SENATE BILL REPORT
SHB 2292

As Reported By Senate Committee On:
Health & Long-Term Care, April 12, 2005

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: 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).

Brief History: Passed House: 4/08/05, 54-42.
Committee Activity: Health & Long-Term Care: 4/12/05 [DPA, DNP].

Brief Summary

- Protects apologies by health care providers from use in a lawsuit.
- Establishes that three findings of serious acts of unprofessional conduct within a ten year period result in the revocation of a health care provider's license.
- Directs medical malpractice insurers and self-insurers to report closed claims.
- Requires medical malpractice insurers to file underwriting standards and that rates be approved by the Insurance Commissioner before rate changes may be made.
- Establishes qualifications for expert witnesses and limits the number of experts per side.
- Creates the option for a voluntary binding arbitration system.

SENATE COMMITTEE ON HEALTH & LONG-TERM CARE

Majority Report: Do pass as amended.
Signed by Senators Keiser, Chair; Thibaudeau, Vice Chair; Franklin, Kastama, Kline and Poulsen.

Minority Report: Do not pass.
Signed by Senators Deccio, Ranking Minority Member; Benson, Brandland, Johnson and Parlette.

Staff: Stephanie Yurcisin (786-7438)

Background: The people of Washington State 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. A $350,000 cap on a claimant's non-economic damages award is established, regardless of the number of health care professionals or institutions 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. An attorney's contingency fee for handling a medical negligence case is limited to 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 exceeding $600,000.

A plaintiff in a medical negligence action must provide 90-days prior notice of the intent to file a lawsuit. All medical negligence actions are subject to mandatory mediation, unless the action is subject to binding arbitration. A medical negligence action must, with limited exceptions, be commenced within the earlier of three years from the act or omission, or one year from the time the patient discovered or should have discovered the injury. Evidence of any collateral source payment made or to be made in the future may be introduced into evidence. If the arbitration clause meets certain requirements, it is declared not to be a contract of adhesion, unconscionable or otherwise improper. 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 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 of the hospital. Joint and several liability is eliminated in medical negligence actions, and each defendant is responsible only for 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. The Office of the Insurance Commissioner (OIC) must notify the public of any medical malpractice insurance rate filing where the rate change is less than 15 percent. The Commissioner must order a public hearing on a rate filing of 15 percent or more, and rate filings are not effective until approved by the Commissioner after the hearing. A supplemental malpractice insurance program is established to provide excess liability coverage to health care facilities and providers who either self-insure or who purchase liability insurance in amounts equal to specified retained limit requirements. Insuring entities and self-insurers must report monthly to the Commissioner any medical malpractice claim that resulted in a final judgment, settlement, or disposition. The Commissioner must use the data to prepare aggregate statistical summaries and an annual report summarizing and analyzing the data.

The Department of Health 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. A person who has committed three incidents of medical malpractice cannot be licensed or continue to be licensed to practice medicine, unless mitigating circumstances are found. The public membership component of the Medical Quality Assurance Commission (MQAC) is increased from four to six members, and at least two of the public members must

be representatives of patient advocacy groups. A health care provider is obligated to disclose his or her treatment experience at the patient's request. Any medical malpractice action verdict or settlement that exceeds $100,000 must be reported to the Department of Health by the court clerk.
Each party in a medical malpractice action is entitled to only two experts on an issue except on a showing of necessity. An attorney filing an action certifies by his or her signature that, to the best of the attorney's knowledge, it is not frivolous. Within 120 days after filing suit, an attorney or plaintiff must file a certificate of merit stating that a qualified expert has been consulted and agrees that the claim likely satisfies a basis for recovery.

Summary of Amended Bill: The Legislature finds that addressing the issues of consumer access to health care and the increasing costs of medical malpractice insurance: (1) requires comprehensive solutions that encourage patient safety; (2) increase oversight of medical malpractice insurance; and (3) 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 and therefore proposes this legislative approach.

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 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 health care professional relating to unprofessional conduct or inability to practice safely 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.

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 for 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 certain acts of unprofessional conduct within a 10-year period results in the permanent revocation of a health care professional's license, absent the presence of mitigating circumstances. A one-time finding of specified mitigating circumstances may excuse a violation if there is either strong potential for rehabilitation or that remediation will prevent future harm. A finding of mitigating circumstances may be issued any time the disciplining authority determines that the act at issue involved a high risk procedure without lower-risk alternatives, the patient was aware of the risks, and the provider took remedial steps prior to the disciplinary action.

Disclosure of Adverse Events. A medical facility must report the occurrence of an "adverse event," for instance, unanticipated deaths or permanent losses of function, or surgery performed on the wrong patient or site, to the Department of Health within 45 days. A

medical facility may report the occurrence of an "incident," which 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 must identify the facility but may not identify any of the individuals involved, however, medical facilities must provide written notification to patients who may have been affected by the adverse event.

