

INITIATIVE 336

I, Sam Reed, Secretary of State of the State of Washington and custodian of its seal, hereby certify that, according to the records on file in my office, the attached copy of Initiative Measure No. 336 to the Legislature is a true and correct copy as it was received by this office.

1 AN ACT Relating to health care quality protection; amending RCW
2 18.71.015, 7.70.050, 18.71.0195, and 70.02.010; adding a new section to
3 chapter 48.19 RCW; adding a new section to chapter 18.130 RCW; adding
4 a new section to chapter 18.71 RCW; adding new sections to chapter 7.70
5 RCW; adding a new section to chapter 70.02 RCW; adding a new chapter to
6 Title 48 RCW; creating a new section; and prescribing penalties.

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

8 **PART I - Medical Liability Insurance Transparency**
9 **and Market Options**

10 NEW SECTION. **Sec. 101.** The legislature declares that the business
11 and practice of health care vitally affects the public interest. The
12 legislature finds that increases in rate filings in insurance have
13 widespread impact in the availability and affordability of medical
14 malpractice liability insurance. In some cases, excessive rate
15 increases result in limiting the availability of affordable insurance
16 in markets, which in turn threatens the viability of the services or
17 products that are to be insured. The legislature further finds that
18 there are several contributing causes to the current medical liability

1 problem, and addressing these causes requires reducing medical errors
2 while increasing patient safety and information and reducing the cost
3 of our medical liability system. It is in the public interest to
4 maintain an efficient and expeditious regulatory environment in which
5 to conduct the business of insurance. This interest must be balanced
6 by the equally important public interest in promoting a greater range
7 of medical liability insurance options to increase accessibility and
8 affordability of this insurance and increase transparency when
9 excessive rate filings impact the very health care practices and
10 businesses that are to be insured. Therefore, it is the intent of the
11 legislature to increase consumer access to information regarding
12 medical malpractice liability and insurance and to reduce costs by
13 increasing patient safety and information.

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

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

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

24 (c) The commissioner disapproves the filing.

25 (2) If the rate filing increase is fifteen percent or greater, the
26 commissioner shall order a public hearing. Any person shall have the
27 right to intervene and participate as a party or have the right to
28 comment at the public hearing.

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

34 (4) If a judicial proceeding directly involving the rate filing and
35 initiated by the insurer or an intervener begins, the commissioner has
36 thirty days after conclusion of the judicial proceedings to approve or
37 disapprove the rate filing. The commissioner may disapprove an

1 application without a hearing if a stay is in effect barring the
2 commissioner from holding a hearing.

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

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

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

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

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

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

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

24 (b) Challenge any action of the insurance commissioner.

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

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

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

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

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

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

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

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

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

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

9 (4) "Commissioner" means the insurance commissioner.

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

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

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

17 (8) "Insuring entity" means:

18 (a) An insurer;

19 (b) A joint underwriting association;

20 (c) A risk retention group; or

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

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

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

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

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

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

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

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

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

- 3 (i) The retained limits required under section 116 of this act; or
4 (ii) Alternative higher retained limits selected by a facility or
5 provider as part of its risk financing program.

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

7 (14) "Underlying insurance" means any liability insurance policy
8 that provides primary or excess liability insurance coverage for
9 medical malpractice claims.

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

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

17 (b) The effective date of coverage under the program, if later than
18 12:01 a.m. on January 1, 2006.

19 (2) The program will not pay claims:

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

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

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

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

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

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

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

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

36 (g) Made against a partnership or professional corporation
37 organized by health care providers, if the board determines that it is
38 not the primary purpose of the partnership or corporation to provide

1 the health care services. For the purposes of this subsection, if
2 fifty percent or more of the partners, owners, or shareholders are
3 health care providers, the board must determine that it is the entity's
4 primary purpose to provide health care services.

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

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

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

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

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

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

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

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

27 (a) Forms under RCW 48.18.100 and 48.18.103; and

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

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

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

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

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

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

3 (4) The program is not a state agency.

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

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

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

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

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

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

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

21 (b) A vacancy occurs on the board.

