



BRIEFLY

Inefficiencies of the current liability system, combined with rising litigation costs and recent increases in malpractice premiums, have led doctors, patients and policy makers to demand reform. In Washington, two dueling liability initiatives will appear on the ballot this November.

## Malpractice at the Ballot Box: I-330 vs. I-336

Liability law has two primary objectives: compensate injured parties and deter negligent behavior. The current system falls short of this by failing to appropriately compensate patients, discouraging error reporting, and leading to the practice of defensive medicine. These liability inefficiencies, combined with rising litigation costs and recent increases in malpractice premiums, have led doctors, patients and policy makers to demand reform.

In Washington, two liability initiatives will appear on the November ballot. Initiative 330 is supported by the Washington State Medical Association and Initiative 336 is supported by the Washington State Trial Lawyers Association. The two initiatives take very different approaches to liability reform.

### BACKGROUND

Driven by rapid advances in technology and increased consumer demand, health care spending now exceeds 15 percent of the nation's gross domestic product (GDP). By 2014, spending is projected to reach 18 percent of GDP (WashACE, 2005). In order to curb health care spending, a variety of cost-cutting measures have been put forth. One suggestion is malpractice litigation reform.

**Malpractice Insurance.** Following a period of relative stability, premium rates for malpractice insurance began increasing rapidly in 1999 (GAO, 2003, p. 3-4). The Congressional Budget Office (CBO) estimates that premiums for physicians nationwide rose an average of 15 percent between 2000 and 2002, nearly twice as fast as total health care spending (2004).

Some health care providers – especially those in high-risk fields – have experienced much greater premium increases. As a result, many have chosen to limit their practice, move to regions with lower premium rates or retire from medicine altogether.

**Malpractice Incidence.** According to the CBO, 15 malpractice claims are filed annually for every 100 physicians (2004). While the rate of claims has remained relatively constant, the cost per successful claim continues to rise. Between 1986 and 2002, the average malpractice claim payment increased at an annual rate of nearly 8 percent (2004). During the same period, legal-defense costs grew by about 8 percent a year as well (2004).



**Insurance Companies.** Malpractice insurance companies collect premiums from health care providers in return for coverage and representation in the event that a patient files suit. In addition to premiums, insurance companies finance claims payments and administrative costs from returns on market investments.

In the 1990s, insurance companies were able to restrain premiums in the face of rising claim costs by taking advantage of high interest rates. While this allowed them to remain both profitable and competitive, it resulted in a shortage of funds once investment returns diminished.

Nationally, investment yields fell from about 5.6 percent in 2000 to an estimated 4.0 percent in 2002 (GAO, 2003, p. 25). At the same time, the cost of malpractice claims continued to increase. Declining profits have led some companies to either cut back or pull out of the market completely. Remaining insurers have raised their rates significantly to cover their costs.

Despite heightened alarm, this is not the first time medical malpractice insurance has been in “crisis.” In fact, the late 1950s, late 1960s, mid-1970s and mid-to-late 1980s experienced a similar phenomenon (Mauney, 2002).

**Defensive Medicine.** Health care providers pass higher malpractice premiums on to patients directly through increased fees and indirectly through changes in the quality of care (Danzon, 1991, p. 61).

While the cost of malpractice claims is only two percent of health care expenditure, studies have found that the effect of the malpractice system on physician behavior has substantial implications for health care costs and outcomes (Kessler & McClellan, 1996, p. 353-4). Fear of liability may drive health care providers to administer treatments with no worthwhile medical benefit. Performing unnecessary tests and procedures increases the cost of healthcare, uses resources inefficiently and can place the patient at greater risk.

## LIABILITY SHORTFALLS

While there has been substantial focus on increasing costs, much less attention is given to whether the current liability system is effective. Key questions that need answering include: Are injured patients receiving appropriate compensation? And, is the threat of litigation a sufficient deterrent to negligent behavior? The answer to both of these questions is no.

