HOUSE BILL REPORT
HB 2292

As Reported by House Committee On:
Judiciary

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

Brief Description: Addressing health care liability reform.

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

Brief History:
Committee Activity:
Judiciary: 3/22/05, 3/25/05 [DPS].

Brief Summary of Substitute Bill

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

HOUSE COMMITTEE ON JUDICIARY

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

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

Staff: Edie Adams (786-7180).

Background:

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

dealing with the same subject, in which case both the initiative and the legislative alternative are submitted to a vote of the people.

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

INITIATIVE 330

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

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

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

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

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

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

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

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

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

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

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

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

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

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

INITIATIVE 336

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

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

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

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

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

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

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

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

Upon written request of a patient or immediate family member of a disabled or deceased patient, a health care facility or provider must make available for examination and copying any records made or received by the facility or provider relating to any adverse medical incident.

The identity of a patient and any information protected by privacy restrictions under federal law may not be disclosed in providing the access. "Adverse incident" means negligence, intentional misconduct, and any other act or omission that caused or could have caused injury or death to a patient.

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

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

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

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

Summary of Substitute Bill:

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

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

PATIENT SAFETY

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

Reports of Unprofessional Conduct: A health care professional who makes a good faith report, files charges, or presents evidence to a disciplining authority against another member

of a health profession relating to unprofessional conduct or inability to practice safely due to a physical or mental condition is immune in a civil action for damages resulting from such good faith activities. A health care professional who prevails in a civil action on the good faith defense is entitled to recover expenses and reasonable attorneys' fees incurred in establishing the defense.

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

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

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

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

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

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

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

an event involving clinical care that could have injured the patient or that resulted in an unanticipated injury less severe than death or a major permanent loss of function.

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

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

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

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

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

INSURANCE INDUSTRY REFORM

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

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

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

The Commissioner must use the data to prepare aggregate statistical summaries of closed claims and an annual report of closed claims and insurer financial reports. The annual report

must include specified information, such as: trends in frequency and severity of claims; an itemization of economic and non-economic damages; an itemization of allocated loss adjustment expenses; a loss ratio analysis; a profitability analysis for medical malpractice insurers; a comparison of loss ratios and profitability; and a summary of approved medical malpractice rate filings for the prior year, including analyzing the trend of losses compared to prior years.

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

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

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

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

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

HEALTH CARE LIABILITY REFORM

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

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

Expert Witnesses: An expert witness in a medical malpractice action must meet the following qualifications: (1) have expertise in the condition at issue in the action; and (2) was engaged

in active practice or teaching in the same or similar area of practice or specialty as the defendant at the time of the incident, or at the time of retirement for a provider who retired no more than five years prior to suit. The court may waive these requirements under specified circumstances.

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

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

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

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

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

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

When determining whether an award of attorneys' fees should be made to a prevailing party, the court may consider: (1) whether the party who rejected the offer of settlement was

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

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

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

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

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

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

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

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

MISCELLANEOUS

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

Substitute Bill Compared to Original Bill:

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

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

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

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

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

Appropriation: None.

Fiscal Note: Requested on March 25, 2005.

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

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

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

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

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

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

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

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

The establishment of expert qualifications and limitations on the number of experts and expert depositions all interfere with the judges' ability to effectively manage trials and get to the truth. These limitations may unnecessarily increase costs and protract litigation. The expert qualifications should relate to the issue in the case rather than to the defendant's particular

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

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

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

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

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

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

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

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

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

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

Persons Signed In To Testify But Not Testifying: None.