22 (2) The board must comprise:

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

26 (b) Three members of the public appointed by the commissioner for
27 staggered three-year terms;

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

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

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

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

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

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

4 (a) A schedule for meetings;

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

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

8 (ii) Limits of coverage available from the program;

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

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

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

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

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

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

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

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

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

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

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

31 (2) The administrator may:

32 (a) Hire staff to operate the program; or

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- 1 (iii) The frequency of previous capital calls by the program;
2 (iv) The effect of raising premiums instead of a capital call;
3 (v) The impact on state revenue; and
4 (vi) Any other factor the commissioner decides is relevant.
5 (3) All money collected by the program belongs to the program.
6 (4) The state investment board must:
7 (a) Manage the assets of the program;
8 (b) Invest program assets in a manner consistent with chapter 48.13
9 RCW; and
10 (c) Charge the program reasonable fees for services provided under
11 this section.

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

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

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

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

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

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

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

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

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

4 (a) Is licensed by Washington state; or

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

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

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

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

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

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

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

20 (A) Its principal office in Washington state; and

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

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

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

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

33 (1) The facility or provider:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

8 (2) The minimum retained limits of liability are:

9 (a) For health care providers:

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

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

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

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

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

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

19 (A) Five hundred thousand dollars per claim; and

20 (B) Annual aggregate limits of five million dollars;

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

22 (A) Five hundred thousand dollars per claim; and

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

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

26 (A) Five hundred thousand dollars per claim; and

27 (B) Annual aggregate limits of five million dollars;

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

30 (A) Five hundred thousand dollars per claim; and

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

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

33 (i) Five hundred thousand dollars per claim; and

34 (ii) Annual aggregate limits of three million dollars.

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

37 (4)(a) Retained limits of liability apply only to claim payments.
38 Each insuring entity and self-insurer that provides certification under

1 subsection (1) of this section must pay defense costs as supplementary
2 payments.

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

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

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

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

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

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

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

27 (i) One million dollars per claim; and

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

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

31 (i) Two million dollars per claim; and

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

33 (3) In addition to the basic limits described in subsection (2) of
34 this section, the program must offer higher limits of coverage to those
35 providers and facilities that are willing to pay additional premiums.
36 The board will determine the limits of liability available through the

1 program based on the limits available in the voluntary medical
2 malpractice insurance market.

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

5 NEW SECTION. **Sec. 119.** From January 1, 2006, through December 31,
6 2006, the annual program premium billed to each participating facility
7 or provider will be determined by the commissioner based on:

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

10 (2) Claims experience for medical malpractice insurance; and

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

12 NEW SECTION. **Sec. 120.** Beginning January 1, 2007, program
13 premiums charged to facilities and providers must be based on the rates
14 and rating plans adopted by the board and accepted by the commissioner
15 under section 122 of this act.

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

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

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

28 (b) Past and prospective operating expenses;

29 (c) Past and prospective investment income;

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

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

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

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

- 1 (i) The amount of surgery performed by a facility or provider; and
- 2 (ii) The risk of diagnostic and therapeutic services provided or
- 3 procedures performed;
- 4 (b) The bed capacity and occupancy rates in a health care facility;
- 5 (c) Differences in financial risk, if any, to the program if a
- 6 facility or provider is self-insured;
- 7 (d) The risk factors for providers who are semiretired or part-time
- 8 professionals;
- 9 (e) If a health care provider is a partnership or professional
- 10 corporation, the risk factors and past and prospective loss and expense
- 11 experience of the partners and employees of that provider;
- 12 (f) If a provider's principal place of practice is Oregon or Idaho,
- 13 any differences in risk or expense to reflect the fact the provider's
- 14 practice is not located in Washington state;
- 15 (g) Higher retained limits selected by a facility or provider; and
- 16 (h) Higher limits of liability coverage purchased from the program
- 17 by a facility or provider.

18 NEW SECTION. **Sec. 121.** The rating plan used by the program must

19 include experience and schedule rating plans. The program must apply

20 these plans equitably to all facilities and providers.

