

FINAL BILL REPORT

2SHB 2292

C 8 L 06

Synopsis as Enacted

Brief Description: Addressing health care liability reform.

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

House Committee on Judiciary

Senate Committee on Health & Long-Term Care

Background:

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

PATIENT SAFETY

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

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

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

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

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

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

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

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

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

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

INSURANCE INDUSTRY REFORM

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

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

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

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

HEALTH CARE LIABILITY REFORM

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

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

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

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

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

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

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

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

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

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

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

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

Summary:

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

PATIENT SAFETY

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

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

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

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

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

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

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

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

INSURANCE INDUSTRY REFORM

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

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

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

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

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

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

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

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

HEALTH CARE LIABILITY REFORM

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

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

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

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

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

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

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

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

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

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

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

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

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

Votes on Final Passage:

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

Effective: June 7, 2006

July 1, 2006 (Sections 112 and 210)