WEST VIRGINIA LEGISLATURE

FIRST REGULAR SESSION, 2003

SECOND ENROLLMENT

COMMITTEE SUBSTITUTE FOR House Bill No. 2122

(By Mr. Speaker, Mr. Kiss, and Delegate Trump)
[By Request of the Executive]

Amended and Again Passed March 8, 2003

In Effect from Passage

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FOR

H. B. 2122

(BY MR. SPEAKER, MR. KISS, AND DELEGATE TRUMP)
[BY REQUEST OF THE EXECUTIVE]

[Amended and Again Passed March 8, 2003,
as a Result of the Objections of the Governor; in Effect From Passage.]

AN ACT to amend and reenact section two, article eleven-a, chapter four of the code of West Virginia, one thousand nine hundred thirty-one, as amended; to amend chapter eleven of said code by adding thereto a new article, designated article thirteen-t; to amend and reeenact section five, article twelve, chapter twenty-nine of said code; to amend and reenact sections six and fourteen, article twelve-b of said chapter; to further amend said chapter by adding thereto a new article, designated article twelve-c; to amend and reenact section fourteen, article three, chapter thirty of said code; to amend and reenact section twelve-a, article fourteen of said chapter; to amend article two, chapter thirty-three of said code by adding thereto a new section, designated section nine-a; to amend and reenact sections fourteen and fourteen-a of article

three of said chapter; to amend and reenact section fifteen-a, article four of said chapter; to amend and reenact sections two and three, article twenty-b of said chapter; to further amend said article by adding thereto a new section, designated section three-a; to amend and reenact sections two through eleven, inclusive, article twenty-f of said chapter; to further amend said article by adding thereto a new section, designated section one-a; to amend and reenact section twenty-four, article twenty-five-a of said chapter; to amend and reenact section twenty-six, article twenty-five-d of said chapter; to amend and reenact section four, article ten, chapter thirty-eight of said code; to amend and reenact sections one, two, three, six, seven, eight, nine and ten, article seven-b, chapter fifty-five of said code; and to further amend said article by adding thereto three new sections, designated sections nine-a, nine-b and nine-c, all relating to medical professional liability generally; transferring funds from board of risk and insurance management and from tobacco settlement medical trust fund; providing a health care provider tax credit for physicians based upon payment of certain medical malpractice liability insurance premiums paid; setting forth legislative findings and purpose; defining terms; creating tax credit and providing eligibility; establishing amount and time period for credit; allowing unused credit to carry forward; providing for the application of the credit; providing for the computation and application of credit; authorizing tax commissioner to promulgate legislative rules relating to the credit; establishing burden of proof relating to claiming the credit; allowing the board of risk and insurance management to include critical access hospitals as charitable or public service organizations eligible for receiving insurance coverage; authorizing the board of risk and insurance management to issue certain coverage to non-transferred health care providers; terminating authority of board of risk and insurance management to issue certain medical professional liability insurance upon transfer of assets to the physicians' mutual insurance company; creating board to study the feasibility

of and propose a mechanism for funding the patient injury compensation fund; establishing term, authority and directives of the board; granting certain duties and conditionally authorizing the board of risk and insurance management to promulgate legislative and emergency rules; requiring the board of medicine and the board of osteopathy to take certain disciplinary actions against physicians in certain circumstances; providing for a limited diversion of premium taxes on certain insurance policies; providing a one-time assessment on all insurance carriers; prohibiting predatory rates and reduced rates designed to gain market share; requiring additional reporting requirements for insurance carriers providing medical malpractice coverage; providing for the creation of a physicians' mutual insurance company and the concomitant novation of certain board of risk and insurance management medical professional liability insurance programs; setting forth additional legislative findings and purpose; providing terms and conditions for transfer of specified assets and moneys to the physicians' mutual; defining terms; prohibiting company from taking certain actions; requiring certain premium taxes to be applied toward restoring West Virginia tobacco medical trust fund; returning premium taxes to originally allocated sources after moneys have been restored to the tobacco settlement medical trust fund; waiver of taxes under certain circumstances; providing for governance and organization of the company; specifying composition of company's board of directors; creating a special account to receive funds transferred from the tobacco settlement medical trust fund; imposing a one time assessment on certain licensed physicians for the privilege of practicing in West Virginia; exempting certain physicians from assessment; requiring competitive bidding in certain circumstances; exempting company from certain requirements imposed on other mutual insurance companies by the insurance commission; providing for additional reporting requirements and actuarial studies for the company; authorizing transfer of funds from special account and of certain assets, obligations and liabilities of

the board of risk and insurance management to the company on a certain date and establishing other terms and conditions associated with the transfer; increasing exemption available to certain physician and surgeon debtors in bankruptcy proceedings; providing additional legislative findings and purposes relating to medical professional liability; defining terms; adding an element of proof in certain malpractice claims; altering notice requirements for malpractice claims; modifying the qualifications for experts who testify in medical professional liability actions; limiting liability for certain noneconomic losses; providing a reversion provision; creating conditional limitations and cap on certain damages; providing for limited severability; eliminating joint, but not several, liability among multiple defendants in medical professional liability actions; prohibiting consideration of certain third parties in malpractice cases; eliminating a cause of action based on ostensible agency in certain circumstances; allowing for reduction in damage awards for certain collateral source payments to plaintiffs; providing mechanism for determining collateral source payments and damages distribution; providing for calculation methodology for determining award payments; altering collection of economic damages upon implementation of patient compensation fund; barring actions against health care providers for certain third party claims; limiting civil liability for designated trauma center care; directing the office of emergency medical services to designate hospitals as trauma centers and provisional trauma centers; placing limitations on eligibility for trauma care caps; requiring the office of emergency medical services to develop a written protocol containing recognized and accepted standards for triage and emergency health procedures; authorizing the secretary of the department of health and human resources to promulgate legislative and emergency rules; and establishing effective date, applicable to all causes of action alleging medical professional liability.

Be it enacted by the Legislature of West Virginia:

That section two, article eleven-a, chapter four of the code of West Virginia, one thousand nine hundred thirty-one, as amended, be amended and reenacted; that chapter eleven of said code be amended by adding thereto a new article, designated article thirteen-t; that section five, article twelve, chapter twenty-nine of said code be amended and reenacted; that sections six and fourteen, article twelve-b of said chapter be amended and reenacted; that said chapter be further amended by adding thereto a new article, designated article twelve-c; that section fourteen, article three, chapter thirty of said code be amended and reenacted; that section twelve-a, article fourteen of said chapter be amended and reenacted; that article two, chapter thirty-three of said code be amended by adding thereto a new section, designated section nine-a; that sections ~~four, four-a,~~ fourteen and fourteen-a, article three of said chapter be amended and reenacted; that section fifteen-a, article four of said chapter be amended and reenacted; that section two, article twenty-b of said chapter be amended and reenacted; that said article be further amended by adding thereto a new section, designated section three-a; that sections two through eleven, inclusive, of article twenty-f of said chapter be amended and reenacted; that said article be further amended by adding thereto a new section, designated section one-a; that section twenty-four, article twenty-five-a of said chapter be amended and reenacted; that section twenty-six, article twenty-five-d of said chapter be amended and reenacted; that section four, article ten, chapter thirty-eight of said code be amended and reenacted; that sections one, two, three, six, seven, eight, nine, and ten, article seven-b, chapter fifty-five of said code be amended and reenacted; and that said article be further amended by adding thereto three new sections, designated sections nine-a, nine-b and nine-c, all to read as follows:

CHAPTER 4. THE LEGISLATURE.

ARTICLE 11A. LEGISLATIVE APPROPRIATION OF TOBACCO SETTLEMENT FUNDS.

§4-11A-2. Receipt of settlement funds and required deposit in West Virginia tobacco settlement medical trust fund.

(a) The Legislature finds and declares that certain dedicated revenues should be preserved in trust for the purpose of stabilizing the state's health related programs and delivery systems. It further finds and declares that these dedicated revenues should be preserved in trust for the purpose of educating the public about the health risks associated with tobacco usage and establishing a program designed to reduce and stop the use of tobacco by the citizens of this state and in particular by teenagers.

(b) There is hereby created a special account in the state treasury, designated the "West Virginia Tobacco Settlement Medical Trust Fund," which shall be an interest-bearing account and may be invested in the manner permitted by section nine, article six, chapter twelve of this code, with the interest income a proper credit to the fund. Unless contrary to federal law, fifty percent of all revenues received pursuant to the master settlement agreement shall be deposited in this fund. Funds paid into the account may also be derived from the following sources:

(1) All interest or return on investment accruing to the fund;

(2) Any gifts, grants, bequests, transfers or donations which may be received from any governmental entity or unit or any person, firm, foundation or corporation;

(3) Any appropriations by the Legislature which may be made for this purpose; and

(4) Any funds or accrued interest remaining in the board of risk and insurance management physicians' mutual insurance company account created pursuant to section seven, article

twenty-f, chapter thirty-three of this code on or after the first day of July, two thousand four.

(c) The moneys from the principal in the trust fund may not be expended for any purpose, except that on the first day of April, two thousand three, the treasurer shall transfer to the board of risk and insurance management physicians' mutual insurance company account created by section seven, article twenty-f, chapter thirty-three of this code, twenty-four million dollars from the West Virginia tobacco settlement medical trust fund for use as the initial capital and surplus of the physicians' mutual insurance company created pursuant to article twenty-f, chapter thirty-three of this code. The remaining moneys in the trust fund resulting from interest earned on the moneys in the fund and the return on investments of the moneys in the fund shall be available only upon appropriation by the Legislature as part of the state budget and expended in accordance with the provisions of section three of this article.

CHAPTER 11. TAXATION.

ARTICLE 13T. TAX CREDIT FOR COMBINED CLAIMS MADE MEDICAL MALPRACTICE PREMIUMS AND MEDICAL MALPRACTICE LIABILITY TAIL INSURANCE PREMIUMS PAID.

§11-13T-1. Legislative finding and purpose.

The Legislature finds that the retention of physicians practicing in this state is in the public interest and promotes the general welfare of the people of this state. The Legislature further finds that the promotion of stable and affordable medical malpractice liability insurance premium rates and medical malpractice liability tail insurance premium rates will induce retention of physicians practicing in this state.

In order to effectively decrease the cost of medical malpractice liability insurance premiums and medical malpractice

liability tail insurance premiums paid in this state on physicians' services, there is hereby provided a tax credit for certain medical malpractice liability insurance premiums and medical malpractice liability tail insurance premiums paid.

§11-13T-2. Definitions.

(a) *General.* — When used in this article, or in the administration of this article, terms defined in subsection (b) of this section have the meanings ascribed to them by this section, unless a different meaning is clearly required by the context in which the term is used.

(b) *Terms defined.* –

(1) "Claims made malpractice insurance policy" means a medical malpractice liability insurance policy that covers claims which:

(A) Are reported during the policy period,

(B) Meet the provisions specified by the policy, and

(C) Are for an incident which occurred during the policy period, or occurred prior to the policy period, as is specified by the policy.

(2) "Combined annual medical liability insurance premiums" means the sum of the actual amount of insurance premiums paid by or on behalf of the taxpayer during the taxable year for medical malpractice insurance coverage under a claims made malpractice insurance policy, plus the actual amount of insurance premiums paid by or on behalf of the taxpayer during the taxable year for tail insurance.

(3) "Eligible taxpayer" means any person subject to tax under section sixteen, article twenty-seven of this chapter or a

physician who is a partner, member, shareholder or employee of an eligible taxpayer.

(4) "Eligible taxpayer organization" means a partnership, limited liability company, or corporation that is an eligible taxpayer.

(5) "Payor" means a natural person who is a partner, member, shareholder or owner, in whole or in part, of an eligible taxpayer organization and who pays medical malpractice insurance premiums or tail insurance premiums or both for or on behalf of the eligible taxpayer organization.

(6) "Person" means and includes any natural person, corporation, limited liability company, trust or partnership.

(7) "Physicians' services" means health care provider services taxable under section sixteen, article twenty-seven of this chapter, performed in this state by physicians licensed by the state board of medicine or the state board of osteopathic medicine.

(8) "Tail insurance" means insurance which covers an eligible taxpayer insured once a claims made malpractice insurance policy is canceled, not renewed or terminated and which covers claims made or asserted after such cancellation or termination for acts relating to the provision of physicians' services by the eligible taxpayer occurring during the period the prior malpractice insurance was in effect.

(9) "Tail insurance premium" means insurance coverage premiums paid by an eligible taxpayer or payor during the taxable year for tail insurance.

(10) "Tail liability" means the medical malpractice liability of an eligible taxpayer insured that results from a claim asserted subsequent to cancellation, nonrenewal or termination of a

claims made malpractice insurance policy for acts relating to the provision of physicians' services by the eligible taxpayer occurring during the period when the prior malpractice insurance was in effect.

§11-13T-3. Eligibility for tax credits; creation of the credit.

There shall be allowed to every eligible taxpayer a credit against the tax payable under section sixteen, article twenty-seven of this chapter. The amount of this credit shall be determined and applied as provided in this article.

§11-13T-4. Amount of credit allowed.

(a) *Allowance.* –

(1) The amount of annual credit allowable under this article to an eligible taxpayer shall be:

(A) Ten percent of the combined annual medical liability insurance premiums paid in excess of thirty thousand dollars, or

(B) Twenty percent of combined annual medical liability insurance premiums paid in excess of seventy thousand dollars.

(2) This credit may be taken for combined annual medical liability insurance premiums paid during any taxable year beginning on or after the first day of January, two thousand two, and ending on or before the thirty-first day of December, two thousand three.

(b) *Exclusions.* -- No credit shall be allowed for any combined annual medical liability insurance premiums, or part or component thereof, paid by or on behalf of an eligible taxpayer employed by this state, its agencies or subdivisions. No credit shall be allowed for any combined annual medical

liability insurance premiums, or part or component thereof, paid by or on behalf of an eligible taxpayer or an eligible taxpayer organization or a payor pursuant to insurance coverage provided under article twelve, chapter twenty-nine of this code. No credit shall be allowed for any combined annual medical liability insurance premiums, or part or component thereof, paid before the first day of January, two thousand two, or paid after the thirty-first day of December, two thousand three.

§11-13T-5. Unused credit; carryforward; credit forfeiture.

