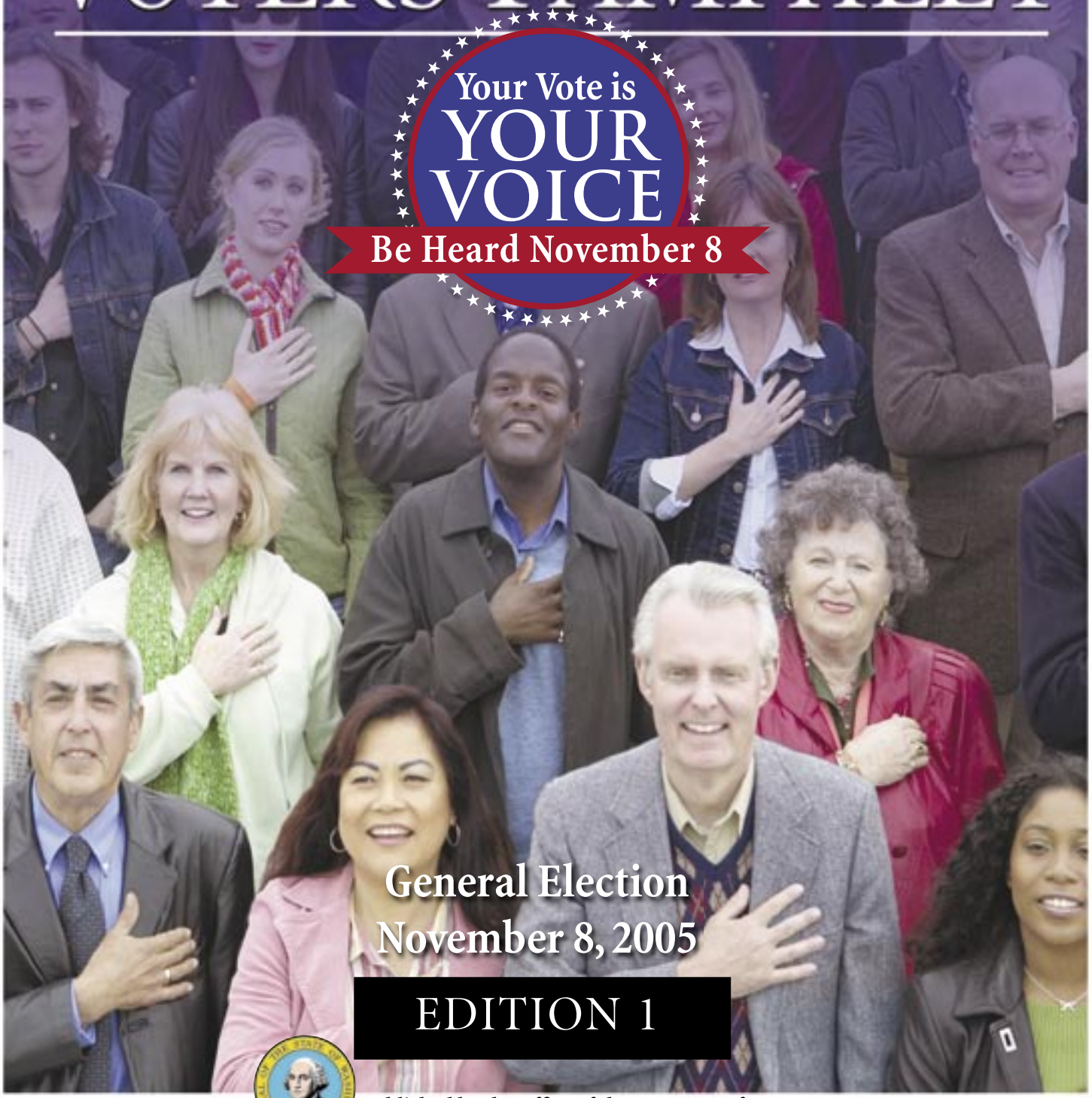
State of Washington

VOTERS' PAMPHLET



General Election
November 8, 2005

EDITION 1

Published by the Office of the Secretary of State

Introduction to the 2005 Voters' Pamphlet

Dear Voter:

The 2005 Voters' Pamphlet provides valuable information on the November 8 General Election.

Each of us has a civic duty to vote and to make informed choices on the ballot.

This year voters must also prepare for changes to the elections process itself.

Over the next two years, Washington will implement some of the most dramatic changes to our voting process since all citizens were granted the right to vote.

These critical improvements hold both election administrators and voters more accountable.

Thirty counties will now conduct all vote-by-mail elections. This is an opportunity to spread out your ballot and your Voters' Pamphlet across the kitchen table and study the issues as you vote.

Counties across the state are replacing punch card ballots with more modern voting equipment. Follow your ballot instructions carefully. They may have changed.

All poll site voters are required to present valid identification like a driver's license or state ID card. Other acceptable forms of ID include a student ID card, tribal ID card, voter registration card, utility bill, bank statement, paycheck, government check, or government document.

A citizen who does not have ID may vote a provisional ballot.

This year several initiatives and a Constitutional Amendment are on the ballot.

I urge you to research the issues, to prepare for voting changes, and most importantly, to exercise this great privilege.

Your participation will improve Washington for your children and grandchildren.

SAM REED
Secretary of State

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Secretary of State Voter Information Hotline 1.800.448.4881

(TDD Hotline for the hearing or speech impaired 1.800.422.8683)

Visit our online voters' guide at www.vote.wa.gov

Voter's Checklist

Every Washington voter will have the opportunity to vote on six statewide measures at the state general election on November 8, 2005. Voters are encouraged to bring any list or sample ballot to the polling place to make voting easier. State law provides: "Any voter may take into the voting booth or voting device any printed or written material to assist in casting his or her vote." (RCW 29A.44.030)

INITIATIVE MEASURE 900

Initiative Measure No. 900 concerns performance audits of governmental entities.

This measure would direct the State Auditor to conduct performance audits of state and local governments, and dedicate 0.16% of the state's portion of sales and use tax collections to fund these audits.

Should this measure be enacted into law? **Yes** ❒ **No** ❒

INITIATIVE MEASURE 901

Initiative Measure No. 901 concerns amending the Clean Indoor Air Act by expanding smoking prohibitions.

This measure would prohibit smoking in buildings and vehicles open to the public and places of employment, including areas within 25 feet of doorways and ventilation openings unless a lesser distance is approved.

Should this measure be enacted into law? **Yes** ❒ **No** ❒

INITIATIVE MEASURE 912

Initiative Measure No. 912 concerns motor vehicle fuel taxes.

This measure would repeal motor vehicle fuel tax increases of 3 cents in 2005 and 2006, 2 cents in 2007, and 1.5 cents per gallon in 2008, enacted in 2005 for transportation purposes.

Should this measure be enacted into law? **Yes** ❒ **No** ❒

INITIATIVE MEASURE 330

Initiative Measure No. 330 concerns claims for personal injury or death arising from health care services.

This measure would change laws governing claims for negligent health care, including restricting noneconomic damages to $350,000 (with exception), shortening time limits for filing cases, limiting repayments to insurers and limiting claimants' attorney fees.

Should this measure be enacted into law? **Yes** ❒ **No** ❒

INITIATIVE MEASURE 336

Initiative Measure No. 336 concerns medical malpractice, including insurance, health care provider licensing, and lawsuits.

This measure would require notices and hearings on insurance rate increases, establish a supplemental malpractice insurance program, require license revocation proceedings after three malpractice incidents, and limit numbers of expert witnesses in lawsuits.

Should this measure be enacted into law? **Yes** ❒ **No** ❒

SENATE JOINT RESOLUTION 8207

The Legislature has proposed a constitutional amendment on qualifications for service on the Commission on Judicial Conduct.

This amendment would permit one member of the Commission on Judicial Conduct to be selected by and from the judges of all courts of limited jurisdiction.

Should this constitutional amendment be: **Approved** ❒ **Rejected** ❒

LOCAL ELECTIONS _____

_____

_____

State and federal law provide procedures for voters to file complaints regarding suspected violations of the Help America Vote Act (HAVA). Information about HAVA and the complaint procedures is available at the Office of the Secretary of State website (www.secstate.wa.gov) or by calling 1.800.448.4881.

Voting in the State of Washington

Voter Qualifications

To register to vote, you must be:

- A citizen of the United States
- A legal resident of Washington State
- At least 18 years old by election day
- If you have been convicted of a crime in Washington, another state, or in federal court, you lose your right to vote in Washington until your civil rights are restored.

In Washington State, you do not have to declare political party membership when you register to vote.

Registration Deadlines

While you may register to vote at any time, keep in mind that there are registration deadlines prior to each election. You must be registered at least **30 days** before an election if you register by mail or through the Motor Voter program. You may register **in person** at the office of your County Auditor or elections department up to **15** days before an election. However, you must vote by absentee ballot for that particular election. The phone number and address of your County Auditor or elections department is located in this pamphlet.

How to Register to Vote

Forms are available on the Internet at **www.vote.wa.gov** or at your County Auditor's office, elections department, public libraries, schools, and other government offices. You may also request a form through the State Voter Information Hotline. *(See Services and Additional Assistance on this page.)*

Keep Your Voter Registration Up-to-date

If your voter registration record does not contain your *current* name or address, you may not be able to vote. You can use the mail-in voter registration form to let your County Auditor or elections department know when you move or change your name. You must re-register or transfer your registration at least **30 days** before the election to be eligible to vote in your new precinct.

Absentee Ballots

Absentee ballot requests must be made to your County Auditor or elections department (not the Secretary of State). No absentee ballots are issued on an election day except to a registered voter who is a resident of a health care facility. A ballot may be requested in person, by phone, mail, electronically or by a member of your immediate family as early as **90** days before an election.

You may also apply in writing to **automatically** receive an absentee ballot before each election. An absentee ballot request form is on the back page of this pamphlet. ***If you have already requested an absentee ballot or have a permanent request for a ballot on file, please do not submit another application.***

You will receive your absentee or mail-in ballot approximately 14 days prior to the election. Upon receipt, vote your ballot. **Please do not** attempt to vote at your polling location. Absentee and mail-in ballots must be signed and postmarked or delivered to your County Auditor or elections department **on or before** election day. In order to assist processing, return your voted ballot early.

Election Dates and Poll Hours

The general election is November 8, 2005. Polling place hours are 7:00 a.m. to 8:00 p.m.

Services and Additional Assistance

Contact your County Auditor or elections department for help with voting your ballot or finding your polling location. The phone number and address of your County Auditor or elections department is located in this pamphlet.

Contact the Office of the Secretary of State for:

- Voters' Pamphlets in other formats (Braille, audio cassette, large print) or languages (Spanish, Chinese);
- Lists of initiatives and referendums;
- Help with finding your elected officials; and
- Voter registration, voting and absentee ballot information.

Much of this information is available through the Secretary of State's website, www.secstate.wa.gov, or in the Secretary of State's online voters' guide, **www.vote.wa.gov** . You also may reach the Office of the Secretary of State using the Voter Information Hotline, 1.800.448.4881 (TDD for the hearing- or speech-impaired only is 1.800.422.8683).

Request for Mail-in Voter Registration Form

(Please print)

Name: _____

Address: _____

City: _____ **ZIP Code:** _____

Telephone: _____ **Number of forms requested:** _____

MAIL TO: Office of the Secretary of State, Voter Registration, PO Box 40230, Olympia, WA 98504-0230

A Reminder to Voters...

It's your voice. Your privilege. Your right. It is your chance to have your voice heard on matters that affect everyday life. Your help is needed to make sure your vote can be legally counted. It's the job of your County Auditor and Election Officials to keep track of voter registration records, and to count—and account for—all of your votes. When your voter information is up to date, it means you're helping to make elections as accurate as possible.

BRING ID TO THE POLLS.

To protect voting rights, new state and federal reforms are in place across Washington. For the first time, voter identification is required. If you are a poll voter, be sure to bring "valid photo identification, such as a driver's license or state identification card, student identification card, or tribal identification card, a voter's voter identification issued by a county elections officer, or a copy of a current utility bill, bank statement, paycheck, or government check or other government document. Any individual who desires to vote in person but cannot provide identification as required by this section shall be issued a provisional ballot." (Chapter 29A.44.205, Revised Code of Washington)

MAKE YOUR MARK TO MAKE IT COUNT.

Make sure you mark your vote correctly on the ballot so your choice is clear. Follow the instructions with your ballot to carefully and clearly mark (or punch) your voting selection.

YOUR SIGNATURE MAKES YOUR VOTE COUNT.

Make sure to sign the outer envelope of your absentee/mail ballot before you return it. *The only way your ballot can legally be counted is by verifying and matching your signature to the one on file*. If your signature has changed you must update your records with your County Auditor or Elections Department.

Public Access to Campaign Spending Reports

Contributions to Candidates and Political Committees

No person may make contributions to a State Legislative Candidate that exceed $675 per election in which the candidate's name is on the ballot. Contributions to State Executive Candidates may not exceed $1,350 in the primary and $1,350 in the general election. A person may give unlimited funds to the exempt activities account of a political party, to ballot issue committees or to other political committees. During the 21 days before the general election, however, a person may contribute no more than $5,000 to a local or judicial office candidate, political party or other political committee. Contributions from corporations, unions, businesses, associations and similar organizations are permitted, subject to limits and other restrictions.

Registration and Reporting by Candidates and Political Committees

No later than two weeks after an individual becomes a candidate or a political committee is organized, a campaign finance registration statement must be filed with the Public Disclosure Commission (PDC) and the local county elections office. (Committees that form within three weeks of the election must register within three business days.) The candidate or committee treasurer is also required to report periodically the source and amount of campaign contributions over $25 and to list campaign expenditures. The occupation and employer of individuals giving more than $100 to a campaign must also be identified.

These reports may be inspected and copied at the PDC's Olympia office, the county elections office in the county where the candidate lives, and on the Internet (www.pdc.wa.gov). Every candidate and political committee participating in the election must make their campaign books and records available for public inspection, by appointment, during the eight days before the election except Saturdays, Sundays, and legal holidays. Use the contact information provided on the campaign registration to make an appointment.

Independent Campaign Expenditures

Anyone making expenditures totaling $100 or more in support of or opposition to a state or local candidate or ballot proposition (not including contributions made to a candidate or political committee) must file a report with the PDC and their county elections office within five days. Forms are available from the PDC and the county election office, or can be downloaded from the PDC website. Finally, all political advertising must identify the person paying for the ad and may have to include other information.

Federal Campaigns

Contributions to U.S. Senate and House of Representative candidates are regulated by federal law. An individual may contribute a maximum of $2,000 in the primary election and $2,000 in the general election to each candidate for U.S. Senator and U.S. Representative. Corporations and unions are prohibited from contributing from their general treasury funds to federal campaigns. Contributions may be made from separate segregated funds (also called political action committees or PACs). Copies of the federal campaign finance reports are available from the Federal Elections Commission (FEC).

Need More Information?

Contact the Public Disclosure Commission, 711 Capitol Way, Room 206, P.O. Box 40908, Olympia, WA 98504-0908; 360.753.1111; E-mail: pdc@pdc.wa.gov; Website: pdc.wa.gov . For federal campaigns, contact the Federal Elections Commission, 202.694.1100 or toll free 1.800.424.9530; Website: www.fec.gov .

INITIATIVE MEASURE 900

PROPOSED TO THE PEOPLE

Official Ballot Title:

Initiative Measure No. 900 concerns performance audits of governmental entities.

This measure would direct the State Auditor to conduct performance audits of state and local governments, and dedicate 0.16% of the state's portion of sales and use tax collections to fund these audits.

Should this measure be enacted into law?

Yes [ ] No [ ]

Note: The Official Ballot Title and Explanatory Statement were written by the Attorney General as required by law. The Fiscal Impact Statement was written by the Office of Financial Management. For more in-depth Office of Fiscal Management analysis, visit www.ofm.wa.gov/initiatives/default.htm . The complete text of Initiative Measure 900 begins on page 25.

Fiscal Impact Statement

Summary of Fiscal Impact

Initiative 900 would reduce state sales-and-use tax revenue flowing to the state fund that finances general government services. It directs that 0.16 percent of this revenue go to a new Performance Audits of Government Account to pay for performance audits of state and local governments. An estimated $17 million would be deposited in the account instead of the state General Fund in the 2005-07 Biennium, and an estimated $25 million would be deposited in the 2007-09 Biennium. Tax revenue in the General Fund pays for state services including education, social, health, and environmental services, and general government activities.

Assumptions for Fiscal Analysis of I-900

The estimates of the amount of sales-and-use tax revenue that would be deposited in the Performance Audits of Government Account is determined by applying the 0.16 percent diversion rate specified in the Initiative to the sales-and-use tax collections projected in the June 2005 revenue forecast produced by the state Economic and Revenue Forecast Council.

The General Fund reduction of $17 million estimated for the 2005-07 Biennium assumes an effective date for the Initiative of Dec. 8, 2005. The General Fund reduction of $25 million that is estimated for the 2007-09 Biennium reflects the fiscal impact of the Initiative over a full, 24-month biennium.

INITIATIVE MEASURE 900

Explanatory Statement

The law as it presently exists:

Two state agencies have authority to conduct performance audits of governmental entities: the Joint Legislative Audit and Review Committee (JLARC) and the State Auditor's office. JLARC is a joint committee of the Legislature, created by statute, consisting of eight members of each house of the Legislature. No more than four members from each house may be of the same political party. JLARC employs a Legislative Auditor and other staff, and has authority to conduct a performance audit of any state agency or program. "Performance audit" is defined as "an objective and systematic assessment of a state agency or any of its programs, functions, or activities, or a unit of local government receiving state funds, by an independent evaluator in order to help public officials improve efficiency, effectiveness, and accountability." JLARC audits local governments only to determine if they are properly using state funds. In addition, upon the request of the Legislative Transportation Committee, a bi-partisan committee comprised of four members of each house of the Legislature, JLRAC conducts performance audits of "transportation-related agencies," defined as state agencies, boards or commissions that receive funding primarily for transportation-related purposes.

The State Auditor is one of the state's constitutional statewide officers, elected by the people to a four-year term. The State Auditor conducts periodic financial and legal compliance audits of both state and local government agencies, as well as entities receiving state contracts or grants. These audits include: examinations of the accounts of all collectors of public revenue; inspections of the books of persons charged with receiving, safekeeping, or disbursing public funds; and investigations relating to "whistleblower" activities. The State Auditor has authority to conduct performance audits, as expressly authorized by the Legislature in the budget or within a work plan approved by JLARC.

In addition, the 2005 Legislature created a citizen advisory board to develop a work plan for the conduct of performance audits. The State Auditor is authorized to contract out for performance audits, following the plan developed by the board. The State Auditor and the Legislative Auditor are both non-voting members of the committee, along with the Director of the Office of Financial Management. The voting members are four citizens nominated by the legislative caucuses and appointed by the Governor, and three more citizen members appointed by the Governor. The citizen board establishes criteria for performance audits consistent with the standards followed by JLARC. A local agency may request the State Auditor to conduct a performance audit, to be conducted under separate contract and paid for with local funds.

The effect of the proposed measure, if it becomes law:

In addition to authority previously granted, Initiative Measure 900 would direct the State Auditor to conduct comprehensive performance audits of all state and local government units, including all agencies and programs in the executive, judicial, and legislative branches of state and local government. The State Auditor would be authorized to contract out for performance audits. Agencies would be required to conduct hearings and to issue periodic reports on the extent to which the Auditor's performance audit recommendations have been implemented.

Beginning on December 8, 2005, the measure would require that 0.16% (sixteen one-hundredths of one percent) of revenue from the state portion of the state sales tax be dedicated to funding performance audits. The revenue would be placed in a separate account in the state treasury. Only the State Auditor or the Auditor's designee could authorize expenditures from the account. The new account would be subject to allotment procedures but would not require an appropriation for expenditures.

Statement For Initiative Measure 900

STATE AND LOCAL GOVERNMENTS SPEND OVER $40 BILLION EVERY YEAR, YET IT'S ILLEGAL FOR US…

…to learn if these revenues are being spent as cost-effectively as possible. That's absurd and I-900 changes that. I-900 provides the State Auditor with substantial, stable funding – about $10 million per year – to independently investigate both the efficiency and effectiveness of state and local governments, their agencies and programs. I-900 dedicates a tiny portion of the existing sales tax to fund this long-overdue reform. $10 million to ensure $40 billion is spent effectively? That's a bargain.

THERE ARE OVER 2000 GOVERNMENTAL ENTITIES IN WASHINGTON – I-900 PUTS THEM ALL ON NOTICE

I-900 gives the State Auditor the authority to examine any state or local government, agency, program, or account. I-900 grants the Auditor subpoena power to obtain all budgets and internal documents necessary for a full accounting. Savings will not only be realized from agencies audited, but from all state and local governments who realize that under I-900, they could be next. It's called accountability.

WASHINGTON IS THE 8TH HIGHEST TAXED STATE IN THE NATION (WWW.TAXFOUNDATION.ORG) – I-900 KEEPS US…

...from hitting #1. I-900 will identify wasteful, ineffective, and unnecessary government programs and agencies, showing politicians how to reform government and prioritize spending without raising taxes. I-900 will change government forever.

OLYMPIA'S LAST MINUTE ALTERNATIVE TO I-900 ISN'T EVEN CLOSE – I-900 IS THE 900 POUND GORILLA

Olympia prohibited independent audits for over 40 years, but when they saw the popularity and support for I-900, they frantically passed a weak alternative. Olympia's version lets a "citizen" commission, all handpicked by Olympia politicians, decide who does and who doesn't get audited – I-900 gives the State Auditor that authority. Olympia's version lets local governments off the hook – I-900 holds all levels of government accountable. I-900 provides stable funding – Olympia's version doesn't. Please Vote Yes.

For more information, visit www.i-900.com or call 425.493.8707.

Rebuttal of Statement Against

Opponents' only objection is that I-900 is "unnecessary" because Olympia passed its own audit bill. But the lead sponsor of that legislation, Democrat Mark Miloscia, admits that he's voting for I-900. He thinks I-900 is dramatically better than Olympia's watered-down bill. So do we.

Hearing politicians complain about I-900's cost is laughable – $10 million per year to ensure cost-effective spending of $40 billion per year? That's a bargain. Taxpayers demand accountability. Please Vote Yes.

Voters' Pamphlet Argument Prepared by:

ERMA TURNER, beauty shop owner, gathered 1367 signatures, Cle Elum; MIKE SIEGEL, KTTH 770 AM radio host and activist, Seattle; MIKE DUNMIRE, retired businessman and enthusiastic supporter of I-900, Bothell; JACK FAGAN, retired policeman, retired Navy, grandfather, campaign organizer, Spokane; MIKE FAGAN, small businessman, community leader, father, campaign organizer, Spokane; TIM EYMAN, $30 car tab guy, taxpayer advocate, Yakima/Mukilteo.

Statement Against Initiative Measure 900

I-900 GOES TOO FAR AND WASTES TAXPAYER'S DOLLARS

Everyone wants government to operate efficiently, and performance reviews are a tool to achieve efficiency when done wisely and with common sense. But, this initiative lacks common sense:

1. Local citizens and their locally elected officials should establish their own goals and priorities, not Olympia;
2. Local governments will have to spend scarce staff time and local taxpayer dollars to collect data for the audits;
3. One size does not fit all. There are over 2,000 units of local government, from large metropolitan cities and counties to small rural mosquito control and irrigation districts. They all have different purposes and responsibilities. Is it really appropriate to compare a unit of government of 300 to a unit of government of 300,000?

I-900 IS UNNECESSARY AND DUPLICATIVE

The 2005 Legislature passed two performance audit bills, one for Department of Transportation programs and another for state agencies. Many local governments already provide accountability by conducting their own performance reviews. This initiative is an unnecessary duplication that would add another layer of government and cost tens of millions of tax dollars.

Before you vote, ask yourself – Would you really trust one partisan elected state official to tell your local government what to do?

WE HOPE YOU WILL ANSWER NO AND VOTE NO ON INITIATIVE 900.

Rebuttal of Statement For

It's flat wrong to claim it's illegal to learn how revenues are spent. Local government budgets are public documents – open to scrutiny and adopted with public input.

Local governments are already most accountable to their citizens. It's more important to be accountable to local voters than to a partisan state official.

Current legislation requires an impartial citizens advisory board set performance criteria for state agencies. I-900 instead creates a bureaucratic, costly process.

Please Vote No.

Voters' Pamphlet Argument Prepared by:

PAM CARTER, President, Association of Washington Cities; CHRIS DUGOVICH, Washington State Council of County and City Employees; DR. RICHARD JOHNSON, Superintendent, Okanogan School District; BOB BEERBOWER, Grays Harbor County Commissioner; MARY PLACE, Yakima City Council; STEVEN D. JENKINS, Mayor, City of Bridgeport.

