



August 23, 2005

SUMMARY OF INITIATIVE 336 TO THE LEGISLATURE
Concerns medical malpractice, including insurance, healthcare
provider licensing, and lawsuits

*This information has been prepared in response to specific questions about the provisions and effects of Initiative 336 and is provided for legislative purposes only; it is **not** provided as an expression for or against the ballot measure. Please remember that it is inappropriate to use public resources to support or oppose a ballot measure. Please refer to pages 22-25 of the 2004-05 Legislative Ethics Manual or contact Senate Counsel for further guidance on when and how comment on ballot measures is appropriate.*

BRIEF SUMMARY

Initiative 336 (I-336) establishes a supplemental medical malpractice insurance program for health care providers and facilities that already have purchased an underlying layer of private malpractice insurance. The Insurance Commissioner must give notice or hold hearings on medical malpractice insurance rate increases. Additionally, malpractice insurers are required to report to the Insurance Commissioner claims that result in a final judgment or settlement. A license to practice medicine will be revoked upon three findings by the Department of Health's Medical Quality Assurance Commission of medical malpractice unless there were mitigating circumstances. In lawsuits, the number of expert witnesses is limited and plaintiffs are required to certify that the case has merit.

BACKGROUND

Health care providers, who are defined as regulated persons who practice health or health-related services, purchase medical malpractice insurance coverage from insurers in the private market. Insurers, in turn, purchase reinsurance, which covers losses over and above a certain level. Many physician specialists have reported difficulties finding medical malpractice insurance coverage. Others have reported a significant rise in premiums.

The Insurance Commissioner is responsible for licensing and regulating insurance companies doing business in this state. This oversight includes approval of rates and rating plans. The Commissioner does not generally review an insurer's underwriting standards and does not receive information related to specific classes or types of insurance coverages provided. In addition, the Commissioner does not currently receive information about medical malpractice claims, judgments, or settlements.

The Department of Health's Medical Quality Assurance Commission (MQAC) is responsible for protecting the public by assuring that quality health care is provided by physicians and physician assistants. MQAC establishes, monitors, and enforces qualifications for licensure, consistent standards of practice, and continuing competency of physicians and physician assistants. The

MQAC is composed of nineteen Governor-appointed members (thirteen individuals licensed to practice medicine, two individuals who are licensed as physician assistants, four members of the general public) and six pro-tem members appointed by the Secretary of the Department of Health. Under the Uniform Disciplinary Act, upon determining that a license holder has committed unprofessional conduct or is unable to practice with reasonable skill and safety, MQAC may issue an order of discipline such as mandating a refund to the patient, revoking the practitioner's license, or other disciplinary actions.

In a medical malpractice legal action, there is no limit on the number of expert witnesses that can testify in a case.

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Medical Liability Insurance. The Insurance Commissioner (Commissioner) must notify the public when any insurer files for a medical malpractice insurance rate change that is less than 15 percent of the then applicable rate. The rate change will be approved after a waiting period of forty-five days unless a hearing is requested or the Commissioner disapproves the filing. If the rate change is 15 percent or greater, the Commissioner must order a public hearing, at which any person may intervene or comment.

I-336 creates a supplemental malpractice insurance program to provide an additional layer of liability coverage to health care professionals for malpractice claims. It is a separate and distinct legal entity and is overseen by a board of governors, who are appointed by the Commissioner. The program pays claims and related defense costs on behalf of a covered health care provider or facility once the primary layer of insurance has paid the claims to the maximum retained limit. The program is funded by annual premiums paid by health care facilities and providers who purchase the supplemental insurance, and the program has the ability to issue a capital call if necessary. The legislature may also appropriate any funds it deems necessary to support the program.

To qualify to be in the program, a provider or facility must have certain ties to Washington State and must have either purchased underlying insurance or be self-insured. For an individual health care provider, the minimum retained limits for the underlying coverage are \$250,000 per claim and an annual aggregate limit of \$750,000. For facilities, the minimum retained limit, which is the amount of underlying coverage for which the provider needs to be insured, increases as the size of the health care facility increases. Under the supplemental insurance program, a provider may obtain excess liability coverage above the level of the retained limits of insurance up to \$1 million per claim with an annual aggregate limit of \$3 million. The basic limits of excess liability covering a health care facility are \$2 million per claim and an annual aggregate limit of \$6 million. In the event of a lawsuit, a provider or facility may not reject any settlement agreed upon between a claimant and either the program or the underlying insurer, although they may appeal any resulting premium increase.

Malpractice insurers providing the primary coverage are required to report to the Commissioner any malpractice claims of their insureds that resulted in a final judgment or settlement. Failure to do so is punishable by fine. The Commissioner must prepare annual aggregate statistical summaries of closed medical malpractice claims and annual reports analyzing trends in claims, types of medical malpractice, and an analysis of the state medical malpractice insurance market. The Department of Health must thoroughly investigate a health care professional if he or she has

had three claims paid within the most recent five-year period and if the total indemnity payment for each claim was \$50,000 or more.

Patient Safety and Patient Right to Know. The number of public members on the MQAC is increased from four to six. At least two of the public members must not be from the health care industry and must be representatives of patient advocacy groups or organizations.

Upon a patient's request, a health care provider must disclose his or her experience with the treatment including its outcomes. If a patient or immediate family member issues a request, a health care facility is obligated to make the records made or received in the course of business, including those records filed to the disciplining authority, relating to any adverse medical event available for examination.

Unless MQAC finds mitigating circumstances, no person against whom three or more medical malpractice judgments were entered within a ten-year period can be licensed or continue to be licensed to practice medicine. The clerk of the court must report to the Department of Health any verdict or settlement in a medical malpractice action in excess of \$100,000.

Medical Liability Cost Savings: In any medical malpractice legal action, each side is limited to two expert witnesses per issue except upon a showing of necessity. Attorneys filing a medical malpractice claim must certify that the claim is not frivolous. If an action is signed and filed in violation of this rule, the court may impose an appropriate sanction on the attorney, including an order to pay expenses and fees to the other party.

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