If any credit remains after application of the credit against tax for any taxable year under this article, the amount thereof shall be carried forward to each ensuing tax year until used or until the first day of July, two thousand ten, whichever occurs first. If any unused credit remains after the first day of July, two thousand ten, the amount thereof is forfeited. No carryback to a prior taxable year is allowed for the amount of any unused portion of this credit.

§11-13T-6. Application of credit against health care provider tax; schedules; estimated taxes.

(a) The credit allowed under this article shall be applied against the tax payable under section sixteen, article twenty-seven of this chapter, for the taxable year in which the combined annual medical liability insurance premiums are paid. To assert credit against the tax payable under section sixteen, article twenty-seven of this chapter, the eligible taxpayer shall prepare and file with the annual tax return filed under article twenty-seven of this chapter, a schedule showing the combined annual medical liability insurance premiums paid for the taxable year, the amount of credit allowed under this article, the tax against which the credit is being applied and other information that the tax commissioner may require. This annual

schedule shall set forth the information and be in the form prescribed by the tax commissioner.

(b) An eligible taxpayer may consider the amount of credit allowed under this article when determining the eligible taxpayer's liability for periodic payments of estimated tax for the taxable year for the tax payable under section sixteen, article twenty-seven of this chapter, in accordance with the procedures and requirements prescribed by the tax commissioner. The annual total tax liability and total tax credit allowed under this article are subject to adjustment and reconciliation pursuant to the filing of the annual schedule required by this section.

§11-13T-7. Computation and application of credit.

(a) *Credit resulting from premiums directly paid by persons who pay the tax imposed by section sixteen, article twenty-seven of this chapter.* — The annual credit allowable under this article for eligible taxpayers other than payors described in subsection (b) of this section, shall be applied as a credit to reduce the eligible taxpayer's annual tax liability imposed under section sixteen, article twenty-seven of this chapter, determined after application of the credit allowed under article thirteen-p of this chapter, if any, and after application of all other allowable credits, deductions and exemptions.

(b) Computation of credit for premiums directly paid by partners, members or shareholders of partnerships, limited liability companies, or corporations for or on behalf of such organizations; application of credit.

(1) Qualification for credit.— Combined annual medical liability insurance premiums paid by a payor (as defined in this article) qualify for tax credit under this article, provided that such payments are made to insure against medical malpractice

liabilities arising out of or resulting from physicians' services provided by a physician while practicing in service to or under the organizational identity of an eligible taxpayer organization or as an employee of such eligible taxpayer organization, and where such insurance covers the medical malpractice liabilities or tail liabilities of:

(A) The eligible taxpayer organization; or

(B) One or more physicians practicing in service to or under the organizational identity of the eligible taxpayer organization or as an employee of the eligible taxpayer organization; or

(C) Any combination thereof.

(2) *Application of credit by the payor against health care provider tax on physician's services.* — The annual credit allowable under this article shall be applied to reduce the tax liability directly payable by the payor under section sixteen, article twenty-seven of this chapter, determined after application of the credit allowed under article thirteen-p of this chapter, if any, and after application of all other allowable credits, deductions and exemptions.

(3) *Application of credit by the eligible taxpayer organization against health care provider tax on physician's services.* — After application of this credit as provided in subdivision (2) of this subsection, remaining annual credit shall then be applied to reduce the tax liability directly payable by the eligible taxpayer organization under section sixteen, article twenty-seven of this chapter, determined after application of the credit allowed under article thirteen-p of this chapter, if any, and after application of all other allowable credits, deductions and exemptions.

(4) *Apportionment among multiple eligible taxpayer organizations.* — Where a payor described in subdivision (1) of

this subsection pays combined annual medical liability insurance premiums for and provides services to or under the organizational identity of two or more eligible taxpayer organizations described in this section or as an employee of two or more such eligible taxpayer organizations, the tax credit shall, for purposes of subdivision (3) of this subsection, be allocated among such eligible taxpayer organizations in proportion to the combined annual medical liability insurance premiums paid directly by the payor during the taxable year to cover physicians' services during such year for, or on behalf of, each eligible taxpayer organization. In no event may the total credit claimed by all payors, eligible taxpayers and eligible taxpayer organizations exceed the credit which would be allowable if the payor had paid all such combined annual medical liability insurance premiums for or on behalf of one eligible taxpayer organization, and if all physician's services had been performed for, or under the organizational identity of, or by employees of, one eligible taxpayer organization.

(c) Application of the credit allowed under this article in combination with all other applicable tax credits, exemptions and deductions shall in no event reduce the tax liability below zero, and shall in no circumstances be applied as a refundable tax credit, or result in a refundable tax credit.

§11-13T-8. Legislative rules.

The tax commissioner shall propose for promulgation rules pursuant to the provisions of article three, chapter twenty-nine-a of this code, as may be necessary to carry out the purposes of this article.

§11-13T-9. Burden of proof.

The burden of proof is on the person claiming the credit allowed by this article to establish by clear and convincing

evidence that the person is entitled to the amount of credit asserted for the taxable year.

CHAPTER 29. MISCELLANEOUS BOARDS AND OFFICERS.

ARTICLE 12. STATE INSURANCE.

§29-12-5. Powers and duties of board.

(a) The board shall have general supervision and control over the insurance of all state property, activities and responsibilities, including the acquisition and cancellation thereof; determination of amount and kind of coverage, including, but not limited to, deductible forms of insurance coverage, inspections or examinations relating thereto, reinsurance, and any and all matters, factors and considerations entering into negotiations for advantageous rates on and coverage of all such state property, activities and responsibilities. The board shall have the authority to employ an executive director for an annual salary of seventy thousand dollars and such other employees, including legal counsel, as may be necessary to carry out its duties. The legal counsel may represent the board before any judicial or administrative tribunal and perform such other duties as may be requested by the board. Any policy of insurance purchased or contracted for by the board shall provide that the insurer shall be barred and estopped from relying upon the constitutional immunity of the state of West Virginia against claims or suits: *Provided,* That nothing herein shall bar the insurer of political subdivisions from relying upon any statutory immunity granted such political subdivisions against claims or suits. The board may enter into any contracts necessary to the execution of the powers granted to it by this article. It shall endeavor to secure the maximum of protection against loss, damage or liability to state property and on account of state activities and responsibilities by proper and adequate insurance coverage through the introduction and employment of sound

and accepted methods of protection and principles of insurance. It is empowered and directed to make a complete survey of all presently owned and subsequently acquired state property subject to insurance coverage by any form of insurance, which survey shall include and reflect inspections, appraisals, exposures, fire hazards, construction, and any other objectives or factors affecting or which might affect the insurance protection and coverage required. It shall keep itself currently informed on new and continuing state activities and responsibilities within the insurance coverage herein contemplated. The board shall work closely in cooperation with the state fire marshal's office in applying the rules of that office insofar as the appropriations and other factors peculiar to state property will permit. The board is given power and authority to make rules governing its functions and operations and the procurement of state insurance.

The board is hereby authorized and empowered to negotiate and effect settlement of any and all insurance claims arising on or incident to losses of and damages to state properties, activities and responsibilities hereunder and shall have authority to execute and deliver proper releases of all such claims when settled. The board may adopt rules and procedures for handling, negotiating and settlement of all such claims. Any discussion or consideration of the financial or personal information of an insured may be held by the board in executive session closed to the public, notwithstanding the provisions of article nine-a, chapter six of this code.

(b) If requested by a political subdivision, a charitable or public service organization, or an emergency medical services agency, the board is authorized to provide property and liability insurance to insure their property, activities and responsibilities. The board is authorized to enter into any necessary contract of insurance to further the intent of this subsection.

The property insurance provided by the board, pursuant to this subsection, may also include insurance on property leased to or loaned to the political subdivision, a charitable or public service organization or an emergency medical services agency which is required to be insured under a written agreement.

The cost of this insurance, as determined by the board, shall be paid by the political subdivision, the charitable or public service organization or the emergency medical services agency and may include administrative expenses. For purposes of this section: *Provided,* That if an emergency medical services agency is a for-profit entity its claims history may not adversely affect other participant's rates in the same class. All funds received by the board (including, but not limited to, state agency premiums, mine subsidence premiums, and political subdivision premiums) shall be deposited with the West Virginia investment management board with the interest income and returns on investment a proper credit to such property insurance trust fund or liability insurance trust fund, as applicable.

"Political subdivision" as used in this subsection shall have the same meaning as in section three, article twelve-a of this chapter.

"Charitable" or public service organization as used in this subsection means any hospital in this state which has been certified as a critical access hospital by the federal centers for medicare and medicaid upon the designation of the state office of rural health policy, the office of community and rural health services, the bureau for public health, or the department of health and human resources, and any bona fide, not-for-profit, tax-exempt, benevolent, educational, philanthropic, humane, patriotic, civic, religious, eleemosynary, incorporated or unincorporated association or organization or a rescue unit or other similar volunteer community service organization or

association, but does not include any nonprofit association or organization, whether incorporated or not, which is organized primarily for the purposes of influencing legislation or supporting or promoting the campaign of any candidate for public office.

"Emergency medical service agency" as used in this subsection shall have the same meaning as in section three, article four-c, chapter sixteen of this code.

(c) (1) The board shall have general supervision and control over the optional medical liability insurance programs providing coverage to health care providers as authorized by the provisions of article twelve-b of this chapter. The board is hereby granted and may exercise all powers necessary or appropriate to carry out and effectuate the purposes of this article.

(2) The board shall:

(A) Administer the preferred medical liability program and the high risk medical liability program and exercise and perform other powers, duties and functions specified in this article;

(B) Obtain and implement, at least annually, from an independent outside source, such as a medical liability actuary or a rating organization experienced with the medical liability line of insurance, written rating plans for the preferred medical liability program and high risk medical liability program on which premiums shall be based;

(C) Prepare and annually review written underwriting criteria for the preferred medical liability program and the high risk medical liability program. The board may utilize review panels, including, but not limited to, the same specialty review panels to assist in establishing criteria;

(D) Prepare and publish, before each regular session of the Legislature, separate summaries for the preferred medical liability program and high risk medical liability program activity during the preceding fiscal year, each summary to be included in the board of risk and insurance management audited financial statements as "other financial information", and which shall include a balance sheet, income statement and cash flow statement, an actuarial opinion addressing adequacy of reserves, the highest and lowest premiums assessed, the number of claims filed with the program by provider type, the number of judgments and amounts paid from the program, the number of settlements and amounts paid from the program and the number of dismissals without payment;

(E) Determine and annually review the claims history debit or surcharge for the high risk medical liability program;

(F) Determine and annually review the criteria for transfer from the preferred medical liability program to the high risk medical liability program;

(G) Determine and annually review the role of independent agents, the amount of commission, if any, to be paid therefor, and agent appointment criteria;

(H) Study and annually evaluate the operation of the preferred medical liability program and the high risk medical liability program, and make recommendations to the Legislature, as may be appropriate, to ensure their viability, including, but not limited to, recommendations for civil justice reform with an associated cost-benefit analysis, recommendations on the feasibility and desirability of a plan which would require all health care providers in the state to participate with an associated cost-benefit analysis, recommendations on additional funding of other state run insurance plans with an associated cost-benefit analysis and recommendations on the desirability

of ceasing to offer a state plan with an associated analysis of a potential transfer to the private sector with a cost-benefit analysis, including impact on premiums;

(I) Establish a five-year financial plan to ensure an adequate premium base to cover the long tail nature of the claims-made coverage provided by the preferred medical liability program and the high risk medical liability program. The plan shall be designed to meet the program's estimated total financial requirements, taking into account all revenues projected to be made available to the program, and apportioning necessary costs equitably among participating classes of health care providers. For these purposes, the board shall:

(i) Retain the services of an impartial, professional actuary, with demonstrated experience in analysis of large group malpractice plans, to estimate the total financial requirements of the program for each fiscal year and to review and render written professional opinions as to financial plans proposed by the board. The actuary shall also assist in the development of alternative financing options and perform any other services requested by the board or the executive director. All reasonable fees and expenses for actuarial services shall be paid by the board. Any financial plan or modifications to a financial plan approved or proposed by the board pursuant to this section shall be submitted to and reviewed by the actuary and may not be finally approved and submitted to the governor and to the Legislature without the actuary's written professional opinion that the plan may be reasonably expected to generate sufficient revenues to meet all estimated program and administrative costs, including incurred but not reported claims, for the fiscal year for which the plan is proposed. The actuary's opinion for any fiscal year shall include a requirement for establishment of a reserve fund;

(ii) Submit its final, approved five-year financial plan, after obtaining the necessary actuary's opinion, to the governor and to the Legislature no later than the first day of January preceding the fiscal year. The financial plan for a fiscal year becomes effective and shall be implemented by the executive director on the first day of July of the fiscal year. In addition to each final, approved financial plan required under this section, the board shall also simultaneously submit an audited financial statement based on generally accepted accounting practices (GAAP) and which shall include allowances for incurred but not reported claims: *Provided,* That the financial statement and the accrual-based financial plan restatement shall not affect the approved financial plan. The provisions of chapter twenty-nine-a of this code shall not apply to the preparation, approval and implementation of the financial plans required by this section;

(iii) Submit to the governor and the Legislature a prospective five-year financial plan beginning on the first day of January, two thousand three, and every year thereafter, for the programs established by the provisions of article twelve-b of this chapter. Factors that the board shall consider include, but shall not be limited to, the trends for the program and the industry; claims history, number and category of participants in each program; settlements and claims payments; and judicial results;

(iv) Obtain annually, certification from participants that they have made a diligent search for comparable coverage in the voluntary insurance market and have been unable to obtain the same;

(J) Meet on at least a quarterly basis to review implementation of its current financial plan in light of the actual experience of the medical liability programs established in article twelve-b of this chapter. The board shall review actual costs incurred, any revised cost estimates provided by the actuary, expendi-

tures and any other factors affecting the fiscal stability of the plan and may make any additional modifications to the plan necessary to ensure that the total financial requirements of these programs for the current fiscal year are met;

(K) To analyze the benefit of and necessity for excess verdict liability coverage;

(L) Consider purchasing reinsurance, in the amounts as it may from time to time determine is appropriate, and the cost thereof shall be considered to be an operating expense of the board;

(M) Make available to participants, optional extended reporting coverage or tail coverage: *Provided,* That, at least five working days prior to offering such coverage to a participant or participants, the board shall notify the president of the Senate and the speaker of the House of Delegates in writing of its intention to do so, and such notice shall include the terms and conditions of the coverage proposed;

(N) Review and approve, reject or modify rules that are proposed by the executive director to implement, clarify or explain administration of the preferred medical liability program and the high risk medical liability program. Notwithstanding any provisions in this code to the contrary, rules promulgated pursuant to this paragraph are not subject to the provisions of sections nine through sixteen, article three, chapter twenty-nine-a of this code. The board shall comply with the remaining provisions of article three and shall hold hearings or receive public comments before promulgating any proposed rule filed with the secretary of state: *Provided,* That the initial rules proposed by the executive director and promulgated by the board shall become effective upon approval by the board notwithstanding any provision of this code;

(O) Enter into settlements and structured settlement agreements whenever appropriate. The policy may not require as a condition precedent to settlement or compromise of any claim the consent or acquiescence of the policy holder. The board may own or assign any annuity purchased by the board to a company licensed to do business in the state;

(P) Refuse to provide insurance coverage for individual physicians whose prior loss experience or current professional training and capability are such that the physician represents an unacceptable risk of loss if coverage is provided;

(Q) Terminate coverage for nonpayment of premiums upon written notice of the termination forwarded to the health care provider not less than thirty days prior to termination of coverage;

(R) Assign coverage or transfer insurance obligations and/or risks of existing or in-force contracts of insurance to a third party medical professional liability insurance carrier with the comparable coverage conditions as determined by the board. Any transfer of obligation or risk shall effect a novation of the transferred contract of insurance and if the terms of the assumption reinsurance agreement extinguish all liability of the board and the state of West Virginia such extinguishment shall be absolute as to any and all parties; and

(S) Meet and consult with and consider recommendations from the medical malpractice advisory panel established by the provisions of article twelve-b of this chapter.