INITIATIVE MEASURE 901

PROPOSED TO THE PEOPLE

Official Ballot Title:

Initiative Measure No. 901 concerns amending the Clean Indoor Air Act by expanding smoking prohibitions.

This measure would prohibit smoking in buildings and vehicles open to the public and places of employment, including areas within 25 feet of doorways and ventilation openings unless a lesser distance is approved.

Should this measure be enacted into law?

Yes [ ] No [ ]

Note: The Official Ballot Title and Explanatory Statement were written by the Attorney General as required by law. The Fiscal Impact Statement was written by the Office of Financial Management. For more in-depth Office of Fiscal Management analysis, visit www.ofm.wa.gov/initiatives/default.htm . The complete text of Initiative Measure 901 begins on page 29.

Fiscal Impact Statement

Summary of Fiscal Impact

Initiative 901 would have no significant fiscal impact on state or local governments. Local government law enforcement and health agencies, which would be charged with implementing and enforcing the Initiative's smoking prohibitions, would carry out enforcement of the Initiative within their normal duties, without the need for new resources.

Assumptions for Analysis of I-901

The Initiative could result in an overall increase in the number of infractions issued by local law enforcement. However, the Initiative provides no specific provisions for expenditure or enforcement levels. The enforcement level assumed in this analysis is determined by local police, health and judicial jurisdictions operating within existing resources.

Based on the Pierce County Health Department's experience with county law similar to I-901 – in which no additional costs for enforcement were incurred – the Initiative will result in no significant additional costs to state or local health agencies.

INITIATIVE MEASURE 901

Explanatory Statement

The law as it presently exists:

Smoking is regulated by the Washington Clean Indoor Air Act (Chapter 70.160 RCW). No person may smoke in a public place, as defined by the Act, except in designated smoking areas. The term "public place" is defined as a portion of a building or vehicle used by and open to the public, regardless of whether the space is publicly or privately owned, and regardless of whether a fee is charged for admission. The following are specifically included in the term "public place": elevators, public buses and trains, museums, concert halls, theaters, auditoriums, exhibition halls, indoor sports arenas, hospitals, nursing homes, health care facilities or clinics, enclosed shopping centers, retail stores and service establishments, financial institutions, educational facilities, ticket areas, public hearing facilities, the state legislative chambers and adjacent hallways, public restrooms, libraries, restaurants, waiting areas, lobbies, and reception areas. A public place does not include a private residence.

The owner or lessee of a public place may designate a smoking area within that space (except not in elevators, streetcars, public areas of retail stores and lobbies of financial institutions, office reception and waiting areas of state or local government buildings, museums, public meetings or hearings, classrooms, lecture halls, or the seating areas and aisles of concert halls, theaters, auditoriums, exhibition halls, and indoor sports arenas). No public place may be designated as a smoking area in its entirety except a bar, tavern, bowling alley, tobacco shop, or restaurant.

Owners or lessees of public places are required to post conspicuous signs showing where smoking is prohibited. Any person intentionally violating the law by smoking in a public place not designated as a smoking area, or by removing, defacing, or destroying a "no smoking" sign, is subject to a civil fine of up to $100.00. Infractions of this law are issued in the same manner as traffic infractions. Local fire districts have authority to enforce the law concerning the duties of owners or persons in control to prohibit smoking in public places, except that health districts enforce the law as to restaurants.

The effect of the proposed measure, if it becomes law:

Initiative Measure No. 901 would amend the Clean Indoor Air Act in several ways. The term "public place" would be expanded to include a reasonable distance around each public facility, presumptively defined as 25 feet from entrances, exits, windows that open, and ventilation intakes that serve an enclosed area where smoking is prohibited. The term "public place" would include private residences used to provide licensed child care, foster care, adult care, or similar social services. The term would also be expanded to include the following additional types of facilities: schools, bars, taverns, bowling alleys, skating rinks, casinos, reception areas, and at least 75% of the sleeping quarters within a hotel or motel and rented to guests.

Smoking would also be prohibited in "places of employment," defined to include any area controlled by an employer which employees are required to pass through, such as: entrances and exits to places of employment; a reasonable distance (presumptively 25 feet) from entrances, exits, windows that open, and ventilation intakes; work areas; restrooms; conference and classrooms; break rooms and cafeterias; and other common areas. The requirement to post "no smoking" signs in public places would also be extended to places of employment.

The current laws allowing owners or lessees to designate smoking areas within public places would be repealed.

Owners or lessees of places covered by the Act are required to prohibit smoking in public places and post appropriate signs prohibiting smoking. A person passing by or through a public place while on a public sidewalk or public right of way would not be defined as intentionally violating the Act. The Act's enforcement system would remain the same, except that local health departments (instead of fire departments) would be given responsibility for enforcement concerning the duties of owners or lessees to prohibit smoking in public places and post appropriate signs, including enforcement related to places of employment.

Statement For Initiative Measure 901

I-901 WILL PROTECT OUR FAMILIES FROM DANGEROUS SECONDHAND SMOKE

I-901 protects families, children, seniors and workers from secondhand smoke, which is responsible for more than 38,000 deaths annually. By decreasing exposure to secondhand smoke, I-901 will save lives. Secondhand smoke has been linked to cancer, lung disease, heart disease, and other serious illnesses in non-smokers. That's why the American Cancer Society, the American Lung Association of Washington, and the American Heart Association urge you to vote *yes! on I-901*. Because children and seniors are especially vulnerable to the effects of secondhand smoke, which can cause asthma, pneumonia and bronchitis, the AARP and Washington nurses strongly support I-901.

EVERYONE HAS THE RIGHT TO BREATHE CLEAN AIR

I-901 protects everyone's right to breathe clean air where we work, eat and socialize. It's impossible to make secondhand smoke stay in the smoking section. Washington's families and children shouldn't be forced to inhale toxic chemicals and smell like smoke just to visit a favorite restaurant or see live music. I-901 will allow asthmatic people to attend events without worrying about secondhand smoke triggering their asthma, and allows non-smokers to sit outside a restaurant without being subjected to cigarette smoke. No one should have to walk through a cloud of toxic smoke to get inside a building.

I-901 IS A FAIR AND COMMON SENSE APPROACH

Washington has already passed a law protecting people in most workplaces from secondhand smoke, but 225,000 workers in restaurants, skating rinks, bars, and bowling alleys are currently unprotected. They deserve the same protections as everyone else. I-901 is a fair and common sense approach that protects all of us from dangerous secondhand smoke.

VOTE YES! ON I-901 OFFICE 206.522.2233
WWW.HEALTHYINDOORAIRWA.ORG

Rebuttal of Statement Against

Everyone has the right to breathe clean indoor air. Why should anyone be forced to breathe toxic secondhand smoke at work? Why should families or children be forced to breathe poisons when they go out to eat or listen to music? Secondhand smoke kills thousands every year. That's why the American Cancer Society says, "I-901 will save lives. It's a common sense health safety measure that protects families, children, seniors and workers." *Yes on I-901.*

Voters' Pamphlet Argument Prepared by:

DENNIS BIGGS, M.D., Board Member, American Cancer Society; MARINA COFER-WILDSMITH, CEO, American Lung Association of Washington; SCOTT SCHERER, Board President, American Heart Association; LINDA HANSON, President, Washington State Parent Teacher Association (PTA); KELLY FOX, President, Washington State Council of Fire Fighters; ED SINGLER, State President, AARP Washington.

Statement Against Initiative Measure 901

I-901 is fatally flawed with extreme policies that will not do what sponsors promise.

I-901 is not a statewide smoking ban, as all tribal facilities and land are exempt resulting in a severe shift of entertainment dollars away from taxpaying non-tribal facilities to tribal facilities.

A 25-foot smoke-free radius around *all* entrances, windows and vents will be enforced on *all non-tribal businesses,* buildings and passers-by. Ashtrays, matchbooks, etc. bring fines. I-901 grants extreme powers to local health departments against private citizens, workers, and property owners.

Shouldn't private property owners have the right to determine whether smoking should be allowed or should the state take that right away from only one class of owners?

I-901 won't protect all workers, nor replace state or federal worker protection laws. I-901's science is defective and not recognized as valid by state and national scientists or officials responsible for workplace safety.

In 1985 Washington led the nation by banning smoking in most public places, allowing business owners to designate smoking areas for customers. Today, 75% of Washington's restaurants are smoke-free.

This extreme ban was tried in Pierce County in 2004. Visit *www.noon901.org* and listen to people from Pierce County whose jobs were lost, businesses closed, charitable bingo facilities bankrupted and Veterans Posts and other private organizations whose contributions to their communities decreased.

I-901 won't mean smokers will quit; they will be more than welcomed at exempt tribal facilities.

I-901 is too *extreme* and won't work – *vote no*.

For more information, visit www.noon901.org .

Rebuttal of Statement For

I-901 ignores everyone's property rights and your freedom of choice. I-901 makes smoking illegal even if the property owner wishes to allow it. I-901 is just too extreme. I-901 is bad policy. It is not a statewide ban. I-901 will cause many workers to lose their jobs and force many businesses and charities to close. I-901 will not protect all workers. Current law already works. Most designated smoking areas already do not allow children.

Voters' Pamphlet Argument Prepared by:

ALAN McWAIN, Spar Restaurant; JIM STEVENSON, Lincoln Bowl; DAVE WILKINSON, Skyway Park Bowl; STEVE KIRBY, State Representative; RICHARD CURTIS, State Representative; VITO CHIECHI, No Committee Initiative 901.

INITIATIVE MEASURE 912

PROPOSED TO THE PEOPLE

Official Ballot Title:

Initiative Measure No. 912 concerns motor vehicle fuel taxes.

This measure would repeal motor vehicle fuel tax increases of 3 cents in 2005 and 2006, 2 cents in 2007, and 1.5 cents per gallon in 2008, enacted in 2005 for transportation purposes.

Should this measure be enacted into law?

Yes [ ] No [ ]

Note: The Official Ballot Title and Explanatory Statement were written by the Attorney General as required by law and revised by the Thurston County Superior Court. The Fiscal Impact Statement was written by the Office of Financial Management. For more in-depth Office of Fiscal Management analysis, visit www.ofm.wa.gov/initiatives/default.htm . The complete text of Initiative Measure 912 begins on page 31.

Fiscal Impact Statement

Summary of Fiscal Impact

Initiative 912 would over 16 years eliminate $5.475 billion in fuel taxes and net bond proceeds, eliminating 80 percent of funding for 265 new transportation projects specified by the Legislature. About $562 million in fuel tax revenue for cities and counties – for new, local-government transportation projects over 16 years – also would be eliminated.

Assumptions for Fiscal Analysis of I-912

The Initiative repeals the phased-in, 9.5-cents-a-gallon increase in the state gasoline tax that is scheduled as follows: 3 cents a gallon on July 1, 2005; 3 cents on July 1, 2006; 2 cents on July 1, 2007; and 1.5 cents on July 1, 2008. The Initiative does not affect scheduled increases in the state tax on diesel fuel.

Over 16 years, the gasoline tax increases would generate $4.434 billion plus $1.041 billion in net bond proceeds – or 80 percent of the cost of 265 new transportation projects specified by the Legislature.

Eliminating the scheduled gasoline tax increases also would eliminate $562 million that cities and counties would have received over the next 16 years for local transportation projects. This revenue includes $482 million that cities and counties would receive as direct revenue distributions from the gasoline tax increases, as well as $80 million in grants to local government.

INITIATIVE MEASURE 912

Explanatory Statement

The law as it presently exists:

The basic motor vehicle fuel tax rate is 23 cents per gallon applied to the sale, distribution, or use of motor vehicle fuel. In 2003, the Legislature added an additional 5 cents per gallon to fund a series of projects for which bonds were issued. This additional tax will expire when the bonds have been retired.

The 2005 session of the Legislature enacted a series of four "step" increases in the motor vehicle fuel tax (often called the "gas tax") primarily to fund a series of public transportation improvements set forth in the biennial transportation budget. The "step" increases are: 3 cents per gallon effective July 1, 2005; 3 additional cents effective July 1, 2006; 2 additional cents effective July 1, 2007; and 1.5 additional cents effective July 1, 2008. The four increases add up to 9.5 cents per gallon. The revenue from these four increases is placed in a new transportation partnership account, after removing funds appropriated for administrative expenses of the motor vehicle fuel tax and special fuel tax programs and refunds, with one exception: approximately seventeen (17) percent of the net revenue from the first two steps is distributed to towns, cities and counties for transportation purposes. Money in the transportation partnership account may be appropriated by the Legislature only for projects and improvements identified as 2005 transportation partnership projects or improvements listed in the biennial transportation budget, including principal and interest on bonds authorized for those projects or improvements.

The effect of the proposed measure, if it becomes law:

Initiative Measure No. 912 would repeal the four "step" increases in the motor vehicle fuel tax as enacted by the 2005 session of the Legislature. If the measure were enacted, the tax would return to its pre-2005 rate, and revenue from the anticipated increases would not be available for the purposes for which it is earmarked, including funding the transportation projects and improvements for which the transportation partnership account was created.

Statement For Initiative Measure 912

THE DECISION IS YOURS. VOTE YES ON I-912 TO REPEAL THE NEW GAS TAX.

If you think you're getting good value for your money in Olympia, then by all means support the recent gas tax increase. But if you're dismayed by how Olympia's been spending your transportation dollars, then please *vote yes on I-912* and repeal the huge new gas tax increase.

THEY DID THE WRONG THING THE WRONG WAY. VOTE YES ON I-912.

Just three short years ago, voters overwhelmingly rejected an increase in the gas tax. The next year, the Legislature passed one anyway, giving us the fifth highest gas tax in America. Some politicians in Olympia even said they opposed raising the gas tax again until they knew that we were receiving good value for the new increase.

That promise was broken. Instead, the Legislature passed the biggest gas tax increase in state history – 9.5 cents, a 33% increase! And it was done at the last minute with an "emergency clause" added to prevent you from having the right of referendum. Even worse, the massive transportation tax increase isn't designed to reduce congestion – even gas tax supporters admit it!

Broken promises, huge tax increases, and disdain for the people – Olympia at its worst.

IT'S ABOUT MORE THAN MONEY. VOTE YES ON I-912 TO REPEAL THE NEW GAS TAX.

It took just 32 days for volunteers to collect more than 400,000 signatures to put I-912 on the ballot. The message is clear: not another penny in higher taxes until we get reduced congestion and better value for our money.

Send the message! *Vote yes on I-912*.

Thank you for taking the time to read this.

For more information, visit NoNewGasTax.com or call 206.330.9487.

Rebuttal of Statement Against

Our gas taxes keep climbing while our roads get more congested. They want taxpayers to pay for a new Viaduct in Seattle but the proposed tunnel will cost billions more and actually carry *fewer* vehicles than the current one.

We already pay one of the nation's highest gas taxes. If that isn't paying for safety and maintenance now, where is the money going?

Vote yes on I-912. Send Olympia a message they can't ignore.

Voters' Pamphlet Argument Prepared by:

JANE MILHANS, I-912 sponsor, financial services, University Place; BRETT BADER, NoNewGasTax.com spokesman, Woodinville; STEVE APPEL, President, Washington Farm Bureau, wheat farmer, Dusty; ERMA TURNER, small business owner and disappointed taxpayer, Cle Elum; SHERYL McGRATH, small business owner hoping our politicians listen, Spokane; TRINA WILBUR, office professional and frustrated commuter, Duvall.

Statement Against Initiative Measure 912

I-912 SLASHES FUNDING FOR ROADS, HIGHWAYS AND BRIDGES, DOES NOTHING TO RELIEVE CONGESTION.

Our roads, highways and bridges are crumbling; threatening our lives, leaving us stuck in traffic and wreaking havoc on our nerves and pocketbooks. I-912 drastically cuts funding earmarked to fix priority projects on Interstate 405, Interstate 90, US 12 and other roadways throughout our state. It offers no solutions for escalating congestion, it only makes matters worse.

I-912 PUTS CITIZENS AND THE ECONOMY AT RISK.

Highway engineers have declared 900 bridges in Washington to be obsolete or deficient. The Alaskan Way Viaduct and 520 Bridge will likely collapse or be rendered inoperable by another major earthquake, putting citizens at grave risk, striking a disastrous blow to trade and crippling our economy. I-912 guts a package that invests in every part of the state and creates thousands of private sector jobs.

I-912 IGNORES SAFEGUARDS THAT ENSURE OUR TAX DOLLARS ARE SPENT WISELY.

We need to protect transportation dollars. The state constitution mandates that gas tax monies be used for highways, roads and bridges. It is the only transportation funding source the Legislature cannot divert.

We are all concerned that our taxes haven't always been used wisely. That's why an unprecedented level of checks and balances – including extensive performance audits – is attached to new transportation dollars. You will get what you pay for.

Waiting won't make it any cheaper. We must improve our roads and bridges now. Visit *www.wsdot.wa.gov/Projects/Funding/2005* to learn about projects in your area.

Save Lives. Reduce congestion. Create jobs. Please vote No on I-912.

Rebuttal of Statement For

We have a choice – pay a few dollars more per month to fix our roads, bridges and highways, or just accept ever increasing congestion and more dangerous roads. I-912 eliminates funding for 274 transportation projects across our state. I-912 offers no solutions; only delays and increased risk on our roads. Protect your transportation dollars and you'll get results: fewer bottlenecks; reduced congestion; safer roads. Please vote no I-912, it takes us in the wrong direction.

Voters' Pamphlet Argument Prepared by:

KELLY FOX, President, Washington State Council of Fire Fighters; BEN LINDEKUGEL, former Director Community Relations, Evergreen Hospital Kirkland; DENIS HAYES, environmental leader; TERRY DORSING, owner, Dorsing Farms; SKIP ROWLEY, President & CEO, Rowley Properties; TERRY ROXANNE TILTON, Assistant Executive Secretary, Washington State Building & Construction Trades Council.

INITIATIVE MEASURE 330

PROPOSED TO THE LEGISLATURE

Official Ballot Title:

Initiative Measure No. 330 concerns claims for personal injury or death arising from health care services.

This measure would change laws governing claims for negligent health care, including restricting noneconomic damages to $350,000 (with exception), shortening time limits for filing cases, limiting repayments to insurers and limiting claimants' attorney fees.

Should this measure be enacted into law?

Yes [ ] No [ ]

Note: The Official Ballot Title and Explanatory Statement were written by the Attorney General as required by law and revised by the Thurston County Superior Court. The Fiscal Impact Statement was written by the Office of Financial Management. For more in-depth Office of Fiscal Management analysis, visit www.ofm.wa.gov/initiatives/default.htm . The complete text of Initiative Measure 330 begins on page 33.

Fiscal Impact Statement

Summary of Fiscal Impact

Initiative 330 would establish restrictions in medical malpractice lawsuits, which may reduce the number of malpractice suits in state courts, lower the number of claims against the state and reduce state insurance-premium costs. The restrictions also may reduce liability and premium costs to local governments. However, conflicting research offers no clear guidance for estimating the magnitude of these potential reductions in state and local government costs. The Initiative also would limit state recovery of worker compensation costs in cases of medical malpractice, costing the Workers Compensation Program an estimated $500,000 to $2 million a year.

Assumptions for Fiscal Analysis of I-330

Initiative 330 could reduce costs to the Office of the Administrator of the Courts because the number of hearings in Superior Court related to health care injury or death claims may be reduced. The Initiative also could reduce costs for state and local governments that purchase health insurance for employees or social service programs because it could reduce health insurance premiums and payouts from self-insured tort liability funds.

Various studies have been conducted to determine how changes in law affecting tort liability and insurance can affect costs for courts, insurance premiums and health care. However, individual study results vary widely, predicting no change or both lower and higher costs in these areas. Due to the conflicting research, there is no clear guidance for estimating the magnitude of the fiscal impact of potential reductions on court costs or insurance premiums.

Initiative provisions would result in a loss of $500,000 to $2 million a year in the Department of Labor and Industries' Workers Compensation Program. That is because the Initiative would prevent the agency from collecting costs incurred after an injured worker is re-injured due to medical malpractice.

INITIATIVE MEASURE 330

Explanatory Statement

The law as it presently exists:

Statutes and court decisions govern lawsuits for personal injury and injury to property, including lawsuits against health care providers (doctors, dentists, and nurses, among others), and health care facilities (hospitals and clinics, among others) for injuries resulting from health care services. These are sometimes called "malpractice suits."

Where a plaintiff in such a lawsuit proves that he or she was injured by the negligent provision of health care services, the plaintiff is entitled to a court judgment requiring the defendants who caused the injury to compensate the plaintiff for his or her damages. Plaintiffs are entitled to compensation for all "economic damages" caused by the injury, defined as "objectively verifiable monetary losses," such as medical expenses, lost earnings, and loss of the use of property. Plaintiffs also are entitled to recover all "noneconomic damages" caused by the injury, defined as "subjective nonmonetary losses," such as pain, suffering, disfigurement, and emotional distress.

When a plaintiff's damages are caused by the fault of more than one defendant, the court determines the percentage of total fault attributable to each defendant and the percentage of fault attributable to the injured plaintiff, if any. With exceptions, where more than one defendant is at fault for a plaintiff's injury, the plaintiff is entitled to recover damages for the injury from each defendant, only in an amount attributable to each defendant's proportionate share of fault. However, where the defendants were acting together, or where one defendant was an agent of another defendant, that defendant also is held responsible for the fault of the other, and the injured plaintiff may recover from either defendant the total damages attributable to their fault. In addition, where the injured plaintiff is free of fault, he or she may recover up to the total judgment for damages from any or all of the defendants, without regard to each defendant's proportionate share of fault.

An employer may be liable for injuries that were negligently caused by an employee. A hospital may be liable for the acts or omissions of health care providers to whom the hospital granted the privilege of providing services at the hospital. In such cases, the injured party may recover damages from the employer or the employee or from the hospital or health care provider.

The fact that an injured plaintiff has been compensated for his or her damages from another source may not be shown at trial where the plaintiff's damages were paid from the plaintiff's assets, the assets of immediate family members, or by insurance paid for with such assets. Third parties, such as insurance companies, who pay expenses that a plaintiff incurs as the result of an injury, have a right to seek reimbursement from the damages recovered by the plaintiff.

Medical malpractice lawsuits normally must be filed within the later of three years of the event that caused the injury or one year from when the injury reasonably should have been discovered. In any event, such a lawsuit must be filed within eight years of the event that caused the injury, unless discovery of the injury is prevented by fraud, intentional concealment, or the presence of a foreign body not intended to have a therapeutic or diagnostic purpose or effect, in which case it must be started within one year of discovery. Where the injured person is incompetent, the period for filing suit does not run during the time of incompetence. The period for filing suit on behalf of minors is similar, except that discovery of the injury by a parent or guardian is treated the same as discovery by the patient.

When a judgment for injuries includes $100,000 or more to compensate an injured plaintiff for "economic damages" that the plaintiff will suffer in the future, the court is required to provide for periodic payment of such damages, rather than a lump sum payment. If an injured plaintiff dies before receiving all of the payments, the court may modify the award, but may not reduce or terminate an award for lost future earnings.

In medical malpractice actions, the court determines whether a party's attorney fees are reasonable by considering several factors set out in the law, including whether the fee is "fixed" or "contingent." A contingent fee is a specified percentage of the damages recovered by the injured person, and is owed to the attorney only if damages are recovered.

With certain exceptions, parties to a lawsuit must mediate their claims before going to trial. In mediation, a neutral third party assists the parties to try to settle their suit. Parties to a dispute also have the option of submitting the dispute to arbitration rather than going to court. In arbitration, a person other than a judge hears and decides the dispute. Arbitration decisions are subject to very limited review by courts.

Explanatory Statement *(continued)*

The effect of the proposed measure, if it becomes law:

Initiative 330 applies to lawsuits for injuries resulting from providing health care or related services, or arranging for such services.

With one exception, the Initiative would limit to $350,000 the total combined "noneconomic damages" that can be awarded to each claimant against all health care professionals and health care institutions who are sued in the same case. Where a health care institution is liable for the wrongful acts or omissions of persons other than health care professionals, there is an exception and the total combined limit on "noneconomic damages" would be $700,000 for each claimant. A single claimant would be defined to include all persons claiming to have sustained damages as the result of the injury or death of a single person.