- 21 (1) The experience rating plan:
 - 22 (a) Must consider the past loss and loss adjustment expense
 - 23 experience of a facility or an individual provider;
 - 24 (b) May consider paid medical malpractice claims if the claims
 - 25 result from negligence on the part of:
 - 26 (i) A facility;
 - 27 (ii) A health care provider; or
 - 28 (iii) An employee of a facility or health care provider; and
 - 29 (c) May consider medical malpractice claims:
 - 30 (i) Paid on behalf of a facility or provider by the program, an
 - 31 insuring entity, or a self-insurer; and
 - 32 (ii) Paid on behalf of a facility or provider before or after the
 - 33 program is established.
- 34 (2) The schedule rating plan must consider the effect of:
 - 35 (a) Risk management programs based on evidence-based practices that
 - 36 improve patient safety. Practices that have been identified and
 - 37 recommended by governmental and private organizations, including:
 - 38 (i) The federal agency for health quality and research;

- 1 (ii) The federal institute of medicine;
2 (iii) The joint commission on accreditation of health care
3 organizations;
4 (iv) The national quality forum; or
5 (v) Any other evidence-based program accepted by the board; and
6 (b) Other objective criteria approved by the board that is expected
7 to reduce either losses or expenses incurred by the program.

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

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

14 (b) The annual funding estimate is actuarially sound.

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

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

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

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

29 (1) Facilities or providers may pay program premiums annually, or
30 in semiannual or quarterly installments. Semiannual and quarterly
31 installments must include the prorated premium and a fee that covers
32 unearned interest or investment income and administrative costs
33 incurred because the facility or provider has decided to pay premium in
34 installments.

35 (2) A facility or provider must pay premiums to their selected
36 insuring entity within thirty days of the billing date. If the
37 insuring entity does not receive the premium due within thirty days,

1 coverage under the program ends at 12:01 a.m. on the thirty-first day.
2 The program and the insuring entity are not required to provide
3 additional notice of cancellation for nonpayment of premium.

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

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

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

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

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

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

24 (i) The program; or

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

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

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

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

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

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

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

5 (a) Are not an admission of fault;

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

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

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

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

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

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

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

25 (a) The loss reserve is established; or

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

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

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

33 (a) Pay its expenses; and

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

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

6 (a) Judgment in any amount;

7 (b) Settlement in any amount; or

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

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

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

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

18 (3) The reporting requirements under this section apply to all:

19 (a) Insuring entities and self-insurers; and

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

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

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

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

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

35 (2) The provider or facility policy number or numbers;

36 (3) The name of the facility, if any, and the location within the
37 facility where the injury occurred;

38 (4) The date of the loss;

1 (5) The date the claim was reported to the insuring entity,
2 self-insurer, facility, or provider;

3 (6) The name and address of the claimant. This claimant
4 information is confidential and exempt from public disclosure, but may
5 be disclosed:

6 (a) Publicly, if the claimant provides written consent;

7 (b) To the department at any time; or

8 (c) To the commissioner at any time for purpose of identifying
9 multiple or duplicate claims arising out of the same occurrence;

10 (7) The date of suit, if filed;

11 (8) The claimant's age and sex;

12 (9) The names and professional license numbers if applicable of all
13 defendants involved in the claim;

14 (10) Specific information about the judgment or settlement
15 including:

16 (a) The date and amount of any judgment or settlement;

17 (b) Whether the settlement:

18 (i) Was the result of an arbitration, judgment, or mediation; and

19 (ii) Occurred before or after trial;

20 (c)(i) The loss adjustment expense paid to defense counsel; and

21 (ii) All other paid allocated loss adjustment expenses;

22 (d) If there is no judgment or settlement:

23 (i) The date and reason for final disposition; and

24 (ii) The date the claim was closed; and

25 (e) Any other information required by the commissioner;

26 (11) A summary of the occurrence that created the claim, which must
27 include:

28 (a) The final diagnosis for which the patient sought or received
29 treatment, including the actual condition of the patient;

30 (b) A description of any misdiagnosis made by the provider of the
31 actual condition of the patient;

32 (c) The operation, diagnostic, or treatment procedure that caused
33 the injury;

34 (d) A description of the principal injury that led to the claim;
35 and

36 (e) The safety management steps the facility or provider has taken
37 to make similar occurrences or injuries less likely in the future; and

38 (12) Any other information required by the commissioner, by rule,
39 that helps the commissioner or department analyze and evaluate the

1 nature, causes, location, cost, and damages involved in medical
2 malpractice cases.