(d) If, after the first day of September, two thousand two, the board has assigned coverages or transferred all insurance obligations and/or risks of existing or in-force contracts of insurance to a third party medical professional liability insurance carrier, and the board otherwise has no covered participants, then the board shall not thereafter offer or provide

professional liability insurance to any health care provider pursuant to the provisions of subsection (c) of this section or the provisions of article twelve-b of this chapter unless the Legislature adopts a concurrent resolution authorizing the board to reestablish medical liability insurance programs.

ARTICLE 12B. WEST VIRGINIA HEALTH CARE PROVIDER PROFESSIONAL LIABILITY INSURANCE AVAILABILITY ACT.

§29-12B-6. Health care provider professional liability insurance programs.

(a) There is hereby established through the board of risk and insurance management optional insurance for health care providers consisting of a preferred professional liability insurance program and a high risk professional liability insurance program.

(b) Each of the programs described in subsection (a) of this section shall provide claims-made coverage for any covered act or omission resulting in injury or death arising out of medical professional liability as defined in subsection (d), section two, article seven-b, chapter fifty-five of this code.

(c) Each of the programs described in subsection (a) of this section shall offer optional prior acts coverage from and after a retroactive date established by the policy declarations. The premium for prior acts coverage may be based upon a five-year maturity schedule depending on the years of prior acts exposure, as more specifically set forth in a written rating manual approved by the board.

(d) Each of the programs described in subsection (a) of this section shall further provide an option to purchase an extended reporting endorsement or tail coverage.

(e) Each of the programs described in subsection (a) of this section shall offer limits for each health care provider in the amount of one million dollars per claim, including repeated exposure to the same event or series of events, and all derivative claims, and three million dollars in the annual aggregate. Health care providers have the option to purchase higher limits of up to two million dollars per claim, including repeated exposure to the same event or series of events, and all derivative claims, and up to four million dollars in the annual aggregate. In addition, hospitals covered by the plan shall have available limits of three million dollars per claim, including repeated exposure to the same event or series of events, and all derivative claims, and five million dollars in the annual aggregate. Installment payment plans as established in the rating manual shall be available to all participants.

(f) Each of the programs described in subsection (a) of this section shall cover any act or omission resulting in injury or death arising out of medical professional liability as defined in subsection (d), section two, article seven-b, chapter fifty-five of this code. The board shall exclude from coverage sexual acts as defined in subdivision (e), section three of this article, and shall have the authority to exclude other acts or omission from coverage.

(g) Each of the programs described in subsection (a) of this section shall apply to damages, except punitive damages, for medical professional liability as defined in subsection (d), section two, article seven-b, chapter fifty-five of this code.

(h) The board may, but is not required, to obtain excess verdict liability coverage for the programs described in subsection (a) of this section.

(i) Each of the programs shall be liable to the extent of the limits purchased by the health care provider as set forth in

subsection (e) of this section. In the event that a claimant and a health care provider are willing to settle within those limits purchased by the health care provider, but the board refuses or declines to settle, and the ultimate verdict is in excess of the purchased limits, the board shall not be liable for the portion of the verdict in excess of the coverage provided in subsection (e) of this section unless the board acts in bad faith, with actual malice, in declining or refusing to settle: *Provided*, That if the board has in effect applicable excess verdict liability insurance, the health care provider shall not be required to prove that the board acted with actual malice in declining or refusing to settle in order to be indemnified for that portion of the verdict in excess of the limits of the purchased policy and within the limits of the excess liability coverage. Notwithstanding any provision of this code to the contrary, the board shall not be liable for any verdict in excess of the combined limit of the purchased policy and any applicable excess liability coverage unless the board acts in bad faith with actual malice.

(j) Rates for each of the programs described in subsection (a) of this section may not be excessive, inadequate or unfairly discriminatory: *Provided*, That the rates charged for the preferred professional liability insurance program shall not be less than the highest approved comparable base rate for a licensed carrier providing five percent of the malpractice insurance coverage in this state for the previous calendar year on file with the insurance commissioner: *Provided, however*, That if there is only one licensed carrier providing five percent or more of the malpractice insurance coverage in the state offering comparable coverage, the board shall have discretion to disregard the approved comparable base rate of the licensed carrier.

(k) The premiums for each of the programs described in subsection (a) of this section are subject to premium taxes imposed by article three, chapter thirty-three of this code.

(l) Nothing in this article shall be construed to preclude a health care provider from obtaining professional liability insurance coverage for claims in excess of the coverage made available by the provisions of this article.

(m) General liability coverage that may be required by a health care provider may be offered as determined by the board.

(n) The board may provide coverage for the run out of, and tail coverage for, any active policy issued pursuant to this article which is not transferred to the physician's mutual insurance company in accordance with section nine, article twenty-f, chapter thirty-three of this code. The board may permit such policy holders to finance, with interest, the tail coverage premium payments therefore, up to a maximum finance period of five years, on such terms as the board may set.

§29-12B-14. Effective date and termination of authority.

Policies written under this article may have an effective date retroactive to the effective date of this article. Except as provided in subsection (n), section six of this article, the authority of the board of risk and insurance management to issue medical liability policies under this article shall cease upon the board's transfer, in accordance with section nine, article twenty-f, chapter thirty-three of this code, of assets, obligations and liabilities to the physicians' mutual insurance company created pursuant to said article, or upon the first day of July, two-thousand four, whichever occurs first. The board shall continue to administer any existing policy of insurance which was issued pursuant to this article, but was not transferred to the physician's mutual insurance company, until the policy expires. Upon the expiration of the policy, the board shall make tail coverage available at an appropriate premium rate to be determined by the board. The board shall continue to administer any tail coverage so provided. On the thirtieth day

of January each year, the board shall report to the legislature's joint committee on government and finance the amount of any unfunded liability associated with the run out and tail coverage provided by this section.

ARTICLE 12C. PATIENT INJURY COMPENSATION PLAN.

§29-12C-1. Patient injury compensation plan study board created; purpose; study of creation and funding of patient injury compensation fund; developing rules and establishing program; and report to the Legislature.

(a) In recognition of the statewide concern over the rising cost of medical malpractice insurance and the difficulty that health care practitioners have in locating affordable medical malpractice insurance, there is hereby created a patient injury compensation fund study board to study the feasability of establishing a patient injury compensation fund to reimburse claimants in medical malpractice actions for any portion of economic damages awarded which are uncollectible due to statutory limitations on damage awards for trauma care and/or the elimination of joint and several liability of tortfeasor health care providers and health care facilities.

(b) The patient injury compensation fund study board shall consist of the director of the board of risk and insurance management, who shall serve as chairperson, the insurance commissioner and an appointee of the governor. The patient injury compensation fund study board shall utilize the resources of the board of risk and insurance management and the insurance commission to effectuate the study required by this article. The patient injury compensation fund study board shall meet upon the call of the chair. A simple majority of the patient injury compensation fund study board members constitutes a quorum for the transaction of business.

(c) The patient injury compensation fund study board is authorized to hold hearings, conduct investigations and consider, without limitation, all options for identifying funding methods and for the operation and administration of a patient injury compensation fund within the following guidelines:

(1) The board of risk and insurance management is responsible for implementing, administering and operating any patient injury compensation fund;

(2) The patient injury compensation fund must be actuarially sound and fully funded in accordance with generally accepted accounting principles;

(3) Eligibility for reimbursement from the patient injury compensation fund is limited to claimants who have been awarded damages in a medical malpractice action but have been certified by the board of risk and insurance management to be unable, after exhausting all reasonable means available by law of recovering the award, to collect all or part of the economic damages awarded due to the limitations on awards established in sections nine and nine-c, article seven-b chapter fifty-five of this code; and

(4) The board of risk and insurance management may invest the moneys in the patient injury compensation fund and use any interest or other return from investments to pay administration expenses and claims granted.

(d) The patient injury compensation fund study board's report and recommendations shall be completed no later than the first day of December, two thousand three, and shall be presented to the joint committee of government and finance during the legislative interim meetings to be held in December, two thousand three.

29-12C-2. Legislative rules.

(a) The Legislature hereby declares that an emergency exists necessitating expeditious implementation of a patient injury compensation fund, if economically feasible, and directs the patient injury compensation fund study board to propose emergency legislative rules relating to the establishment, implementation and operation of the patient injury compensation fund in conjunction with its report and recommendations to the Legislature under section one of this article. The rules proposed by the patient injury compensation fund study board shall:

(1) Provide the funding mechanism and the methodology for processing and timely and accurately collect funds;

(2) Assure the actuarial soundness of the patient injury compensation fund and sufficient moneys to satisfy all foreseeable claims against the patient injury compensation fund, giving due consideration to relevant loss or claim experience or trends and normal costs of operation;

(3) Provide a reasonable reserve fund for unexpected contingencies, consistent with generally accepted accounting principles;

(4) Establish appropriate procedures for notification of payment adjustments prior to any payment periods established in which a funding adjustment will be in effect, consistent with generally accepted accounting principles;

(5) Establish procedures for determining eligibility for and distribution of funds to claimants seeking reimbursement;

(6) Establish the requirements and procedure for certifying that a claimant has been unable to collect a portion of the economic damages recovered;

(7) Establish the process for submitting a claim for payment from the patient injury compensation fund; and

(8) Establish any additional requirements and criteria consistent with and necessary to effectuate the provisions of this article.

(b) If the Legislature accepts, in whole or in part, the recommendations of the patient injury compensation fund study board, enacts legislation establishing a patient injury compensation fund and approves rules governing the initial establishment, implementation and operation of the patient injury compensation fund, those rules shall be filed with the secretary of state as emergency rules.

CHAPTER 30. PROFESSIONS AND OCCUPATIONS.

ARTICLE 3. WEST VIRGINIA MEDICAL PRACTICE ACT.

§30-3-14. Professional discipline of physicians and podiatrists; reporting of information to board pertaining to medical professional liability and professional incompetence required; penalties; grounds for license denial and discipline of physicians and podiatrists; investigations; physical and mental examinations; hearings; sanctions; summary sanctions; reporting by the board; reapplication; civil and criminal immunity; voluntary limitation of license; probable cause determinations.

(a) The board may independently initiate disciplinary proceedings as well as initiate disciplinary proceedings based on information received from medical peer review committees, physicians, podiatrists, hospital administrators, professional societies and others.

The board may initiate investigations as to professional incompetence or other reasons for which a licensed physician

or podiatrist may be adjudged unqualified based upon criminal convictions; complaints by citizens, pharmacists, physicians, podiatrists, peer review committees, hospital administrators, professional societies or others; or unfavorable outcomes arising out of medical professional liability. The board shall initiate an investigation if it receives notice that three or more judgments, or any combination of judgments and settlements resulting in five or more unfavorable outcomes arising from medical professional liability have been rendered or made against the physician or podiatrist within a five-year period. The board may not consider any judgments or settlements as conclusive evidence of professional incompetence or conclusive lack of qualification to practice.

(b) Upon request of the board, any medical peer review committee in this state shall report any information that may relate to the practice or performance of any physician or podiatrist known to that medical peer review committee. Copies of the requests for information from a medical peer review committee may be provided to the subject physician or podiatrist if, in the discretion of the board, the provision of such copies will not jeopardize the board's investigation. In the event that copies are provided, the subject physician or podiatrist is allowed fifteen days to comment on the requested information and such comments must be considered by the board.

The chief executive officer of every hospital shall, within sixty days after the completion of the hospital's formal disciplinary procedure and also within sixty days after the commencement of and again after the conclusion of any resulting legal action, report in writing to the board the name of any member of the medical staff or any other physician or podiatrist practicing in the hospital whose hospital privileges have been revoked, restricted, reduced or terminated for any cause, including resignation, together with all pertinent information relating to such action. The chief executive officer shall also

report any other formal disciplinary action taken against any physician or podiatrist by the hospital upon the recommendation of its medical staff relating to professional ethics, medical incompetence, medical professional liability, moral turpitude or drug or alcohol abuse. Temporary suspension for failure to maintain records on a timely basis or failure to attend staff or section meetings need not be reported. Voluntary cessation of hospital privileges for reasons unrelated to professional competence or ethics need not be reported.