Under the Initiative, when a plaintiff's injury is caused by the fault of more than one health care provider, health care professional, or health care institution, each would be liable for its proportionate share of the injured party's damages, based on its proportion of fault. Exceptions to this rule would exist where the health care defendants acted together, or where one health care defendant is the agent of another, or acts under the direct supervision or control of another. In those circumstances, a health care defendant would be responsible for payment of the proportionate share of the damages attributable to the fault of the other defendant, and the injured plaintiff would be allowed to recover those damages from either. However, unlike current law, there would be no exception allowing an injured plaintiff to recover up to the entire amount of a judgment for damages from any or all defendants in cases where the plaintiff is free of fault.

The Initiative would change current law so that a hospital would be liable for the negligence of a health care provider granted privileges to practice at the hospital only if the health care provider is an actual agent or employee of the hospital. In addition, health care professionals and health care institutions would not be liable for the acts or omissions of any other health care provider who is not an actual agent or employee of the provider, or who was not acting under the provider's direct supervision or control.

The Initiative would allow a party at trial to show that an injured plaintiff has been compensated for his or her damages from any source, including the assets of the plaintiff or the plaintiff's family, or insurance purchased with such assets. Unlike current law, a third party, such as an insurance company, who has compensated the plaintiff for his or her damages would have no right to seek reimbursement from the damages recovered by the plaintiff.

The Initiative would impose a new requirement that a plaintiff give at least ninety days' notice prior to filing a lawsuit. Under the Initiative, lawsuits generally would have to be filed within a shorter period, the sooner of one year from the time the injured party discovers or reasonably should have discovered the cause of the injury, or within three years of the injury-causing event. In the case of fraud, intentional concealment, or the presence of a foreign body not intended to have a therapeutic or diagnostic effect, a lawsuit could be commenced within one year from its discovery. Where the injured person is incompetent, the time for filing a suit would continue to run during the incompetence.

The Initiative would change the law regarding periodic payment of future damages by (1) expanding future damages subject to periodic payment, and (2) reducing from $100,000 to $50,000 future damage awards to be paid periodically. Future damages subject to periodic rather than lump sum payment would include damages for future medical treatment, care or custody, loss of future wages, loss of bodily function, and future pain and suffering. If the plaintiff dies before receiving all payments, upon request of any party, the court would eliminate periodic payments awarded for future medical treatment, care or custody, loss of bodily function, and future pain and suffering. Periodic payments for loss of future earnings would not be reduced, but must be paid to the plaintiff's dependents.

The Initiative would prohibit attorneys from contracting for or collecting contingent fees in medical malpractice lawsuits in an amount more than 40% of the first $50,000 recovered, 33.33% of the next $50,000 recovered, 25% of the next $500,000 recovered, and 15% of any recovery in excess of $600,000.

The Initiative would require mediation in medical malpractice lawsuits with no exceptions. Contracts for health care or related services could require disputes concerning malpractice to be submitted to arbitration. Disputes subject to binding arbitration would not be subject to mediation requirements.

Statement For Initiative Measure 330

Doctors, nurses, and over 320,000 patients who signed petitions placing I-330 on the ballot are united in support of its reforms. I-330 improves health care access, and puts patients' needs ahead of personal injury lawyers.

KEEP DOCTORS IN WASHINGTON

Lawsuits by greedy personal injury lawyers force medical liability premiums up and force doctors to restrict services or move out of Washington – even if they've never been sued. Over half of Washington doctors statewide have had to refer patients to new physicians for services they can no longer offer. I-330 will keep doctors in Washington and increase health care access.

PUTTING PATIENTS FIRST

I-330 establishes a reasonable cap on noneconomic, "pain-and-suffering," damages of $350,000 to $1,050,000. *Under I-330, juries will be able to award unlimited economic damages, enabling patients to recover all medical costs, all current and future lost income, the cost of prescription drugs, and other family needs*. I-330 allows doctors and patients to choose arbitration or mediation instead of costly court battles; *everyone will benefit from speedier resolution and lower fees for personal injury lawyers*.

LESS MONEY FOR PERSONAL INJURY LAWYERS

I-330 limits fees for personal injury lawyers using a sliding scale: the higher the award, the more money goes to the injured patient. *Right now, there is no limit on how much money personal injury lawyers can collect, and many routinely receive 40% or more of what juries thought they were setting aside for injured patients!*

Vote Yes on I-330.

For more information, visit www.yesoni330.org or call 877.740.0177.

Rebuttal of Statement Against

Our opponents' arguments are a collection of smokescreens, half-truths and misleading soundbites, but what else would you expect from a campaign run by trial lawyers?

I-330 clearly states "damages awarded for loss of future earnings *may not be reduced or payments terminated* by reason of the death of the judgment creditor." (Section 10, subsection 4)

And I-330 requires patients' *voluntary* consent before arbitration. (Section 8)

Don't buy the lawyers' lies, visit www.theirlipsaremoving.com . I-330: Vote Yes!

Voters' Pamphlet Argument Prepared by:

KENNETH ISAACS, M.D., Doctors, Nurses, and Patients for a Healthy Washington; MARIANNE TEFFT, concerned patient; CYNTHIA MARKUS, M.D., J.D., concerned physician and attorney; DANA WALLACE, R.N., Chair, Nurses For I-330/Against I-336; TIMOTHY SHELDON, State Senator (D-Potlatch).

Statement Against Initiative Measure 330

BEFORE YOU VOTE ON I-330, BE SURE TO READ THE FINE PRINT.

There is a big difference between the ballot description of I-330 and the actual Initiative. I-330 contains 20 pages of fine print. Read it at www.TruthInTheFinePrint.com .

I-330 GIVES THE INSURANCE INDUSTRY MANY HIDDEN BENEFITS AT YOUR EXPENSE.

• I-330 allows the insurance industry to pay money they owe you over a period of twenty or thirty years or longer. If you die before they pay what they owe, the insurance company gets to keep your money instead of paying it to your family. [Section 10(4)]

• The insurance industry is raising rates while making record profits. [State Insurance Commissioner 03/01/2005]. Even if I-330 passes, they still don't have to lower doctors' insurance rates. Insurance rates aren't even mentioned in I-330. [I-330, Full Text]

I-330 WOULD FORCE YOU TO GIVE UP YOUR RIGHT TO YOUR DAY IN COURT.

• Under I-330, before you can get health insurance, medical care or a prescription, HMOs, insurance companies, and hospitals can force you to sign a mandatory binding arbitration contract saying, *"By signing this contract you are agreeing to have any issue of malpractice decided by neutral arbitration and you are giving up your right to a jury or court trial."* This also applies to nursing and veterans homes. [Section 8(2)]

• Under I-330, the cap on damages applies to all cases of medical negligence, regardless of how bad the negligence or how serious the injury. There are no exceptions even in serious cases of true medical negligence resulting in brain damage, loss of limb, permanent paralysis, or death. I-330 shields the few doctors who repeatedly cause serious injuries. Because I-330 allows continued secrecy, you can never learn who they are. [Section 2(1)]

VOTE NO ON I-330 – IT'S THE WRONG SOLUTION. READ THE FINE PRINT.

For more information, visit www.TruthInTheFinePrint.org or call 206.697.4744.

Rebuttal of Statement For

I-330: so bad for patients and taxpayers that seniors, nurses, firefighters and veterans oppose it.

Read the fine print: real cap is $350,000, no exceptions for true medical negligence causing severe injuries; insurance industry keeps the money they owe your families if you die; insurers can force you to give up your day in court to get medical care or prescriptions; insurance industry not required to lower rates.

• The wrong solution. No on I-330.

Voters' Pamphlet Argument Prepared by:

HONORABLE EILEEN CODY, R.N., Chair, House Health Care Committee; CHERYL MARSHALL, member, Washington ARC, King County Parent Coalition; HONORABLE MIKE KREIDLER, Insurance Commissioner, State of Washington; KELLY FOX, President, Washington State Council of Fire Fighters; SHEILA MALMBERG, registered nurse practicing Wenatchee and Chelan; WILL PARRY, Washington State Alliance for Retired Americans.

INITIATIVE MEASURE 336

PROPOSED TO THE LEGISLATURE

Official Ballot Title:

Initiative Measure No. 336 concerns medical malpractice, including insurance, health care provider licensing, and lawsuits.

This measure would require notices and hearings on insurance rate increases, establish a supplemental malpractice insurance program, require license revocation proceedings after three malpractice incidents, and limit numbers of expert witnesses in lawsuits.

Should this measure be enacted into law?

Yes [ ] No [ ]

Note: The Official Ballot Title and Explanatory Statement were written by the Attorney General as required by law. The Fiscal Impact Statement was written by the Office of Financial Management. For more in-depth Office of Fiscal Management analysis, visit www.ofm.wa.gov/initiatives/default.htm . The complete text of Initiative Measure 336 begins on page 40.

Fiscal Impact Statement

Summary of Fiscal Impact

Initiative 336 would result in additional costs in the state Office of the Insurance Commissioner – ranging from $384,000 to more than $639,000 a year – due largely to changes in requirements affecting field examinations of insurers. The Initiative also is expected to increase by $58,000 the state Department of Health's costs for licensing health care providers. The Initiative also could prompt an increase or decrease in court filings or hearings, but conflicting research offers no clear guidance for estimating the magnitude of the Initiative's fiscal impact on courts.

Assumptions for Fiscal Analysis of I-336

Higher costs in the Office of the Insurance Commissioner would result mostly from new responsibilities that the Initiative places with the Insurance Commissioner, and which are related to the Supplemental Malpractice Insurance Program (SMIP) and its Board of Governors. These new responsibilities would result in new costs for conducting full examinations of all insurers' finances and operations at least once every three years, collecting and distributing to the Department of Health all medical malpractice claims data, and preparing annual reports of all medical malpractice claims data. In addition, the Office of the Insurance Commissioner would incur new costs related to public notice and/or public hearings for certain insurance rate filings, and from potential, additional judicial proceedings.

Higher costs in the Department of Health are due in part to the Initiative's requirements for investigation and regulation of health care professionals found liable in court for three or more medical malpractice claims paid within the most recent five-year period in amounts of $50,000 or more. In addition, new costs would arise from new requirements related to processing medical malpractice claims data from the Office of the Insurance Commissioner and reports of medical malpractice verdicts or settlements in excess of $100,000 from the courts.

The Initiative may impact court system litigation costs. Various studies have been conducted to determine how changes in law affecting tort liability and insurance can affect costs for courts, insurance premiums and health care. However, individual study results vary widely, predicting no change or both lower and higher costs in these areas. Due to the conflicting research, there is no clear guidance for estimating the magnitude of the fiscal impact of potential reductions on court costs or insurance premiums.

Sections of the Initiative that have the potential to increase court activity include: conferring standing on any person to file an action challenging the decision of the Insurance Commissioner on a requested health insurance rate increase; failure of providers to supply, upon request, information regarding the provider's experience with particular treatments, if violations result in civil liability; allowing a process to increase the number of experts; and allowing sanctions for violation of the attorney certification requirements.

Sections of the Initiative that have the potential to decrease court activity include: requirements that attorneys certify their claims are not frivolous; limits on the number of expert witnesses to two for each side; and requirements that medical malpractice actions be supported by an expert's certificate of merit.

INITIATIVE MEASURE 336

Explanatory Statement

The law as it presently exists:

A person injured by negligently provided health care services may recover damages from the health care provider in an action commonly known as a "medical malpractice" lawsuit. Presently, one basis for such a lawsuit is that the injured patient was not adequately informed concerning the medical procedure that caused the injury, and if adequately informed, the injured patient would not have consented to it.

Health care providers may purchase malpractice insurance from private insurance companies to protect against the risk of the costs associated with a medical malpractice lawsuit. Companies offering medical malpractice insurance policies in this state are required to file their rates with the Insurance Commissioner for review and approval. The Insurance Commissioner may reject rates found to be excessive, inadequate, or unfairly discriminatory. The Insurance Commissioner is a statewide elected official.

Health care providers, such as doctors, dentists, and nurses, are licensed and regulated by the state of Washington. It is illegal to provide health care services without an appropriate license. The disciplinary boards for each profession may act upon complaints regarding health care services provided by licensed professionals under their jurisdiction. The boards may discipline health care providers for professional misconduct, including the revocation of a provider's license.

Court rules prohibit attorneys from pursuing frivolous claims and defenses in all types of lawsuits, including medical malpractice lawsuits. By signing a complaint or other claim, an attorney, or a self-represented party, certifies that to the best of her or his knowledge a claim or defense is well grounded in fact and law and that it is not filed for an improper purpose.

The effect of the proposed measure, if it becomes law:

This measure consists of three parts. **Part I** of the Initiative would enact new requirements related to the Insurance Commissioner's review of medical malpractice insurance rates and would establish a new supplemental malpractice insurance program.

The Initiative would require public notice of medical malpractice insurance rate increases proposed by insurers. If an insurer proposes a rate increase of less than 15 percent, the Insurance Commissioner would be required to notify the public of the proposed change and, depending on the circumstances, may hold a public hearing on the increase. A public hearing would be required if the proposed rate increase is more than 15 percent. If a hearing is commenced, the rate increase would be suspended until it is resolved. All materials filed by an insurer with respect to a requested rate increase would be open to the public. The Initiative would permit any person to participate in proceedings related to the rate increase, and may receive an award of attorney fees and other expenses from the insurer under some circumstances.

The Initiative would also establish a new supplemental malpractice insurance program to pay claims and related defense costs on behalf of health care facilities or providers who are eligible and choose to participate in the program. With specified limitations, the program would pay claims that exceed the policy limits of the participants' other insurance or self-insurance. To obtain coverage under this new program, a facility or provider would be required to document required levels of insurance coverage or self-insurance for malpractice claims.

The program would be a separate and distinct legal entity, not a state agency. The Legislature, however, would be permitted to appropriate money for the program.

A board of governors consisting of seven members would oversee the program. The Insurance Commissioner would appoint a total of five members, and the Washington State Medical Association and the Washington State Hospital Association would each appoint one member. The board would be required to adopt a plan for the program, including details of operation. The program would charge annual premiums to health care facilities and providers who decide to buy excess malpractice liability insurance from the program. The program would also be allowed to require facilities to pay additional sums, in addition to the annual premium, in order to be eligible to buy or renew coverage from the program, subject to approval by the Insurance Commissioner. The program would be required to report annually to the Insurance Commissioner regarding the program's transactions, financial condition, and operations.

The Initiative would also establish eligibility requirements for health care facilities and providers to buy coverage from the program, including requiring that they be properly licensed in Washington. Health care facilities or providers would be excluded from the program if they do not provide proof of financial responsibility or meet criteria established by the board. Federal employees, and facilities operated by the state or federal governments, would also be excluded.

The Initiative would permit the board to establish minimum requirements for underlying medical malpractice insurance which covered health care providers or facilities must purchase in order to be eligible to the program. The Initiative would specify the

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Explanatory Statement *(continued)*

The effect of the proposed measure, if it becomes law: *(continued)*

dollar amounts of coverage that this underlying insurance must provide. The program would provide coverage only for damage awards that exceed the limits of underlying insurance policies, up to maximum limits set forth in the Initiative.

The review and approval of the Insurance Commissioner would be required for the rates that the program charges to health care providers and facilities. The Initiative sets forth criteria for the Commissioner to follow in deciding whether to approve or reject rates.

The Initiative would also prohibit health care providers or health care facilities from rejecting certain settlement offers. If a claimant (such as a plaintiff in a medical malpractice lawsuit) and either the program or another insuring or self-insuring entity agree to a settlement, the provider or facility may not reject it. If a provider or facility believes that a claim was without merit and payment of the claim results in a premium increase, the provider or facility can appeal to the board for reconsideration of the premium increase.

The Initiative would also require insurance companies to report monthly to the Insurance Commissioner with regard to medical malpractice claims that result in judgments or settlements in any amount, or are otherwise resolved. The Insurance Commissioner would be required to produce annual reports, beginning in 2007, summarizing data from the monthly reports and summarizing the medical malpractice insurance market in the state. The Initiative would require the Department of Health to thoroughly investigate a health care professional with three malpractice claims paid within a five-year period totaling $50,000 or more.

Part II of the Initiative would amend existing laws related to regulation and discipline of licensed health care providers. It would add two additional public members (to bring the total public members to six) to the Washington State Medical Quality Assurance Commission, which regulates the practice of medicine. At least two of the public members would be required to be representatives of patient advocacy groups or organizations, not from the health care industry.

The Initiative would also prohibit the Medical Quality Assurance Commission from licensing, or continuing to license, a person found to have committed three or more incidents of medical malpractice within a ten-year period, as demonstrated by final judgments entered in a court of law. The board may find mitigating circumstances as described in the Initiative.

The Initiative would amend current law to provide that the failure of a health care provider to disclose the provider's experience with the injury-causing treatment in response to the patient's request, including treatment outcomes, would establish a medical malpractice claim based on lack of informed consent.

The Initiative would require that malpractice verdicts or settlements exceeding $100,000 must be reported to the Department of Health. Health care facilities or providers would also be required to provide patients, or the immediate family members of deceased patients, with records made or received in the course of business by a health care facility or provider. State law making certain disciplinary reports confidential would be amended to make reports available to such requesters.

Part III of the Initiative would limit each side in medical malpractice lawsuits to two expert witnesses on an issue, unless they can show that more are necessary. It would also require attorneys who draft, assist in drafting, or file medical malpractice lawsuits or related documents in such a suit to certify in writing that there is a reasonable basis for the claims asserted. Within 120 days of filing a medical malpractice lawsuit, the attorney or plaintiff would be required to certify that the attorney or plaintiff has consulted at least one qualified expert who believes that the claim satisfies at least one basis for recovery under the law.

Statement For Initiative Measure 336

I-336 FOR BETTER, SAFER HEALTH CARE – HOLDS HMOs, THE INSURANCE INDUSTRY, LAWYERS AND DOCTORS ACCOUNTABLE

• *I-336 is the only initiative to:* Crack down on doctors whose negligence has been found to cause serious injury or death three or more times

• End secrecy in legal proceedings so the public can learn the safety records of hospitals, clinics, and doctors

• Require insurers to pass savings to consumers

• Increase patient safety

• Require lawyers to have doctors certify a lawsuit as legitimate before filing a medical negligence lawsuit

• Punish lawyers who file frivolous lawsuits

Three Strikes and You're Out

I-336 prohibits doctors from practicing medicine in Washington if their negligence has been found by a court of law to have seriously injured or killed at least three patients.

I-336 WOULD FINALLY GIVE YOU THE RIGHT TO KNOW GOOD DOCTORS FROM BAD

Currently, you have no right to know about negligent HMOs, hospitals, or doctors. The insurance industry, HMOs, and hospitals can keep serious medical negligence a secret by forcing injured patients into "gag orders." I-336 would change that by giving you the right to know about negligent HMOs, hospitals, and doctors.

INSURANCE COMPANIES WOULD HAVE TO JUSTIFY RATE INCREASES, HOLDING INSURANCE RATES DOWN

The insurance industry would have to open their books to the public to justify rate increases. The Insurance Commissioner could deny unwarranted increases.

I-336 is the only initiative that cracks down on frivolous lawsuits.

Other initiatives treat serious lawsuits over true medical negligence that causes severe injuries the same way as frivolous lawsuits. I-336 is the only initiative cracking down on frivolous lawsuits without closing the courtroom doors on true and serious medical negligence cases where someone lost a child, or is confined to a wheelchair for life.

VOTE YES I-336 – THE ONLY INITIATIVE THAT PROTECTS PATIENTS AND LOWERS INSURANCE RATES FOR DOCTORS

For more information, visit www.bettersafercare.org or call 206.250.2746.

Rebuttal of Statement Against

Here are just a few of those supporting I-336: • Many leading nurses and health care professionals • Major senior organizations • Veterans • Firefighters.

Why? Because I-336 is the *only* measure that will actually reduce insurance rates and improve patient care. Other measures help the insurance industry at patients' expense.

Join a growing coalition of health care professionals, seniors, and emergency rescue workers. Vote *yes* on I-336.

Voters' Pamphlet Argument Prepared by:

DYLAN MALONE, Chair, Better Safer Health Care; HONORABLE TOM CAMPBELL, past Co-Chair, House Health Care Committee; HONORABLE KAREN KEISER, Chair, Senate Health Care Committee; RICK BENDER, President, Washington State Labor Council; STEVE DZIELAK, Washington State Alliance for Retired Americans; CHERYL MARSHALL, member Washington ARC, King County Parent Coalition.

Statement Against Initiative Measure 336

I-336 IS A PERSONAL INJURY LAWYER INITIATIVE

Just when voters are being asked to enact meaningful reform to lower malpractice costs, greedy personal injury lawyers have responded with a cynical attempt to punish good doctors and make even more money from lawsuits. I-336 helps the lawyers: they wrote it, they lobbied for it, and personal injury lawyer money funds it. *According to the State Public Disclosure Commission, I-336 has received nearly every dollar of funding from one source: the Washington State Trial Lawyers Association!*

Behind the smoke screen, I-336 will reduce access to care and drive more doctors out of state. Its sole purpose is to benefit personal injury lawyers! The lawyers wrote I-336 to guarantee themselves even more money filing lawsuits against good doctors – even those who've done nothing wrong.

I-336 CREATES MORE BUREAUCRACY

I-336 establishes a new state-run, taxpayer-financed, "supplemental" insurance program. Doctors would pay a second "excess" liability premium. It creates another deep pocket for personal injury lawyers to sue – that's why they're willing to spend whatever it takes to pass I-336.

I-336 PUTS PERSONAL INJURY LAWYERS FIRST, PATIENTS LAST

I-336 does nothing to change the legal system that is driving good doctors out of practice and away from Washington. I-336 is a smoke-and-mirrors solution to a life-and-death problem. *The bottom line: this initiative was written by lawyers, for lawyers – if it passes lawyers win, patients, doctors, and nurses lose.*

Vote No on I-336.

For more information, visit www.yesoni330.org or call (toll free) 877.740.0177.

Rebuttal of Statement For

The "three-strikes rule" won't actually "crack down" on bad doctors or frivolous lawsuits. The standard for "frivolous" lawsuits is so high it's nearly meaningless. The rule for doctors is nothing more than an effort to extort more money from good physicians for the benefit of personal injury lawyers. Like most of I-336, "three strikes" is just another soundbite masquerading as reform. Put patients first: choose real reform. Vote *yes* on I-330 – *no* on I-336.

Voters' Pamphlet Argument Prepared by:

KENNETH ISAACS, M.D., Doctors, Nurses and Patients for a Healthy Washington; MARIANNE TEFFT, concerned patient; CYNTHIA MARKUS, M.D., J.D., concerned physician and attorney; DANA WALLACE, R.N., Chair, Nurses For I-330/Against I-336; TIMOTHY SHELDON, State Senator (D-Potlatch).

SENATE JOINT RESOLUTION 8207

PROPOSED CONSTITUTIONAL AMENDMENT

Official Ballot Title:

The Legislature has proposed a constitutional amendment on qualifications for service on the Commission on Judicial Conduct.

This amendment would permit one member of the Commission on Judicial Conduct to be selected by and from the judges of all courts of limited jurisdiction.

Should this constitutional amendment be:

Approved [ ] Rejected [ ]

Votes cast by the 2005 Legislature on final passage:
Senate: Yeas, 46; Nays, 0.
House: Yeas, 90; Nays, 2.

Note: The Official Ballot Title and Explanatory Statement were written by the Attorney General as required by law. The complete text of Senate Joint Resolution 8207 begins on page 53.

Explanatory Statement

The law as it presently exists:

The Commission on Judicial Conduct consists of eleven members. Three members are judges, two members are lawyers admitted to practice in Washington, and the remaining six members are non-lawyers appointed by the Governor. Of the three members who are judges, one is selected by and from the Court of Appeals judges, one is selected by and from the Superior Court judges, and one is selected by and from the District Court judges.

District Courts are courts established in each county to hear certain types of civil and criminal cases. District Court judges are elected by the residents of the county. Cities and towns may participate in the District Court system, or they may establish separate Municipal Courts, with municipal judges elected by the residents of the city or town. Because they are not District Court judges, Municipal Court judges do not qualify under existing constitutional language to serve on the Commission on Judicial Conduct.

The effect of the proposed amendment, if it becomes law:

The proposed constitutional amendment would replace the phrase "district court judges" with the broader term "limited jurisdiction court judges." The term "court of limited jurisdiction" includes both District Courts and Municipal Courts. The effect of this amendment would be to permit a judge of any court of limited jurisdiction – that is, either a district judge or a municipal judge – to be selected for one of the three judicial positions on the Commission on Judicial Conduct. The position would be filled by selection by all of the judges of all courts of limited jurisdiction. The other two judicial positions on the Commission – one for a judge of the Court of Appeals and one for a Superior Court judge – would not be affected by the amendment.