According to David Hoffman, Vice President for ethics and compliance and general counsel at Wyckoff Heights Medical Center, the real crisis is that “the wrong people are getting most of the money” (2005).

**Protecting Patients.** Two medical malpractice studies, one conducted in Colorado and Utah and the other in New York, found that adverse events (medical errors resulting in injury) occurred in 2.9 and 3.7 percent of hospitalizations, respectively (Thomas et al., 2000; Harvard Medical Practice Study, 1990, Ch 7 p. 36). In Colorado and Utah, 6.6 percent of these adverse events resulted in death (Thomas et al., 2000). In New York hospi-



tals it was 13.6 percent (Harvard Medical Practice Study, 1990, Executive Summary p. 3). Using these statistics, Kohn, Corrigan and Donaldson estimate that between 44,000 and 98,000 Americans die each year as a result of medical errors (2000, p. 1).

Few individuals are compensated by the malpractice liability system. In the Harvard study on New York hospitals, one out of nine patients identified as having sustained an injury due to negligence filed a claim (Harvard Medical Practice Study, 1990, Executive Summary p. 6).

Exacerbating the problem, many of those that do file a claim have not sustained an injury caused by negligence (Danzon, 1991, p. 55). Nationally, approximately 70 percent of claims result in no insurance payment (CBO, 2004).

## REFORM

In 2000, the Institute of Medicine published a study entitled “To Err is Human: Building a Safer Health System.” The findings and recommendations put forth in this report have helped set the stage for a true reform debate.

According to the authors, health care remains a decade behind other high-risk industries in its attention to basic safety (Kohn et al., 2000, p. 5). For this to change, “The focus must shift from blaming individuals for past errors to a focus on preventing future errors” (p. 5). While health care providers must be held accountable for their actions, blaming an individual does little to make the system safer (p. 5)

Improvement in patient safety requires the implementation of four overarching reform measures (p. 6). These measures are:

- Enhance the safety knowledge base and create leadership
- Identify and learn from errors through strong mandatory reporting efforts and the encouragement of voluntary efforts
- Set performance standards and expectations for improvements in safety
- Create and implement safety systems inside health care organizations

The existing system of liability is an impediment to patient safety. Many health care providers refrain from disclosing information about errors due to fear of litigation. As a result, less than five percent of known errors are ever reported (Kohn et al, 2000, p. 180). Failure to report slows efforts to improve the quality of care.

***Current Malpractice Reform Efforts.*** Across the nation, states have adopted reforms in an attempt to curb the cost of malpractice insurance and litigation. Likewise, scholars and policy analysts are continuing to examine the effects of the various reform proposals.

While most agree that the current litigation system creates unnecessary costs and imperfect outcomes, there is much less consensus on what the appropriate solutions are. Suggestions include tort reform, medical reform and insurance reform.



According to Kessler and McClellan, malpractice reforms that directly reduce provider liability (e.g. caps on damage awards, abolition of punitive damages, elimination of mandatory prejudgment interest, and collateral-source-rule reforms) lead to a five to nine percent reduction in medical expenditures (1996, p. 353 & 386). Similarly, Viscusi and Born found that “liability reforms reduce losses, lower premiums, and enhance insurer profitability” (2005, p. 41). And, according to Kessler, Sage and Becker, the adoption of direct malpractice reforms lead to greater growth in the supply of physicians (2005).

However, some reforms appear to be more effective than others. For example, Kessler and McClellan found that “reforms that limit liability only indirectly – caps on contingency fees, mandatory periodic payments, joint-and-several liability reform, and patient compensation funds – are not associated with substantial effects on either expenditures or outcomes” (1996, p. 386). Some studies have found no correlation between reforms and industry improvements (Danzon, 1991).

### **CASE STUDY: CALIFORNIA**

In 1975 California enacted the Medical Injury Compensation Reform Act. MICRA imposed a \$250,000 cap on non-economic damages (e.g. pain, suffering, disfigurement, loss of ability to enjoy life, etc.), allowed defendants to introduce evidence of alternate compensation, authorized periodic payments, and imposed limits on lawyer contingency fees. Since its enactment, studies have repeatedly found that these reforms have reduced malpractice costs in California without restricting access to the courts.