Any managed care organization operating in this state which provides a formal peer review process shall report in writing to the board, within sixty days after the completion of any formal peer review process and also within sixty days after the commencement of and again after the conclusion of any resulting legal action, the name of any physician or podiatrist whose credentialing has been revoked or not renewed by the managed care organization. The managed care organization shall also report in writing to the board any other disciplinary action taken against a physician or podiatrist relating to professional ethics, professional liability, moral turpitude or drug or alcohol abuse within sixty days after completion of a formal peer review process which results in the action taken by the managed care organization. For purposes of this subsection, "managed care organization" means a plan that establishes, operates or maintains a network of health care providers who have entered into agreements with and been credentialed by the plan to provide health care services to enrollees or insureds to whom the plan has the ultimate obligation to arrange for the provision of or payment for health care services through organizational arrangements for ongoing quality assurance, utilization review programs or dispute resolutions.

Any professional society in this state comprised primarily of physicians or podiatrists which takes formal disciplinary action against a member relating to professional ethics, profes-

sional incompetence, medical professional liability, moral turpitude or drug or alcohol abuse shall report in writing to the board within sixty days of a final decision the name of the member, together with all pertinent information relating to the action.

Every person, partnership, corporation, association, insurance company, professional society or other organization providing professional liability insurance to a physician or podiatrist in this state, including the state board of risk and insurance management, shall submit to the board the following information within thirty days from any judgment or settlement of a civil or medical professional liability action excepting product liability actions: The name of the insured; the date of any judgment or settlement; whether any appeal has been taken on the judgment and, if so, by which party; the amount of any settlement or judgment against the insured; and other information required by the board.

Within thirty days from the entry of an order by a court in a medical professional liability action or other civil action in which a physician or podiatrist licensed by the board is determined to have rendered health care services below the applicable standard of care, the clerk of the court in which the order was entered shall forward a certified copy of the order to the board.

Within thirty days after a person known to be a physician or podiatrist licensed or otherwise lawfully practicing medicine and surgery or podiatry in this state or applying to be licensed is convicted of a felony under the laws of this state or of any crime under the laws of this state involving alcohol or drugs in any way, including any controlled substance under state or federal law, the clerk of the court of record in which the conviction was entered shall forward to the board a certified true and correct abstract of record of the convicting court. The

abstract shall include the name and address of the physician or podiatrist or applicant, the nature of the offense committed and the final judgment and sentence of the court.

Upon a determination of the board that there is probable cause to believe that any person, partnership, corporation, association, insurance company, professional society or other organization has failed or refused to make a report required by this subsection, the board shall provide written notice to the alleged violator stating the nature of the alleged violation and the time and place at which the alleged violator shall appear to show good cause why a civil penalty should not be imposed. The hearing shall be conducted in accordance with the provisions of article five, chapter twenty-nine-a of this code. After reviewing the record of the hearing, if the board determines that a violation of this subsection has occurred, the board shall assess a civil penalty of not less than one thousand dollars nor more than ten thousand dollars against the violator. The board shall notify any person so assessed of the assessment in writing and the notice shall specify the reasons for the assessment. If the violator fails to pay the amount of the assessment to the board within thirty days, the attorney general may institute a civil action in the circuit court of Kanawha County to recover the amount of the assessment. In any civil action, the court's review of the board's action shall be conducted in accordance with the provisions of section four, article five, chapter twenty-nine-a of this code. Notwithstanding any other provision of this article to the contrary, when there are conflicting views by recognized experts as to whether any alleged conduct breaches an applicable standard of care, the evidence must be clear and convincing before the board may find that the physician or podiatrist has demonstrated a lack of professional competence to practice with a reasonable degree of skill and safety for patients.

Any person may report to the board relevant facts about the conduct of any physician or podiatrist in this state which in the opinion of that person amounts to medical professional liability or professional incompetence.

The board shall provide forms for filing reports pursuant to this section. Reports submitted in other forms shall be accepted by the board.

The filing of a report with the board pursuant to any provision of this article, any investigation by the board or any disposition of a case by the board does not preclude any action by a hospital, other health care facility or professional society comprised primarily of physicians or podiatrists to suspend, restrict or revoke the privileges or membership of the physician or podiatrist.

(c) The board may deny an application for license or other authorization to practice medicine and surgery or podiatry in this state and may discipline a physician or podiatrist licensed or otherwise lawfully practicing in this state who, after a hearing, has been adjudged by the board as unqualified due to any of the following reasons:

(1) Attempting to obtain, obtaining, renewing or attempting to renew a license to practice medicine and surgery or podiatry by bribery, fraudulent misrepresentation or through known error of the board;

(2) Being found guilty of a crime in any jurisdiction, which offense is a felony, involves moral turpitude or directly relates to the practice of medicine. Any plea of nolo contendere is a conviction for the purposes of this subdivision;

(3) False or deceptive advertising;

(4) Aiding, assisting, procuring or advising any unauthorized person to practice medicine and surgery or podiatry contrary to law;

(5) Making or filing a report that the person knows to be false; intentionally or negligently failing to file a report or record required by state or federal law; willfully impeding or obstructing the filing of a report or record required by state or federal law; or inducing another person to do any of the foregoing. The reports and records covered in this subdivision mean only those that are signed in the capacity as a licensed physician or podiatrist;

(6) Requesting, receiving or paying directly or indirectly a payment, rebate, refund, commission, credit or other form of profit or valuable consideration for the referral of patients to any person or entity in connection with providing medical or other health care services or clinical laboratory services, supplies of any kind, drugs, medication or any other medical goods, services or devices used in connection with medical or other health care services;

(7) Unprofessional conduct by any physician or podiatrist in referring a patient to any clinical laboratory or pharmacy in which the physician or podiatrist has a proprietary interest unless the physician or podiatrist discloses in writing such interest to the patient. The written disclosure shall indicate that the patient may choose any clinical laboratory for purposes of having any laboratory work or assignment performed or any pharmacy for purposes of purchasing any prescribed drug or any other medical goods or devices used in connection with medical or other health care services.

As used in this subdivision, "proprietary interest" does not include an ownership interest in a building in which space is leased to a clinical laboratory or pharmacy at the prevailing rate

under a lease arrangement that is not conditional upon the income or gross receipts of the clinical laboratory or pharmacy;

(8) Exercising influence within a patient-physician relationship for the purpose of engaging a patient in sexual activity;

(9) Making a deceptive, untrue or fraudulent representation in the practice of medicine and surgery or podiatry;

(10) Soliciting patients, either personally or by an agent, through the use of fraud, intimidation or undue influence;

(11) Failing to keep written records justifying the course of treatment of a patient, including, but not limited to, patient histories, examination and test results and treatment rendered, if any;

(12) Exercising influence on a patient in such a way as to exploit the patient for financial gain of the physician or podiatrist or of a third party. Any influence includes, but is not limited to, the promotion or sale of services, goods, appliances or drugs;

(13) Prescribing, dispensing, administering, mixing or otherwise preparing a prescription drug, including any controlled substance under state or federal law, other than in good faith and in a therapeutic manner in accordance with accepted medical standards and in the course of the physician's or podiatrist's professional practice: *Provided,* That a physician who discharges his or her professional obligation to relieve the pain and suffering and promote the dignity and autonomy of dying patients in his or her care and, in so doing, exceeds the average dosage of a pain relieving controlled substance, as defined in Schedules II and III of the Uniform Controlled Substance Act, does not violate this article;

(14) Performing any procedure or prescribing any therapy that, by the accepted standards of medical practice in the community, would constitute experimentation on human subjects without first obtaining full, informed and written consent;

(15) Practicing or offering to practice beyond the scope permitted by law or accepting and performing professional responsibilities that the person knows or has reason to know he or she is not competent to perform;

(16) Delegating professional responsibilities to a person when the physician or podiatrist delegating the responsibilities knows or has reason to know that the person is not qualified by training, experience or licensure to perform them;

(17) Violating any provision of this article or a rule or order of the board or failing to comply with a subpoena or subpoena duces tecum issued by the board;

(18) Conspiring with any other person to commit an act or committing an act that would tend to coerce, intimidate or preclude another physician or podiatrist from lawfully advertising his or her services;

(19) Gross negligence in the use and control of prescription forms;

(20) Professional incompetence; or

(21) The inability to practice medicine and surgery or podiatry with reasonable skill and safety due to physical or mental impairment, including deterioration through the aging process, loss of motor skill or abuse of drugs or alcohol. A physician or podiatrist adversely affected under this subdivision shall be afforded an opportunity at reasonable intervals to demonstrate that he or she may resume the competent practice

of medicine and surgery or podiatry with reasonable skill and safety to patients. In any proceeding under this subdivision, neither the record of proceedings nor any orders entered by the board shall be used against the physician or podiatrist in any other proceeding.

(d) The board shall deny any application for a license or other authorization to practice medicine and surgery or podiatry in this state to any applicant who, and shall revoke the license of any physician or podiatrist licensed or otherwise lawfully practicing within this state who, is found guilty by any court of competent jurisdiction of any felony involving prescribing, selling, administering, dispensing, mixing or otherwise preparing any prescription drug, including any controlled substance under state or federal law, for other than generally accepted therapeutic purposes. Presentation to the board of a certified copy of the guilty verdict or plea rendered in the court is sufficient proof thereof for the purposes of this article. A plea of nolo contendere has the same effect as a verdict or plea of guilt.

(e) The board may refer any cases coming to its attention to an appropriate committee of an appropriate professional organization for investigation and report. Except for complaints related to obtaining initial licensure to practice medicine and surgery or podiatry in this state by bribery or fraudulent misrepresentation, any complaint filed more than two years after the complainant knew, or in the exercise of reasonable diligence should have known, of the existence of grounds for the complaint shall be dismissed: *Provided*, That in cases of conduct alleged to be part of a pattern of similar misconduct or professional incapacity that, if continued, would pose risks of a serious or substantial nature to the physician's or podiatrist's current patients, the investigating body may conduct a limited investigation related to the physician's or podiatrist's current capacity and qualification to practice and may recommend

conditions, restrictions or limitations on the physician's or podiatrist's license to practice that it considers necessary for the protection of the public. Any report shall contain recommendations for any necessary disciplinary measures and shall be filed with the board within ninety days of any referral. The recommendations shall be considered by the board and the case may be further investigated by the board. The board after full investigation shall take whatever action it considers appropriate, as provided in this section.

(f) The investigating body, as provided for in subsection (e) of this section, may request and the board under any circumstances may require a physician or podiatrist or person applying for licensure or other authorization to practice medicine and surgery or podiatry in this state to submit to a physical or mental examination by a physician or physicians approved by the board. A physician or podiatrist submitting to an examination has the right, at his or her expense, to designate another physician to be present at the examination and make an independent report to the investigating body or the board. The expense of the examination shall be paid by the board. Any individual who applies for or accepts the privilege of practicing medicine and surgery or podiatry in this state is considered to have given his or her consent to submit to all examinations when requested to do so in writing by the board and to have waived all objections to the admissibility of the testimony or examination report of any examining physician on the ground that the testimony or report is privileged communication. If a person fails or refuses to submit to an examination under circumstances which the board finds are not beyond his or her control, failure or refusal is prima facie evidence of his or her inability to practice medicine and surgery or podiatry competently and in compliance with the standards of acceptable and prevailing medical practice.

(g) In addition to any other investigators it employs, the board may appoint one or more licensed physicians to act for it in investigating the conduct or competence of a physician.

(h) In every disciplinary or licensure denial action, the board shall furnish the physician or podiatrist or applicant with written notice setting out with particularity the reasons for its action. Disciplinary and licensure denial hearings shall be conducted in accordance with the provisions of article five, chapter twenty-nine-a of this code. However, hearings shall be heard upon sworn testimony and the rules of evidence for trial courts of record in this state shall apply to all hearings. A transcript of all hearings under this section shall be made, and the respondent may obtain a copy of the transcript at his or her expense. The physician or podiatrist has the right to defend against any charge by the introduction of evidence, the right to be represented by counsel, the right to present and cross-examine witnesses and the right to have subpoenas and subpoenas duces tecum issued on his or her behalf for the attendance of witnesses and the production of documents. The board shall make all its final actions public. The order shall contain the terms of all action taken by the board.

(i) In disciplinary actions in which probable cause has been found by the board, the board shall, within twenty days of the date of service of the written notice of charges or sixty days prior to the date of the scheduled hearing, whichever is sooner, provide the respondent with the complete identity, address and telephone number of any person known to the board with knowledge about the facts of any of the charges; provide a copy of any statements in the possession of or under the control of the board; provide a list of proposed witnesses with addresses and telephone numbers, with a brief summary of his or her anticipated testimony; provide disclosure of any trial expert pursuant to the requirements of rule 26(b)(4) of the West Virginia rules of civil procedure; provide inspection and

copying of the results of any reports of physical and mental examinations or scientific tests or experiments; and provide a list and copy of any proposed exhibit to be used at the hearing: *Provided*, That the board shall not be required to furnish or produce any materials which contain opinion work product information or would be a violation of the attorney-client privilege. Within twenty days of the date of service of the written notice of charges, the board shall disclose any exculpatory evidence with a continuing duty to do so throughout the disciplinary process. Within thirty days of receipt of the board's mandatory discovery, the respondent shall provide the board with the complete identity, address and telephone number of any person known to the respondent with knowledge about the facts of any of the charges; provide a list of proposed witnesses with addresses and telephone numbers, to be called at hearing, with a brief summary of his or her anticipated testimony; provide disclosure of any trial expert pursuant to the requirements of rule 26(b)(4) of the West Virginia rules of civil procedure; provide inspection and copying of the results of any reports of physical and mental examinations or scientific tests or experiments; and provide a list and copy of any proposed exhibit to be used at the hearing.

(j) Whenever it finds any person unqualified because of any of the grounds set forth in subsection (c) of this section, the board may enter an order imposing one or more of the following:

(1) Deny his or her application for a license or other authorization to practice medicine and surgery or podiatry;

(2) Administer a public reprimand;

(3) Suspend, limit or restrict his or her license or other authorization to practice medicine and surgery or podiatry for not more than five years, including limiting the practice of that

person to, or by the exclusion of, one or more areas of practice, including limitations on practice privileges;

(4) Revoke his or her license or other authorization to practice medicine and surgery or podiatry or to prescribe or dispense controlled substances for a period not to exceed ten years;

(5) Require him or her to submit to care, counseling or treatment designated by the board as a condition for initial or continued licensure or renewal of licensure or other authorization to practice medicine and surgery or podiatry;

(6) Require him or her to participate in a program of education prescribed by the board;

(7) Require him or her to practice under the direction of a physician or podiatrist designated by the board for a specified period of time; and

(8) Assess a civil fine of not less than one thousand dollars nor more than ten thousand dollars.