Statement For SJR 8207

VOTE YES –
SENATE JOINT RESOLUTION (SJR) 8207

SJR 8207 is a corrective measure amending the State Constitution to include elected municipal court judges as persons eligible to serve on the Commission on Judicial Conduct.

The Commission on Judicial Conduct was created under the Constitution to discipline judges when they violate the ethical rules set out in the Code of Judicial Conduct. Currently, the Commission membership consists of six non-lawyers appointed by the Governor, two lawyers appointed by the State Bar Association, and three judges: one judge each from the Court of Appeals, the Superior Court, and the District Court.

Municipal Court judges, like all judges, are subject to discipline for violation of the ethical rules. This amendment corrects an oversight that excludes elected municipal court judges from participating in the Commission that disciplines judges for ethical violations. Fairness requires that municipal court judges also be represented by their peers and have an opportunity to assist the Commission.

This measure would not change the number of or manner in which Commission members are selected. It only changes the Constitutional language from "district" to "limited jurisdiction" judges, thereby including municipal court judges as persons eligible to participate in the Commission.

The Legislature passed this Resolution with near unanimity (only two "no" votes), and sent it to the voters for approval as an amendment to the Constitution. This Resolution is supported by the following organizations:

Judicial Conduct Commission
Association of Washington Cities
District and Municipal Court Judges Association
Board for Judicial Administration.

Voters' Pamphlet Argument Prepared by:

ADAM KLINE, State Senator, Chair, Senate Judiciary Committee; STEPHEN L. JOHNSON, State Senator, Ranking Member, Senate Judiciary Committee; BRENDAN WILLIAMS, State Representative, Vice Chair, House Judiciary Committee; SKIP PRIEST, State Representative, Ranking Member, House Judiciary Committee; JUDITH HIGHTOWER, Judge, Seattle Municipal Court; ALICIA NAKATA, Judge, Chelan County District Court.

Statement Against SJR 8207

State law requires that the argument and rebuttal statement against a constitutional amendment be written by one or more members of the state Legislature who voted against that proposed measure on final passage or, in the event that no such member of the Legislature consents to prepare the statement, by any other responsible individual or individuals to be appointed by the Speaker of the House of Representatives, the President of the State Senate, and the Secretary of State. No legislator who voted against Senate Joint Resolution 8207 or other individual opposing the measure consented to write an argument against the measure for publication in this pamphlet.

The Office of the Secretary of State is not authorized to edit statements, nor is it responsible for their contents.

Address Confidentiality Program

If you are a victim of domestic violence, sexual assault or stalking who has chosen not to register to vote because you are afraid the perpetrator will track you down, the Office of the Secretary of State has a program that might be able to help you. The Address Confidentiality Program (ACP) works together with community domestic violence and sexual assault programs in an effort to keep crime victims a little safer. The Address Confidentiality Program provides crime victims with a substitute mailing address that can be used when the victim works with the state and local government agencies. The ACP also provides crime victims with confidential voter registration. All ACP participants must be referred to the program by a local domestic violence or sexual assault advocate who can help the victim develop a comprehensive safety plan.

Need More Information?

For more information about the ACP and the phone number of victim resources in your community, call the ACP at 360.753.2972 or visit www.secstate.wa.gov/acp .

Complete Text of

INITIATIVE MEASURE NO. 900

AN ACT Relating to performance audits of governmental entities; amending RCW 82.08.020 and 43.88.160; adding new sections to chapter 43.09 RCW; adding a new section to chapter 82.12 RCW; creating new sections; and providing an effective date.

BE IT ENACTED BY THE PEOPLE OF THE STATE OF WASHINGTON:

POLICIES AND PURPOSES

NEW SECTION. **Sec. 1.** It is essential that state and local governments establish credibility with the taxpayers by implementing long-overdue performance audits to ensure accountability and guarantee that tax dollars are spent as cost-effectively as possible. Are politicians spending our current tax revenues as cost-effectively as possible? Voters don't know because politicians have repeatedly blocked our state auditor from conducting independent, comprehensive performance audits on state and local governments, agencies, programs, and accounts. Currently, Washington is the only state in the nation that prohibits the independently elected state auditor from doing the job he or she was hired to do without explicit legislative permission. This handicap is costing the taxpayers billions of dollars in potential savings. Thankfully, this common sense initiative remedies this egregious failure of politicians to enact this reform. It is absurd for politicians to unilaterally impose tax increases or to seek voter approval for tax increases without first learning if we're getting the biggest bang for the buck from our current tax revenues. This measure requires the state auditor to conduct independent, comprehensive performance audits on state and local governments, agencies, programs, and accounts. This act dedicates a portion of the state's existing sales and use tax (1/100th of 1%) to fund these comprehensive performance audits. Similar performance reviews in Texas have saved taxpayers there nine billion dollars out of nineteen billion dollars in identified savings over the past decade. The performance audits required by this common sense initiative will identify solutions to our public policy problems, saving the taxpayers billions of dollars.

REQUIRING INDEPENDENT, COMPREHENSIVE PERFORMANCE AUDITS OF STATE AND LOCAL GOVERNMENTS, AGENCIES, PROGRAMS, AND ACCOUNTS

NEW SECTION. **Sec. 2.** A new section is added to chapter 43.09 RCW to read as follows:

In addition to audits authorized under RCW 43.88.160, the state auditor shall conduct independent, comprehensive performance audits of state government and each of its agencies, accounts, and programs; local governments and each of their agencies, accounts, and programs; state and local education governmental entities and each of their agencies, accounts, and programs; state and local transportation governmental entities and each of their agencies, accounts, and programs; and other governmental entities, agencies, accounts, and programs. The term "government" means an agency, department, office, officer, board, commission, bureau, division, institution, or institution of higher education. This includes individual agencies and programs, as well as those programs and activities that cross agency lines. "Government" includes all elective and nonelective offices in the executive branch and includes the judicial and legislative branches. The state auditor shall review and analyze the economy, efficiency, and effectiveness of the policies, management, fiscal affairs, and operations of state and local governments, agencies, programs, and accounts. These performance audits shall be conducted in accordance with the United States general accounting office government auditing standards. The scope for each performance audit shall not be limited and shall include nine specific elements: (1) identification of cost savings; (2) identification of services that can be reduced or eliminated; (3) identification of programs or services that can be transferred to the private sector; (4) analysis of gaps or overlaps in programs or services and recommendations to correct gaps or overlaps; (5) feasibility of pooling information technology systems within the department; (6) analysis of the roles and functions of the department, and recommendations to change or eliminate departmental roles or functions; (7) recommendations for statutory or regulatory changes that may be necessary for the department to properly carry out its functions; (8) analysis of departmental performance data, performance measures, and self-assessment systems; and (9) identification of best practices. The state auditor may contract out any performance audits. For counties and cities, the audit may be conducted as part of audits otherwise required by state law. Each audit report shall be submitted to the corresponding legislative body or legislative bodies and made available to the public on or before thirty days after the completion of each audit or each follow-up audit. On or before thirty days after the performance audit is made public, the corresponding legislative body or legislative bodies shall hold at least one public hearing to consider the findings of the audit and shall receive comments from the public. The state auditor is authorized to issue subpoenas to governmental entities for required documents, memos, and budgets to conduct the performance audits. The state auditor may, at any time, conduct a performance audit to determine not only the efficiency, but also the effectiveness, of any government agency, account, or program. No legislative body, officeholder, or employee may impede or restrict the authority or the actions of the state auditor to conduct independent, comprehensive performance audits. To the greatest extent possible, the state auditor shall instruct and advise the appropriate governmental body on a step-by-step remedy to whatever ineffectiveness and inefficiency is discovered in the audited entity. For performance audits of state government and its agencies, programs, and accounts,

the legislature must consider the state auditor reports in connection with the legislative appropriations process. An annual report will be submitted by the joint legislative audit and review committee by July 1st of each year detailing the status of the legislative implementation of the state auditor's recommendations. Justification must be provided for recommendations not implemented. Details of other corrective action must be provided as well. For performance audits of local governments and their agencies, programs, and accounts, the corresponding legislative body must consider the state auditor reports in connection with its spending practices. An annual report will be submitted by the legislative body by July 1st of each year detailing the status of the legislative implementation of the state auditor's recommendations. Justification must be provided for recommendations not implemented. Details of other corrective action must be provided as well. The people encourage the state auditor to aggressively pursue the largest, costliest governmental entities first but to pursue all governmental entities in due course. Follow-up performance audits on any state and local government, agency, account, and program may be conducted when determined necessary by the state auditor. Revenues from the Performance Audits of Government Account, created in section 5 of this act, shall be used for the cost of the audits.

DEDICATING A PORTION OF THE STATE'S EXISTING SALES AND USE TAX (1/100TH OF 1%) TO FUND THE PERFORMANCE AUDITS

Sec. 3. RCW 82.08.020 and 2003 c 361 s 301 are each amended to read as follows:

(1) There is levied and there shall be collected a tax on each retail sale in this state equal to six and five-tenths percent of the selling price.

(2) There is levied and there shall be collected an additional tax on each retail car rental, regardless of whether the vehicle is licensed in this state, equal to five and nine-tenths percent of the selling price. The revenue collected under this subsection shall be deposited in the multimodal transportation account created in RCW 47.66.070.

(3) Beginning July 1, 2003, there is levied and collected an additional tax of three-tenths of one percent of the selling price on each retail sale of a motor vehicle in this state, other than retail car rentals taxed under subsection (2) of this section. The revenue collected under this subsection shall be deposited in the multimodal transportation account created in RCW 47.66.070.

(4) For purposes of subsection (3) of this section, "motor vehicle" has the meaning provided in RCW 46.04.320, but does not include farm tractors or farm vehicles as defined in RCW 46.04.180 and 46.04.181, off-road and nonhighway vehicles as defined in RCW 46.09.020, and snowmobiles as defined in RCW 46.10.010.

(5) Beginning on December 8, 2005, 0.16 percent of the taxes collected under subsection (1) of this section shall be dedicated to funding comprehensive performance audits required under section 2 of this act. The revenue identified in this subsection shall be deposited in the Performance Audits of Government Account created in section 5 of this act.

(6) The taxes imposed under this chapter shall apply to successive retail sales of the same property.

(((~~(6)~~))) (7) The rates provided in this section apply to taxes imposed under chapter 82.12 RCW as provided in RCW 82.12.020.

NEW SECTION. **Sec. 4.** A new section is added to chapter 82.12 RCW to read as follows:

Beginning on December 8, 2005, 0.16 percent of the taxes collected under RCW 82.12.020 based on the rate in RCW 82.08.020(1) shall be dedicated to funding comprehensive performance audits under section 2 of this act. Revenue identified in this section shall be deposited in the Performance Audits of Government Account created in section 5 of this act.

CREATING THE PERFORMANCE AUDITS OF GOVERNMENT ACCOUNT

NEW SECTION. **Sec. 5.** A new section is added to chapter 43.09 RCW to read as follows:

The Performance Audits of Government Account is hereby created in the custody of the state treasurer. Revenue identified in RCW 82.08.020(5) and section 4 of this act shall be deposited in the account. Money in the account shall be used to fund the performance audits and follow-up performance audits under section 2 of this act and shall be expended by the state auditor in accordance with this act. Only the state auditor or the state auditor's designee may authorize expenditures from the account. The account is subject to allotment procedures under chapter 43.88 RCW, but an appropriation is not required for expenditures.

Sec. 6. RCW 43.88.160 and 2002 c 260 s 1 are each amended to read as follows:

This section sets forth the major fiscal duties and responsibilities of officers and agencies of the executive branch. The regulations issued by the governor pursuant to this chapter shall provide for a comprehensive, orderly basis for fiscal management and control, including efficient accounting and reporting therefor, for the executive branch of the state government and may include, in addition, such requirements as will generally promote more efficient public management in the state.

(1) Governor; director of financial management. The governor, through the director of financial management, shall devise and supervise a modern and complete accounting system for each agency to the end that all revenues, expenditures, receipts, disbursements, resources, and obligations of the state shall be properly and systematically accounted for. The accounting system shall include the development of accurate, timely records and reports of all

financial affairs of the state. The system shall also provide for central accounts in the office of financial management at the level of detail deemed necessary by the director to perform central financial management. The director of financial management shall adopt and periodically update an accounting procedures manual. Any agency maintaining its own accounting and reporting system shall comply with the updated accounting procedures manual and the rules of the director adopted under this chapter. An agency may receive a waiver from complying with this requirement if the waiver is approved by the director. Waivers expire at the end of the fiscal biennium for which they are granted. The director shall forward notice of waivers granted to the appropriate legislative fiscal committees. The director of financial management may require such financial, statistical, and other reports as the director deems necessary from all agencies covering any period.

(2) Except as provided in chapter 43.88C RCW, the director of financial management is responsible for quarterly reporting of primary operating budget drivers such as applicable workloads, caseload estimates, and appropriate unit cost data. These reports shall be transmitted to the legislative fiscal committees or by electronic means to the legislative evaluation and accountability program committee. Quarterly reports shall include actual monthly data and the variance between actual and estimated data to date. The reports shall also include estimates of these items for the remainder of the budget period.

(3) The director of financial management shall report at least annually to the appropriate legislative committees regarding the status of all appropriated capital projects, including transportation projects, showing significant cost overruns or underruns. If funds are shifted from one project to another, the office of financial management shall also reflect this in the annual variance report. Once a project is complete, the report shall provide a final summary showing estimated start and completion dates of each project phase compared to actual dates, estimated costs of each project phase compared to actual costs, and whether or not there are any outstanding liabilities or unsettled claims at the time of completion.

(4) In addition, the director of financial management, as agent of the governor, shall:

(a) Develop and maintain a system of internal controls and internal audits comprising methods and procedures to be adopted by each agency that will safeguard its assets, check the accuracy and reliability of its accounting data, promote operational efficiency, and encourage adherence to prescribed managerial policies for accounting and financial controls. The system developed by the director shall include criteria for determining the scope and comprehensiveness of internal controls required by classes of agencies, depending on the level of resources at risk.

Each agency head or authorized designee shall be assigned the responsibility and authority for establishing and maintaining internal audits following the standards of internal auditing of the institute of internal auditors;

(b) Make surveys and analyses of agencies with the object of determining better methods and increased effectiveness in the use of manpower and materials; and the director shall authorize expenditures for employee training to the end that the state may benefit from training facilities made available to state employees;

(c) Establish policies for allowing the contracting of child care services;

(d) Report to the governor with regard to duplication of effort or lack of coordination among agencies;

(e) Review any pay and classification plans, and changes thereunder, developed by any agency for their fiscal impact: PROVIDED, That none of the provisions of this subsection shall affect merit systems of personnel management now existing or hereafter established by statute relating to the fixing of qualifications requirements for recruitment, appointment, or promotion of employees of any agency. The director shall advise and confer with agencies including appropriate standing committees of the legislature as may be designated by the speaker of the house and the president of the senate regarding the fiscal impact of such plans and may amend or alter the plans, except that for the following agencies no amendment or alteration of the plans may be made without the approval of the agency concerned: Agencies headed by elective officials;

(f) Fix the number and classes of positions or authorized employee years of employment for each agency and during the fiscal period amend the determinations previously fixed by the director except that the director shall not be empowered to fix the number or the classes for the following: Agencies headed by elective officials;

(g) Adopt rules to effectuate provisions contained in (a) through (f) of this subsection.

(5) The treasurer shall:

(a) Receive, keep, and disburse all public funds of the state not expressly required by law to be received, kept, and disbursed by some other persons: PROVIDED, That this subsection shall not apply to those public funds of the institutions of higher learning which are not subject to appropriation;

(b) Receive, disburse, or transfer public funds under the treasurer's supervision or custody;

(c) Keep a correct and current account of all moneys received and disbursed by the treasurer, classified by fund or account;

(d) Coordinate agencies' acceptance and use of credit cards and other payment methods, if the agencies have received authorization under RCW 43.41.180;

(e) Perform such other duties as may be required by law or by regulations issued pursuant to this law.

It shall be unlawful for the treasurer to disburse public funds in the treasury except upon forms or by alternative means duly prescribed by the director of financial management. These forms or alternative means shall provide for

authentication and certification by the agency head or the agency head's designee that the services have been rendered or the materials have been furnished; or, in the case of loans or grants, that the loans or grants are authorized by law; or, in the case of payments for periodic maintenance services to be performed on state owned equipment, that a written contract for such periodic maintenance services is currently in effect; and the treasurer shall not be liable under the treasurer's surety bond for erroneous or improper payments so made. When services are lawfully paid for in advance of full performance by any private individual or business entity other than equipment maintenance providers or as provided for by RCW 42.24.035, such individual or entity other than central stores rendering such services shall make a cash deposit or furnish surety bond coverage to the state as shall be fixed in an amount by law, or if not fixed by law, then in such amounts as shall be fixed by the director of the department of general administration but in no case shall such required cash deposit or surety bond be less than an amount which will fully indemnify the state against any and all losses on account of breach of promise to fully perform such services. No payments shall be made in advance for any equipment maintenance services to be performed more than twelve months after such payment. Any such bond so furnished shall be conditioned that the person, firm or corporation receiving the advance payment will apply it toward performance of the contract. The responsibility for recovery of erroneous or improper payments made under this section shall lie with the agency head or the agency head's designee in accordance with regulations issued pursuant to this chapter. Nothing in this section shall be construed to permit a public body to advance funds to a private service provider pursuant to a grant or loan before services have been rendered or material furnished.

(6) The state auditor shall:

(a) Report to the legislature the results of current post audits that have been made of the financial transactions of each agency; to this end the auditor may, in the auditor's discretion, examine the books and accounts of any agency, official, or employee charged with the receipt, custody, or safekeeping of public funds. Where feasible in conducting examinations, the auditor shall utilize data and findings from the internal control system prescribed by the office of financial management. The current post audit of each agency may include a section on recommendations to the legislature as provided in (c) of this subsection.

(b) Give information to the legislature, whenever required, upon any subject relating to the financial affairs of the state.

(c) Make the auditor's official report on or before the thirty-first of December which precedes the meeting of the legislature. The report shall be for the last complete fiscal period and shall include determinations as to whether agencies, in making expenditures, complied with the laws of this state. The state auditor is authorized to perform or participate in performance verifications and performance audits as expressly authorized by the legislature in the omnibus biennial appropriations acts or in the performance audit work plan approved by the joint legislative audit and review committee. The state auditor, upon completing an audit for legal and financial compliance under chapter 43.09 RCW or a performance verification, may report to the joint legislative audit and review committee or other appropriate committees of the legislature, in a manner prescribed by the joint legislative audit and review committee, on facts relating to the management or performance of governmental programs where such facts are discovered incidental to the legal and financial audit or performance verification. The auditor may make such a report to a legislative committee only if the auditor has determined that the agency has been given an opportunity and has failed to resolve the management or performance issues raised by the auditor. If the auditor makes a report to a legislative committee, the agency may submit to the committee a response to the report. This subsection (6) shall not be construed to authorize the auditor to allocate other than de minimis resources to performance audits except as expressly authorized in the appropriations acts or in the performance audit work plan. The results of a performance audit conducted by the state auditor that has been requested by the joint legislative audit and review committee must only be transmitted to the joint legislative audit and review committee.

(d) Be empowered to take exception to specific expenditures that have been incurred by any agency or to take exception to other practices related in any way to the agency's financial transactions and to cause such exceptions to be made a matter of public record, including disclosure to the agency concerned and to the director of financial management. It shall be the duty of the director of financial management to cause corrective action to be taken within six months, such action to include, as appropriate, the withholding of funds as provided in RCW 43.88.110. The director of financial management shall annually report by December 31st the status of audit resolution to the appropriate committees of the legislature, the state auditor, and the attorney general. The director of financial management shall include in the audit resolution report actions taken as a result of an audit including, but not limited to, types of personnel actions, costs and types of litigation, and value of recouped goods or services.

(e) Promptly report any irregularities to the attorney general.

(f) Investigate improper governmental activity under chapter 42.40 RCW.

(g) In addition to the authority given to the state auditor in this subsection (6), the state auditor is authorized to conduct performance audits identified in section 2 of this act. Nothing in this subsection (6) shall limit, impede, or restrict the state auditor from conducting performance audits identified in section 2 of this act.

(7) The joint legislative audit and review committee may:

(a) Make post audits of the financial transactions of any agency and management surveys and program reviews as

Complete Text of

INITIATIVE MEASURE NO. 900

(continued)

provided for in chapter 44.28 RCW as well as performance audits and program evaluations. To this end the joint committee may in its discretion examine the books, accounts, and other records of any agency, official, or employee.

(b) Give information to the legislature or any legislative committee whenever required upon any subject relating to the performance and management of state agencies.

(c) Make a report to the legislature which shall include at least the following:

(i) Determinations as to the extent to which agencies in making expenditures have complied with the will of the legislature and in this connection, may take exception to specific expenditures or financial practices of any agencies; and

(ii) Such plans as it deems expedient for the support of the state's credit, for lessening expenditures, for promoting frugality and economy in agency affairs, and generally for an improved level of fiscal management.

CONSTRUCTION CLAUSE

NEW SECTION. **Sec. 7.** The provisions of this act are to be liberally construed to effectuate the intent, policies, and purposes of this act.

SEVERABILITY CLAUSE

NEW SECTION. **Sec. 8.** If any provision of this act or its application to any person or circumstance is held invalid, the remainder of the act or the application of the provision to other persons or circumstances is not affected.

MISCELLANEOUS

NEW SECTION. **Sec. 9.** Part headings used in this act are not part of the law.

EFFECTIVE DATE

NEW SECTION. **Sec. 10.** This act shall be called the Performance Audits of Government Act and takes effect December 8, 2005.

Complete Text of

INITIATIVE MEASURE NO. 901

AN ACT Relating to the prohibition of smoking in public places and places of employment; amending RCW 70.160.020, 70.160.030, 70.160.050, and 70.160.070; adding new sections to chapter 70.160 RCW; creating a new section; and repealing RCW 70.160.010, 70.160.040, and 70.160.900.

BE IT ENACTED BY THE PEOPLE OF THE STATE OF WASHINGTON:

NEW SECTION. **Sec. 1.** A new section is added to chapter 70.160 RCW to read as follows:

INTENT AND FINDINGS. The people of the state of Washington recognize that exposure to second-hand smoke is known to cause cancer in humans. Second-hand smoke is a known cause of other diseases including pneumonia, asthma, bronchitis, and heart disease. Citizens are often exposed to second-hand smoke in the workplace, and are likely to develop chronic, potentially fatal diseases as a result of such exposure. In order to protect the health and welfare of all citizens, including workers in their places of employment, it is necessary to prohibit smoking in public places and workplaces.

Sec. 2. RCW 70.160.020 and 1985 c 236 s 2 are each amended to read as follows:

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

(1) "Smoke" or "smoking" means the carrying or smoking of any kind of lighted pipe, cigar, cigarette, or any other lighted smoking equipment.

(2) "Public place" means that portion of any building or vehicle used by and open to the public, regardless of whether the building or vehicle is owned in whole or in part by private persons or entities, the state of Washington, or other public entity, and regardless of whether a fee is charged for admission, and includes a presumptively reasonable minimum distance, as set forth in section 6 of this act, of twenty-five feet from entrances, exits, windows that open, and ventilation intakes that serve an enclosed area where smoking is prohibited. A public place does not include a private residence unless the private residence is used to provide licensed child care, foster care, adult care, or other similar social service care on the premises.

Public places include, but are not limited to: Schools, elevators, public conveyances or transportation facilities, museums, concert halls, theaters, auditoriums, exhibition halls, indoor sports arenas, hospitals, nursing homes, health care facilities or clinics, enclosed shopping centers, retail stores, retail service establishments, financial institutions, educational facilities, ticket areas, public hearing facilities, state legislative chambers and immediately adjacent

hallways, public restrooms, libraries, restaurants, waiting areas, lobbies, ((~~and reception areas~~)) bars, taverns, bowling alleys, skating rinks, casinos, reception areas, and no less than seventy-five percent of the sleeping quarters within a hotel or motel that are rented to guests. A public place does not include a private residence. This chapter is not intended to restrict smoking in private facilities which are occasionally open to the public except upon the occasions when the facility is open to the public.

(3) ((~~"Restaurant" means any building, structure, or area used, maintained, or advertised as, or held out to the public to be, an enclosure where meals are made available to be consumed on the premises, for consideration of payment.~~)) "Place of employment" means any area under the control of a public or private employer which employees are required to pass through during the course of employment, including, but not limited to: Entrances and exits to the places of employment, and including a presumptively reasonable minimum distance, as set forth in section 6 of this act, of twenty-five feet from entrances, exits, windows that open, and ventilation intakes that serve an enclosed area where smoking is prohibited; work areas; restrooms; conference and classrooms; break rooms and cafeterias; and other common areas. A private residence or home-based business, unless used to provide licensed child care, foster care, adult care, or other similar social service care on the premises, is not a place of employment.