According to Hamm, Wazzan, and French, the California cap on non-economic damages decreased loss payments by an estimated 44 percent between 1990 and 2004 (2005, p. 19). Similarly, the MICRA cap reduced medical liability insurance premiums by an estimated 20 to 43 percent (p. 25). Compared to the rest of the country, in 2004 California had the third lowest average payment per malpractice claim (p. 17).

### **WASHINGTON**

Like the rest of the nation, Washington experienced large increases in both the cost of health care and the cost of malpractice insurance premiums. Several medical malpractice insurance companies (Washington Casualty Company and St. Paul Companies) stopped offering malpractice insurance to physicians in the state.

While Insurance Commissioner Kreidler (2005) recently announced that malpractice insurance is once again becoming more available and affordable, future hard markets are likely and the current liability system continues to increase the cost of health care both directly and indirectly while failing to properly protect and compensate patients.

This November, voters will face dueling liability-reform initiatives with very different approaches to solving the health care “crisis.” Initiative 330, supported by the Washington State Medical Association, the Washington State Hospital Association, and Doctors, Nurses and Patients for a Healthy Washington, proposes curbing costs by lowering the incidence and payout



of medical liability cases. Initiative 336, supported by Washington State Trial Lawyers, Washington Citizen Action and Citizens for Better Safer Healthcare, advocates controlling costs by reducing the amount of malpractice and preventing spikes in insurance rates. Since the two initiatives do not conflict, it is possible that both could pass.

### **INITIATIVE 330**

Initiative 330 places caps on noneconomic damages, permits periodic payments of damages, implements a sliding scale for attorney contingency fees, increases the use of arbitration, expands evidence of payments from other sources, abolishes joint-and-several liability and tightens the statute of limitation. See Table 1A.

**Limiting Awards.** Advocates of I-330 argue that rising jury awards have caused insurance premiums to rise, compelled doctors to limit their practice, and increased the prevalence of defensive medicine. In 2003 alone, medical malpractice cost an estimated \$26.5 billion nationally (Towers Perrin, 2005, p. 15).

In order to lower the cost of malpractice insurance and litigation, the initiative would limit excessive verdicts by making juries aware of payments received by plaintiffs from other sources. In addition, caps would be placed on noneconomic damages. Economic damages, things like medical expenses and lost wages, would remain uncapped.

Opponents of I-330 criticize efforts to limit patient awards. Despite the large payouts, jury verdicts are rare and malpractice insurance costs represent only a small portion of health care expenditure. However, this argument fails to take into account the benefits of lowered defensive medicine practices.

Critics also maintain that the cap on noneconomic damages is unconstitutional. A similar restriction was enacted by the Legislature in 1986 and subsequently overturned by the Washington Supreme Court in the 1989 case *Sofie v. Fibreboard Corp.* because it infringed on the right to trial by jury. Still, supporters of I-330 argue that the new cap has been carefully constructed to withstand court scrutiny. To date, all attempts by the opposition to have I-330 or sections of I-330 removed from the ballot have been turned down. However, if I-330 passes, it will most likely go back to the courts for further ruling.

**Patient Recovery.** While lowering overall malpractice payouts, supporters believe the initiative still maximizes patient recovery of damages by guaranteeing payment over time and introducing a sliding scale on attorney fees.

However, while a sliding scale contingency fee system may discourage cases that lack merit, it also favors less meritorious cases with greater economic value (Hoffman, 2005). As a result, critics claim that some injured patients might not be able to find a lawyer willing to take their case.