3 NEW SECTION. **Sec. 128.** The commissioner must prepare aggregate
4 statistical summaries of closed claims based on calendar year data
5 submitted under section 126 of this act.

6 (1) At a minimum, data must be sorted by calendar year and
7 calendar-accident year. The commissioner may also decide to display
8 data in other ways.

9 (2) The summaries must be available by March 31st of each year.

10 NEW SECTION. **Sec. 129.** Beginning in 2007, the commissioner must
11 prepare an annual report by June 30th that summarizes and analyzes the
12 closed claim reports for medical malpractice filed under section 126 of
13 this act and the annual financial reports filed by insurers writing
14 medical malpractice insurance in this state. The report must include:

15 (1) An analysis of closed claim reports of prior years for which
16 data are collected and show:

17 (a) Trends in the frequency and severity of claims payments;

18 (b) The types of medical malpractice for which claims have been
19 paid; and

20 (c) Any other information the commissioner determines illustrates
21 trends in closed claims;

22 (2) An analysis of the medical malpractice insurance market in
23 Washington state, including:

24 (a) An analysis of the financial reports of the insurers with a
25 combined market share of at least ninety percent of net written medical
26 malpractice premium in Washington state for the prior calendar year;

27 (b) A loss ratio analysis of medical malpractice insurance written
28 in Washington state; and

29 (c) A profitability analysis of each insurer writing medical
30 malpractice insurance;

31 (3) A comparison of loss ratios and the profitability of medical
32 malpractice insurance in Washington state to other states based on
33 financial reports filed with the national association of insurance
34 commissioners and any other source of information the commissioner
35 deems relevant;

36 (4) A summary of the rate filings for medical malpractice that have
37 been approved by the commissioner for the prior calendar year,

1 including an analysis of the trend of direct and incurred losses as
2 compared to prior years;

3 (5) The commissioner must post reports required by this section on
4 the internet no later than thirty days after they are due; and

5 (6) The commissioner may adopt rules that require persons and
6 entities required to report under section 126 of this act to report
7 data related to:

8 (a) The frequency and severity of open claims for the reporting
9 period;

10 (b) The amounts reserved for incurred claims;

11 (c) Changes in reserves from the previous reporting period;

12 (d) Any other information that helps the commissioner monitor
13 losses and claims development in the Washington state medical
14 malpractice insurance market; and

15 (e) Any additional information requested by the department or the
16 board.

17 NEW SECTION. **Sec. 130.** The commissioner may adopt all rules
18 needed to implement this chapter.

19 NEW SECTION. **Sec. 131.** Sections 101, 102, and 104 through 130 of
20 this act constitute a new chapter in Title 48 RCW.

21 NEW SECTION. **Sec. 132.** A new section is added to chapter 18.130
22 RCW to read as follows:

23 (1) As used in this section:

24 (a) "Claim" has the same meaning as in section 104(2) of this act.

25 (b) "Health care professional" means a person engaged in a
26 profession listed in RCW 18.130.040.

27 (c) "Supplemental malpractice insurance program" has the same
28 meaning as in section 104(11) of this act.

29 (2) The department must provide the program with any available
30 information needed to set premiums, including data on hospital bed
31 capacity and occupancy rates.

32 (3) The department must thoroughly investigate a health care
33 professional if:

34 (a) A health care professional has three claims paid within the
35 most recent five-year period; and

1 (b) The total indemnity payment for each claim was fifty thousand
2 dollars or more.

3 (4) The department may adopt any rules needed to implement this
4 section.