Sec. 3. RCW 70.160.030 and 1985 c 236 s 3 are each amended to read as follows:

No person may smoke in a public place ((~~except in designated smoking areas~~)) or in any place of employment.

Sec. 4. RCW 70.160.050 and 1985 c 236 s 5 are each amended to read as follows:

Owners, or in the case of a leased or rented space the lessee or other person in charge, of a place regulated under this chapter shall ((~~make every reasonable effort to~~)) prohibit smoking in public places ((~~by posting~~)) and places of employment and shall post signs prohibiting ((~~or permitting~~)) smoking as appropriate under this chapter. Signs shall be posted conspicuously at each building entrance. In the case of retail stores and retail service establishments, signs shall be posted conspicuously at each entrance and in prominent locations throughout the place. ((~~The boundary between a nonsmoking area and a smoking permitted area shall be clearly designated so that persons may differentiate between the two areas.~~))

Sec. 5. RCW 70.160.070 and 1985 c 236 s 7 are each amended to read as follows:

(1) Any person intentionally violating this chapter by smoking in a public place ((~~not designated as a smoking area~~)) or place of employment, or any person removing, defacing, or destroying a sign required by this chapter, is subject to a civil fine of up to one hundred dollars. Any person passing by or through a public place while on a public sidewalk or public right of way has not intentionally violated this chapter. Local law enforcement agencies shall enforce this section by issuing a notice of infraction to be assessed in the same manner as traffic infractions. The provisions contained in chapter 46.63 RCW for the disposition of traffic infractions apply to the disposition of infractions for violation of this subsection except as follows:

(a) The provisions in chapter 46.63 RCW relating to the provision of records to the department of licensing in accordance with RCW 46.20.270 are not applicable to this chapter; and

(b) The provisions in chapter 46.63 RCW relating to the imposition of sanctions against a person's driver's license or vehicle license are not applicable to this chapter.

The form for the notice of infraction for a violation of this subsection shall be prescribed by rule of the supreme court.

(2) When violations of RCW ((~~70.160.040 or~~)) 70.160.050 occur, a warning shall first be given to the owner or other person in charge. Any subsequent violation is subject to a civil fine of up to one hundred dollars. Each day upon which a violation occurs or is permitted to continue constitutes a separate violation.

(3) Local ((~~fire~~)) health departments ((~~or fire districts~~)) shall enforce RCW ((~~70.160.040 or~~)) 70.160.050 regarding the duties of owners or persons in control of public places ((~~, and local health departments shall enforce RCW 70.160.040 or 70.160.050 regarding the duties of owners of restaurants~~)) and places of employment by either of the following actions:

(a) Serving notice requiring the correction of any violation; or

(b) Calling upon the city or town attorney or county prosecutor or local health department attorney to maintain an action for an injunction to enforce RCW ((~~70.160.040 and~~)) 70.160.050, to correct a violation, and to assess and recover a civil penalty for the violation.

NEW SECTION. **Sec. 6.** A new section is added to chapter 70.160 RCW to read as follows:

PRESUMPTIVELY REASONABLE DISTANCE. Smoking is prohibited within a presumptively reasonable minimum distance of twenty-five feet from entrances, exits, windows that open, and ventilation intakes that serve an enclosed area where smoking is prohibited so as to ensure that tobacco smoke does not enter the area through entrances, exits, open windows, or other means. Owners, operators, managers, employers, or other persons who own or control a public place or place of employment may seek to rebut the presumption that twenty-five feet is a reasonable minimum distance by making application to the director of the local health department or district in which the public place or place of employment is located. The presumption will be rebutted if the applicant can show by clear and convincing evidence that, given the unique circumstances presented by the

Complete Text of

INITIATIVE MEASURE NO. 901

(continued)

location of entrances, exits, windows that open, ventilation intakes, or other factors, smoke will not infiltrate or reach the entrances, exits, open windows, or ventilation intakes or enter into such public place or place of employment and, therefore, the public health and safety will be adequately protected by a lesser distance.

NEW SECTION. **Sec. 7.** The following acts or parts of acts are each repealed:

(1) RCW 70.160.010 (Legislative intent) and 1985 c 236 s 1;

(2) RCW 70.160.040 (Designation of smoking areas in public places—Exceptions—Restaurant smoking areas—Entire facility or area may be designated as nonsmoking) and 1985 c 236 s 4; and

(3) RCW 70.160.900 (Short title—1985 c 236) and 1985 c 236 s 10.

NEW SECTION. **Sec. 8.** CAPTIONS NOT LAW. Captions used in this act are not any part of the law.

Complete Text of

INITIATIVE MEASURE NO. 912

AN ACT Relating to reducing the motor vehicle fuel tax rate; amending RCW 82.36.025 and 46.68.090; and creating new sections.

BE IT ENACTED BY THE PEOPLE OF THE STATE OF WASHINGTON:

POLICIES AND PURPOSES

NEW SECTION. **Sec. 1**. In 2002 voters overwhelmingly rejected a nine cent per gallon increase to the motor vehicle fuel tax rate. Since that time, politicians have voted to increase the motor vehicle fuel tax rate by fourteen and one-half cents per gallon. This measure would repeal the most recent increase to the motor vehicle fuel tax rate of nine and one-half cents.

REPEALING THE 9 AND ONE-HALF CENT INCREASE IN THE MOTOR VEHICLE FUEL TAX RATE

Sec. 2. RCW 82.36.025 and 2005 c ... (ESSB 6103) s 101 are each amended to read as follows:

(1) A motor vehicle fuel tax rate of twenty-three cents per gallon applies to the sale, distribution, or use of motor vehicle fuel.

(2) Beginning July 1, 2003, an additional and cumulative motor vehicle fuel tax rate of five cents per gallon applies to the sale, distribution, or use of motor vehicle fuel. This subsection (2) expires when the bonds issued for transportation 2003 projects are retired.

((~~(3) Beginning July 1, 2005, an additional and cumulative motor vehicle fuel tax rate of three cents per gallon applies to the sale, distribution, or use of motor vehicle fuel.~~

~~(4) Beginning July 1, 2006, an additional and cumulative motor vehicle fuel tax rate of three cents per gallon applies to the sale, distribution, or use of motor vehicle fuel.~~

~~(5) Beginning July 1, 2007, an additional and cumulative motor vehicle fuel tax rate of two cents per gallon applies to the sale, distribution, or use of motor vehicle fuel.~~

~~(6) Beginning July 1, 2008, an additional and cumulative motor vehicle fuel tax rate of one and one-half cents per gallon applies to the sale, distribution, or use of motor vehicle fuel.~~))

Sec. 3. RCW 46.68.090 and 2005 c ... (ESSB 6103) s 103 are each amended to read as follows:

(1) All moneys that have accrued or may accrue to the motor vehicle fund from the motor vehicle fuel tax and special fuel tax shall be first expended for purposes enumerated in (a) and (b) of this subsection. The remaining net tax amount shall be distributed monthly by the state treasurer in accordance with subsections (2) through (7) of this section.

(a) For payment of refunds of motor vehicle fuel tax and special fuel tax that has been paid and is refundable as provided by law;

(b) For payment of amounts to be expended pursuant to appropriations for the administrative expenses of the offices of state treasurer, state auditor, and the department of licensing of the state of Washington in the administration of the motor vehicle fuel tax and the special fuel tax, which sums shall be distributed monthly.

(2) All of the remaining net tax amount collected under RCW 82.36.025(1) and 82.38.030(1) shall be distributed as set forth in (a) through (j) of this section.

(a) For distribution to the motor vehicle fund an amount equal to 44.387 percent to be expended for highway purposes of the state as defined in RCW 46.68.130;

(b) For distribution to the special category C account, hereby created in the motor vehicle fund, an amount equal to 3.2609 percent to be expended for special category C projects. Special category C projects are category C projects that, due to high cost only, will require bond financing to complete construction.

The following criteria, listed in order of priority, shall be used in determining which special category C projects have the highest priority:

(i) Accident experience;

(ii) Fatal accident experience;

(iii) Capacity to move people and goods safely and at reasonable speeds without undue congestion; and

(iv) Continuity of development of the highway transportation network.

Moneys deposited in the special category C account in the

motor vehicle fund may be used for payment of debt service on bonds the proceeds of which are used to finance special category C projects under this subsection (2) (b);

(c) For distribution to the Puget Sound ferry operations account in the motor vehicle fund an amount equal to 2.3283 percent;

(d) For distribution to the Puget Sound capital construction account in the motor vehicle fund an amount equal to 2.3726 percent;

(e) For distribution to the urban arterial trust account in the motor vehicle fund an amount equal to 7.5597 percent;

(f) For distribution to the transportation improvement account in the motor vehicle fund an amount equal to 5.6739 percent and expended in accordance with RCW 47.26.086;

(g) For distribution to the cities and towns from the motor vehicle fund an amount equal to 10.6961 percent in accordance with RCW 46.68.110;

(h) For distribution to the counties from the motor vehicle fund an amount equal to 19.2287 percent: (i) Out of which there shall be distributed from time to time, as directed by the department of transportation, those sums as may be necessary to carry out the provisions of RCW 47.56.725; and (ii) less any amounts appropriated to the county road administration board to implement the provisions of RCW 47.56.725(4), with the balance of such county share to be distributed monthly as the same accrues for distribution in accordance with RCW 46.68.120;

(i) For distribution to the county arterial preservation account, hereby created in the motor vehicle fund an amount equal to 1.9565 percent. These funds shall be distributed by the county road administration board to counties in proportions corresponding to the number of paved arterial lane miles in the unincorporated area of each county and shall be used for improvements to sustain the structural, safety, and operational integrity of county arterials. The county road administration board shall adopt reasonable rules and develop policies to implement this program and to assure that a pavement management system is used;

(j) For distribution to the rural arterial trust account in the motor vehicle fund an amount equal to 2.5363 percent and expended in accordance with RCW 36.79.020.

(3) The remaining net tax amount collected under RCW 82.36.025(2) and 82.38.030(2) shall be distributed to the transportation 2003 account (nickel account).

(4) The remaining net tax amount collected under RCW ((~~82.36.025(3) and~~)) 82.38.030(3) shall be distributed as follows:

(a) 8.3333 percent shall be distributed to the incorporated cities and towns of the state in accordance with RCW 46.68.110;

(b) 8.3333 percent shall be distributed to counties of the state in accordance with RCW 46.68.120; and

(c) The remainder shall be distributed to the transportation partnership account created in RCW 46.68.— (section 104, chapter ... (ESSB 6103), Laws of 2005).

(5) The remaining net tax amount collected under RCW ((~~82.36.025(4) and~~)) 82.38.030(4) shall be distributed as follows:

(a) 8.3333 percent shall be distributed to the incorporated cities and towns of the state in accordance with RCW 46.68.110;

(b) 8.3333 percent shall be distributed to counties of the state in accordance with RCW 46.68.120; and

(c) The remainder shall be distributed to the transportation partnership account created in RCW 46.68.— (section 104, chapter ... (ESSB 6103), Laws of 2005).

(6) The remaining net tax amount collected under RCW ((~~82.36.025 (5) and (6) and~~)) 82.38.030 (5) and (6) shall be distributed to the transportation partnership account created in RCW 46.68.— (section 104, chapter ... (ESSB 6103), Laws of 2005).

(7) Nothing in this section or in RCW 46.68.130 may be construed so as to violate any terms or conditions contained in any highway construction bond issues now or hereafter authorized by statute and whose payment is by such statute pledged to be paid from any excise taxes on motor vehicle fuel and special fuels.

MISCELLANEOUS

NEW SECTION. **Sec. 4.** The provisions of this act are to be liberally construed to effectuate the intent, policies, and purposes of this act.

NEW SECTION. **Sec. 5.** If any provision of this act or its application to any person or circumstance is held invalid, the remainder of the act or the application of the provision to other persons or circumstances is not affected. If the repeal or reduction of any tax in this act is judicially held to impair any contract in existence as of the effective date of this act, any unused taxing authority shall be repealed as of the effective date of this act and the repeal of pledged revenues shall apply to any other contract, including novation, renewal, or refunding (in the case of bond contract).

NEW SECTION. **Sec. 6.** Part headings used in this act are not part of the law.

Complete Text of

INITIATIVE MEASURE NO. 330

AN ACT Relating to health care liability reform; amending RCW 4.56.250, 7.70.020, 7.70.070, 7.70.100, 4.16.350, 7.70.080, 74.34.200, 4.22.070, and 4.22.015; adding a new section to chapter 4.56 RCW; adding a new section to chapter 7.04 RCW; adding new sections to chapter 7.70 RCW; and creating new sections.

BE IT ENACTED BY THE PEOPLE OF THE STATE OF WASHINGTON:

Sec. 1. RCW 4.56.250 and 1986 c 305 s 301 are each amended to read as follows:

(1) As used in this section, the following terms have the meanings indicated unless the context clearly requires otherwise.

(a) "Economic damages" means objectively verifiable monetary losses, including medical expenses, loss of earnings, burial costs, loss of use of property, cost of replacement or repair, cost of obtaining substitute domestic services, loss of employment, and loss of business or employment opportunities.

(b) "Noneconomic damages" means subjective, nonmonetary losses, including((,)) but not limited to pain, suffering, inconvenience, mental anguish, disability or disfigurement incurred by the injured party, loss of ability to enjoy life, emotional distress, loss of society and companionship, loss of consortium, injury to reputation and humiliation, ((~~and~~)) destruction of the parent-child relationship, and other nonpecuniary damages of any type.

(c) "Bodily injury" means physical injury, sickness, or disease, including death.

(d) "Average annual wage" means the average annual wage in the state of Washington as determined under RCW 50.04.355.

(2) Except as provided in section 2 of this act, in no action seeking damages for personal injury or death may a claimant recover a judgment for noneconomic damages exceeding an amount determined by multiplying 0.43 by the average annual wage and by the life expectancy of the person incurring noneconomic damages, as the life expectancy is determined by the life expectancy tables adopted by the insurance commissioner. For purposes of determining the maximum amount allowable for noneconomic damages, a claimant's life expectancy shall not be less than fifteen years. The limitation contained in this subsection applies to all claims for noneconomic damages made by a claimant who incurred bodily injury. Claims for loss of consortium, loss of society and companionship, destruction of the parent-child relationship, and all other derivative claims asserted by persons who did not sustain bodily injury are to be included within the limitation on claims for noneconomic damages arising from the same bodily injury.

(3) If a case is tried to a jury, the jury shall not be informed of the limitation contained in subsection (2) of this section.

NEW SECTION. **Sec. 2.** A new section is added to chapter 4.56 RCW to read as follows:

(1) In any action or arbitration for damages for injury or death occurring as a result of health care or related services, or the arranging for the provision of health care or related services, whether brought under chapter 7.70 RCW, RCW 4.20.010, 4.20.020, 4.20.046, 4.20.060, 4.24.010, or 48.43.545(1), any other applicable law, or any combination thereof, that is based upon the alleged wrongful acts or omissions of one or more health care professionals, whether or not those health care professionals are named as defendants, the total combined civil liability for noneconomic damages for all health care professionals, all persons, entities, and health care institutions for whose conduct the health care professionals could be held liable, and all persons, entities, and health care institutions that could be held liable for the conduct of any health care professionals, shall not exceed three hundred fifty thousand dollars for each claimant, regardless of the number of health care professionals, health care providers, or health care institutions against whom the claim for injury or death is or could have been asserted or the number of separate causes of action on which the claim is based.

(2) Any and all health care institutions against whom liability is imposed based upon a wrongful act or omission of any health care professional are specifically included within the limitation on liability for noneconomic damages contained in subsection (1) of this section, even if the health care institution also is or could be held liable for a wrongful act or omission of a person other than a health care professional, another health care institution, or a related entity, facility, or institution.

(3) If, in an action or arbitration for injury or death occurring as a result of health care or related services, or the arranging for health care or related services, whether brought under chapter 7.70 RCW, RCW 4.20.010, 4.20.020, 4.20.046, 4.20.060, 4.24.010, or 48.43.545(1), any other applicable law, or any combination thereof, one or more health care institutions are liable for any wrongful acts or omissions of persons other than health care professionals, but are not liable for any alleged wrongful act or omission of any health care professional, the total civil liability for noneconomic damages for each such health care institution, including all persons, entities, and other health care institutions for whose conduct the health care institution could be liable, shall not exceed three hundred fifty thousand dollars for each claimant, and the total combined limit of civil liability for noneconomic damages for all health care institutions, including all persons, entities, and other health care institutions for whose conduct the health care institutions could be held liable, shall not exceed seven hundred thousand dollars for each claimant, regardless of the number of health care institutions, health care professionals, or health care providers against whom the claim for damages for injury or death is or could have been asserted or the number of separate causes of action on which the claim is based.

(4) A claimant shall not be permitted to obtain more than

one recovery of noneconomic damages by splitting his or her claim or cause of action for damages for injury or death occurring as a result of health care or related services, or the arranging for the provision of health care or related services, or by bringing separate actions for such injury or death against more than one health care professional or health care institution. A claimant who has recovered noneconomic damages in one action for damages for injury or death occurring as a result of health care or related services, or the arranging for the provision of health care or related services, shall be precluded from seeking or recovering additional noneconomic damages for the injury or death in any other action.

(5) If the jury's assessment of noneconomic damages exceeds the limitations contained in subsection (1), (2), or (3) of this section, nothing in RCW 4.44.450 precludes the court from entering a judgment that limits the total amount of noneconomic damages to those limits provided in subsections (1), (2), and (3) of this section.

(6) If a case is tried to a jury, the jury shall not be informed of the limitations on noneconomic damages contained in subsections (1), (2), and (3) of this section.

(7) The definitions in this subsection apply throughout this section unless the context clearly requires otherwise.

(a) "Claimant" means a person, including a decedent's estate, seeking or who has sought recovery of damages in an action or arbitration for injury or death occurring as a result of health care or related services, or the arranging for the provision of health care or related services. All persons claiming to have sustained damages as a result of the injury or death of a single person are considered a single claimant, and the limitations on noneconomic damages specified in subsections (1), (2), and (3) of this section shall include all noneconomic damages claimed by or on behalf of the person whose injury or death occurred as a result of health care or related services, or the arranging for the provision of health care or related services, as well as all claims for noneconomic damages asserted by or on behalf of others arising from the same injury or death.

(b) "Economic damages" has the meaning set forth in RCW 4.56.250(1)(a).

(c) "Health care institution" means any entity, whether or not incorporated, facility, or institution that is licensed, registered, or certified by this state to provide health care or related services or to arrange for the provision of health care or related services, including, but not limited to, an ambulatory diagnostic, treatment, or surgical facility, an adult family home, an ambulance, aid, or emergency medical service, a blood bank or blood center, a boarding home, a community health center, a community mental health center, a comprehensive community health center, a disability insurer, a drug and alcohol treatment center, an extended care facility, a group home, a health carrier, a health care service contractor, a health maintenance organization, a home health agency, a hospice, a hospice care center, a hospital, an independent clinical laboratory, an in-home services agency, an intermediate care facility, a kidney disease treatment facility, a long-term care facility, a migrant health center, a nursing home, a pharmacy, a psychiatric hospital, a psychiatric, neuropsychiatric, or mental health facility, a rehabilitation facility, a renal dialysis center, a rural health care facility, a skilled nursing facility, a soldiers or veterans home, a sperm bank, a tissue bank, a tribal clinic, or a visiting nurse service, including any related entity, facility, or institution owned or operated by the health care institution, and any officer, director, employee, agent, or apparent agent of the health care institution or such related entity, facility, or institution, acting in the course and scope of his or her employment or agency, including in the event such officer, director, employee, or agent is deceased, his or her estate or personal representative.

(d) "Health care professional" means:

(i) Any health care provider described in RCW 7.70.020 (1) and (2);

(ii) Any clinic, corporation, limited liability company, partnership, or limited liability partnership comprised of one or more of the health care providers described in RCW 7.70.020(1), and any officer, director, employee, agent, or apparent agent thereof acting within the scope of his or her employment or agency, including in the event such officer, director, employee, agent, or apparent agent is deceased, his or her estate or personal representative; or

(iii) Any entity, facility, or institution that is owned or operated by a health care provider described in RCW 7.70.020(1), or by a clinic, corporation, limited liability company, partnership, or limited liability partnership comprised of one or more of the health care providers described in RCW 7.70.020(1), and any officer, director, employee, agent, or apparent agent thereof acting in the course and scope of his or her employment or agency, including in the event such officer, director, employee, agent, or apparent agent is deceased, his or her estate or personal representative.

(e) "Health care provider" means any person or entity described in RCW 7.70.020.

(f) "Noneconomic damages" has the meaning set forth in RCW 4.56.250(1)(b).

Sec. 3. RCW 7.70.020 and 1995 c 323 s 3 are each amended to read as follows:

As used in this chapter "health care provider" means either:

(1) A person licensed, registered, or certified by this state to provide health care or related services, including, but not limited to, a licensed acupuncturist, a physician, an osteopathic physician, a dentist, a nurse, an optometrist, a podiatric physician and surgeon, a chiropractor, a physical therapist, a psychologist, a pharmacist, an optician, a physician's assistant, a midwife, an osteopathic physician's assistant, an advanced registered nurse practitioner, a drugless healer, a naturopath, a dental hygienist, a denturist, an ocularist, an occupational therapist, a pharmacy assistant, a radiologic technologist, a nursing assistant, a respiratory

care practitioner, a health care assistant, a dietician, a nutritionist, a surgical technologist, a mental health counselor, a marriage and family therapist, a social worker, or a physician's trained mobile intensive care paramedic, including, in the event such person is deceased, his or her estate or personal representative;

(2) An employee or agent of a person described in ((~~part~~)) subsection (1) ((~~above~~)) of this section, acting in the course and scope of his or her employment or agency, including, in the event such employee or agent is deceased, his or her estate or personal representative; or

(3) An entity, whether or not incorporated, facility, or institution employing one or more persons described in ((~~part~~)) subsection (1) ((~~above~~)) of this section, including, but not limited to, a hospital, clinic, health maintenance organization, or nursing home; or an officer, director, employee, or agent thereof acting in the course and scope of his or her employment or agency, including in the event such officer, director, employee, or agent is deceased, his or her estate or personal representative.

Sec. 4. RCW 7.70.070 and 1975-'76 2nd ex.s. c 56 s 12 are each amended to read as follows:

(1) Except as set forth in subsection (2) of this section, the court shall, in any action under this chapter, determine the reasonableness of each party's attorneys' fees. The court shall take into consideration the following:

((~~(1)~~)) (a) The time and labor required, the novelty and difficulty of the questions involved, and the skill requisite to perform the legal service properly;

((~~(2)~~)) (b) The likelihood, if apparent to the client, that the acceptance of the particular employment will preclude other employment by the lawyer;

((~~(3)~~)) (c) The fee customarily charged in the locality for similar legal services;

((~~(4)~~)) (d) The amount involved and the results obtained;

((~~(5)~~)) (e) The time limitations imposed by the client or by the circumstances;

((~~(6)~~)) (f) The nature and length of the professional relationship with the client;

((~~(7)~~)) (g) The experience, reputation, and ability of the lawyer or lawyers performing the services;

((~~(8)~~)) (h) Whether the fee is fixed or contingent.

(2)(a) An attorney may not contract for or collect a contingency fee for representing a person in connection with an action for damages for injury or death occurring as a result of health care or related services, or the arranging for the provision of health care or related services, in excess of the following limits:

(i) Forty percent of the first fifty thousand dollars recovered;

(ii) Thirty-three and one-third percent of the next fifty thousand dollars recovered;

(iii) Twenty-five percent of the next five hundred thousand dollars recovered;

(iv) Fifteen percent of any amount in which the recovery exceeds six hundred thousand dollars.

(b) The limitations in this section apply regardless of whether the recovery is by judgment, settlement, arbitration, mediation, or other form of alternative dispute resolution.

(c) If periodic payments are awarded to the plaintiff, the court shall place a total value on these payments and include this amount in computing the total award from which attorneys' fees are calculated under this subsection.

(d) For purposes of this subsection, "recovered" means the net sum recovered after deducting any disbursements or costs incurred in connection with the arbitration, litigation, or settlement of the claim. Costs of medical care incurred by the plaintiff and the attorney's office overhead costs or charges are not deductible disbursements or costs for such purposes.