Similarly, opponents argue that capping plaintiff attorney fees while leaving defense attorney fees uncapped gives an unfair advantage to defendants. However, I-330 supporters maintain that defendant spending is dictated by

**Table 1A. Summary of Initiative 330 Provisions and Debate**

Reform	Currently	If I-330 enacted	The Debate
Time Limit	Within 3 years of the act or 1 year after discovered/should have been discovered, whichever period is longer. Exception: those under 18, incompetent, disabled or imprisoned.	Within 3 years of the act or 1 year after discovered/should have been discovered, whichever occurs first. Children under 6 years must file a lawsuit within 3 years or before their 8th birthday.	For: Will reduce the number of cases. Hard to attribute cause after too much time has passed.
			Against: Limits the time injured patients have to file and weakens exceptions.
Notice	N/A	Defendant must be given at least 90 days notice before action for damages can be commenced.	For: Provides defendants with sufficient time to prepare.
			Against: Further lengthens the process.
Mediation	Mediation required prior to going to trial.	Mediation requirements strengthened. All medical malpractice action must initially undergo mediation, without exception.	For: Allows for quicker settlements. Lets both parties "lay their cards on the table" so attorneys have more rational basis to advise clients.
			Against: Requires mediation for cases resulting in death. Reduces judicial discretion.
Collateral Source Rule	May present evidence that patient has been compensated for the injury from other sources, except for the patient's assets or insurance.	Collateral source rule fully abolished. May present evidence of past or future compensation from all sources.	For: Prevents double payments and decreases the defendant's liability.
			Against: Claimant will not be compensated for expenses paid using personal or family assets.
Noneconomic Damages	No limits on the amount of noneconomic damages (e.g. pain, suffering, disfigurement, loss of ability to enjoy life, etc.) that can be awarded.	A \$350,000 cap on damages from health care officials and a \$700,000 cap on damages from health care institutions for a combined cap of \$1,050,000, regardless of the number of individual and institutional defendants. Claimant only allowed to recover noneconomic damages once.	For: Limits excessive jury awards without limiting recovery of actual damages. Lowers losses to insurance companies and may lower frequency of lawsuits.
			Against: Few payouts exceed \$1 million and the cap does not allow for exceptions for those with severe injuries.
Attorney fees	Attorney fees can be either fixed or contingent; Court authorized to determine reasonableness of fees.	Sliding scale: Contingent attorney fees cannot exceed 40 percent of the first \$50,000 recovered, 33 1/3 percent of the next \$50,000 recovered, 25 percent of the next \$50,000 recovered, and 15 percent of any recovery exceeding \$600,000.	For: Ensures patients get more of the award. Could decrease the number of cases by decreasing financial incentives for attorneys.
			Against: Plaintiff attorney contingent fees are capped while defendant attorney fees are not.
Joint and Several Liability	Each defendant liable for the plaintiff's total damages, regardless of the defendant's proportion of fault.	Eliminated. Each party only responsible for the percent the party is at fault. Hospitals liable only if the provider is an actual agent or employee and was acting within the course and scope of his position.	For: Health care professionals and institutions held accountable for their actions and not those of others.
			Against: Could prevent those injured from collecting.
Arbitration	Parties authorized to contract to submit controversies to arbitration. Arbitration clauses between patient and doctor considered invalid.	Arbitration clauses in which a patient gives up the right to a jury trial permitted in contracts for medical services. However, may be rescinded by written notice within 30 days of signature.	For: Quicker settlements. Tends to lower settlement amount. Patients can seek medical treatment elsewhere if they choose not to sign.
			Against: Requires patient to agree to arbitration before receiving medical care.
Period Payments	Authorizes period payments of future economic damages when awards exceed \$100,000.	Periodic payments include noneconomic damages. Amount for periodic payments lowered to \$50,000. If the claimant dies, courts can eliminate future payments for medical treatment, care or custody, loss of bodily function, or future pain and suffering.	For: Ensures patient receives benefits on an on-going basis. This could reduce insurers' costs.
			Against: If patient dies before fully paid, part of the money goes to the insurance company and not the family.
Vulnerable Adult	Prevailing vulnerable adult plaintiff awarded actual damages plus the cost of suit.	Removes defendant payment of prevailing plaintiff's attorney fees and experts. Restricts the definition of costs.	For: Makes it more in line with other malpractice litigation. Streamlines.
			Against: Removes needed exceptions for vulnerable adults.