The Department of Health must investigate reports of adverse events and establish a system for the reporting and must also evaluate the data to identify patterns 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 of Health to become coordinated quality improvement programs are expanded to include consortiums of health care providers made up of at least five providers.

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

Medicaid Malpractice Premium Assistance. The Department of Health must develop a program to provide business and occupation tax credit for physicians who serve uninsured, Medicare, and Medicaid patients in a private practice or a reduced fee access program for 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 judgment, settlement, or no payment to the Commissioner within 60 days after the claim is closed or face a fine imposed by the Commissioner of up to $250 per day up to a total of $10,000. If an insuring entity or self-insurer does not report the claim to the Commissioner, the provider or facility must report it or face a fine imposed by the Department of Health 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 costs and fees incurred. 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, and the information is subject to public disclosure. When an insurer takes an adverse action against an insured, such as cancellation of 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 the nature or scope of coverage; 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 to 90 days. For a cancellation, the insurer must deliver or mail the notice, and in the case of a non-renewal, 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 insurance policy, file the policy rate and forms with the Commissioner who 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.

Expert Witnesses. An expert witness in a medical malpractice action must have expertise in the condition at issue and have been engaged in active practice or teaching in the same or similar area of practice at the time of the incident, or at the time of retirement for a recently-retired provider. 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.

The number of expert witnesses allowed in a medical negligence action is limited to two per side on an issue, except upon showing of good cause. All parties 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.

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. 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. Failure to file a proper certificate of merit results in dismissal of the case. If this occurs, the fact of filing may not be used against the health care provider in liability insurance rate setting, personal credit history, or professional credentialing.

Affidavits of Noninvolvement. A medical provider named as a defendant may file an affidavit of noninvolvement with the court explaining that the provider was misidentified or not involved and may therefore be dismissed. Penalties are established for falsely claiming noninvolvement.

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. The maximum award an arbitrator can make is $1,000,000 for both economic and non-economic damages. The arbitrator is selected by agreement of the parties; if there is no agreement the court will choose from names submitted by each side. The arbitration follows specified time periods that will result in the commencement of the arbitration no later than 10 months after the parties submit to voluntary arbitration.

The number of experts allowed for each side is generally limited, and limits are also placed on discovery and depositions. The losing party is responsible for the arbitrator's fees and expenses, and the decision is final unless there was corruption or misconduct.

Mandatory Mediation. The claimant must provide the defendant 90-days notice prior to filing suit. A claim is subject to mandatory mediation unless it is subject to arbitration.

Collateral Sources. A defendant may present evidence that the injured person has other sources of payments of benefits available. The plaintiff, however, can introduce evidence of amounts paid to secure these 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 or defense, an attorney certifies, subject to sanctions, that the claim or defense is not frivolous.

MISCELLANEOUS. The Secretary of State is directed to place this act as a referendum on the ballot at the next regular general election. A statement of subject and a concise description is designated for the ballot title.

Amended Bill Compared to Original Bill: The striker deletes the "substantial and significant evidence" standard of proof for physicians and physicians' assistants for license suspension or revocation. It clarifies the requirements of the B&O tax credit program for physicians who serve underinsured, Medicare, and Medicaid patients. It alters the reporting date to November 15, 2006.

The striker adds a provision allowing the court to forward the name of an attorney filing a frivolous suit or defense to the bar association for discipline consideration. It deletes a provision allowing a court to award prevailing party attorney's fees where the party made an offer of settlement that was not accepted.

The striker additionally inserts 90-day pre-suit notice and a mandatory mediation provisions. It adds a provision allowing affidavits of noninvolvement. The measure is designated a referendum.
There is a technical amendments to the requirement that medical facilities have policies in place to inform patients about unanticipated outcomes, to clarify that the expert witness qualifications apply to health care experts, and regarding expiring sections of the arbitration act.

Appropriation: None.

Fiscal Note: Available.

Committee/Commission/Task Force Created: No.

Effective Date: Ninety days after adjournment of session in which bill is passed.

Testimony For: The Washington State insurance market continues to improve, and this approach is a substantially better option than either of the two initiatives. It is more balanced and responsibly addresses issues to make sure the insurance market can weather future downturns. This bill represents the best pieces of legislation passed in other states.

Testimony Against: This bill does not reform the litigation system like Initiative 330 does.
The small pieces of liability reform present here are not substantial enough to have meaningful impact.
Voters should pick between the two initiatives and should not be further confused by an additional option. There are concerns that portions of the striker do not address legal liability concerns.

Who Testified: PRO: Commissioner Mike Kreidler, Office of the Insurance Commissioner. OTHER: Larry Shannon, Washington State Trial Lawyers.

CON: Cliff Webster, Washington State Medical Association; Lisa Thatcher, Washington State Hospital Association; Kris Tefft, Association of Washington Business; Dana Childers, Liability Reform Coalition.