(k) Notwithstanding the provisions of section eight, article one, chapter thirty of this code, if the board determines the evidence in its possession indicates that a physician's or podiatrist's continuation in practice or unrestricted practice constitutes an immediate danger to the public, the board may take any of the actions provided for in subsection (j) of this section on a temporary basis and without a hearing if institution of proceedings for a hearing before the board are initiated simultaneously with the temporary action and begin within fifteen days of the action. The board shall render its decision within five days of the conclusion of a hearing under this subsection.

(l) Any person against whom disciplinary action is taken pursuant to the provisions of this article has the right to judicial review as provided in articles five and six, chapter twenty-nine-a of this code: *Provided*, That a circuit judge may also remand the matter to the board if it appears from competent evidence presented to it in support of a motion for remand that there is newly discovered evidence of such a character as ought to produce an opposite result at a second hearing on the merits before the board and:

(1) The evidence appears to have been discovered since the board hearing; and

(2) The physician or podiatrist exercised due diligence in asserting his or her evidence and that due diligence would not have secured the newly discovered evidence prior to the appeal.

A person may not practice medicine and surgery or podiatry or deliver health care services in violation of any disciplinary order revoking, suspending or limiting his or her license while any appeal is pending. Within sixty days, the board shall report its final action regarding restriction, limitation, suspension or revocation of the license of a physician or podiatrist, limitation on practice privileges or other disciplinary action against any physician or podiatrist to all appropriate state agencies, appropriate licensed health facilities and hospitals, insurance companies or associations writing medical malpractice insurance in this state, the American medical association, the American podiatry association, professional societies of physicians or podiatrists in the state and any entity responsible for the fiscal administration of medicare and medicaid.

(m) Any person against whom disciplinary action has been taken under the provisions of this article shall, at reasonable intervals, be afforded an opportunity to demonstrate that he or she can resume the practice of medicine and surgery or podiatry

on a general or limited basis. At the conclusion of a suspension, limitation or restriction period the physician or podiatrist may resume practice if the board has so ordered.

(n) Any entity, organization or person, including the board, any member of the board, its agents or employees and any entity or organization or its members referred to in this article, any insurer, its agents or employees, a medical peer review committee and a hospital governing board, its members or any committee appointed by it acting without malice and without gross negligence in making any report or other information available to the board or a medical peer review committee pursuant to law and any person acting without malice and without gross negligence who assists in the organization, investigation or preparation of any such report or information or assists the board or a hospital governing body or any committee in carrying out any of its duties or functions provided by law is immune from civil or criminal liability, except that the unlawful disclosure of confidential information possessed by the board is a misdemeanor as provided for in this article.

(o) A physician or podiatrist may request in writing to the board a limitation on or the surrendering of his or her license to practice medicine and surgery or podiatry or other appropriate sanction as provided in this section. The board may grant the request and, if it considers it appropriate, may waive the commencement or continuation of other proceedings under this section. A physician or podiatrist whose license is limited or surrendered or against whom other action is taken under this subsection may, at reasonable intervals, petition for removal of any restriction or limitation on or for reinstatement of his or her license to practice medicine and surgery or podiatry.

(p) In every case considered by the board under this article regarding discipline or licensure, whether initiated by the board

or upon complaint or information from any person or organization, the board shall make a preliminary determination as to whether probable cause exists to substantiate charges of disqualification due to any reason set forth in subsection (c) of this section. If probable cause is found to exist, all proceedings on the charges shall be open to the public who are entitled to all reports, records and nondeliberative materials introduced at the hearing, including the record of the final action taken: *Provided,* That any medical records, which were introduced at the hearing and which pertain to a person who has not expressly waived his or her right to the confidentiality of the records, may not be open to the public nor is the public entitled to the records.

(q) If the board receives notice that a physician or podiatrist has been subjected to disciplinary action or has had his or her credentials suspended or revoked by the board, a hospital or a professional society, as defined in subsection (b) of this section, for three or more incidents during a five-year period, the board shall require the physician or podiatrist to practice under the direction of a physician or podiatrist designated by the board for a specified period of time to be established by the board.

(r) Notwithstanding any other provisions of this article, the board may, at any time, on its own motion, or upon motion by the complainant, or upon motion by the physician or podiatrist, or by stipulation of the parties, refer the matter to mediation. The board shall obtain a list from the West Virginia state bar's mediator referral service of certified mediators with expertise in professional disciplinary matters. The board and the physician or podiatrist may choose a mediator from that list. If the board and the physician or podiatrist are unable to agree on a mediator, the board shall designate a mediator the list by neutral rotation. The mediation shall not be considered a proceeding open to the public and any reports and records introduced at the mediation shall not become part of the public record. The

mediator and all participants in the mediation shall maintain and preserve the confidentiality of all mediation proceedings and records. The mediator may not be subpoenaed or called to testify or otherwise be subject to process requiring disclosure of confidential information in any proceeding relating to or arising out of the disciplinary or licensure matter mediated: *Provided,* That any confidentiality agreement and any written agreement made and signed by the parties as a result of mediation may be used in any proceedings subsequently instituted to enforce the written agreement. The agreements may be used in other proceedings if the parties agree in writing.

ARTICLE 14. OSTEOPATHIC PHYSICIANS AND SURGEONS.

§30-14-12a. Initiation of suspension or revocation proceedings allowed and required; reporting of information to board pertaining to professional malpractice and professional incompetence required; penalties; probable cause determinations.

(a) The board may independently initiate suspension or revocation proceedings as well as initiate suspension or revocation proceedings based on information received from any person.

The board shall initiate investigations as to professional incompetence or other reasons for which a licensed osteopathic physician and surgeon may be adjudged unqualified if the board receives notice that three or more judgments or any combination of judgments and settlements resulting in five or more unfavorable outcomes arising from medical professional liability have been rendered or made against such osteopathic physician within a five-year period.

(b) Upon request of the board, any medical peer review committee in this state shall report any information that may relate to the practice or performance of any osteopathic

physician known to that medical peer review committee. Copies of such requests for information from a medical peer review committee may be provided to the subject osteopathic physician if, in the discretion of the board, the provision of such copies will not jeopardize the board's investigation. In the event that copies are provided, the subject osteopathic physician has fifteen days to comment on the requested information and such comments must be considered by the board.

After the completion of a hospital's formal disciplinary procedure and after any resulting legal action, the chief executive officer of such hospital shall report in writing to the board within sixty days the name of any member of the medical staff or any other osteopathic physician practicing in the hospital whose hospital privileges have been revoked, restricted, reduced or terminated for any cause, including resignation, together with all pertinent information relating to such action. The chief executive officer shall also report any other formal disciplinary action taken against any osteopathic physician by the hospital upon the recommendation of its medical staff relating to professional ethics, medical incompetence, medical malpractice, moral turpitude or drug or alcohol abuse. Temporary suspension for failure to maintain records on a timely basis or failure to attend staff or section meetings need not be reported.

Any professional society in this state comprised primarily of osteopathic physicians or physicians and surgeons of other schools of medicine which takes formal disciplinary action against a member relating to professional ethics, professional incompetence, professional malpractice, moral turpitude or drug or alcohol abuse, shall report in writing to the board within sixty days of a final decision the name of such member, together with all pertinent information relating to such action.

Every person, partnership, corporation, association, insurance company, professional society or other organization providing professional liability insurance to an osteopathic physician in this state shall submit to the board the following information within thirty days from any judgment, dismissal or settlement of a civil action or of any claim involving the insured: The date of any judgment, dismissal or settlement; whether any appeal has been taken on the judgment, and, if so, by which party; the amount of any settlement or judgment against the insured; and such other information required by the board.

Within thirty days after a person known to be an osteopathic physician licensed or otherwise lawfully practicing medicine and surgery in this state or applying to be licensed is convicted of a felony under the laws of this state, or of any crime under the laws of this state involving alcohol or drugs in any way, including any controlled substance under state or federal law, the clerk of the court of record in which the conviction was entered shall forward to the board a certified true and correct abstract of record of the convicting court. The abstract shall include the name and address of such osteopathic physician or applicant, the nature of the offense committed and the final judgment and sentence of the court.

Upon a determination of the board that there is probable cause to believe that any person, partnership, corporation, association, insurance company, professional society or other organization has failed or refused to make a report required by this subsection, the board shall provide written notice to the alleged violator stating the nature of the alleged violation and the time and place at which the alleged violator shall appear to show good cause why a civil penalty should not be imposed. The hearing shall be conducted in accordance with the provisions of article five, chapter twenty-nine-a of this code. After reviewing the record of such hearing, if the board determines

that a violation of this subsection has occurred, the board shall assess a civil penalty of not less than one thousand dollars nor more than ten thousand dollars against such violator. The board shall notify anyone assessed of the assessment in writing and the notice shall specify the reasons for the assessment. If the violator fails to pay the amount of the assessment to the board within thirty days, the attorney general may institute a civil action in the circuit court of Kanawha County to recover the amount of the assessment. In any such civil action, the court's review of the board's action shall be conducted in accordance with the provisions of section four, article five, chapter twenty-nine-a of this code.

Any person may report to the board relevant facts about the conduct of any osteopathic physician in this state which in the opinion of such person amounts to professional malpractice or professional incompetence.

The board shall provide forms for filing reports pursuant to this section. Reports submitted in other forms shall be accepted by the board.

The filing of a report with the board pursuant to any provision of this article, any investigation by the board or any disposition of a case by the board does not preclude any action by a hospital, other health care facility or professional society comprised primarily of osteopathic physicians or physicians and surgeons of other schools of medicine to suspend, restrict or revoke the privileges or membership of such osteopathic physician.

(c) In every case considered by the board under this article regarding suspension, revocation or issuance of a license whether initiated by the board or upon complaint or information from any person or organization, the board shall make a preliminary determination as to whether probable cause exists

to substantiate charges of cause to suspend, revoke or refuse to issue a license as set forth in subsection (a), section eleven of this article. If such probable cause is found to exist, all proceedings on such charges shall be open to the public who are entitled to all reports, records, and nondeliberative materials introduced at such hearing, including the record of the final action taken: *Provided,* That any medical records, which were introduced at such hearing and which pertain to a person who has not expressly waived his right to the confidentiality of such records, shall not be open to the public nor is the public entitled to such records. If a finding is made that probable cause does not exist, the public has a right of access to the complaint or other document setting forth the charges, the findings of fact and conclusions supporting such finding that probable cause does not exist, if the subject osteopathic physician consents to such access.

(d) If the board receives notice that an osteopathic physician has been subjected to disciplinary action or has had his or her credentials suspended or revoked by the board, a medical peer review committee, a hospital or professional society, as defined in subsection (b) of this section, for three or more incidents in a five-year period, the board shall require the osteopathic physician to practice under the direction of another osteopathic physician for a specified period to be established by the board.

CHAPTER 33. INSURANCE.

ARTICLE 2. INSURANCE COMMISSIONER.

§33-2-9a. Imposing a one-time assessment on all insurance carriers.

For the purpose of completely novating the physician liability currently borne by the state under the West Virginia health care provider professional liability insurance availability

act found in article twelve-b, chapter twenty-nine of this code, and to help capitalize the physicians' mutual insurance company created pursuant to article twenty-f of this chapter, and for all the reasons set forth in section two of said article, the insurance commissioner shall impose a special one-time assessment of two thousand five hundred dollars on all insurers licensed under this chapter for the privilege of writing insurance in the state of West Virginia, except risk retention groups defined in subsection (f), section four, article thirty-two of this chapter and risk purchasing groups defined in subsection (e), section seventeen of said article. The assessment is due and payable on the first day of July, two thousand three. The commissioner shall transfer funds collected pursuant to this section to the physicians' mutual insurance company.

ARTICLE 3. LICENSING, FEES AND TAXATION OF INSURERS.

§33-3-14. Annual financial statement and premium tax return; remittance by insurer of premium tax, less certain deductions; special revenue fund created.

(a) Every insurer transacting insurance in West Virginia shall file with the commissioner, on or before the first day of March, each year, a financial statement made under oath of its president or secretary and on a form prescribed by the commissioner. The insurer shall also, on or before the first day of March of each year subject to the provisions of section fourteen-c of this article, under the oath of its president or secretary, make a premium tax return for the previous calendar year, on a form prescribed by the commissioner showing the gross amount of direct premiums, whether designated as a premium or by some other name, collected and received by it during the previous calendar year on policies covering risks resident, located or to be performed in this state and compute the amount of premium tax chargeable to it in accordance with the provisions of this article, deducting the amount of quarterly pay-

ments as required to be made pursuant to the provisions of section fourteen-c of this article, if any, less any adjustments to the gross amount of the direct premiums made during the calendar year, if any, and transmit with the return to the commissioner a remittance in full for the tax due. The tax is the sum equal to two percent of the taxable premium, and also includes any additional tax due under section fourteen-a of this article. All taxes received by the commissioner shall be paid into the insurance tax fund created in subsection (b) of this section: *Provided*, That each year, the first one million six hundred sixty-seven thousand dollars of the portion of taxes received by the commissioner from insurance policies for medical liability insurance as defined in section three, article twenty-f of this chapter and from any insurer on its medical malpractice line, shall be temporarily dedicated to replenishing moneys appropriated from the tobacco settlement account pursuant to subsection (c), section two, article eleven-a, chapter four of this code. Upon determination by the commissioner that these moneys have been fully replenished to the tobacco settlement account, the commissioner shall resume depositing taxes received from medical malpractice premiums as provided in subsection (b) of this section.

(b) There is created in the state treasury a special revenue fund, administered by the treasurer, designated the "insurance tax fund." This fund is not part of the general revenue fund of the state. It consists of all amounts deposited in the fund pursuant to subsection (a) of this section, sections fifteen and seventeen of this article, any appropriations to the fund, all interest earned from investment of the fund and any gifts, grants or contributions received by the fund.

