 RCW.

(4) This chapter does not apply to any arbitration governed by chapter 7.-- RCW (sections 309 through 319 of this act) except to the extent provided in that chapter.

(5) This chapter does not apply to any arbitration agreement between employers and employees or between employers and associations of employees.

Mandatory Mediation

Sec. 322. RCW 7.70.100 and 1993 c 492 s 419 are each amended to read as follows:

(1) No action based upon a health care provider's professional negligence 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 of 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 injury occurring as a result of health care provided after July 1, 1993, shall be subject to mandatory mediation prior to trial except as provided in subsection (6) of this section.

((~~(2)~~)) (4) The supreme court shall by rule adopt procedures to implement mandatory mediation of actions under this chapter. The ((~~rules shall~~)) implementation contemplates the adoption of rules by the supreme court which will require mandatory mediation without exception unless subsection (6) of this section applies. The rules on mandatory mediation shall 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 mandatory mediation requirement of subsection (4) of this section does not apply to an action subject to mandatory arbitration under chapter 7.06 RCW or to an action in which the parties have agreed, subsequent to the arisal of the claim, to submit the claim to arbitration under chapter 7.04 or 7.-- (sections 309 through 319 of this act) RCW.

(7) The implementation also contemplates the adoption of a rule by the supreme court for procedures for the parties to certify to the court the manner of mediation used by the parties to comply with this section.

Collateral Sources

Sec. 323. RCW 7.70.080 and 1975-'76 2nd ex.s. c 56 s 13 are each amended to read as follows:

Any party may present evidence to the trier of fact that the ((~~patient~~)) plaintiff has already been compensated for the injury complained of from any source except the assets of the ((~~patient, his~~)) plaintiff, the plaintiff's representative, or ((~~his~~)) the plaintiff's 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 and evidence of any amount paid by the plaintiff, or his or her representative or immediate family, to secure the right to the compensation. ((~~Insurance bargained for or provided on behalf of an employee shall be considered insurance purchased with the assets of the employee.~~)) Compensation as used in this section shall mean payment of money or other property to or on

behalf of the patient, rendering of services to the patient free of charge to the patient, or indemnification of expenses incurred by or on behalf of the patient. Notwithstanding this section, evidence of compensation by a defendant health care provider may be offered only by that provider.

Preventing Frivolous Lawsuits

NEW SECTION. **Sec. 324.** A new section is added to chapter 7.70 RCW to read as follows:

In any action under this section, an attorney that has drafted, or assisted in drafting and filing an action, counterclaim, cross-claim, third-party claim, or a defense to a claim, upon signature and filing, certifies that to the best of the party's or attorney's knowledge, information, and belief, formed after reasonable inquiry it is not frivolous, and is well grounded in fact and is warranted by existing law or a good faith argument for the extension, modification, or reversal of existing law, and that it is not interposed for any improper purpose, such as to harass or to cause frivolous litigation. If an action is signed and filed in violation of this rule, the court, upon motion or upon its own initiative, may impose upon the person who signed it, a represented party, or both, an appropriate sanction, which may include an order to pay to the other party or parties the amount of the reasonable expenses incurred because of the filing of the action, counterclaim, cross-claim, third-party claim, or a defense to a claim, including a reasonable attorney fee. The court may also forward the name of the attorney filing a claim in violation of this section to the bar association for investigation. The procedures governing the enforcement of RCW 4.84.185 shall apply to this section.

PART IV - MISCELLANEOUS PROVISIONS

NEW SECTION. **Sec. 401.** Part headings and subheadings used in this act are not any part of the law.

NEW SECTION. **Sec. 402.** (1) Sections 107 through 111 of this act constitute a new chapter in Title 70 RCW.

(2) Sections 201 through 206 of this act constitute a new chapter in Title 48 RCW.

(3) Sections 309 through 319 of this act constitute a new chapter in Title 7 RCW.

NEW SECTION. **Sec. 403.** Sections 318 through 320 of this act expire December 31, 2005.

NEW SECTION. **Sec. 404.** 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. 405.** The secretary of state shall submit this act to the people for their adoption and ratification, or rejection, at the next general election to be held in this state, in accordance with Article II, section 1 of the state Constitution and the laws adopted to facilitate its operation. In accordance with RCW 29A.72.050, the legislature designates the following as the statement of subject of this referendum bill to be included in the ballot title:

"Improving patient safety, reducing medical errors, and reforming malpractice insurance;"

and the legislature designates the following as the concise description of this referendum bill to be included in the ballot title:

"This bill would improve health care by increasing patient safety, reducing medical errors, reforming medical malpractice insurance, and resolving medical malpractice claims fairly.""

SHB 2292 - S COMM AMD
By Committee on Health & Long-Term Care

On page 1, line 3 of the title, after "fairly" strike the remainder of the title and insert "; amending RCW 5.64.010, 4.24.260, 18.71.015, 18.130.160, 18.130.172, 43.70.510, 48.18.290, 48.18.2901, 48.18.100,

48.18.103, 48.19.043, 48.19.060, 4.16.190, 7.04.010, 7.--.---, 7.70.100, and 7.70.080; reenacting and amending RCW 69.41.010; reenacting RCW 4.16.350; adding a new section to chapter 18.130 RCW; adding new sections to chapter 7.70 RCW; adding a new section to chapter 42.17 RCW; adding a new section to chapter 48.19 RCW; adding a new section to chapter 48.18 RCW; adding a new chapter to Title 70 RCW; adding a new chapter to Title 48 RCW; adding a new chapter to Title 7 RCW; creating new sections; prescribing penalties; providing an expiration date; and providing for submission of this act to a vote of the people."

--- END ---