5 NEW SECTION. **Sec. 133.** The legislature may appropriate for the
6 biennium ending June 30, 2007, any sum of money it deems necessary to
7 the department of health to:

8 (1) Provide capital and surplus to the supplemental malpractice
9 insurance program; and

10 (2) Pay administrative expenses incurred to establish the
11 supplemental malpractice insurance program.

12 **PART II - Patient Safety and Patient Right to Know**

13 **Sec. 201.** RCW 18.71.015 and 1999 c 366 s 4 are each amended to
14 read as follows:

15 The Washington state medical quality assurance commission is
16 established, consisting of thirteen individuals licensed to practice
17 medicine in the state of Washington under this chapter, two individuals
18 who are licensed as physician assistants under chapter 18.71A RCW, and
19 ~~((four))~~ six individuals who are members of the public. At least two
20 of the public members shall not be from the health care industry and
21 shall be representatives of patient advocacy groups or organizations.
22 Each congressional district now existing or hereafter created in the
23 state must be represented by at least one physician member of the
24 commission. The terms of office of members of the commission are not
25 affected by changes in congressional district boundaries. Public
26 members of the commission may not be a member of any other health care
27 licensing board or commission, or have a fiduciary obligation to a
28 facility rendering health services regulated by the commission, or have
29 a material or financial interest in the rendering of health services
30 regulated by the commission.

31 The members of the commission shall be appointed by the governor.
32 Members of the initial commission may be appointed to staggered terms
33 of one to four years, and thereafter all terms of appointment shall be
34 for four years. The governor shall consider such physician and
35 physician assistant members who are recommended for appointment by the
36 appropriate professional associations in the state. In appointing the

1 initial members of the commission, it is the intent of the legislature
2 that, to the extent possible, the existing members of the board of
3 medical examiners and medical disciplinary board repealed under section
4 336, chapter 9, Laws of 1994 sp. sess. be appointed to the commission.
5 No member may serve more than two consecutive full terms. Each member
6 shall hold office until a successor is appointed.

7 Each member of the commission must be a citizen of the United
8 States, must be an actual resident of this state, and, if a physician,
9 must have been licensed to practice medicine in this state for at least
10 five years.

11 The commission shall meet as soon as practicable after appointment
12 and elect officers each year. Meetings shall be held at least four
13 times a year and at such place as the commission determines and at such
14 other times and places as the commission deems necessary. A majority
15 of the commission members appointed and serving constitutes a quorum
16 for the transaction of commission business.

17 The affirmative vote of a majority of a quorum of the commission is
18 required to carry any motion or resolution, to adopt any rule, or to
19 pass any measure. The commission may appoint panels consisting of at
20 least three members. A quorum for the transaction of any business by
21 a panel is a minimum of three members. A majority vote of a quorum of
22 the panel is required to transact business delegated to it by the
23 commission.

24 Each member of the commission shall be compensated in accordance
25 with RCW 43.03.265 and in addition thereto shall be reimbursed for
26 travel expenses incurred in carrying out the duties of the commission
27 in accordance with RCW 43.03.050 and 43.03.060. Any such expenses
28 shall be paid from funds appropriated to the department of health.

29 Whenever the governor is satisfied that a member of a commission
30 has been guilty of neglect of duty, misconduct, or malfeasance or
31 misfeasance in office, the governor shall file with the secretary of
32 state a statement of the causes for and the order of removal from
33 office, and the secretary shall forthwith send a certified copy of the
34 statement of causes and order of removal to the last known post office
35 address of the member.

36 Vacancies in the membership of the commission shall be filled for
37 the unexpired term by appointment by the governor.

1 The members of the commission are immune from suit in an action,
2 civil or criminal, based on its disciplinary proceedings or other
3 official acts performed in good faith as members of the commission.

4 Whenever the workload of the commission requires, the commission
5 may request that the secretary appoint pro tempore members of the
6 commission. When serving, pro tempore members of the commission have
7 all of the powers, duties, and immunities, and are entitled to all of
8 the emoluments, including travel expenses, of regularly appointed
9 members of the commission.