(c) The treasurer shall dedicate and transfer from the insurance tax fund to the regional jail and correctional facility investment fund created under the provisions of section twenty-one, article six, chapter twelve of this code, on or before

the tenth day of each month, an amount equal to one twelfth of the projected annual investment earnings to be paid and the capital invested to be returned, as certified to the treasurer by the investment management board: *Provided,* That the amount dedicated and transferred may not exceed twenty million dollars in any fiscal year. In the event there are insufficient funds available in any month to transfer the amount required pursuant to this subsection to the regional jail and correctional facility investment fund, the deficiency shall be added to the amount transferred in the next succeeding month in which revenues are available to transfer the deficiency. Each month a lien on the revenues generated from the insurance premium tax, the annuity tax and the minimum tax, provided in this section and sections fifteen and seventeen of this article, up to a maximum amount equal to one twelfth of the projected annual principal and return is granted to the investment management board to secure the investment made with the regional jail and correctional facility authority pursuant to section twenty, article six, chapter twelve of this code. The treasurer shall, no later than the last business day of each month, transfer amounts the treasurer determines are not necessary for making refunds under this article to meet the requirements of subsection (d), section twenty-one, article six, chapter twelve of this code, to the credit of the general revenue fund. Commencing on the first day of the month following the month in which the investment created under the provisions of section twenty-one, article six, chapter twelve of this code, is returned to the investment management board, the treasurer shall transfer all amounts deposited in the insurance tax fund as appropriated by the Legislature.

§ 33-3-14a. Additional premium tax.

For the purpose of providing additional revenue for the state general revenue fund, there is hereby levied and imposed, in addition to the taxes imposed by section fourteen of this article, an additional premium tax equal to one percent of

taxable premiums. Except as otherwise provided in this section, all provisions of this article relating to the levy, imposition and collection of the regular premium tax shall be applicable to the levy, imposition and collection of the additional tax. All moneys received from the additional tax imposed by this section, less deductions allowed by this article for refunds and for costs of administration, shall be received by the commissioner and shall be paid by him or her into the state treasury for the benefit of the state fund: *Provided*, That each year, the first eight hundred thirty-three thousand dollars of the portion of taxes received by the commissioner from insurance policies for medical liability insurance as defined in section three, article twenty-f of this chapter and from any insurer on its medical malpractice line, shall be temporarily dedicated to replenishing moneys appropriated from the tobacco settlement account pursuant to subsection (c), section two, article eleven-a of chapter four of this code. Upon determination by the commissioner that these moneys have been fully replenished to the tobacco settlement account, the commissioner shall resume depositing taxes received from medical malpractice premiums as provided herein.

ARTICLE 4. GENERAL PROVISIONS.

§33-4-15a. Credit for reinsurance; definitions; requirements; trust accounts; reductions from liability; security; effective date.

(a) For purposes of this section, an "accredited reinsurer" is one which:

(1) Has filed an application for accreditation and received a letter of accreditation from the commissioner;

(2) Is licensed to transact insurance or reinsurance in at least one of the fifty states of the United States or the District of Columbia or, in the case of a United States branch of an alien

assuming insurer, is entered through and licensed to transact insurance or reinsurance in at least one of the fifty states of the United States or the District of Columbia;

(3) Has filed with the application a certified statement that the company submits to this state's jurisdiction and that the company will comply with the laws and rules of the state of West Virginia;

(4) Has filed with the application a certified statement that the company submits to the examination authority granted the commissioner by section nine, article two of this chapter and will pay all examination costs and fees as required by that section, and the one-time assessment on insurers imposed under section nine-a, article two of this chapter;

(5) Has filed with the application a copy of its most recent annual statement in a form consistent with the requirements of subdivision (8) of this subsection and a copy of its last audited financial statement;

(6) Has filed any other information the commissioner requests to determine that the company qualifies for accreditation under this section;

(7) Has remitted the applicable processing fee with its application for accreditation;

(8) Files with the commissioner after initial accreditation on or before the first day of March of each year a true statement of its financial condition, transactions and affairs as of the preceding thirty-first day of December. The statement shall be on the appropriate national association of insurance commissioners annual statement blank; shall be prepared in accordance with the national association of insurance commissioners annual statement instructions; and shall follow the accounting practices and procedures prescribed by the national association

of insurance commissioners accounting practices and procedures manual as amended. The statement shall be accompanied by the applicable annual statement filing fee. The commissioner may grant extensions of time for filing of this annual statement upon application by the accredited reinsurer; and

(9) Files with the commissioner after initial accreditation by the first day of June of each year a copy of its audited financial statement for the period ending the preceding thirty-first day of December.

(b) If the commissioner determines that the assuming insurer has failed to continue to meet any of these qualifications, he or she may upon written notice and hearing, as prescribed by section thirteen, article two of this chapter, revoke an assuming insurer's accreditation. Credit shall not be allowed to a ceding insurer if the assuming insurer's accreditation has been revoked by the commissioner after notice and hearing.

(c) Credit for reinsurance shall be allowed a domestic ceding insurer or any foreign or alien insurer transacting insurance in West Virginia that is domiciled in a jurisdiction that employs standards regarding credit for reinsurance that are not substantially similar to those applicable under this article as either an asset or a deduction from liability on account of reinsurance ceded only when the reinsurer meets one of the following requirements:

(1) Credit shall be allowed when the reinsurance is ceded to an assuming insurer which is licensed to transact insurance or reinsurance in this state.

(2) Credit shall be allowed when the reinsurance is ceded to an assuming insurer which is accredited as a reinsurer in this state prior to the effective date of the reinsurance contract.

(3) Credit shall be allowed when the reinsurance is ceded to an assuming insurer which is domiciled and licensed in, or in the case of a United States branch of an alien assuming insurer, is entered through one of the fifty states of the United States or the District of Columbia and which employs standards regarding credit for reinsurance substantially similar to those applicable under this statute, and the ceding insurer provides evidence suitable to the commissioner that the assuming insurer:

(A) Maintains a surplus as regards policyholders in an amount not less than twenty million dollars: *Provided,* That the requirements of this paragraph do not apply to reinsurance ceded and assumed pursuant to pooling arrangements among insurers in the same holding company system;

(B) The ceding insurer provides the commissioner with a certified statement from the assuming insurer that the assuming insurer submits to the authority of this state to examine its books and records granted the commissioner by section nine, article two of this chapter and will pay all examination costs and fees as required by that section; and

(C) The reinsurer complies with the provisions of subdivision (6), subsection (c) herein.

(4) Credit shall be allowed when the reinsurance is ceded to an assuming insurer which maintains a trust fund as required by subsection (d) herein in a qualified United States financial institution, as defined by this section, for the payment of the valid claims of its United States policyholders and ceding insurers, their assigns and successors in interest, and complies with the provisions of subdivision (6) herein.

(5) Credit shall be allowed when the reinsurance is ceded to an assuming insurer not meeting the requirements of subdivisions (1) through (4), inclusive, subsection (c) of this section, but only with respect to the insurance of risks located in

jurisdictions where such reinsurance is required by applicable law or regulation of that jurisdiction.

(6) If the assuming insurer is not licensed or accredited to transact insurance or reinsurance in this state, the credit permitted by subdivisions (3) and (4) of this subsection shall not be allowed unless the assuming insurer agrees in the reinsurance agreements:

(A) That in the event of the failure of the assuming insurer to perform its obligations under the terms of the reinsurance agreement, the assuming insurer, at the request of the ceding insurer, shall submit to the jurisdiction of any court of competent jurisdiction in any state of the United States, shall comply with all requirements necessary to give such court jurisdiction and shall abide by the final decision of such court or of any appellate court in the event of an appeal; and

(B) To designate the secretary of state as its true and lawful attorney upon whom may be served any lawful process in any action, suit or proceeding instituted by or on behalf of the ceding company. Process shall be served upon the secretary of state, or accepted by him or her, in the same manner as provided for service of process upon unlicensed insurers under section thirteen of this article: *Provided,* That this provision is not intended to conflict with or override the obligation of the parties to a reinsurance agreement to arbitrate their disputes, if such an obligation is created in the agreement.

(d) Whenever an assuming insurer establishes a trust fund for the payment of claims pursuant to the provisions of this section, the following requirements shall apply:

(1) The assuming insurer shall report annually to the commissioner information substantially the same as that required to be reported on the national association of insurance commissioners annual statement form by licensed insurers to

enable the commissioner to determine the sufficiency of the trust fund. In the case of a single assuming insurer, the trust shall consist of a trusteed account representing the assuming insurer's liabilities attributable to business written in the United States and, in addition, the assuming insurer shall maintain a trusteed surplus of not less than twenty million dollars. In the case of a group, including incorporated and individual unincorporated underwriters, the trust shall consist of a trusteed account representing the group's liabilities attributable to business written in the United States and, in addition, the group shall maintain a trusteed surplus of which one hundred million dollars shall be held jointly for the benefit of United States ceding insurers of any member of the group. The incorporated members of the group shall not be engaged in any business other than underwriting as a member of the group and shall be subject to the same level of solvency regulation and control by the group's domiciliary regulator as are the unincorporated members. The group shall make available to the commissioner an annual certification of the solvency of each underwriter by the group's domiciliary regulator and its independent public accountants.

(2) In the case of a group of incorporated insurers under common administration which complies with the filing requirements contained in the previous paragraph; which has continuously transacted an insurance business outside the United States for at least three years immediately prior to making application for accreditation; which submits to this state's authority to examine its books and records and bears the expense of the examination; and which has aggregate policyholders' surplus of ten billion dollars, the trust shall be in an amount equal to the group's several liabilities attributable to business ceded by United States ceding insurers to any member of the group pursuant to reinsurance contracts issued in the name of the group. The group shall also maintain a joint trusteed surplus of which one hundred million dollars shall be held jointly for the

benefit of United States ceding insurers of any member of the group as additional security for any such liabilities. Each member of the group shall make available to the commissioner an annual certification of the member's solvency by the member's domiciliary regulator and its independent public accountants.

(3) Any trust that is subject to the provisions of this section shall be established in a form approved by the commissioner. The trust instrument shall provide that contested claims shall be valid and enforceable upon the final order of any court of competent jurisdiction in the United States. The trust shall vest legal title to its assets in the trustees of the trust for its United States policyholders and ceding insurers, their assigns and successors in interest. The trust and the assuming insurer shall be subject to examination as determined by the commissioner. The trust described herein shall remain in effect for as long as the assuming insurer shall have outstanding obligations due under the reinsurance agreements subject to the trust.

(4) No later than the twenty-eighth day of February of each year the trustees of the trust shall report to the commissioner in writing setting forth the balance of the trust and listing the trust's investments at the preceding year's end. The trustees shall certify the date of termination of the trust, if so planned, or certify that the trust shall not expire prior to the next following December thirty-first.

(e) A reduction from liability for the reinsurance ceded by a ceding insurer subject to the requirements of this article to an assuming insurer not meeting the requirements of subsection (c) of this section shall be allowed in an amount not exceeding the liabilities carried by the ceding insurer. The reduction shall be in the amount of funds held by or on behalf of the ceding insurer, including funds held in trust for the ceding insurer, under a reinsurance contract with the assuming insurer as

security for the payment of obligations thereunder: *Provided,* That the security is held in the United States subject to withdrawal solely by, and under the exclusive control of, the ceding insurer; or, in the case of a trust, held in a qualified United States financial institution, as defined by this section. The security may be in the form of:

(1) Cash;

(2) Securities listed by the securities valuation office of the national association of insurance commissioners and qualifying as admitted assets; or

(3) Clean, irrevocable, unconditional letters of credit, issued or confirmed by a qualified United States financial institution, as defined by this section, no later than the thirty-first day of December of the year for which filing is being made, and in the possession of the ceding company on or before the filing date of its annual statement: *Provided,* That letters of credit meeting applicable standards of issuer acceptability as of the dates of their issuance or confirmation shall, notwithstanding the issuing or confirming institution's subsequent failure to meet applicable standards of issuer acceptability, continue to be acceptable as security until their expiration, extension, renewal, modification or amendment, whichever first occurs.

(f) For purposes of this section, a "qualified United States financial institution" means an institution that:

(1) Is organized or licensed under the laws of the United States or any state thereof;

(2) Is regulated, supervised and examined by United States federal or state authorities having regulatory authority over banks and trust companies; and

(3) Has been determined by either the commissioner, or the securities valuation office of the national association of insurance commissioners, to meet the standards of financial condition and standing as are considered necessary and appropriate to regulate the quality of financial institutions whose letters of credit will be acceptable to the commissioner.

(g) A "qualified United States financial institution" means, for purposes of those provisions of this law specifying those institutions that are eligible to act as a fiduciary of a trust, an institution that:

(1) Is organized or, in the case of a United States branch or agency office of a foreign banking organization, licensed under the laws of the United States or any state thereof and has been granted authority to operate with fiduciary powers; and

(2) Is regulated, supervised and examined by federal or state authorities having regulatory authority over banks and trust companies.

(h) The provisions of this section shall apply to all cessions on or after the first day of January, one thousand nine hundred ninety-three.

ARTICLE 20B. RATES AND MALPRACTICE INSURANCE POLICIES.

§33-20B-2. Ratemaking.

Any and all modifications of rates shall be made in accordance with the following provisions:

(a) Due consideration shall be given to the past and prospective loss experience within and outside this state.

(b) Due consideration shall be given to catastrophe hazards, if any, to a reasonable margin for underwriting profit and contingencies, to dividends, savings or unabsorbed premium

deposits allowed or returned by insurers to their policyholders, members or subscribers and actual past expenses and demonstrable prospective or projected expenses applicable to this state.

(c) Rates shall not be excessive, inadequate, predatory or unfairly discriminatory.

(d) Risks may not be grouped by territorial areas for the establishment of rates and minimum premiums.

(e) An insurer may use guide "A" rates and other nonapproved rates, also known as "consent to rates": *Provided*, That the insurer shall, prior to entering into an agreement with an individual provider or any health care entity, submit guide "A" rates and other nonapproved rates to the commissioner for review and approval: *Provided, however*, That the commissioner shall propose legislative rules for promulgation in accordance with the provisions of article three, chapter twenty-nine-a of this code, which set forth the standards and procedure for reviewing and approving guide "A" rates and other nonapproved rates. No insurer may require execution of a consent to rate endorsement for the purpose of offering to issue or issuing a contract or coverage to an insured or continuing an existing contract or coverage at a rate in excess of that provided by a filing otherwise applicable.