(3) Subsection (2) of this section applies to all contingency fee arrangements or agreements, including any modification of the amount of any contingency fee, entered into after the effective date of this section.

Sec. 5. RCW 7.70.100 and 1993 c 492 s 419 are each amended to read as follows:

(1) No action for damages for injury or death occurring as a result of health care or related services, or the arranging for the provision of health care or related services, may be commenced unless the defendant has been given at least ninety days' notice of the intention to commence the action. If the notice is served within ninety days before the expiration of the applicable statute of limitations, the time for the commencement of the action must be extended ninety days from the service of the notice.

(2) The provisions of subsection (1) of this section are not applicable with respect to any defendant whose name is unknown to the plaintiff at the time of filing the complaint and who is identified therein by a fictitious name.

(3) After the filing of the ninety-day presuit notice, and before a superior court trial, all causes of action, whether based in tort, contract, or otherwise, for damages ((~~arising from~~)) for injury or death occurring as a result of health care or related services, or the arranging for the provision of health care or related services, provided after July 1, 1993, shall be subject to mandatory mediation prior to trial.

((~~(2)~~)) (4) The supreme court shall by rule adopt procedures to implement mandatory mediation of actions under this chapter. The rules shall require mandatory mediation without exception and address, at a minimum:

(a) Procedures for the appointment of, and qualifications of, mediators. A mediator shall have experience or expertise related to actions arising from injury occurring as a result of health care, and be a member of the state bar association who has been admitted to the bar for a minimum of five years or who is a retired judge. The parties may stipulate to a nonlawyer mediator. The court may prescribe additional qualifications of mediators;

(b) Appropriate limits on the amount or manner of compensation of mediators;

(c) The number of days following the filing of a claim ((~~under this chapter~~)) within which a mediator must be selected;

(d) The method by which a mediator is selected. The rule shall provide for designation of a mediator by the superior court if the parties are unable to agree upon a mediator;

(e) The number of days following the selection of a mediator within which a mediation conference must be held;

(f) A means by which mediation of an action ((~~under this chapter~~)) may be waived by a mediator who has determined that the claim is not appropriate for mediation; and

(g) Any other matters deemed necessary by the court.

((~~(3)~~)) (5) Mediators shall not impose discovery schedules upon the parties.

(6) The supreme court shall by rule also adopt procedures for the parties to certify to the court the manner of mediation used by the parties to comply with this section.

Sec. 6. RCW 4.16.350 and 1998 c 147 s 1 are each amended to read as follows:

(1) Any civil action or arbitration for damages for injury or death occurring as a result of health care or related services, or the arranging for the provision of health care or related services, which is provided after June 25, 1976, against((~~:~~

~~(1) A person licensed by this state to provide health care or related services, including, but not limited to, a physician, osteopathic physician, dentist, nurse, optometrist, podiatric physician and surgeon, chiropractor, physical therapist, psychologist, pharmacist, optician, physician's assistant, osteopathic physician's assistant, nurse practitioner, or physician's trained mobile intensive care paramedic, including, in the event such person is deceased, his estate or personal representative;~~

~~(2) An employee or agent of a person described in subsection (1) of this section, acting in the course and scope of his employment, including, in the event such employee or agent is deceased, his estate or personal representative; or~~

~~(3) An entity, whether or not incorporated, facility, or institution employing one or more persons described in subsection (1) of this section, including, but not limited to, a hospital, clinic, health maintenance organization, or nursing home; or an officer, director, employee, or agent thereof acting in the course and scope of his employment, including, in the event such officer, director, employee, or agent is deceased, his estate or personal representative;~~)) a health care provider as defined in RCW 7.70.020, or a health care institution as defined in section 2(7)(c) of this act, based upon alleged professional negligence shall be commenced within three years of the act or omission alleged to have caused the injury, death, or condition, or within one year of the time the patient or his or her representative or custodial parent or guardian discovered or reasonably should have discovered that the injury, death, or condition was caused by said act or omission, whichever period ((~~expires later, except that in no event shall an action be commenced more than eight years after said act or omission: PROVIDED, That the time for commencement of an action is tolled upon proof of fraud, intentional concealment, or the presence of a foreign body not intended to have a therapeutic or diagnostic purpose or effect, until the date the patient or the patient's representative has actual knowledge of the act of fraud or concealment, or of the presence of the foreign body; the patient or the patient's representative has one year from the date of the actual knowledge in which to commence a civil action for damages.~~

~~For purposes of this section, notwithstanding RCW 4.16.190, the knowledge of a custodial parent or guardian shall be imputed to a person under the age of eighteen years, and such imputed knowledge shall operate to bar the claim of such minor to the same extent that the claim of an adult would be barred under this section. Any action not commenced in accordance with this section shall be barred.~~

~~For purposes of this section, with respect to care provided after June 25, 1976, and before August 1, 1986, the knowledge of a custodial parent or guardian shall be imputed as of April 29, 1987, to persons under the age of eighteen years~~)) occurs first.

(2) In no event may an action be commenced more than three years after the act or omission alleged to have caused the injury or condition except:

(a) Upon proof of fraud, intentional concealment, or the presence of a foreign body not intended to have a therapeutic or diagnostic purpose or effect, in which case the patient or the patient's representative has one year from the date the patient or the patient's representative or custodial parent or guardian has actual knowledge of the act of fraud or concealment or of the presence of the foreign body within which to commence a civil action for damages.

(b) In the case of a minor, upon proof that the minor's custodial parent or guardian and the defendant or the defendant's insurer have committed fraud or collusion in the failure to bring an action on behalf of the minor, in which case the patient or the patient's representative has one year from the date the patient or the patient's representative other than the custodial parent or guardian who committed the fraud or collusion has actual knowledge of the fraud or collusion, or one year from the date of the minor's eighteenth birthday, whichever provides a longer period.

(c) In the case of a minor under the full age of six years, in which case the action on behalf of the minor must be commenced within three years, or prior to the minor's eighth birthday, whichever provides a longer period.

(3) For purposes of this section, the tolling provisions of RCW 4.16.190 do not apply.

(4) This section does not apply to a civil action based on intentional conduct brought against those individuals or entities specified in this section by a person for recovery of damages for injury occurring as a result of childhood sexual abuse as defined in RCW 4.16.340(5).

(5) This section applies to all causes of action for injury or death occurring as a result of health care or related services, or the arranging for the provision of health care or related services, filed on or after the effective date of this section.

However, any action which, if filed on or after the effective date of this section, would have been timely under former law, but now would be barred under the chapter . . ., Laws of 2005 amendments contained in this section, may be brought within one year following the effective date of this section.

(6) Any action not commenced in accordance with this section is barred.

Sec. 7. RCW 7.70.080 and 1975-'76 2nd ex.s. c 56 s 13 are each amended to read as follows:

(1) Any party may present evidence to the trier of fact that the patient or claimant has already been, or will be, compensated for the injury complained of from ((~~any source except the assets of the patient, his representative, or his immediate family, or insurance purchased with such assets. In the event such evidence is admitted, the plaintiff may present evidence of an obligation to repay such compensation. Insurance bargained for or provided on behalf of an employee shall be considered insurance purchased with the assets of the employee~~)) a collateral source. In the event the evidence is admitted, the other party may present evidence of any amount that was paid or contributed to secure the right to any compensation. Compensation as used in this section shall mean payment of money or other property to or on behalf of the patient or claimant, rendering of services to the patient free of charge to the patient or claimant, or indemnification of expenses incurred by or on behalf of the patient or claimant. Notwithstanding this section, evidence of compensation by a defendant health care provider may be offered only by that provider.

(2) Unless otherwise provided by superseding federal law, there is no right of subrogation or reimbursement from the patient's or claimant's tort recovery with respect to compensation covered in subsection (1) of this section.

NEW SECTION. **Sec. 8.** A new section is added to chapter 7.04 RCW to read as follows:

(1) A contract for health care or related services that contains a provision for arbitration of a dispute as to professional negligence of a health care provider as defined in RCW 7.70.020, whether brought under chapter 7.70 RCW, RCW 4.20.010, 4.20.020, 4.20.046, 4.20.060, or 4.24.010, any other applicable law, or any combination thereof, must have the provision as the first article of the contract and the provision must be expressed in the following language:

"It is understood that any dispute as to medical malpractice that is as to whether any health care or related services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by Washington law, and not by a lawsuit or resort to court process except as Washington law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have such a dispute decided in a court of law before a jury, and instead are accepting the use of arbitration."

(2) Immediately before the signature line provided for the individual contracting for the health care or related services, there must appear the following in at least ten-point bold red type:

"NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE ONE OF THIS CONTRACT."

(3) Once signed, such a contract governs all subsequent open-book account transactions for health care or related services for which the contract was signed until or unless rescinded by written notice within thirty days of signature. Written notice of such rescission may be given by a guardian or other legal representative of the patient if the patient is incapacitated or a minor.

(4) Where the contract is one for health care or related services to a minor, it may not be disaffirmed if signed by the minor's parent or legal guardian.

(5) A contract for the provision of health care or related services that contains a provision for arbitration of a dispute as to professional negligence of a health care provider shall not be deemed a contract of adhesion, or unconscionable, or otherwise improper, where it complies with subsections (1) through (3) of this section.

(6) Subsections (1) through (3) of this section do not apply to any health benefit plan contract offered by an organization regulated under Title 48 RCW that has been negotiated to contain an arbitration agreement with subscribers and enrollees under such a contract.

NEW SECTION. **Sec. 9.** A new section is added to chapter 7.70 RCW to read as follows:

RCW 7.70.100, 7.70.110, 7.70.120, and 7.70.130 do not apply if there is a contract for binding arbitration under section 8 of this act.

NEW SECTION. **Sec. 10.** A new section is added to chapter 7.70 RCW to read as follows:

(1) The definitions in this subsection apply throughout this section unless the context clearly requires otherwise.

(a) "Future damages" includes damages for future health care or related services, care or custody, loss of future earnings, loss of bodily function, or future pain and suffering of the judgment creditor.

(b) "Periodic payments" means the payment of money or delivery of other property to the judgment creditor at regular intervals.

(2) In any action for damages for injury occurring as a result of health care or related services, or for the arranging for the provision of health care or related services, the court shall, at the request of either party, enter a judgment ordering that money damages or its equivalent for future damages of the judgment creditor be paid in whole or in part by periodic

payments rather than by a lump-sum payment if the award equals or exceeds fifty thousand dollars in future damages. In entering a judgment ordering the payment of future damages by periodic payments, the court shall make a specific finding as to the dollar amount of periodic payments which will compensate the judgment creditor for such future damages. As a condition to authorizing periodic payments of future damages, the court shall require the judgment debtor who is not adequately insured to post security adequate to ensure full payment of such damages awarded by the judgment. Upon termination of periodic payments of future damages, the court shall order the return of this security, or so much as remains, to the judgment debtor.

(3)(a) The judgment ordering the payment of future damages by periodic payments must specify the recipient or recipients of the payments, the dollar amount of the payments, the interval between payments, and the number of payments or the period of time over which payments must be made. The payments are only subject to modification in the event of the death of the judgment creditor.

(b) In the event that the court finds that the judgment debtor has exhibited a continuing pattern of failing to make the payments, as specified in (a) of this subsection, the court shall find the judgment debtor in contempt of court and, in addition to the required periodic payments, shall order the judgment debtor to pay the judgment creditor all damages caused by the failure to make such periodic payments, including court costs and attorneys' fees.

(4) In the event of the death of the judgment creditor, the court, upon petition of any party in interest, shall modify the judgment to eliminate future periodic payments of damages awarded for future medical treatment, care or custody, loss of bodily function, or future pain and suffering of the judgment creditor. However, money damages awarded for loss of future earnings may not be reduced or payments terminated by reason of the death of the judgment creditor, but must be paid to persons to whom the judgment creditor owed a duty of support, as provided by law, immediately prior to his or her death. In such cases, the court that rendered the original judgment may, upon petition of any party in interest, modify the judgment to award and apportion the unpaid future damages in accordance with this subsection (4).

(5) Following the occurrence or expiration of all obligations specified in the periodic payment judgment, any obligation of the judgment debtor to make further payments ceases and any security given under subsection (2) of this section reverts to the judgment debtor.

(6) For purposes of this section, the provisions of RCW 4.56.250 do not apply.

(7) It is intended in enacting this section to authorize, in actions for damages for injury occurring as a result of health care or related services, or the arranging for the provision of health care or related services, the entry of judgments that provide for the payment of future damages through periodic payments rather than lump-sum payments. By authorizing periodic payment judgments, it is further intended that the courts will utilize such judgments to provide compensation sufficient to meet the needs of an injured plaintiff and those persons who are dependent on the plaintiff for whatever period is necessary while eliminating the potential windfall from a lump-sum recovery that was intended to provide for the care of an injured plaintiff over an extended period who then dies shortly after the judgment is paid, leaving the balance of the judgment award to persons and purposes for which it was not intended. It is also intended that all elements of the periodic payment program be specified with certainty in the judgment ordering such payments and that the judgment not be subject to modification at some future time that might alter the specifications of the original judgment, except in the event of the death of the judgment creditor.

NEW SECTION. **Sec. 11.** It is intended in enacting sections 12 and 13 of this act that health care providers should remain personally liable for their own negligent or wrongful acts or omissions in connection with the provision of health care services, but that their vicarious liability for the negligent or wrongful acts or omissions of others should be curtailed. To that end, it is intended that *Adamski v. Tacoma General Hospital*, 20 Wn. App. 98, 579 P.2d 970 (1978), and its holding that hospitals may be held liable for a physician's acts or omissions under so-called "apparent agency" or "ostensible agency" theories should be reversed, so that hospitals will not be liable for the act or omission of a health care provider granted hospital privileges unless the health care provider is an actual agent or employee of the hospital. It is further intended that, notwithstanding any generally applicable principle of vicarious liability to the contrary, individual health care professionals will not be liable for the negligent or wrongful acts of others, except those who were acting under their direct supervision and control.

NEW SECTION. **Sec. 12.** A new section is added to chapter 7.70 RCW to read as follows:

A public or private hospital shall be liable for an act or omission of a health care provider granted privileges to provide health care at the hospital only if the health care provider is an actual agent or employee of the hospital and the act or omission of the health care provider occurred while the health care provider was acting within the course and scope of the health care provider's agency or employment with the hospital.

NEW SECTION. **Sec. 13.** A new section is added to chapter 7.70 RCW to read as follows:

A person who is a health care provider under RCW 7.70.020 (1) or (2) shall not be personally liable for any act or omission of any other health care provider who was not the person's actual agent or employee or who was not acting under the person's direct supervision and control at the time of the act or omission.

Sec. 14. RCW 74.34.200 and 1999 c 176 s 15 are each amended to read as follows:

(1) In addition to other remedies available under the law, a vulnerable adult who has been subjected to abandonment, abuse, financial exploitation, or neglect either while residing in a facility or in the case of a person residing at home who receives care from a home health, hospice, or home care agency, or an individual provider, shall have a cause of action for damages on account of his or her injuries, pain and suffering, and loss of property sustained thereby. This action shall be available where the defendant is or was a corporation, trust, unincorporated association, partnership, administrator, employee, agent, officer, partner, or director of a facility, or of a home health, hospice, or home care agency licensed or required to be licensed under chapter 70.127 RCW, as now or subsequently designated, or an individual provider.

(2) It is the intent of the legislature, however, that where there is a dispute about the care or treatment of a vulnerable adult, the parties should use the least formal means available to try to resolve the dispute. Where feasible, parties are encouraged but not mandated to employ direct discussion with the health care provider, use of the long-term care ombudsman or other intermediaries, and, when necessary, recourse through licensing or other regulatory authorities.

(3) In an action brought under this section, a prevailing plaintiff shall be awarded his or her actual damages, together with the costs of the suit((~~, including a reasonable attorney's fee~~)). The term "costs" includes((~~, but is not limited to,~~)) the reasonable fees for a guardian((~~,~~)) and guardian ad litem, ((~~and experts,~~)) if any, that ((~~may be~~)) were necessary to the litigation of a claim brought under this section.

NEW SECTION. **Sec. 15.** In the event that the Washington state supreme court or other court of competent jurisdiction rules or affirms that section 2 of this act is unconstitutional, then the prescribed limitations on noneconomic damages set forth in section 2 of this act take effect upon the ratification of a state constitutional amendment that empowers the legislature to enact limits on the amount of noneconomic damages recoverable in any or all civil causes of action or upon the enactment by the United States congress of a law permitting such limitations on noneconomic damages, whichever occurs first.

Sec. 16. RCW 4.22.070 and 1993 c 496 s 1 are each amended to read as follows:

(1) In all actions involving fault of more than one entity, the trier of fact shall determine the percentage of the total fault which is attributable to every entity which caused the claimant's damages except entities immune from liability to the claimant under Title 51 RCW. The sum of the percentages of the total fault attributed to at-fault entities shall equal one hundred percent. The entities whose fault shall be determined include the claimant or person suffering personal injury or incurring property damage, defendants, third-party defendants, entities ((~~released by~~)) who have entered into a release, covenant not to sue, covenant not to enforce judgment, or similar agreement with the claimant, entities with any other individual defense against the claimant, and entities immune from liability to the claimant, but shall not include those entities immune from liability to the claimant under Title 51 RCW. Judgment shall be entered against each defendant except those entities who have ((~~been released by~~)) entered into a release, covenant not to sue, covenant not to enforce judgment, or similar agreement with the claimant or are immune from liability to the claimant or have prevailed on any other individual defense against the claimant in an amount which represents that party's proportionate share of the claimant's total damages. The liability of each defendant shall be several only and shall not be joint except:

(a) A party shall be responsible for the fault of another person or for payment of the proportionate share of another party where both were acting in concert or when a person was acting as an agent or servant of the party.

(b) If the trier of fact determines that the claimant or party suffering bodily injury or incurring property damages was not at fault, the defendants against whom judgment is entered shall be jointly and severally liable for the sum of their proportionate shares of the ((~~claimants [claimant's]~~)) claimant's total damages.

(2) Notwithstanding the provisions of subsection (1)(a) and (b) of this section, in an action for damages for injury or death occurring as a result of health care or related services, or the arranging for the provision of health care or related services, whether brought under chapter 7.70 RCW, RCW 4.20.010, 4.20.020, 4.20.046, 4.24.010, or 48.43.545(1), any other applicable law, or any combination thereof, the liability of each health care provider, health care professional, and health care institution, as those terms are defined in section 2(7) of this act, shall be several only except that a party shall be responsible for the fault of another person or for payment of the proportionate share of another party where both were acting in concert or when a person was acting as the actual agent or servant of the party or was acting under the party's direct supervision and control.

(3) If a defendant is jointly and severally liable under one of the exceptions listed in subsection((~~s~~)) (1)(a) ((~~or (1)~~)), (b), or (2) of this section, such defendant's rights to contribution against another jointly and severally liable defendant, and the effect of settlement by either such defendant, shall be determined under RCW 4.22.040, 4.22.050, and 4.22.060.

(((~~3~~))) (4) (a) Nothing in this section affects any cause of action relating to hazardous wastes or substances or solid waste disposal sites.

(b) Nothing in this section shall affect a cause of action arising from the tortious interference with contracts or business relations.

(c) Nothing in this section shall affect any cause of action

Complete Text of
INITIATIVE MEASURE NO. 330
(continued)

arising from the manufacture or marketing of a fungible product in a generic form which contains no clearly identifiable shape, color, or marking.

Sec. 17. RCW 4.22.015 and 1981 c 27 s 9 are each amended to read as follows:

"Fault" includes acts or omissions, including misuse of a product, that are in any measure negligent or reckless toward the person or property of the actor or others, or that subject a person to strict tort liability or liability on a product liability claim. The term also includes breach of warranty, unreasonable assumption of risk, and unreasonable failure to avoid an injury or to mitigate damages. Legal requirements of causal relation apply both to fault as the basis for liability and to contributory fault.

A comparison of fault for any purpose under RCW 4.22.005 through ((~~4.22.060~~)) 4.22.070 shall involve consideration of both the nature of the conduct of the parties to the action and the extent of the causal relation between such conduct and the damages.

NEW SECTION. **Sec. 18.** If any provision of this act or its application to any person or circumstance is held invalid, the remainder of the act or the application of the provision to other persons or circumstances is not affected.

NEW SECTION. **Sec. 19.** Sections 1 through 3, 7, 10 through 14, 16, and 17 of this act apply to all causes of action, whether filed or not, that the parties have not settled or in which judgment has not been entered before the effective date of this section.

NEW SECTION. **Sec. 20.** Sections 5, 8, and 9 of this act apply to all causes of action filed on or after the effective date of this section.

Complete Text of
INITIATIVE MEASURE NO. 336

AN ACT Relating to health care quality protection; amending RCW 18.71.015, 7.70.050, 18.71.0195, and 70.02.010; adding a new section to chapter 48.19 RCW; adding a new section to chapter 18.130 RCW; adding a new section to chapter 18.71 RCW; adding new sections to chapter 7.70 RCW; adding a new section to chapter 70.02 RCW; adding a new chapter to Title 48 RCW; creating a new section; and prescribing penalties.

BE IT ENACTED BY THE PEOPLE OF THE STATE OF WASHINGTON:

PART I - Medical Liability Insurance Transparency and Market Options

NEW SECTION. **Sec. 101.** The legislature declares that the business and practice of health care vitally affects the public interest. The legislature finds that increases in rate filings in insurance have widespread impact in the availability and affordability of medical malpractice liability insurance. In some cases, excessive rate increases result in limiting the availability of affordable insurance in markets, which in turn threatens the viability of the services or products that are to be insured. The legislature further finds that there are several contributing causes to the current medical liability problem, and addressing these causes requires reducing medical errors while increasing patient safety and information and reducing the cost of our medical liability system. It is in the public interest to maintain an efficient and expeditious regulatory environment in which to conduct the business of insurance. This interest must be balanced by the equally important public interest in promoting a greater range of medical liability insurance options to increase accessibility and affordability of this insurance and increase transparency when excessive rate filings impact the very health care practices and businesses that are to be insured. Therefore, it is the intent of the legislature to increase consumer access to information regarding medical malpractice liability and insurance and to reduce costs by increasing patient safety and information.

NEW SECTION. **Sec. 102.** (1) The insurance commissioner shall notify the public of any rate filing by an insurer for a rate change affecting medical malpractice that is less than fifteen percent of the then applicable rate. The filing is approved forty-five days after public notice unless:

(a) A consumer or his or her representative requests a hearing within thirty days of public notice and the commissioner grants the hearing;

(b) The commissioner on his or her own motion determines to hold a hearing; or

(c) The commissioner disapproves the filing.

(2) If the rate filing increase is fifteen percent or greater,

the commissioner shall order a public hearing. Any person shall have the right to intervene and participate as a party or have the right to comment at the public hearing.

(3) If rate hearings are commenced under subsection (1) or (2) of this section, the applicant may not use the rates until the commissioner approves the filing, either as originally submitted or as amended, after the public hearing and consistent with the requirements of this section.

(4) If a judicial proceeding directly involving the rate filing and initiated by the insurer or an intervener begins, the commissioner has thirty days after conclusion of the judicial proceedings to approve or disapprove the rate filing. The commissioner may disapprove an application without a hearing if a stay is in effect barring the commissioner from holding a hearing.

(5) Upon a final determination of a disapproval or amendment of a rate filing under this section, the insurer must issue an endorsement changing the rate to comply with the commissioner's disapproval. The endorsement is effective on the date the rate is no longer effective.

(6) The public notice required under subsections (1) and (2) of this section must be made via distribution to the news media, posting on the web site maintained by the commissioner, and by mail to any member of the public who requests placement on a mailing list maintained by the commissioner for this purpose.

(7) All medical malpractice insurance rate filings and related material submitted to the commissioner by the insurer under this section are available for public inspection pursuant to the public disclosure act, chapter 42.17 RCW.

(8) Hearings and other administrative proceedings arising under this section must be conducted under chapter 34.05 RCW.

NEW SECTION. **Sec. 103.** A new section is added to chapter 48.19 RCW to read as follows:

(1) With respect to administrative or legal proceedings authorized by or arising under section 102 of this act, any person may:

(a) Initiate or intervene as a party, or comment in writing or in person at any public hearing on the proceedings; or

(b) Challenge any action of the insurance commissioner.

(2) The commissioner or a court shall award reasonable advocacy and witness fees and expenses to any person who demonstrates that:

(a) The person represents the interests of consumers; and

(b) The person made a substantial contribution to the adoption of any order, rule, or decision by the commissioner or a court.

(3) When an award of fees or expenses under this section occurs in a proceeding related to a rate application, the award must be paid by the applicant.