10 **Sec. 202.** RCW 7.70.050 and 1975-'76 2nd ex.s. c 56 s 10 are each
11 amended to read as follows:

12 (1) The following shall be necessary elements of proof that injury
13 resulted from health care in a civil negligence case or arbitration
14 involving the issue of the alleged breach of the duty to secure an
15 informed consent by a patient or his or her representatives against a
16 health care provider:

17 (a) That the health care provider failed to inform the patient of
18 a material fact or facts relating to the treatment;

19 (b) That the patient consented to the treatment without being aware
20 of or fully informed of such material fact or facts;

21 (c) That a reasonably prudent patient under similar circumstances
22 would not have consented to the treatment if informed of such material
23 fact or facts;

24 (d) That the treatment in question proximately caused injury to the
25 patient.

26 (2)(a) Under the provisions of this section a fact is defined as or
27 considered to be a material fact, if a reasonably prudent person in the
28 position of the patient or his or her representative would attach
29 significance to it deciding whether or not to submit to the proposed
30 treatment.

31 (b) The failure of a health care provider to disclose, upon patient
32 request, the provider's experience with the treatment, including
33 treatment outcomes, is a violation of this section.

34 (3) Material facts under the provisions of this section which must
35 be established by expert testimony shall be either:

36 (a) The nature and character of the treatment proposed and
37 administered;

1 (b) The anticipated results of the treatment proposed and
2 administered;

3 (c) The recognized possible alternative forms of treatment; or

4 (d) The recognized serious possible risks, complications, and
5 anticipated benefits involved in the treatment administered and in the
6 recognized possible alternative forms of treatment, including
7 nontreatment.

8 (4) If a recognized health care emergency exists and the patient is
9 not legally competent to give an informed consent and/or a person
10 legally authorized to consent on behalf of the patient is not readily
11 available, his or her consent to required treatment will be implied.

12 NEW SECTION. Sec. 203. A new section is added to chapter 18.71
13 RCW to read as follows:

14 (1) No person who has been found to have within a ten-year period
15 committed three or more incidents of medical malpractice shall be
16 licensed or continue to be licensed by the commission to practice
17 medicine.

18 (2) The disciplining authority may make a finding of mitigating
19 circumstances against a licensee on any of the following circumstances:

20 (a) There is a strong potential for rehabilitation of the license
21 holder; or

22 (b) There is a strong potential that remedial education and
23 training will prevent future harm to the public.

24 (3) Nothing in this section limits the authority of the
25 disciplining authority to revoke a license or take other disciplinary
26 action when the license holder has committed only one or two acts of
27 unprofessional conduct.

28 (4) For the purposes of this section:

29 (a) "Medical malpractice" means both the failure to practice
30 medicine with that level of care, skill, and treatment recognized under
31 chapter 7.70 RCW and any similar wrongful act, neglect, or default in
32 other states which are considered medical malpractice; and

33 (b) "Found to have committed" means that the malpractice has been
34 found in a final judgment entered in a court of law.

35 NEW SECTION. Sec. 204. A new section is added to chapter 7.70 RCW
36 to read as follows:

1 In any action under this chapter where a verdict or settlement is
2 recorded or reported to the court in an amount in excess of one hundred
3 thousand dollars, the clerk of the court shall report such verdict to
4 the department of health.

5 **Sec. 205.** RCW 18.71.0195 and 1998 c 132 s 2 are each amended to
6 read as follows:

7 (1) The contents of any report filed under RCW 18.130.070 shall be
8 confidential and exempt from public disclosure pursuant to chapter
9 42.17 RCW, except that it may be reviewed by: (a) ~~((by))~~ The licensee
10 involved or his or her counsel or authorized representative who may
11 submit any additional exculpatory or explanatory statements or other
12 information, which statements or other information shall be included in
13 the file ~~((, or))~~; (b) ~~((by))~~ a representative of the commission, or
14 investigator thereof, who has been assigned to review the activities of
15 a licensed physician; (c) a patient requesting information relating to
16 adverse medical incidents under section 206 of this act; or (d) the
17 immediate family members of a deceased or disabled patient requesting
18 information relative to adverse medical incidents under section 206 of
19 this act.