(f) Except to the extent necessary to meet the provisions of subdivision (c) of this section, uniformity among insurers, in any matters within the scope of this section, is neither required nor prohibited.

(g) Rates made in accordance with this section may be used subject to the provisions of this article.

§33-20B-3. Rate filings.

(a) On or before the first day of July, two thousand four and on the first day of July each year thereafter, or at such other time specified by the commissioner, every insurer offering malpractice insurance in this state shall make a rate filing, in accordance with the provisions of section four, article twenty of this chapter, regardless of whether any increase or decrease is indicated, pursuant to subsection (a), section four, article twenty of this chapter. The information furnished in support of a filing shall include: (i) The experience or judgment of the insurer or rating organization making the filing; (ii) its interpretation of any statistical data the filing relies upon; (iii) the experience of other insurers or rating organizations; (iv) the character and extent of the coverage contemplated; (v) the proposed effective date of any requested change and (vi) any other relevant factors required by the commissioner. When a filing is not accompanied by the information required by this section upon which the insurer supports the filing, the commissioner shall require the insurer to furnish the information and, in that event, the waiting period prescribed by subsection (b) of this section shall commence as of the date the information is furnished.

A filing and any supporting information shall be open to public inspection as soon as the filing is received by the commissioner. Any interested party may file a brief with the commissioner supporting his or her position concerning the filing. Any person or organization may file with the commissioner a signed statement declaring and supporting his or her or its position concerning the filing. Upon receipt of any such statement prior to the effective date of the filing, the commissioner shall mail or deliver a copy of the statement to the filer, which may file a reply. This section is not applicable to any memorandum or statement of any kind by any employee of the commissioner.

(b) Every filing shall be on file for a waiting period of ninety days before it becomes effective. The commissioner may

extend the waiting period for an additional period not to exceed thirty days if he or she gives written notice within the waiting period to the insurer or rating organization which made the filing that he or she needs the additional time for the consideration of the filing. Upon written application by the insurer or rating organization, the commissioner may authorize a filing which he or she has reviewed to become effective before the expiration of the waiting period or any extension of the waiting period. A filing shall be deemed to meet the requirements of this article unless disapproved by the commissioner within the waiting period or any extension thereof.

(c) No insurer shall make or issue a contract or policy of malpractice insurance except in accordance with the filings which are in effect for the insurer as provided in this article.

§33-20B-3a. Rate prohibitions.

Reduced rates charged for certain specialties or risks found by the commissioner to be predatory, designed to gain market share or otherwise inadequate are prohibited.

ARTICLE 20F. PHYSICIANS' MUTUAL INSURANCE COMPANY.

§33-20F-1a. Scope of article.

This article applies only to the physicians' mutual insurance company created as a novation of the medical professional liability insurance programs created in article twelve-b, chapter twenty-nine of this code.

§33-20F-2. Findings and purpose.

(a) The Legislature finds that:

(1) There is a nationwide crisis in the field of medical liability insurance;

(2) Similar crises have occurred at least three times during the past three decades;

(3) Such crises are part of a naturally recurring cycle of a hard market period, when medical professional liability coverage is difficult to obtain, and a soft market period, when coverage is more readily available;

(4) Such crises are particularly acute in this state due to the small size of the insurance market;

(5) During a hard market period, insurers tend to flee this state, creating a crisis for physicians who are left without professional liability coverage;

(6) During the current crisis, physicians in West Virginia find it increasingly difficult, if not impossible, to obtain medical liability insurance either because coverage is unavailable or unaffordable;

(7) The difficulty or impossibility of obtaining medical liability insurance may result in many qualified physicians leaving the state;

(8) Access to quality health care is of utmost importance to the citizens of West Virginia;

(9) A mechanism is needed to provide an enduring solution to this recurring medical liability crisis;

(10) A physicians' mutual insurance company or a similar entity has proven to be a successful mechanism in other states for helping physicians secure insurance and for stabilizing the insurance market;

(11) There is a substantial public interest in creating a method to provide a stable medical liability market in this state;

(12) The state has attempted to temporarily alleviate the current medical crisis by the creation of programs to provide medical liability coverage through the board of risk and insurance management;

(13) The state-run program is a substantial actual and potential liability to the state;

(14) There is substantial public benefit in transferring the actual and potential liability of the state to the private sector and creating a stable self-sufficient entity which will be a source of liability insurance coverage for physicians in this state;

(15) A stable, financially viable insurer in the private sector will provide a continuing source of insurance funds to compensate victims of medical malpractice; and

(16) Because the public will greatly benefit from the formation of a physicians' mutual insurance company, state efforts to encourage and support the formation of such an entity, including providing a low-interest loan for a portion of the entity's initial capital, is in the clear public interest.

(b) The purpose of this article is to create a mechanism for the formation of a physicians' mutual insurance company that will provide:

(1) A means for physicians to obtain medical liability insurance that is available and affordable; and

(2) Compensation to persons who suffer injuries as a result of medical professional liability as defined in subsection (d), section two, article seven-b, chapter fifty-five of this code.

§33-20F-3. Definitions.

For purposes of this article, the term:

(a) "Board of medicine" means the West Virginia board of medicine as provided in section five, article three, chapter thirty of this code.

(b) "Board of osteopathy" means the West Virginia board of osteopathy as provided in section three, article fourteen, chapter thirty of this code.

(c) "Commissioner" means the insurance commissioner of West Virginia as provided in section one, article two, chapter thirty-three of this code.

(d) "Company" means the physicians' mutual insurance company created pursuant to the terms of this article.

(e) "Medical liability insurance" means, for the purposes of this article: All policies previously issued by the board of risk and insurance management pursuant to article twelve-b, chapter twenty-nine of this code which are transferred by the board of risk and insurance management to the company, pursuant to subsection (b), section nine of this article and all policies of insurance subsequently issued by the company to physicians, physician corporations, physician-operated clinics and such other individual health care providers as the commissioner may, upon written application of the company, approve.

(f) "Physician" means an individual who is licensed by the board of medicine or the board of osteopathy to practice medicine or podiatry in West Virginia.

(g) "Transfer date" means the date on which the assets, obligations and liabilities resulting from the board of risk and insurance management's issuance of medical liability policies to physicians, physician corporations and physician-operated clinics pursuant to article twelve-b, chapter twenty-nine of this code are transferred to the company.

§33-20F-4. Authorization for creation of company; requirements and limitations.

(a) Subject to the provisions of this article, a physicians' mutual insurance company may be created as a domestic, private, nonstock, nonprofit corporation. As an incentive for its creation, the company may be eligible for funds from the Legislature in accordance with the provisions of section seven of this article. The company must remain for the duration of its existence a domestic mutual insurance company owned by its policyholders and may not be converted into a stock corporation, a for-profit corporation or any other entity not owned by its policyholders. The company may not declare any dividend to its policyholders; sell, assign or transfer substantial assets of the company; or write coverage outside this state, except for counties adjoining this state, until after any and all debts owed by the company to the state have been fully paid.

(b) For the duration of its existence, the company is not and may not be considered a department, unit, agency, or instrumentality of the state for any purpose. All debts, claims, obligations, and liabilities of the company, whenever incurred, shall be the debts, claims, obligations, and liabilities of the company only and not of the state or of any department, unit, agency, instrumentality, officer, or employee of the state.

(c) The moneys of the company are not and may not be considered part of the general revenue fund of the state. The debts, claims, obligations, and liabilities of the company are not and may not be considered a debt of the state or a pledge of the credit of the state.

(d) The company is not subject to provisions of article nine-a, chapter six of this code or the provisions of article one, chapter twenty-nine-b of this code.

(e) (1) All premiums collected by the company are subject to the premium taxes and surcharges contained in sections fourteen and fourteen-a, article three of this chapter: *Provided*, That while the loan to the company of moneys from the West Virginia tobacco settlement medical trust fund pursuant to section nine of this article remains outstanding, the commissioner may waive the company's premium taxes and surcharges if payment would render the company insolvent or otherwise financially impaired.

(2) On and after the first day of July, two thousand and three, any premium taxes and surcharges paid by the company and by any insurer on its medical malpractice line pursuant to sections fourteen and fourteen-a, article three of this chapter, shall be temporarily applied toward replenishing the moneys appropriated from the West Virginia tobacco settlement medical trust fund pursuant to subsection (c), section two, article eleven-a, chapter four of this code pending repayment of the loan of such moneys by the company.

(3) The state treasurer shall notify the commissioner when the moneys appropriated from the West Virginia tobacco settlement medical trust have been fully replenished, at which time the commissioner shall resume depositing premium taxes and surcharges diverted pursuant to subdivision (2) of this subsection in accordance with the provisions of sections fourteen and fourteen-a, article three of this chapter.

(4) Payments received by the treasurer from the company in repayment of any outstanding loan made pursuant to section nine of this article shall be deposited in the West Virginia tobacco settlement medical trust fund and dedicated to replenishing the moneys appropriated therefrom under subsection (c), section two, article eleven-a, chapter four of this code. Once the moneys appropriated from the West Virginia tobacco settlement medical trust fund have been fully replenished, the treasurer

shall deposit any payments from the company in repayment of any outstanding loan made pursuant to section nine of this article in said fund and transfer a like amount from said fund to the commissioner for disbursement in accordance with the provisions of sections fourteen and fourteen-a, article three of this chapter.

§33-20F-5. Governance and organization.

(a)(1) The board of risk and insurance management shall implement the initial formation and organization of the company as provided by this article.

(2) From the first day of July, two thousand three, until the thirtieth day of June, two thousand four, the company shall be governed by a provisional board of directors consisting of the members of the board of risk and insurance management, the dean of the West Virginia University School of Medicine or a physician representative designated by him or her, and five physician directors, elected by the policyholders whose policies are to be transferred to the company pursuant to section nine of this article.

(3) Only physicians who are licensed to practice medicine in this state pursuant to article three or article fourteen, chapter thirty of this code and who have purchased medical professional liability coverage from the board of risk and insurance management are eligible to serve as physician directors on the provisional board of directors. One of the physician directors shall be selected from a list of three physicians nominated by the West Virginia medical association. The board of risk and insurance management shall develop procedures for the nomination of the remaining physician directors and for the conduct of the election, to be held no later than the first day of June, two thousand three, of all of the physician directors, including, but not limited to, giving notice of the election to the

policyholders. These procedures shall be exempt from the provisions of article three, chapter twenty-nine of this code.

(b) From the first day of July, two thousand four, the company shall be governed by a board of directors consisting of eleven directors, as follows:

(1) Five directors who are physicians licensed to practice medicine in this state by the board of medicine or the board of osteopathy, including at least one general practitioner and one specialist: *Provided*, That only physicians who have purchased medical professional liability coverage from the board of risk and insurance management are eligible to serve as physician representatives on the company's first board of directors.

(2) Three directors who have substantial experience as an officer or employee of a company in the insurance industry;

(3) Two directors with general knowledge and experience in business management who are officers and employees of the company and are responsible for the daily management of the company; and

(4) One director who is a dean of a West Virginia school of medicine or osteopathy or his or her designated physician representative. This director's position shall rotate annually among the dean of the West Virginia University School of Medicine, the dean of the Marshall University Joan C. Edwards School of Medicine and the dean of the West Virginia School of Osteopathic Medicine. This director shall serve until such time as the moneys loaned to the company from the West Virginia tobacco settlement medical trust fund have been replenished as provided in subsection (e), section four of this article. After the moneys have been replenished the West Virginia tobacco settlement medical trust fund, this director

shall be a physician licensed to practice medicine in this state by the board of medicine or the board of osteopathy.

(c) In addition to the eleven directors required by subsection (b) of this section, the bylaws of the company may provide for the addition of at least two directors who represent an entity or institution which lends or otherwise provides funds to the company.

(d) The directors and officers of the company are to be chosen in accordance with the articles of incorporation and bylaws of the company. The initial board of directors selected in accordance with the provisions of subdivision (3), subsection (a) of this section shall serve for the following terms: (1) Three for four-year terms; (2) three for three-year terms; (3) three for two-year terms; and (4) two for one-year terms. Thereafter, the directors shall serve staggered terms of four years. If an additional director is added to the board as provided in subsection (c) of this section, his or her initial term shall be for four years. No director chosen pursuant to subsection (b) of this section may serve more than two consecutive terms.

(e) The incorporators are to prepare and file articles of incorporation and bylaws in accordance with the provisions of this article and the provisions of chapters thirty-one and thirty-three of this code.

§33-20F-6. Management and administration of the company.

(a) If it is determined that the services of a third-party administrator or other firm or company are necessary to properly administer the affairs of the company prior to the first day of July, two thousand four, the provisional board of directors shall avail itself of any existing contracts entered into by the board of risk and insurance management to manage its affairs. The terms of the company's participation in the contract

shall be established by the board of risk and insurance management.

(b) The provisional board of directors may enter into a one-year contract with a third-party administrator or other firm or company with suitable qualifications and experience to administer some or all of the affairs of the company from the first day of July, two thousand four, until the thirtieth day of June, two thousand five, subject to the continuing direction of the board of directors as required by the articles of incorporation and bylaws of the company, and the contract. Any contract entered into pursuant to this subsection must be awarded by competitive bidding not later than the first day of November, two thousand three.

(c) After the first day of July, two thousand four, if the company's board of directors determines that the affairs of the company may be administered suitably and efficiently, the company may enter into a contract with a licensed insurer, licensed health service plan, insurance service organization, third-party administrator, insurance brokerage firm or other firm or company with suitable qualifications and experience to administer some or all of the affairs of the company, subject to the continuing direction of the board of directors as required by the articles of incorporation and bylaws of the company, and the contract. All such contracts shall be awarded by competitive bidding.

(d) The company shall file a true copy of the contract with the commissioner as provided in section twenty-one, article five of this chapter.

§33-20F-7. Initial capital and surplus; special assessment.

(a) There is hereby created in the state treasury a special revenue account designated as the "Board of Risk and Insurance Management Physicians' Mutual Insurance Company Account"

solely for the purpose of receiving moneys transferred from the West Virginia Tobacco Medical Trust Fund pursuant to subsection (c), section two, article eleven-a, chapter four of this code for the company's use as initial capital and surplus.