NEW SECTION. **Sec. 104.** The definitions in this section apply throughout this chapter unless the context requires otherwise.

(1) "Board" means the board of governors created under section 107 of this act.

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

(a) Two or more claims arising out of a single injury or incident of medical malpractice is one claim.

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

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

(4) "Commissioner" means the insurance commissioner.

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

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

(7) "Health care provider" or "provider" means a health care provider as defined in RCW 48.43.005.

(8) "Insuring entity" means:

(a) An insurer;

(b) A joint underwriting association;

(c) A risk retention group; or

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

(9) "Intervener" means any person, including every individual, firm, company, corporation, association, or organization, engaging in the activities described in section 103 of this act.

(10) "Medical malpractice" means a negligent act, error, or omission in providing or failing to provide professional health care services, subject to chapter 7.70 RCW.

(11) "Program" means the supplemental malpractice insurance program created under section 105 of this act.

(12) "Retained limit" means the dollar amount of loss retained by a facility or provider. A provider or facility may finance claim payments that fall within a retained limit by self-insuring or buying insurance from an insuring entity. Under this chapter, the amount of a retained limit means:

(a) If the facility or provider bought insurance from an insuring entity, the higher of:

(i) The retained limits required under section 116 of this act; or

(ii) Alternative higher limits of underlying coverage purchased by the facility or provider; or

(b) If a provider or facility self-insured medical malpractice claims, the higher of:

(i) The retained limits required under section 116 of this act; or

(ii) Alternative higher retained limits selected by a facility or provider as part of its risk financing program.

(13) "Tail coverage" means extended reporting period coverage.

(14) "Underlying insurance" means any liability insurance policy that provides primary or excess liability insurance

coverage for medical malpractice claims.

NEW SECTION. **Sec. 105.** (1) A supplemental malpractice insurance program is created to provide an excess layer of liability coverage for medical malpractice claims. Subject to subsection (2) of this section, the program will pay claims and related defense costs on behalf of a covered health care facility or provider if the claim is first made against the facility or provider:

(a) After 12:01 a.m. on January 1, 2006; or

(b) The effective date of coverage under the program, if later than 12:01 a.m. on January 1, 2006.

(2) The program will not pay claims:

(a) That the board excludes from coverage when it establishes coverage specifications under section 108(1)(b) of this act;

(b) That fall within the applicable retained limits, subject to subsection (3) of this section;

(c) That exceed the limits of liability coverage purchased by the facility or provider as described in section 116 of this act;

(d) That result from a provider or employee operating a motor vehicle;

(e) That result from a crime, as defined in RCW 7.69.020(1), that is subject to a finding of intent. This exclusion applies whether or not the criminal conduct is the basis for a medical malpractice claim;

(f) Made against an employee of a covered provider or facility if the employee:

(i) Acts outside the scope of his or her employment; or

(ii) Provides health care services without the collaboration, direction, or supervision of a covered provider; or

(g) Made against a partnership or professional corporation organized by health care providers, if the board determines that it is not the primary purpose of the partnership or corporation to provide the health care services. For the purposes of this subsection, if fifty percent or more of the partners, owners, or shareholders are health care providers, the board must determine that it is the entity's primary purpose to provide health care services.

(3) If an aggregate limit of underlying insurance purchased from an insuring entity is exhausted due to claim payments, the program will pay claims that fall within the retained limit. This subsection does not:

(a) Increase the limits of liability provided by the program; or

(b) Apply to self-insurers qualified under section 114 of this act.

(4) The obligation of the program to pay related defense costs under subsection (1) of this section ends when the program pays the applicable limit of liability purchased by the facility or provider.

(5)(a) To obtain coverage under the program for a medical malpractice claim, a facility or provider must provide documentation to the program of the insurance or self-insurance program in effect at the time the incident occurred and meet the other requirements of this chapter.

(b) All medical malpractice liability insurance purchased by a facility or provider that is applicable to a claim covered by the program must be paid before the program will provide coverage, even if the insurance limits exceed the retained limits.

NEW SECTION. **Sec. 106.** (1) The program has the general corporate powers and authority granted under the laws of Washington state.

(2) The program is not an insurer as defined in RCW 48.01.050, and is exempt from filing:

(a) Forms under RCW 48.18.100 and 48.18.103; and

(b) Rates, except as provided under section 122 of this act.

(3) The program is a separate and distinct legal entity. Liability or a cause of action may not arise against the following for any acts or omissions made in good faith while performing their duties under this chapter:

(a) The program or any member of the board;

(b) The commissioner, any of the commissioner's staff, or any authorized representative of the commissioner;

(c) The secretary of the department of health, any of the department's staff, or any authorized representative of the secretary;

(d) Any person or entity, its agents, or employees reporting data required by sections 125 through 127 of this act.

(4) The program is not a state agency.

(a) The state is not liable for any debts or obligations of the program.

(b) The legislature may appropriate money at its discretion for deposit into the program.

(5) The program is exempt from payment of all fees and all taxes levied by this state or any of its subdivisions, except taxes levied on real or personal property.

(6) The program is not a member of the Washington insurance guaranty association under chapter 48.32 RCW. The Washington insurance guaranty association, Washington state, and any political subdivisions of this state are not responsible for losses sustained by the program.

NEW SECTION. **Sec. 107.** A board of governors will oversee the operations of the program. The management and operations of the program are subject to the supervision and approval of the board.

(1) The commissioner and associations must appoint representatives to the board within thirty days:

(a) After the effective date of this act; or

(b) A vacancy occurs on the board.

(2) The board must comprise:

(a) The commissioner or a designated representative employed by the office of the insurance commissioner, who will serve as chairperson of the board;

(b) Three members of the public appointed by the

commissioner for staggered three-year terms;

(c) A person with relevant insurance or risk management experience appointed by the commissioner for a three-year term;

(d) A person selected by the Washington state medical association; and

(e) A person selected by the Washington state hospital association.

(3) The program may reimburse board members for their actual expenses to attend meetings, subject to per diem rates and rules established by the office of financial management.

(4) The program must reimburse the commissioner for any staff services provided at the request of the board or the program.

NEW SECTION. **Sec. 108.** (1) The board must adopt a program plan of operation within sixty days after the members are appointed. The plan of operation must include:

(a) A schedule for meetings;

(b) Specifications for program coverage provisions, including but not limited to:

(i) Types of claims that the program will not cover;

(ii) Limits of coverage available from the program;

(iii) Eligibility criteria for providers and facilities that want to buy excess medical malpractice coverage from the program;

(iv) Circumstances under which a retroactive date will be applied for injuries that occurred before 12:01 a.m. on January 1, 2006; and

(v) Rules the program will follow when it provides tail coverage;

(c) Rules requiring a specific duration of tail coverage that must be offered by insuring entities and self-insurers who provide proof of financial responsibility under section 114 of this act;

(d) Criteria under which the program may purchase reinsurance;

(e) A process that health care facilities and providers must follow to buy coverage from the program;

(f) A process for billing and collecting annual premiums from facilities and providers who buy coverage from the program; and

(g) Any other administrative activities or procedures needed to establish and operate the program.

(2) The plan of operation is subject to approval by the commissioner before it takes effect.

(3) The board may amend the plan of operation as needed. All amendments are subject to approval by the commissioner before they take effect.

NEW SECTION. **Sec. 109.** (1) The board must appoint an administrator to manage the program.

(2) The administrator may:

(a) Hire staff to operate the program; or

(b) Contract for all or part of the services needed to operate the program.

(3) At least annually, each contractor must report to the board. The report must provide information on all expenses incurred and all subcontracting arrangements.

(4) The program must pay for all administrative and contracted services, subject to review and approval of the board.

NEW SECTION. **Sec. 110.** (1) The program must charge an annual premium to health care facilities and providers who decide to buy excess medical malpractice liability coverage from the program. The program must use this money to pay claims, administrative costs, and other expenses of the program.

(2) In addition to authority granted under subsection (1) of this section, the program may increase its surplus by issuing a capital call. A capital call requires facilities and providers to pay a sum, in addition to the annual premium, to be eligible to buy or renew coverage from the program. If a facility or provider does not pay the amount of a call, the program may not cancel coverage or deny benefits of existing coverage that are in effect at the time of the capital call. Before issuing a capital call, the program must:

(a) Notify the commissioner at least ninety days before the capital call. This notice must state the:

(i) Specific purpose or purposes of the capital call and the amount of money the program has budgeted for each stated purpose;

(ii) Total amount of money the program intends to raise by issuing the capital call;

(iii) Analytical and factual basis used by the program to determine a capital call is the best option available to the program for raising capital; and

(iv) Alternative method or methods of raising capital the program considered and the reasons the program rejected each alternative in favor of the capital call;

(b) Provide any additional information that the commissioner determines is useful or necessary in evaluating the merits of the proposed capital call; and

(c) Receive approval of the commissioner for the capital call. The commissioner may disapprove a capital call if he or she does not believe it is in the best interest of the program, its participating facilities and providers, or the citizens of the state of Washington. In making this determination, the commissioner may consider:

(i) The financial health of the program and the impact on the medical malpractice marketplace;

(ii) The possible use of other means to raise capital;

(iii) The frequency of previous capital calls by the program;

(iv) The effect of raising premiums instead of a capital call;

(v) The impact on state revenue; and

(vi) Any other factor the commissioner decides is relevant.

(3) All money collected by the program belongs to the program.

(4) The state investment board must:

(a) Manage the assets of the program;

(b) Invest program assets in a manner consistent with chapter 48.13 RCW; and

(c) Charge the program reasonable fees for services provided under this section.

NEW SECTION. **Sec. 111.** (1) The program must file an annual statement with the commissioner by March 1st of each year. The statement must contain information about the program's transactions, financial condition, and operations during the past calendar year. The commissioner may establish rules for the form and content of this statement. The statement must:

(a) Be in the form and according to instructions adopted by the national association of insurance commissioners for property and casualty insurers; and

(b) Include any additional information requested by the commissioner.

(2) The program must maintain its records according to the accounting practices and procedures manual adopted by the national association of insurance commissioners.

(3) The program must provide the commissioner with free access to all the books, records, files, papers, and documents that relate to the operation of the program. The commissioner may call, qualify, and examine all persons having knowledge of the program's operations.

(4) The commissioner may enter and examine the operation and experience of the program at any time.

(a) The commissioner must examine the transactions, financial condition, and operations of the program at least once every three years.

(b) The commissioner must conduct each examination using the procedures prescribed for insurance companies in chapter 48.03 RCW. The program must reimburse the commissioner for the cost of each examination.

NEW SECTION. **Sec. 112.** (1) A health care facility is eligible to buy coverage from the program if the facility is located in Washington state and:

(a) Is licensed by Washington state; or

(b) Ends business operations after January 1, 2006, and needs to buy tail coverage. The facility must maintain financial responsibility as required under section 114 of this act to buy tail coverage.

(2) A health care provider is eligible to buy coverage from the program if:

(a) The provider is licensed by and maintains a principal place of practice in Washington state;

(b) The provider's principal place of practice is Idaho or Oregon and:

(i) The provider is a resident of Washington state;

(ii) The provider is licensed in Washington state; and

(iii) The provider performs procedures in an Idaho or Oregon facility. In this subsection, "Idaho or Oregon facility" means a facility located in Idaho or Oregon that is an affiliate of a corporation organized under the laws of Washington state and maintains:

(A) Its principal office in Washington state; and

(B) A facility in Washington state that is covered by the program;

(c) The provider retires or ceases business operations after January 1, 2006, and needs to buy tail coverage. The provider must maintain financial responsibility as required under section 114 of this act to buy tail coverage; or

(d) The provider meets the description in section 113(2) of this act, but practices his or her profession outside the scope of the exclusion. Coverage under the program applies only to claims arising out of the practice of medicine that is outside the scope of the exclusion in section 113(2) of this act.

NEW SECTION. **Sec. 113.** A health care facility or provider is not eligible for coverage under the program if:

(1) The facility or provider:

(a) Has not provided proof of financial responsibility to the program as required by section 114 of this act; or

(b) Does not meet the criteria established by the board to be eligible for coverage by the program. Any facility or provider denied coverage by the program may appeal the decision to the board;

(2) The provider is a federal employee or contractor covered under the federal tort claims act and is acting within the scope of his or her employment or contractual duties; or

(3) The health care facility is operated by state or federal government.

NEW SECTION. **Sec. 114.** To obtain coverage from the program, each eligible health care facility or provider must provide the program with proof of financial responsibility to pay medical malpractice claims that fall within the retained limits. Financial responsibility must include the facility or provider and all officers, agents, and employees while acting in the course and scope of their employment with the facility or provider. A facility or provider may establish proof of financial responsibility by:

(1) Qualifying as a self-insurer under criteria established by the board that will result in financial responsibility equivalent to the retained limits established in section 116 of this act; or

(2) Buying medical malpractice insurance in amounts equal to the retained limits listed in section 116 of this act from an insuring entity accepted by the program.

NEW SECTION. **Sec. 115.** (1) Each insuring entity or self-insurer that provides medical malpractice insurance to health care facilities or providers in Washington state must offer limits of coverage equal to those specified under section 116 of this act.

(2) Each insuring entity or self-insurer that provides certification under section 116(1) of this act:

(a) Must provide medical malpractice tail coverage that meets the criteria established by the board under section 108(1)(c) of this act;

(b) May not cancel or nonrenew coverage unless the facility or provider is given written notice of:

(i) Fifteen days if coverage is canceled for nonpayment of premiums; or

(ii) Ninety days if coverage is canceled or nonrenewed for any reason other than nonpayment of premiums;

(c) Must provide the program with the same notice as required under (b) of this subsection; and

(d) Must keep a copy of each notice issued under (c) of this subsection for at least ten years from the date of mailing or delivery.

NEW SECTION. **Sec. 116.** (1) If a health care facility or provider buys insurance to establish proof of financial responsibility, the insuring entity that provides underlying coverage must certify in writing to the program that the facility or provider has medical malpractice coverage with limits of liability as specified in this section. The limits set forth in this section apply to any joint liability of a provider and his or her corporation or partnership.

(2) The minimum retained limits of liability are:

(a) For health care providers:

(i) Two hundred fifty thousand dollars per claim; and

(ii) Annual aggregate limits of seven hundred fifty thousand dollars;

(b) For facilities with fewer than twenty-five employees that do not provide surgical services:

(i) Two hundred fifty thousand dollars per claim; and

(ii) Annual aggregate limits of one million two hundred fifty thousand dollars;

(c)(i) For hospitals with a capacity of less than one hundred beds:

(A) Five hundred thousand dollars per claim; and

(B) Annual aggregate limits of five million dollars;

(ii) For hospitals with a capacity of one hundred or more beds:

(A) Five hundred thousand dollars per claim; and

(B) Annual aggregate limits of eight million dollars;

(d)(i) For health maintenance organizations that do not provide hospital services:

(A) Five hundred thousand dollars per claim; and

(B) Annual aggregate limits of five million dollars;

(ii) For health maintenance organizations that provide hospital services:

(A) Five hundred thousand dollars per claim; and

(B) Annual aggregate limits of eight million dollars; and

(e) For all other types of health care facilities:

(i) Five hundred thousand dollars per claim; and

(ii) Annual aggregate limits of three million dollars.

(3) The program must establish alternative rates for facilities or providers who elect to maintain higher retained limits.

(4)(a) Retained limits of liability apply only to claim payments. Each insuring entity and self-insurer that provides certification under subsection (1) of this section must pay defense costs as supplementary payments.

(b) If a medical malpractice claim is large enough that the program must make claim payments, the insuring entity or self-insurer and the program will share defense costs on a pro rata basis based on the total amount of claim payments.

NEW SECTION. **Sec. 117.** Subject to the terms, conditions, and exclusions of its contract with a facility or provider, an insuring entity or self-insurer that provides certification under section 116(1) of this act agrees to pay the following costs:

(1) Attorney fees and other costs incurred in the settlement or defense of any claims; and

(2) Any settlement, arbitration award, or judgment imposed against a facility or provider under this chapter up to the retained limits or the limits of all available underlying insurance.

NEW SECTION. **Sec. 118.** (1) Subject to exclusions established by the board, the limitations established in section 105 of this act, and the retained limits agreed to by the facility or provider, the program will pay all sums a covered facility or provider is legally obligated to pay as damages up to the limits of liability purchased from the program.

(2) The coverage limits under this subsection are excess of the retained limits.

(a) The basic limits of excess liability coverage under the program for a health care provider, including providers who provide services in a partnership or as part of a professional corporation, are:

(i) One million dollars per claim; and

(ii) An annual aggregate limit of three million dollars.

(b) The basic limits of excess liability coverage for a health care facility are:

(i) Two million dollars per claim; and

(ii) An annual aggregate limit of six million dollars.

(3) In addition to the basic limits described in subsection (2) of this section, the program must offer higher limits of coverage to those providers and facilities that are willing to pay additional premiums. The board will determine the limits of liability available through the program based on the limits available in the voluntary medical malpractice insurance market.

(4) Program coverage is always excess to the retained limits provided by the facility or provider.

NEW SECTION. **Sec. 119.** From January 1, 2006, through December 31, 2006, the annual program premium billed to each participating facility or provider will be determined by the commissioner based on:

(1) An analysis of rates and rating plans used by medical malpractice insurers;

(2) Claims experience for medical malpractice insurance; and

(3) Any other factors the commissioner determines are relevant.

NEW SECTION. **Sec. 120.** Beginning January 1, 2007,

program premiums charged to facilities and providers must be based on the rates and rating plans adopted by the board and accepted by the commissioner under section 122 of this act.

(1) The board must contract with an actuary experienced in developing medical malpractice rates and rating plans to develop annual funding estimates.

(2) By July 1st of each year, the actuary must submit to the board the classifications, rates, and rating plan the program will use to determine premiums for the next calendar year. The rates and rating plan must consider:

(a) Past and prospective loss experience in Washington state for experience periods acceptable to the commissioner. If data from Washington state are not available or are not statistically credible, the program may use loss experience from those states that are likely to produce loss experience similar to that in Washington state;

(b) Past and prospective operating expenses;

(c) Past and prospective investment income;

(d) A contingency factor to protect the program from adverse loss development; and

(e) All other relevant factors within and outside Washington state.

(3) The classifications, rates, and rating plan used to develop premiums for individual facilities and providers must consider:

(a) Past and prospective loss and expense experience for different types of medical care offered by participating facilities or providers, including:

(i) The amount of surgery performed by a facility or provider; and

(ii) The risk of diagnostic and therapeutic services provided or procedures performed;

(b) The bed capacity and occupancy rates in a health care facility;

(c) Differences in financial risk, if any, to the program if a facility or provider is self-insured;

(d) The risk factors for providers who are semiretired or part-time professionals;

(e) If a health care provider is a partnership or professional corporation, the risk factors and past and prospective loss and expense experience of the partners and employees of that provider;

(f) If a provider's principal place of practice is Oregon or Idaho, any differences in risk or expense to reflect the fact the provider's practice is not located in Washington state;

(g) Higher retained limits selected by a facility or provider; and

(h) Higher limits of liability coverage purchased from the program by a facility or provider.

NEW SECTION. **Sec. 121.** The rating plan used by the program must include experience and schedule rating plans. The program must apply these plans equitably to all facilities and providers.

(1) The experience rating plan:

(a) Must consider the past loss and loss adjustment expense experience of a facility or an individual provider;

(b) May consider paid medical malpractice claims if the claims result from negligence on the part of:

(i) A facility;

(ii) A health care provider; or

(iii) An employee of a facility or health care provider; and

(c) May consider medical malpractice claims:

(i) Paid on behalf of a facility or provider by the program, an insuring entity, or a self-insurer; and

(ii) Paid on behalf of a facility or provider before or after the program is established.

(2) The schedule rating plan must consider the effect of:

(a) Risk management programs based on evidence-based practices that improve patient safety. Practices that have been identified and recommended by governmental and private organizations, including:

(i) The federal agency for health quality and research;

(ii) The federal institute of medicine;

(iii) The joint commission on accreditation of health care organizations;

(iv) The national quality forum; or

(v) Any other evidence-based program accepted by the board; and

(b) Other objective criteria approved by the board that is expected to reduce either losses or expenses incurred by the program.

NEW SECTION. **Sec. 122.** (1) Before the rates and rating plans described in sections 120 and 121 of this act become effective, the commissioner's staff must independently evaluate the rates and rating plan and agree that:

(a) The rates and rating plan will result in premiums that are not excessive, inadequate, or unfairly discriminatory; and

(b) The annual funding estimate is actuarially sound.

(2) The program may collect the premiums that are in effect for the previous year if the classifications, rates, and rating plan have not been approved by the board and the commissioner by September 30th. If new classifications, rates, and a rating plan are later approved, the program must collect or refund the balance of the premium from the provider or facility.

(a) To collect or refund the premium, the program may adjust any outstanding semiannual or quarterly installment payments, if applicable.

(b) To save administrative expenses, the program may decide not to collect, refund, or adjust for nominal amounts of premium.

NEW SECTION. **Sec. 123.** Each facility or provider must pay an annual premium to buy excess medical malpractice coverage from the program.

(1) Facilities or providers may pay program premiums annually, or in semiannual or quarterly installments. Semiannual and quarterly installments must include the prorated premium and a fee that covers unearned interest

or investment income and administrative costs incurred because the facility or provider has decided to pay premium in installments.

(2) A facility or provider must pay premiums to their selected insuring entity within thirty days of the billing date. If the insuring entity does not receive the premium due within thirty days, coverage under the program ends at 12:01 a.m. on the thirty-first day. The program and the insuring entity are not required to provide additional notice of cancellation for nonpayment of premium.

(3) An insuring entity must bill and collect program premiums the same way it collects premiums for underlying insurance or coverage within the retained limit. The insuring entity must pay premium to the program within twenty days after receipt from a facility or provider.

(4) If the insuring entity does not pay premium to the program on time:

(a) The commissioner may suspend the certificate of authority, charter, or license of the insuring entity until the premium is paid;

(b) The insuring entity or surplus lines producer responsible for the delinquency is liable for the premium due plus a penalty equal to ten percent of the amount of the overdue premium.

(5) A self-insurer must pay premium to the program within thirty days after the program sends the self-insurer a premium bill. If the program does not receive the premium due within thirty days, coverage under the program ends at 12:01 a.m. on the thirty-first day. The program is not required to provide additional notice of cancellation for nonpayment of premium.

NEW SECTION. **Sec. 124.** (1)(a) To encourage prompt payment of claims and control defense costs, a facility or provider may not reject any settlement agreed upon between a claimant and:

(i) The program; or

(ii) An insuring entity or self-insurer that provides certification under section 116 of this act.

(b) If a facility or provider feels a claim paid under (a) of this subsection was without merit and the payment results in a higher premium charge through application of the experience rating plan, the provider or facility may appeal to the board for reconsideration of the premium increase. In evaluating the appeal, the board must consider:

(i) The merits of the claim and the likelihood the program would prevail at trial;

(ii) Actual claim payments and defense costs incurred by the program;

(iii) The estimated cost of defense for a particular claim; and

(iv) The likelihood further negotiation or litigation would result in lower payments for claim and defense costs by the program.

(2) A provider or facility, the program, an insuring entity, or a self-insurer that provides medical malpractice coverage may voluntarily make payments for medical expenses prior to any determination of fault. These payments:

(a) Are not an admission of fault;

(b) Are not admissible as evidence of fault in a formal or informal legal proceeding;

(c) Will be deducted from any judgment, settlement, or arbitration award; and

(d) Will not be repaid by the claimant regardless of the amount of judgment, settlement, or award.

(3) Subsection (2) of this section does not restrict a right of contribution or indemnity under the laws of Washington state.

NEW SECTION. **Sec. 125.** (1) Each insuring entity or self-insurer that provides medical malpractice coverage to a facility or provider covered by the program must notify the program if it establishes a loss reserve for a claim that exceeds one hundred twenty-five thousand dollars.

(2) Each facility or provider that is self-insured must notify the program if a claim is made that exceeds one hundred twenty-five thousand dollars.

(3) Notices required under subsections (1) and (2) of this section must be sent by certified mail to the program within ten working days after the date:

(a) The loss reserve is established; or

(b) The facility or provider is notified of the claim.

(4) Notices and all related communications and correspondence provided under this section are confidential and are not available to any person or any public or private agency.

(5) The program may elect to participate in the defense of a facility or provider. If the program has the right but not the duty to defend and decides to participate in the defense the program will:

(a) Pay its expenses; and

(b) Not contribute to the expenses of the facility, provider, insuring entity, or self-insurer until the applicable retained limit has been paid.