Source: Senate Bill Report Initiative 330, Initiative 330, [www.wsba.org](http://www.wsba.org), [www.yesoni330.org](http://www.yesoni330.org) & <http://www.walrc.org/>





plaintiff spending so the de facto result will be to decrease defendant spending as well.

**Lowering Litigation Expenditure.** Initiative 330 strengthens current requirements that parties to a malpractice case undergo mediation before proceeding to trial.

In addition, the initiative allows doctors and patients to commit to resolve malpractice claims through arbitration. Supporters assert binding arbitration will allow claims to be paid more quickly and with less money wasted on litigation. However, critics maintain that the arbitration clause stifles patients' rights. A patient in need of immediate emergency medical care would have no choice but to sign away his or her right to a trial by jury. Supporters of I-330 counter that the Federal Emergency Medical Treatment and Active Labor Act prevents hospitals from rejecting patients suffering from an emergency medical condition.

### INITIATIVE 336

I-336 revokes licenses of negligent physicians, bans secret settlements, requires public hearings on large malpractice rate increases, establishes a supplemental insurance fund, limits the number of expert witnesses, places requirements on lawsuit certification, and increases the membership of the Medical Quality Assurance Commission. See Table 1B.

**Accountability.** Supporters of I-336 argue that controlling the amount of medical malpractice is the best way to achieve lower insurance costs. Studies have repeatedly shown that a small number of physicians account for a large percent of malpractice payouts (DeMaria, 2003). Even with state professional review mechanisms, Sloan et al. found that less than ten percent of physicians were disciplined in any manner for adverse claims (1989). The three-strikes rule, the patient right to know enhancements, and the changes made to the Medical Quality Assurance Commission are all aimed at holding doctors accountable for preventable medical injuries.

Critics of the initiative argue that the three-strikes rule will not remove "bad" doctors. Very few doctors have had three judgments made against them in a ten-year period and so the only real effect would be to force doctors to make early, lucrative settlements for fear of having their licenses revoked. In addition, the rule is both arbitrary and unfair; it fails to take into account the fact that some doctors are practicing in higher risk fields and performing a larger number of procedures. Lastly, allowing confidential records to be accessed would kill peer review of doctors and hurt efforts to improve patient safety.

**Regulation.** Supporters of I-330 blame "price gouging" insurance companies for the instability of Washington's medical malpractice system. In order to prevent future premium spiking and insurance shortages, the initiative strengthens the power of the state insurance commissioner, tracks malpractice claims, and provides supplemental insurance for doctors.

Opponents maintain that these reforms would drive up health care costs and create an unnecessary insurance program. Doctors covered by the Supplemental Insurance Program are prevented from rejecting settlement offers.

