SENATE BILL REPORT
2SHB 2292

As Reported By Senate Committee On:
Health & Long-Term Care, February 22, 2006

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: 1/23/06, 54-43.
Committee Activity: Health & Long-Term Care: 2/20/06, 2/22/06 [DPA].

SENATE COMMITTEE ON HEALTH & LONG-TERM CARE

Majority Report: Do pass as amended.
Signed by Senators Keiser, Chair; Thibaudeau, Vice Chair; Deccio, Ranking Minority Member; Benson, Brandland, Johnson, Kastama, Kline, Parlette and Poulsen.

Staff: Edith Rice (786-7444)

Background: 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 makes expressions of sympathy relating to the pain, suffering, or death of an injured person inadmissible in a civil trial. A statement of fault, however, is not made inadmissible under this provision.

Reports of Unprofessional Conduct: A 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 currently has 19 members consisting of 13 licensed physicians, two physician assistants, and four members of the public.

Health Care Provider Discipline: The Uniform Disciplinary Act (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 (Secretary) and the 16 health profession boards and commissions according to the profession that the health care provider is a member of 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, and surrender of the license. In the selection of a sanction the first consideration is what is necessary to protect or compensate the public, and the second consideration is what may rehabilitate the license holder or applicant.

Disclosure of Adverse Events: A hospital is required to inform the Department of Health 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. Hospitals must report this information within two business days of the hospital leaders learning of the event.

Coordinated Quality Improvement Programs: Hospitals maintain quality improvement committees to improve the quality of health care services and prevent medical malpractice. Quality improvement proceedings review medical staff privileges and employee competency, collect information related to negative health care outcomes, and conduct safety improvement activities. Provider groups and medical facilities other than hospitals are encouraged to conduct similar activities.

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.

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 polices 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 the 1998 Washington Supreme Court decision *DeYoung v. Providence Medical Center*, the eight-year statute of repose was held unconstitutional on equal protection grounds.

Certificate of Merit: A lawsuit is commenced either by filing a complaint or 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 (Civil Rule 11). 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.

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.

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 requires comprehensive solutions that encourage patient safety, increase oversight of medical malpractice insurance, and making the civil justice system more understandable, fair, and efficient. The Legislature intends to prioritize patient safety and the prevention of medical errors, to provide incentives to settle cases prior to going to court, and to provide the insurance commissioner with tools and information necessary to regulate medical malpractice insurance rates and policies so they are fair to insurers and the insured.

Part I

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 within 30 days of the act or within 30 days of the time the health care provider discovered the act, whichever is longer.

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 (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 from the health care industry.

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.

Adverse health event : "Adverse event" is defined as the list of serious reportable events adopted by the national quality forum in 2002. "Incident" is defined as a situation involving patient care which results in an unanticipated injury not part of the patient's illness, or a situation which could result in injury or require additional health care services but did not. Other definitions are provided.

Adverse Event Notification: Medical facilities must notify the Department of Health (DOH) within 48 hours of confirmation that an adverse event has occurred. A report must be submitted to the DOH within 45 days after confirmation that an adverse event has occurred.
If DOH determines that an adverse event has not been reported or investigated, DOH will direct the facility to report or investigate it.

Independent entity to receive notification of adverse events and incidents: DOH will contract with an independent entity to develop an internet based system for reporting adverse events by facilities immediately available to DOH. The system will protect confidentiality, and the independent entity will develop recommendations for changes in health care practices for the purpose of reducing the number and severity of adverse events.

Whistleblower protection: An adverse event or incidents are specifically mentioned as information for which whistleblowers are protected if reported to DOH in good faith.

Confidentiality: Notification or reports of adverse events or are subject to the confidentiality provisions in current law and are exempt from public disclosure.

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

Part II

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 to the Office of the Insurance Commissioner (OIC). OIC may fine those who violate this requirement, up to $250 per day. The reports must contain specified data that is (to the extent possible) consistent with the format for data reported to the national practitioner data bank.