NEW SECTION. **Sec. 126.** (1) Beginning on March 1, 2006, every insuring entity or self-insurer that provides medical malpractice insurance to any facility or provider in Washington state must report to the commissioner by the 1st of each month any claim related to medical malpractice, if the claim resulted in a final:

(a) Judgment in any amount;

(b) Settlement in any amount; or

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

(2) If a claim is not reported by an entity listed in subsection (1) of this section, the facility or provider must report the claim to the commissioner.

(a) Reports under this subsection must be filed with the commissioner within thirty days after the claim is resolved.

(b) If a facility or provider violates the requirements of this subsection, the facility or provider license is subject to a fine or disciplinary action by the department.

(3) The reporting requirements under this section apply to

all:

(a) Insuring entities and self-insurers; and

(b) Providers and facilities, regardless of whether they buy coverage from the program.

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

(5) The commissioner will provide the department with electronic access to all information received under this section related to licensed facilities and providers.

NEW SECTION. **Sec. 127.** The reports required under section 126 of this act must contain the following data in a form prescribed by the commissioner:

(1) The health care provider's name, address, provider professional license number, and type of medical specialty for which the provider is insured;

(2) The provider or facility policy number or numbers;

(3) The name of the facility, if any, and the location within the facility where the injury occurred;

(4) The date of the loss;

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

(6) The name and address of the claimant. This claimant information is confidential and exempt from public disclosure, but may be disclosed:

(a) Publicly, if the claimant provides written consent;

(b) To the department at any time; or

(c) To the commissioner at any time for purpose of identifying multiple or duplicate claims arising out of the same occurrence;

(7) The date of suit, if filed;

(8) The claimant's age and sex;

(9) The names and professional license numbers if applicable of all defendants involved in the claim;

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

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

(b) Whether the settlement:

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

(ii) Occurred before or after trial;

(c)(i) The loss adjustment expense paid to defense counsel; and

(ii) All other paid allocated loss adjustment expenses;

(d) If there is no judgment or settlement:

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

(ii) The date the claim was closed; and

(e) Any other information required by the commissioner;

(11) A summary of the occurrence that created the claim, which must include:

(a) The final diagnosis for which the patient sought or received treatment, including the actual condition of the patient;

(b) A description of any misdiagnosis made by the provider of the actual condition of the patient;

(c) The operation, diagnostic, or treatment procedure that caused the injury;

(d) A description of the principal injury that led to the claim; and

(e) The safety management steps the facility or provider has taken to make similar occurrences or injuries less likely in the future; and

(12) Any other information required by the commissioner, by rule, that helps the commissioner or department analyze and evaluate the nature, causes, location, cost, and damages involved in medical malpractice cases.

NEW SECTION. **Sec. 128.** The commissioner must prepare aggregate statistical summaries of closed claims based on calendar year data submitted under section 126 of this act.

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

(2) The summaries must be available by March 31st of each year.

NEW SECTION. **Sec. 129.** Beginning in 2007, the commissioner must prepare an annual report by June 30th that summarizes and analyzes the closed claim reports for medical malpractice filed under section 126 of this act and the annual financial reports filed by insurers writing medical malpractice insurance in this state. The report must include:

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

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

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

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

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

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

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

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

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

(4) A summary of the rate filings for medical malpractice that have been approved by the commissioner for the prior

calendar year, including an analysis of the trend of direct and incurred losses as compared to prior years;

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

(6) The commissioner may adopt rules that require persons and entities required to report under section 126 of this act to report data related to:

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

(b) The amounts reserved for incurred claims;

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

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

(e) Any additional information requested by the department or the board.

NEW SECTION. **Sec. 130.** The commissioner may adopt all rules needed to implement this chapter.

NEW SECTION. **Sec. 131.** Sections 101, 102, and 104 through 130 of this act constitute a new chapter in Title 48 RCW.

NEW SECTION. **Sec. 132.** A new section is added to chapter 18.130 RCW to read as follows:

(1) As used in this section:

(a) "Claim" has the same meaning as in section 104(2) of this act.

(b) "Health care professional" means a person engaged in a profession listed in RCW 18.130.040.

(c) "Supplemental malpractice insurance program" has the same meaning as in section 104(11) of this act.

(2) The department must provide the program with any available information needed to set premiums, including data on hospital bed capacity and occupancy rates.

(3) The department must thoroughly investigate a health care professional if:

(a) A health care professional has three claims paid within the most recent five-year period; and

(b) The total indemnity payment for each claim was fifty thousand dollars or more.

(4) The department may adopt any rules needed to implement this section.

NEW SECTION. **Sec. 133.** The legislature may appropriate for the biennium ending June 30, 2007, any sum of money it deems necessary to the department of health to:

(1) Provide capital and surplus to the supplemental malpractice insurance program; and

(2) Pay administrative expenses incurred to establish the supplemental malpractice insurance program.

PART II - Patient Safety and Patient Right to Know

Sec. 201. RCW 18.71.015 and 1999 c 366 s 4 are each amended to read as follows:

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

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

Each member of the commission must be a citizen of the United States, must be an actual resident of this state, and, if a physician, must have been licensed to practice medicine in this state for at least five years.

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

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

Each member of the commission shall be compensated in accordance with RCW 43.03.265 and in addition thereto shall be reimbursed for travel expenses incurred in carrying out

the duties of the commission in accordance with RCW 43.03.050 and 43.03.060. Any such expenses shall be paid from funds appropriated to the department of health.

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

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

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

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

Sec. 202. RCW 7.70.050 and 1975-'76 2nd ex.s. c 56 s 10 are each amended to read as follows:

(1) The following shall be necessary elements of proof that injury resulted from health care in a civil negligence case or arbitration involving the issue of the alleged breach of the duty to secure an informed consent by a patient or his or her representatives against a health care provider:

(a) That the health care provider failed to inform the patient of a material fact or facts relating to the treatment;

(b) That the patient consented to the treatment without being aware of or fully informed of such material fact or facts;

(c) That a reasonably prudent patient under similar circumstances would not have consented to the treatment if informed of such material fact or facts;

(d) That the treatment in question proximately caused injury to the patient.

(2)(a) Under the provisions of this section a fact is defined as or considered to be a material fact, if a reasonably prudent person in the position of the patient or his or her representative would attach significance to it deciding whether or not to submit to the proposed treatment.

(b) The failure of a health care provider to disclose, upon patient request, the provider's experience with the treatment, including treatment outcomes, is a violation of this section.

(3) Material facts under the provisions of this section which must be established by expert testimony shall be either:

(a) The nature and character of the treatment proposed and administered;

(b) The anticipated results of the treatment proposed and administered;

(c) The recognized possible alternative forms of treatment; or

(d) The recognized serious possible risks, complications, and anticipated benefits involved in the treatment administered and in the recognized possible alternative forms of treatment, including nontreatment.

(4) If a recognized health care emergency exists and the patient is not legally competent to give an informed consent and/or a person legally authorized to consent on behalf of the patient is not readily available, his or her consent to required treatment will be implied.

NEW SECTION. **Sec. 203.** A new section is added to chapter 18.71 RCW to read as follows:

(1) No person who has been found to have within a ten-year period committed three or more incidents of medical malpractice shall be licensed or continue to be licensed by the commission to practice medicine.

(2) The disciplining authority may make a finding of mitigating circumstances against a licensee on any of the following circumstances:

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

(b) There is a strong potential that remedial education and training will prevent future harm to the public.

(3) Nothing in this section limits the authority of the disciplining authority to revoke a license or take other disciplinary action when the license holder has committed only one or two acts of unprofessional conduct.

(4) For the purposes of this section:

(a) "Medical malpractice" means both the failure to practice medicine with that level of care, skill, and treatment recognized under chapter 7.70 RCW and any similar wrongful act, neglect, or default in other states which are considered medical malpractice; and

(b) "Found to have committed" means that the malpractice has been found in a final judgment entered in a court of law.

NEW SECTION. **Sec. 204.** A new section is added to chapter 7.70 RCW to read as follows:

In any action under this chapter where a verdict or settlement is recorded or reported to the court in an amount in excess of one hundred thousand dollars, the clerk of the court shall report such verdict to the department of health.

Sec. 205. RCW 18.71.0195 and 1998 c 132 s 2 are each amended to read as follows:

(1) The contents of any report filed under RCW 18.130.070 shall be confidential and exempt from public disclosure pursuant to chapter 42.17 RCW, except that it may be reviewed by: (a) ((~~by~~)) The licensee involved or his or her counsel or authorized representative who may submit any additional exculpatory or explanatory statements or other information, which statements or other information shall be included in the file((~~, or~~)); (b) ((~~by~~)) a representative of the commission, or investigator thereof, who has been assigned

to review the activities of a licensed physician; (c) a patient requesting information relating to adverse medical incidents under section 206 of this act; or (d) the immediate family members of a deceased or disabled patient requesting information relative to adverse medical incidents under section 206 of this act.

Upon a determination that a report is without merit, the commission's records may be purged of information relating to the report.

(2) Every individual, medical association, medical society, hospital, medical service bureau, health insurance carrier or agent, professional liability insurance carrier, professional standards review organization, agency of the federal, state, or local government, or the entity established by RCW 18.71.300 and its officers, agents, and employees are immune from civil liability, whether direct or derivative, for providing information to the commission under RCW 18.130.070, or for which an individual health care provider has immunity under the provisions of RCW 4.24.240, 4.24.250, or 4.24.260.

NEW SECTION. **Sec. 206.** A new section is added to chapter 70.02 RCW to read as follows:

Upon receipt of a written request from a patient or an immediate family member of a deceased or disabled family member to examine or copy records made or received in the course of business by a health care facility or provider relating to any adverse medical incident, the health care facility or provider, as promptly as required by the circumstances, but not later than fifteen working days after receiving the request, shall:

(1) Make the information available for examination during regular business hours and provide a copy, if requested, to the patient or an immediate family member of a deceased or disabled family member. In providing such access, the identity of patients involved in the incidents shall not be disclosed, and any privacy restrictions imposed by federal law shall be maintained; or

(2) Inform the patient or an immediate family member of a deceased or disabled patient if the information does not exist or cannot be found.

Sec. 207. RCW 70.02.010 and 2002 c 318 s 1 are each amended to read as follows:

The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

(1) "Adverse medical incident" means medical negligence, intentional misconduct, and any other act, neglect, or default of a health care facility or health care provider that caused or could have caused injury to or death of a patient, including, but not limited to, those incidents that are required by state or federal law to be reported to any government agency or body, and incidents that are reported to or reviewed by the Washington state medical quality assurance commission.

(2) "Audit" means an assessment, evaluation, determination, or investigation of a health care provider by a person not employed by or affiliated with the provider to determine compliance with:

(a) Statutory, regulatory, fiscal, medical, or scientific standards;

(b) A private or public program of payments to a health care provider; or

(c) Requirements for licensing, accreditation, or certification.

((~~(2)~~)) (3) "Directory information" means information disclosing the presence, and for the purpose of identification, the name, residence, sex, and the general health condition of a particular patient who is a patient in a health care facility or who is currently receiving emergency health care in a health care facility.

((~~(3)~~)) (4) "General health condition" means the patient's health status described in terms of "critical," "poor," "fair," "good," "excellent," or terms denoting similar conditions.

((~~(4)~~)) (5) "Health care" means any care, service, or procedure provided by a health care provider:

(a) To diagnose, treat, or maintain a patient's physical or mental condition; or

(b) That affects the structure or any function of the human body.

((~~(5)~~)) (6) "Health care facility" means a hospital, clinic, nursing home, laboratory, office, or similar place where a health care provider provides health care to patients.

((~~(6)~~)) (7) "Health care information" means any information, whether oral or recorded in any form or medium, that identifies or can readily be associated with the identity of a patient and directly relates to the patient's health care, including a patient's deoxyribonucleic acid and identified sequence of chemical base pairs. The term includes any record of disclosures of health care information.

((~~(7)~~)) (8) "Health care provider" means a person who is licensed, certified, registered, or otherwise authorized by the law of this state to provide health care in the ordinary course of business or practice of a profession.

((~~(8)~~)) (9) "Institutional review board" means any board, committee, or other group formally designated by an institution, or authorized under federal or state law, to review, approve the initiation of, or conduct periodic review of research programs to assure the protection of the rights and welfare of human research subjects.

((~~(9)~~)) (10) "Maintain," as related to health care information, means to hold, possess, preserve, retain, store, or control that information.

((~~(10)~~)) (11) "Patient" means an individual who receives or has received health care. The term includes a deceased individual who has received health care.

((~~(11)~~)) (12) "Person" means an individual, corporation, business trust, estate, trust, partnership, association, joint venture, government, governmental subdivision or agency, or any other legal or commercial entity.

((~~(12)~~)) (13) "Reasonable fee" means the charges for

duplicating or searching the record, but shall not exceed sixty-five cents per page for the first thirty pages and fifty cents per page for all other pages. In addition, a clerical fee for searching and handling may be charged not to exceed fifteen dollars. These amounts shall be adjusted biennially in accordance with changes in the consumer price index, all consumers, for Seattle-Tacoma metropolitan statistical area as determined by the secretary of health. However, where editing of records by a health care provider is required by statute and is done by the provider personally, the fee may be the usual and customary charge for a basic office visit.

((~~(13)~~)) (14) "Third-party payor" means an insurer regulated under Title 48 RCW authorized to transact business in this state or other jurisdiction, including a health care service contractor, and health maintenance organization; or an employee welfare benefit plan; or a state or federal health benefit program.

PART III - Medical Liability Cost Savings

NEW SECTION. **Sec. 301.** A new section is added to chapter 7.70 RCW to read as follows:

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

NEW SECTION. **Sec. 302.** A new section is added to chapter 7.70 RCW to read as follows:

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

(2) Within one hundred twenty days after filing a lawsuit under this chapter, the attorney of record, or the plaintiff if pro se, must file a certificate of merit. The certificate must state that the attorney or pro se plaintiff has consulted with a qualified expert who believes on a more probable than not basis that the claim set forth satisfies at least one of the basis for recovery under this chapter. Upon a showing of good cause, a court may extend the time frame for filing the certificate for a period not to exceed sixty days.

PART IV - Severability

NEW SECTION. **Sec. 401.** If any provision of this act or its application to any person or circumstance is held invalid, the remainder of the act or the application of the provision to other persons or circumstances is not affected.

PLEASE NOTE

In the text of the measures, any language in double parentheses with a line through it is existing state law and will be taken out of the law if the measure is approved by voters. Any underlined language does not appear in current state law but will be added to the law if the measure is approved by voters.

Complete Text of

SENATE JOINT RESOLUTION NO. 8207

BE IT RESOLVED, BY THE SENATE AND HOUSE OF REPRESENTATIVES OF THE STATE OF WASHINGTON, IN LEGISLATIVE SESSION ASSEMBLED:

THAT, At the next general election to be held in this state the secretary of state shall submit to the qualified voters of the state for their approval and ratification, or rejection, an amendment to Article IV, section 31 of the Constitution of the state of Washington to read as follows:

Article IV, section 31. (1) There shall be a commission on judicial conduct, existing as an independent agency of the judicial branch, and consisting of a judge selected by and from the court of appeals judges, a judge selected by and from the superior court judges, a judge selected by and from the ((~~district~~)) limited jurisdiction court judges, two persons admitted to the practice of law in this state selected by the state bar association, and six persons who are not attorneys appointed by the governor.

(2) Whenever the commission receives a complaint against a judge or justice, or otherwise has reason to believe that a judge or justice should be admonished, reprimanded, censured, suspended, removed, or retired, the commission shall first investigate the complaint or belief and then conduct initial proceedings for the purpose of determining whether probable cause exists for conducting a public hearing or hearings to deal with the complaint or belief. The investigation and initial proceedings shall be confidential. Upon beginning an initial proceeding, the commission shall notify the judge or justice of the existence of and basis for the initial proceeding.

(3) Whenever the commission concludes, based on an initial proceeding, that there is probable cause to believe that a judge or justice has violated a rule of judicial conduct or that the judge or justice suffers from a disability which is permanent or likely to become permanent and which seriously interferes with the performance of judicial duties, the commission shall conduct a public hearing or hearings and shall make public all those records of the initial proceeding that provide the basis for its conclusion. If the commission concludes that there is not probable cause, it shall notify the judge or justice of its conclusion.

(4) Upon the completion of the hearing or hearings, the commission in open session shall either dismiss the case, or shall admonish, reprimand, or censure the judge or justice, or shall censure the judge or justice and recommend to the supreme court the suspension or removal of the judge or justice, or shall recommend to the supreme court the retirement of the judge or justice. The commission may not recommend suspension or removal unless it censures the judge or justice for the violation serving as the basis for the recommendation. The commission may recommend retirement of a judge or justice for a disability which is permanent or likely to become permanent and which seriously interferes with the performance of judicial duties.

(5) Upon the recommendation of the commission, the supreme court may suspend, remove, or retire a judge or justice. The office of a judge or justice retired or removed by the supreme court becomes vacant, and that person is ineligible for judicial office until eligibility is reinstated by the supreme court. The salary of a removed judge or justice shall cease. The supreme court shall specify the effect upon salary when it suspends a judge or justice. The supreme court may not suspend, remove, or retire a judge or justice until the commission, after notice and hearing, recommends that action be taken, and the supreme court conducts a hearing, after notice, to review commission proceedings and findings against the judge or justice.

(6) Within thirty days after the commission admonishes, reprimands, or censures a judge or justice, the judge or justice shall have a right of appeal de novo to the supreme court.

(7) Any matter before the commission or supreme court may be disposed of by a stipulation entered into in a public proceeding. The stipulation shall be signed by the judge or justice and the commission or court. The stipulation may impose any terms and conditions deemed appropriate by the commission or court. A stipulation shall set forth all material facts relating to the proceeding and the conduct of the judge or justice.

(8) Whenever the commission adopts a recommendation that a judge or justice be removed, the judge or justice shall be suspended immediately, with salary, from his or her judicial position until a final determination is made by the supreme court.

(9) The legislature shall provide for commissioners' terms of office and compensation. The commission shall employ one or more investigative officers with appropriate professional training and experience. The investigative officers of the commission shall report directly to the commission. The commission shall also employ such administrative or other staff as are necessary to manage the affairs of the commission.

(10) The commission shall, to the extent that compliance does not conflict with this section, comply with laws of general applicability to state agencies with respect to rule-making procedures, and with respect to public notice of and attendance at commission proceedings other than initial proceedings. The commission shall establish rules of procedure for commission proceedings including due process and confidentiality of proceedings.

BE IT FURTHER RESOLVED, That the secretary of state shall cause notice of this constitutional amendment to be published at least four times during the four weeks next preceding the election in every legal newspaper in the state.

County Auditor and Elections Department Information

County Auditor Elections Department	Mailing Address	City	ZIP	☎ Telephone Number	These numbers require special telephone equipment to operate. TDD SERVICE ONLY for the speech or hearing impaired.
Adams	210 W Broadway, Ste 200	Ritzville	99169	509.659.3249	509.659.1122
Asotin	P O Box 129	Asotin	99402	509.243.2084	1.800.855.1155
Benton	P O Box 470	Prosser	99350	509.736.3085	1.800.855.1155
Chelan	P O Box 400	Wenatchee	98807	509.667.6808	1.800.833.6388
Clallam	223 E 4th St, Ste 1	Port Angeles	98362	360.417.2221	1.800.833.6388
Clark	P O Box 8815	Vancouver	98666-8815	360.397.2345	360.397.6032
Columbia	341 E Main St	Dayton	99328-1361	509.382.4541	1.800.833.6388
Cowlitz	207 4th Ave N	Kelso	98626	360.577.3005	360.577.3061
Douglas	P O Box 456	Waterville	98858	509.745.8527	509.745.8527, Ext 297
Ferry	350 E Delaware Ave #2	Republic	99166	509.775.5208	1.800.833.6388
Franklin	P O Box 1451	Pasco	99301	509.545.3538	1.800.833.6388
Garfield	P O Box 278	Pomeroy	99347	509.843.1411	1.800.833.6388
Grant	P O Box 37	Ephrata	98823	509.754.2011 Ext 343	1.800.833.6388
Grays Harbor	100 W Broadway, Ste 2	Montesano	98563	360.249.4232	360.249.6575
Island	P O Box 5000	Coupeville	98239	360.679.7366	360.679.7305
Jefferson	P O Box 563	Port Townsend	98368	360.385.9119	1.800.833.6388
King	500 4th Ave, Rm 553	Seattle	98104	206.296.8683	206.296.0109
Kitsap	1026 Sidney Ave, Ste 175	Port Orchard	98366	360.337.7128	1.800.833.6388
Kittitas	205 W 5th Ave, Ste 105	Ellensburg	98926	509.962.7503	1.800.833.6388
Klickitat	205 S Columbus MSCH 2	Goldendale	98620	509.773.4001	1.800.833.6388
Lewis	P O Box 29	Chehalis	98532-0029	360.740.1278	360.740.1480
Lincoln	P O Box 28	Davenport	99122	509.725.4971	1.800.833.6388
Mason	P O Box 400	Shelton	98584	360.427.9670 Ext 469	1.800.833.6388
Okanogan	P O Box 1010	Okanogan	98840	509.422.7240	1.800.833.6388
Pacific	P O Box 97	South Bend	98586-0097	360.875.9317	360.875.9400
Pend Oreille	P O Box 5015	Newport	99156	509.447.3185 Option 3	509.447.3186
Pierce	2401 S 35th St, Rm 200	Tacoma	98409	253.798.7430 1.800.446.4979	1.800.833.6388
San Juan	P O Box 638	Friday Harbor	98250	360.378.3357	360.378.4151
Skagit	P O Box 1306	Mount Vernon	98273	360.336.9305	360.336.9332
Skamania	P O Box 790	Stevenson	98648	509.427.3730	1.800.833.6388
Snohomish	3000 Rockefeller Ave MS 505	Everett	98201	425.388.3444	425.388.3700
Spokane	1033 W Gardner	Spokane	99260	509.477.2320	509.477.2333
Stevens	215 S Oak St, Rm 106	Colville	99114	509.684.7514 1.866.307.9060	1.800.833.6384
Thurston	2000 Lakeridge Dr SW	Olympia	98502	360.786.5408	360.754.2933
Wahkiakum	P O Box 543	Cathlamet	98612	360.795.3219	1.800.833.6388
Walla Walla	P O Box 1856	Walla Walla	99362	509.524.2530	1.800.833.6388
Whatcom	311 Grand Ave, Ste 103	Bellingham	98225	360.676.6742	360.738.4555
Whitman	400 N Main	Colfax	99111	509.397.6270	1.800.833.6388
Yakima	128 N 2nd St, Rm 117	Yakima	98901	509.574.1340	1.800.833.6388

➢ Attention speech or hearing impaired **T**elecommunications **D**evice for the **D**eaf users: If you are using an "800 number" from the list above for **TDD** service, you must be prepared to give the relay service operator the telephone number for your county auditor or elections department.

Absentee Ballot Application

If you have requested an absentee ballot or have a permanent request for an absentee ballot on file, please do not submit another application.

To be filled out by applicant. Please print in ink.

Registered Name: _____

Street Address: _____

City: _____ ZIP Code: _____

Telephone: (Day) _____ (Eve.) _____

For identification purposes only (optional): Voter registration number, if known: _____

Birth Date: _____ Have you recently registered to vote? Yes ❒ No ❒

I hereby declare that I am a registered voter.

Date _____

Signature ✍ _____

To be valid, your signature must be included.

Send my ballot to the following address (if different from above):

Mailing Address: _____

City: _____ State: _____

ZIP Code: _____ Country: _____

Mail this absentee ballot request form to your county auditor or elections department. See previous page for your county's mailing address.

This application is for:

General Election only

November 8, 2005 ❒

Permanent Request

All future elections ❒

For office use only

Precinct Code: _____

Levy Code: _____

Ballot Code: _____

Ballot Mailed: _____

Absentee Ballot Application

If you have requested an absentee ballot or have a permanent request for an absentee ballot on file, please do not submit another application.

To be filled out by applicant. Please print in ink.

Registered Name: _____

Street Address: _____

City: _____ ZIP Code: _____

Telephone: (Day) _____ (Eve.) _____

For identification purposes only (optional): Voter registration number, if known: _____

Birth Date: _____ Have you recently registered to vote? Yes ❒ No ❒

I hereby declare that I am a registered voter.

Date _____

Signature ✍ _____

To be valid, your signature must be included.

Send my ballot to the following address (if different from above):

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City: _____ State: _____

ZIP Code: _____ Country: _____

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Precinct Code: _____

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Ballot Mailed: _____

[redacted]

[redacted]

[redacted]