20 Upon a determination that a report is without merit, the
21 commission's records may be purged of information relating to the
22 report.

23 (2) Every individual, medical association, medical society,
24 hospital, medical service bureau, health insurance carrier or agent,
25 professional liability insurance carrier, professional standards review
26 organization, agency of the federal, state, or local government, or the
27 entity established by RCW 18.71.300 and its officers, agents, and
28 employees are immune from civil liability, whether direct or
29 derivative, for providing information to the commission under RCW
30 18.130.070, or for which an individual health care provider has
31 immunity under the provisions of RCW 4.24.240, 4.24.250, or 4.24.260.

32 NEW SECTION. **Sec. 206.** A new section is added to chapter 70.02
33 RCW to read as follows:

34 Upon receipt of a written request from a patient or an immediate
35 family member of a deceased or disabled family member to examine or
36 copy records made or received in the course of business by a health
37 care facility or provider relating to any adverse medical incident, the

1 health care facility or provider, as promptly as required by the
2 circumstances, but not later than fifteen working days after receiving
3 the request, shall:

4 (1) Make the information available for examination during regular
5 business hours and provide a copy, if requested, to the patient or an
6 immediate family member of a deceased or disabled family member. In
7 providing such access, the identity of patients involved in the
8 incidents shall not be disclosed, and any privacy restrictions imposed
9 by federal law shall be maintained; or

10 (2) Inform the patient or an immediate family member of a deceased
11 or disabled patient if the information does not exist or cannot be
12 found.

13 **Sec. 207.** RCW 70.02.010 and 2002 c 318 s 1 are each amended to
14 read as follows:

15 The definitions in this section apply throughout this chapter
16 unless the context clearly requires otherwise.

17 (1) "Adverse medical incident" means medical negligence,
18 intentional misconduct, and any other act, neglect, or default of a
19 health care facility or health care provider that caused or could have
20 caused injury to or death of a patient, including, but not limited to,
21 those incidents that are required by state or federal law to be
22 reported to any government agency or body, and incidents that are
23 reported to or reviewed by the Washington state medical quality
24 assurance commission.

25 (2) "Audit" means an assessment, evaluation, determination, or
26 investigation of a health care provider by a person not employed by or
27 affiliated with the provider to determine compliance with:

28 (a) Statutory, regulatory, fiscal, medical, or scientific
29 standards;

30 (b) A private or public program of payments to a health care
31 provider; or

32 (c) Requirements for licensing, accreditation, or certification.

33 ~~((+2))~~ (3) "Directory information" means information disclosing
34 the presence, and for the purpose of identification, the name,
35 residence, sex, and the general health condition of a particular
36 patient who is a patient in a health care facility or who is currently
37 receiving emergency health care in a health care facility.

1 ~~((3))~~ (4) "General health condition" means the patient's health
2 status described in terms of "critical," "poor," "fair," "good,"
3 "excellent," or terms denoting similar conditions.

4 ~~((4))~~ (5) "Health care" means any care, service, or procedure
5 provided by a health care provider:

6 (a) To diagnose, treat, or maintain a patient's physical or mental
7 condition; or

8 (b) That affects the structure or any function of the human body.

9 ~~((5))~~ (6) "Health care facility" means a hospital, clinic,
10 nursing home, laboratory, office, or similar place where a health care
11 provider provides health care to patients.

12 ~~((6))~~ (7) "Health care information" means any information,
13 whether oral or recorded in any form or medium, that identifies or can
14 readily be associated with the identity of a patient and directly
15 relates to the patient's health care, including a patient's
16 deoxyribonucleic acid and identified sequence of chemical base pairs.
17 The term includes any record of disclosures of health care information.

18 ~~((7))~~ (8) "Health care provider" means a person who is licensed,
19 certified, registered, or otherwise authorized by the law of this state
20 to provide health care in the ordinary course of business or practice
21 of a profession.