The Office of the Commissioner is required to prepare aggregate statistical summaries of closed claims based on the data submitted, while protecting the confidentiality of the underlying data.
OIC must prepare an annual report starting in 2010 which should include an analysis of closed claim information and any information the Commissioner finds is relevant to trends in medical malpractice. OIC will monitor losses and claim development patterns in the Washington state medical malpractice insurance market.
If the National Association of Insurance Commissioners adopts revised model statistical reporting standards for medica malpractice insurance, the OIC must analyze them and report any changes and recommendations to the Legislature by December 1, the year after they are adopted.
Written notice of a medical malpractice policy non-renewal must be delivered or mailed to the named insured at least 90 days before policy expiration and must include the actual reason for refusing to renew.
Medical malpractice policy forms or application forms are subject to the requirements under current law which must be filed with and approved by the OIC unless exempted from doing so by rule.
Part III

HEALTH CARE LIABILITY REFORM

Statutes of Limitations and Repose:
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.
This means that a civil action for injury from health care must be commenced within three years of the act causing injury or within one year of the time that the patient discovered the injury or should have discovered the injury, whichever is later. However, this cannot be more than eight years after the original act causing the injury.
There are exceptions for fraud or intentional concealment until the date the patient has actual knowledge of the act of fraud or concealment, then they have one year from knowledge of the fraud or concealment. Knowledge of a custodial parent or guardian is imputed to a minor (person under 18 years of age). This means that tolling of the statute of limitations during minority is eliminated. Any actions not meeting these requirements are barred.

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). If there is more than one defendant, a certificate of merit must be filed for each defendant. The person executing the certificate of merit must state that there is reasonable probability that the defendant's conduct did not follow the accepted standard of care required.

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 settings, personal credit history, or professional licensing or credentialing.

Voluntary Arbitration: A 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.

Arbitration award: The maximum award an arbitrator can 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 (an agency created by operation of law - a principle's actions would reasonably lead a third party to conclude that an agency relationship existed). Fees and expenses shall be paid by the non-prevailing party.

Appeal: 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.

Notice: Ninety days notice of intent to file a lawsuit is required if the lawsuit is based on a health care provider's professional negligence. Mandatory mediation does not apply to parties who have agreed to arbitration.

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).

Frivolous Lawsuits: When signing and filing a claim, counterclaim, cross claim, or defense, an attorney must certify 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.

Amended Bill Compared to Second Substitute Bill: The amended bill provides that statements of fault or apology are not admissible if conveyed within 30 days of the act, no longer contains a reference to mandatory revocation of a health care professional license. Adverse events are defined and reporting requirements for adverse events are described. The amended bill removes the reference to burden of proof for license suspension or revocation, and deletes the reference to business and occupation tax credits for physicians treating the uninsured. Reference to filing underwriting standards is removed, the limitation on number of expert witnesses is deleted, as is the reference to offers of settlement. A 90 day notice of intent to file a medical malpractice lawsuit is required.

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: This bill is an improvement, but not necessarily everything everyone wanted. There is more work to be done in the future, but this is a good start. This bill has appropriate trade-offs. This bill will allow us to be better prepared for future changes. Real data will allow us to make meaningful changes in the future. This is an important first step. We fully support the striking amendment. This is an important step towards comprehensive reform. We have agreed to continue the dialogue started with this striking amendment. We have concerns about the additional data required. This will add cost, and we have concerns about the penalties in this bill.

Testimony Against: None.

Who Testified: PRO: Governor Christine Gregoire; Insurance Commissioner Mike Kreidler; Representative Pat Lantz, Prime sponser; Randy Revelle, Washington State Hospital Association; Peter Dunbar, MD, Washington State Medical Association; John Budlong, Washington State Trail Lawyers Association; Mary Selecky, Secretary, Department of Health; Gary Morse, Physicians Insurance; S. Brooke Taylor, Washington State Bar Association; Tom Parker, Surplus Lines; Mike Kapplohn, Farmers Insurance.