**Table 1B. Summary of Initiative 336 Provisions and Debate**

<b>Reform</b>	<b>Currently</b>	<b>If I-336 enacted</b>	<b>The Debate</b>
Additional Medical Malpractice Insurance	Health care providers purchase coverage from insurers in the private market.	Supplemental malpractice insurance program created to provide additional liability coverage. Premiums based off professionals' malpractice history. A participating provider or facility may not reject any settlement agreement but may appeal any resulting premium increases.	For: Provides doctors with additional layer of protection. Voluntary. Uses experience rating.
			Against: Drives up health care costs by creating an unnecessary "state-run" insurance company. Creates second source of payouts for lawyers. Doctors can't reject settlement offer.
Disclosure	Insurance companies required to report some information regarding claims.	Insurance company must report all claims resulting in a final judgment, settlement, or disposition of a medical malpractice claim resulting in no indemnity payment. Details about health care provider/facility and the occurrence must be included.	For: Tracks malpractice claims and provides the public with access to information.
			Against: A provider who has a closed claim with no indemnity paid would be subjected to public disclosure.
Insurance Commission	Responsible for the licensing and regulation of insurance companies. Does not receive information about medical malpractice claims, judgments, or settlements. Generally does not review insurer's underwriting standards nor receive information related to specific coverage.	Commissioner must notify public when any insurer files for a rate change. If rate change is 15 percent or greater, must order a public hearing. Insurers required to report to Commissioner any malpractice claim that resulted in a final judgment or settlement. Commissioner must prepare annual statistics summarizing claims and insurance market.	For: Requires insurance companies to justify major rate hikes. Prevents premium spiking.
			Against: Unnecessary. The Office of Insurance Commissioner already has the authority to approve or reject insurance rates.
Department of Health's Medical Quality Assurance Commission	Establishes, monitors, and enforces qualifications for licensure, consistent standards of practice, and continuing competency.	The number of members from the public on the MQAC raised. All verdicts or settlements in a medical malpractice action in excess of \$100,000 must be reported to the Dept. of Health.	For: Enhances oversight.
			Against: Physician discipline will not be improved by including more civilian members on the MQAC. The real problem is that it lacks funding.
Three Strikes	Under the Uniform Disciplinary Act, MQAC may issue orders of discipline ranging from revocation of license to mandating a refund to the patient against a license holder that has committed unprofessional conduct or is unable to practice with reasonable skill or safety.	Must thoroughly investigate health care professional if had 3 claims paid within 5 year period and if the total indemnity payment for each claim was \$50,000 or more. Unless mitigating circumstances, license revoked for person with 3 or more judgments entered against them within a 10-year period.	For: Holds doctors accountable for preventable injuries.
			Against: Will force practitioners to settle rather than risk trial. Encourages early and easy settlement of cases for the benefit of plaintiffs and their attorneys. Won't remove "bad" doctors - very few doctors have had 3 judgments within 10 years.
Expert Witnesses	No limit on the number of expert witnesses allowed per issue in medical malpractice action.	Each side is limited to 2 expert witnesses per issue except upon the show of necessity.	For: Reduces cost and length of trial.
			Against: A disadvantage to physician defendants when there are multiple defendants.
Patient Right To Know	N/A	Upon patient or immediate family member request, health care provider must disclose his/her experience with the treatment including outcomes.	For: Easier for patients to get information about medical errors. Eliminates secrecy agreements.
			Against: Will create opportunity for personal injury lawyers to gather more information to be used against physician. Will discourage candid reporting.
Frivolous Lawsuits	N/A	Attorneys filing claim must certify that the claim is not frivolous. If frivolous action is signed and filed, court may impose an appropriate sanction.	For: Reduce and discourage frivolous lawsuits. Holds attorneys accountable.
			Against: Provides no functional benefit or effect. Easy to get certificate of merit.





**Litigation Costs.** Initiative 336 aims to reduce the duration of trials and the number of frivolous lawsuits by limiting the number of expert witnesses per issue in a trial to two. In addition, attorneys must get an expert to certify that the case has merit or face sanctions. Supporters claim that expert certification can help keep frivolous cases out of court and allow for greater chances of settlement by presenting facts early on.

Opponents of I-336 argue that these measures simply protect personal injury lawyers' share of awards. They also maintain that the expert certification requirement is easy to obtain and so will provide no functional benefit.

## FINDING THE MIDDLE GROUND

Washington needs comprehensive reform that addresses patient safety and compensation, malpractice insurance affordability and stability, and tort effectiveness. However, "finding fault with the tort system's inability to meet certain lofty but abstract ideals is rather easy. A much tougher challenge is devising another system that could actually do a better job of securing the variety of often incompatible goals" (Harvard Medical Practice Study, 1990, Ch 2 p. 9).

By capping noneconomic damages and encouraging mediation and arbitration in place of litigation, I-330 should modestly restrain the cost of malpractice insurance. On the other hand, I-336's three-strikes provision should increase plaintiffs' leverage, increasing the size of negotiated settlements and ultimately the cost of malpractice insurance. It is not clear whether either initiative will have much impact on the number of medical errors made.

Whether either of the medical malpractice liability initiatives provide sufficient and equitable reforms will be decided by the voters.

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