22 ~~((8))~~ (9) "Institutional review board" means any board,
23 committee, or other group formally designated by an institution, or
24 authorized under federal or state law, to review, approve the
25 initiation of, or conduct periodic review of research programs to
26 assure the protection of the rights and welfare of human research
27 subjects.

28 ~~((9))~~ (10) "Maintain," as related to health care information,
29 means to hold, possess, preserve, retain, store, or control that
30 information.

31 ~~((10))~~ (11) "Patient" means an individual who receives or has
32 received health care. The term includes a deceased individual who has
33 received health care.

34 ~~((11))~~ (12) "Person" means an individual, corporation, business
35 trust, estate, trust, partnership, association, joint venture,
36 government, governmental subdivision or agency, or any other legal or
37 commercial entity.

38 ~~((12))~~ (13) "Reasonable fee" means the charges for duplicating or
39 searching the record, but shall not exceed sixty-five cents per page

1 for the first thirty pages and fifty cents per page for all other
2 pages. In addition, a clerical fee for searching and handling may be
3 charged not to exceed fifteen dollars. These amounts shall be adjusted
4 biennially in accordance with changes in the consumer price index, all
5 consumers, for Seattle-Tacoma metropolitan statistical area as
6 determined by the secretary of health. However, where editing of
7 records by a health care provider is required by statute and is done by
8 the provider personally, the fee may be the usual and customary charge
9 for a basic office visit.

10 (~~(13)~~) (14) "Third-party payor" means an insurer regulated under
11 Title 48 RCW authorized to transact business in this state or other
12 jurisdiction, including a health care service contractor, and health
13 maintenance organization; or an employee welfare benefit plan; or a
14 state or federal health benefit program.

15 **PART III - Medical Liability Cost Savings**

16 NEW SECTION. **Sec. 301.** A new section is added to chapter 7.70 RCW
17 to read as follows:

18 In any action under this chapter, each side shall presumptively be
19 entitled to only two expert witnesses on an issue, except upon a
20 showing of necessity. Where there are multiple parties on a side and
21 the parties cannot agree as to which experts will be called on an
22 issue, the court, upon a showing of necessity, shall allow additional
23 experts on an issue to be called as the court deems appropriate.

24 NEW SECTION. **Sec. 302.** A new section is added to chapter 7.70 RCW
25 to read as follows:

26 (1) In any action under this section, an attorney that has drafted,
27 or assisted in drafting and filing an action, counterclaim,
28 cross-claim, third-party claim, or a defense to a claim, upon signature
29 and filing, certifies that to the best of the party's or attorney's
30 knowledge, information, and belief, formed after reasonable inquiry it
31 is not frivolous, and is well grounded in fact and is warranted by
32 existing law or a good faith argument for the extension, modification,
33 or reversal of existing law, and that it is not interposed for any
34 improper purpose, such as to harass or to cause frivolous litigation.
35 If an action is signed and filed in violation of this rule, the court,
36 upon motion or upon its own initiative, may impose upon the person who

1 signed it, a represented party, or both, an appropriate sanction, which
2 may include an order to pay to the other party or parties the amount of
3 the reasonable expenses incurred because of the filing of the action,
4 counterclaim, cross-claim, third-party claim, or a defense to a claim,
5 including a reasonable attorney fee. The procedures governing the
6 enforcement of RCW 4.84.185 shall apply to this section.

7 (2) Within one hundred twenty days after filing a lawsuit under
8 this chapter, the attorney of record, or the plaintiff if pro se, must
9 file a certificate of merit. The certificate must state that the
10 attorney or pro se plaintiff has consulted with a qualified expert who
11 believes on a more probable than not basis that the claim set forth
12 satisfies at least one of the basis for recovery under this chapter.
13 Upon a showing of good cause, a court may extend the time frame for
14 filing the certificate for a period not to exceed sixty days.

15 **PART IV - Severability**

16 NEW SECTION. **Sec. 401.** If any provision of this act or its
17 application to any person or circumstance is held invalid, the
18 remainder of the act or the application of the provision to other
19 persons or circumstances is not affected.

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