(b) On the first day of July, two thousand three, a special one-time assessment, in the amount of one thousand dollars, shall be imposed on every physician licensed by the board of medicine or by the board of osteopathy for the privilege of practicing medicine in this state: *Provided,* That the following physicians shall be exempt from the assessment:

(1)A faculty physician who meets the criteria for full-time faculty under subsection (f), section one, article eight, chapter eighteen-b of this code, who is a full-time employee of a school of medicine or osteopathic medicine in this state, and who does not maintain a private practice;

(2) A resident physician who is a graduate of a medical school or college of osteopathic medicine enrolled and who is participating in an accredited full-time program of post-graduate medical education in this state;

(3) A physician who has presented suitable proof that he or she is on active duty in armed forces of the United States and who will not be reimbursed by the armed forces for the assessment;

(4) A physician who receives more than fifty percent of his or her practice income from providing services to federally qualified health center as that term is defined in 42 U.S.C. §1396d(l)(2); and

(5) A physician who practices solely under a special volunteer medical license authorized by section ten-a, article three or section twelve-b, article fourteen, chapter thirty of this code. The assessment is to be imposed and collected by the

board of medicine and the board of osteopathy on forms prescribed by each licensing board.

(c) The entire proceeds of the special assessment collected pursuant to subsection (b) of this section shall be dedicated to the company. The board of medicine and the board of osteopathy shall promptly pay over to the company all amounts collected pursuant to this section to be used as policyholder surplus for the company.

(d) Any physician who applies to purchase insurance from the company and who has not paid the assessment pursuant to subsection (b) of this section shall pay one thousand dollars to the company as a condition of obtaining insurance from the company.

§33-20F-8. Application for license; authority of commissioner.

(a) As soon as practical, the company established pursuant to the provisions of this article shall file its corporate charter and bylaws with the commissioner and apply for a license to transact insurance in this state. Notwithstanding any other provision of this code, the commissioner shall act on the documents within fifteen days of the filing by the company.

(b) In recognition of the medical liability insurance crisis in this state at the time of enactment of this article and the critical need to expedite the initial operation of the company, the Legislature hereby authorizes the commissioner to review the documentation submitted by the company and to determine the initial capital and surplus requirements of the company, notwithstanding the provisions of section five-b, article three of this chapter. The commissioner has the sole discretion to determine the capital and surplus funds of the company and to monitor the economic viability of the company during its initial operation and duration on not less than a monthly basis. The

company shall furnish the commissioner with all information and cooperate in all respects necessary for the commissioner to perform the duties set forth in this section and in other provisions of this chapter, including annual audited financial statements required by article thirty-three of this chapter and fidelity bond coverage for each of the directors of the company.

(c) Subject to the provisions of subsection (d) of this section, the commissioner may waive other requirements imposed on mutual insurance companies by the provisions of this chapter as the commissioner determines is necessary to enable the company to begin insuring physicians in this state at the earliest possible date.

(d) Within forty months of the date of the issuance of its license to transact insurance, the company shall comply with the capital and surplus requirements set forth in section five-b, article three of this chapter.

§33-20F-9. Kinds of coverage authorized; transfer of policies from the state board of risk and insurance management; risk management practices authorized.

(a) Upon approval by the commissioner for a license to transact insurance in this state, the company may issue nonassessable policies of malpractice insurance, as defined in subdivision (9), subsection (e), section ten, article one of this chapter, insuring a physician. Additionally, the company may issue other types of casualty or liability insurance as may be approved by the commissioner.

(b) On the transfer date:

(1) The company shall accept from the board of risk and insurance management the transfer of any and all medical liability insurance obligations and risks of existing or in force contracts of insurance covering physicians, physician corpora-

tions and physician-operated clinics issued by the board pursuant to article twelve-b, chapter twenty-nine of this code. The transfer shall not include medical liability insurance obligations and risks of existing or in-force contracts of insurance covering hospitals and non-physician providers;

(2) The company shall assume all responsibility for and defend, indemnify and hold harmless the board of risk and insurance management and the state with respect to any and all liabilities and duties arising from the assets and responsibilities transferred to the company pursuant to article twelve-b, chapter twenty-nine of this code;

(3) The board of risk and insurance management shall disburse and pay to the company any funds attributable to premiums paid for the insurance obligations transferred to the company pursuant to subdivision (1) of this subsection, with earnings thereon, less paid losses and expenses, and deposited in the medical liability fund created by section ten, article twelve-b, chapter twenty-nine of this code as reflected on the ledgers of the board of risk and insurance management;

(4) The board of risk and insurance management shall disburse and pay to the company any funds in the board of risk and insurance management physicians' mutual insurance company account created by section seven of this article. All funds in this account shall be transferred pursuant to terms of a surplus note or other loan arrangement satisfactory to the board of risk and insurance management and the insurance commissioner.

(c) The board of risk and insurance management shall cause an independent actuarial study to be performed to determine the amount of all paid losses, expenses and assets associated with the policies the board has in force pursuant to article twelve-b, chapter twenty-nine of this code. The actuarial study shall

determine the paid losses, expenses and assets associated with the policies to be transferred to the company pursuant to subsection (b) of this section and the paid losses, expenses and assets associated with those policies retained by the board. The determination shall not include liabilities created by issuance of new tail insurance policies for nonphysician providers authorized by subsection (n), section six, article twelve-b, chapter twenty-nine of this code.

(d) The board of risk and insurance management may enter into such agreements, including loan agreements, with the company that are necessary to accomplish the transfers addressed in this section.

(e) The company shall make policies of insurance available to physicians in this state, regardless of practice type or specialty. Policies issued by the company to each class of physicians are to be essentially uniform in terms and conditions of coverage.

(f) Notwithstanding the provisions of subsection (b), (c) or (e) of this section, the company may:

(1) Establish reasonable classifications of physicians, insured activities and exposures based on a good faith determination of relative exposures and hazards among classifications;

(2) Vary the limits, coverages, exclusions, conditions and loss-sharing provisions among classifications;

(3) Establish, for an individual physician within a classification, reasonable variations in the terms of coverage, including rates, deductibles and loss-sharing provisions, based on the insured's prior loss experience and current professional training and capability; and

(4) Except with respect to policies transferred from the board of risk and insurance management under this section, refuse to provide insurance coverage for individual physicians whose prior loss experience or current professional training and capability are such that the physician represents an unacceptable risk of loss if coverage is provided.

(g) The company shall establish reasonable risk management and continuing education requirements which policyholders must meet in order to be and remain eligible for coverage.

§33-20F-10. Controlling law.

To the extent applicable, and when not in conflict with the provisions of this article, the provisions of chapters thirty-one and thirty-three of this code apply to the company created pursuant to the provisions of this article. If a provision of this article and another provision of this code are in conflict, the provision of this article controls.

§33-20F-11. Liberal construction.

This article is enacted to address a situation critical to the citizens of the state of West Virginia by providing a mechanism for the speedy and deliberate creation of a company to begin offering medical liability insurance to physicians in this state at the earliest possible date ; and to accomplish this purpose, this article shall be liberally construed.

ARTICLE 25A. HEALTH MAINTENANCE ORGANIZATION ACT.

§33-25A-24. Scope of provisions; applicability of other laws.

(a) Except as otherwise provided in this article, provisions of the insurance laws and provisions of hospital or medical service corporation laws are not applicable to any health maintenance organization granted a certificate of authority

under this article. The provisions of this article shall not apply to an insurer or hospital or medical service corporation licensed and regulated pursuant to the insurance laws or the hospital or medical service corporation laws of this state except with respect to its health maintenance corporation activities authorized and regulated pursuant to this article. The provisions of this article may not apply to an entity properly licensed by a reciprocal state to provide health care services to employer groups, where residents of West Virginia are members of an employer group, and the employer group contract is entered into in the reciprocal state. For purposes of this subsection, a "reciprocal state" means a state which physically borders West Virginia and which has subscriber or enrollee hold harmless requirements substantially similar to those set out in section seven-a of this article.

(b) Factually accurate advertising or solicitation regarding the range of services provided, the premiums and copayments charged, the sites of services and hours of operation and any other quantifiable, nonprofessional aspects of its operation by a health maintenance organization granted a certificate of authority, or its representative may not be construed to violate any provision of law relating to solicitation or advertising by health professions: *Provided,* That nothing contained in this subsection shall be construed as authorizing any solicitation or advertising which identifies or refers to any individual provider or makes any qualitative judgment concerning any provider.

(c) Any health maintenance organization authorized under this article may not be considered to be practicing medicine and is exempt from the provisions of chapter thirty of this code, relating to the practice of medicine.

(d) The provisions of sections fifteen and twenty, article four (general provisions); section nine-a, article two (one-time assessment); section seventeen, article six (noncomplying

forms); section twenty, article five (borrowing by insurers); article six-c (guaranteed loss ratio); article seven (assets and liabilities); article eight (investments); article eight-a (use of clearing corporations and federal reserve book-entry system); article nine (administration of deposits); article twelve (agents, brokers, solicitors and excess line); section fourteen, article fifteen (individual accident and sickness insurance); section sixteen, article fifteen (coverage of children); section eighteen, article fifteen (equal treatment of state agency); section nineteen, article fifteen (coordination of benefits with medicaid); article fifteen-b (uniform health care administration act); section three, article sixteen (required policy provisions); section three-f, article sixteen (treatment of temporomandibular disorder and craniomandibular disorder); section eleven, article sixteen (coverage of children); section thirteen, article sixteen (equal treatment of state agency); section fourteen, article sixteen (coordination of benefits with medicaid); article sixteen-a (group health insurance conversion); article sixteen-d (marketing and rate practices for small employers); article twenty-five-c (health maintenance organization patient bill of rights); article twenty-seven (insurance holding company systems); article thirty-four-a (standards and commissioner's authority for companies considered to be in hazardous financial condition); article thirty-five (criminal sanctions for failure to report impairment); article thirty-seven (managing general agents); article thirty-nine (disclosure of material transactions); article forty-one (privileges and immunity); and article forty-two (women's access to health care) shall be applicable to any health maintenance organization granted a certificate of authority under this article. In circumstances where the code provisions made applicable to health maintenance organizations by this section refer to the "insurer", the "corporation" or words of similar import, the language shall be construed to include health maintenance organizations.

(e) Any long-term care insurance policy delivered or issued for delivery in this state by a health maintenance organization shall comply with the provisions of article fifteen-a of this chapter.

ARTICLE 25D. PREPAID LIMITED HEALTH SERVICE ORGANIZATION ACT.

§33-25D-26. Scope of provisions; applicability of other laws.

(a) Except as otherwise provided in this article, provisions of the insurance laws, provisions of hospital, medical, dental or health service corporation laws and provisions of health maintenance organization laws are not applicable to any prepaid limited health service organization granted a certificate of authority under this article. The provisions of this article do not apply to an insurer, hospital, medical, dental or health service corporation, or health maintenance organization licensed and regulated pursuant to the insurance laws, hospital, medical, dental or health service corporation laws or health maintenance organization laws of this state except with respect to its prepaid limited health service corporation activities authorized and regulated pursuant to this article. The provisions of this article do not apply to an entity properly licensed by a reciprocal state to provide a limited health care service to employer groups, where residents of West Virginia are members of an employer group, and the employer group contract is entered into in the reciprocal state. For purposes of this subsection, a "reciprocal state" means a state which physically borders West Virginia and which has subscriber or enrollee hold harmless requirements substantially similar to those set out in section ten of this article.

(b) Factually accurate advertising or solicitation regarding the range of services provided, the premiums and copayments charged, the sites of services and hours of operation and any other quantifiable, nonprofessional aspects of its operation by

a prepaid limited health service organization granted a certificate of authority, or its representative do not violate any provision of law relating to solicitation or advertising by health professions: *Provided,* That nothing contained in this subsection authorizes any solicitation or advertising which identifies or refers to any individual provider or makes any qualitative judgment concerning any provider.

(c) Any prepaid limited health service organization authorized under this article is not considered to be practicing medicine and is exempt from the provision of chapter thirty of this code relating to the practice of medicine.

(d) The provisions of section nine, article two, examinations; section nine-a, article two, one-time assessment; section thirteen, article two, hearings; sections fifteen and twenty, article four, general provisions; section twenty, article five, borrowing by insurers; section seventeen, article six, noncomplying forms; article six-c, guaranteed loss ratio; article seven, assets and liabilities; article eight, investments; article eight-a, use of clearing corporations and federal reserve book-entry system; article nine, administration of deposits; article ten, rehabilitation and liquidation; article twelve, agents, brokers, solicitors and excess line; section fourteen, article fifteen, individual accident and sickness insurance; section sixteen, article fifteen, coverage of children; section eighteen, article fifteen, equal treatment of state agency; section nineteen, article fifteen, coordination of benefits with medicaid; article fifteen-b, uniform health care administration act; section three, article sixteen, required policy provisions; section eleven, article sixteen, coverage of children; section thirteen, article sixteen, equal treatment of state agency; section fourteen, article sixteen, coordination of benefits with medicaid; article sixteen-a, group health insurance conversion; article sixteen-d, marketing and rate practices for small employers; article twenty-seven, insurance holding company systems; article

thirty-three, annual audited financial report; article thirty-four, administrative supervision; article thirty-four-a, standards and commissioner's authority for companies considered to be in hazardous financial condition; article thirty-five, criminal sanctions for failure to report impairment; article thirty-seven, managing general agents; article thirty-nine, disclosure of material transactions; and article forty-one, privileges and immunity, all of this chapter are applicable to any prepaid limited health service organization granted a certificate of authority under this article. In circumstances where the code provisions made applicable to prepaid limited health service organizations by this section refer to the "insurer", the "corporation" or words of similar import, the language includes prepaid limited health service organizations.

(e) Any long-term care insurance policy delivered or issued for delivery in this state by a prepaid limited health service organization shall comply with the provisions of article fifteen-a of this chapter.

(f) A prepaid limited health service organization granted a certificate of authority under this article is exempt from paying municipal business and occupation taxes on gross income it receives from its enrollees, or from their employers or others on their behalf, for health care items or services provided directly or indirectly by the prepaid limited health service organization.

CHAPTER 38. LIENS.

ARTICLE 10. FEDERAL TAX LIENS; ORDERS AND DECREES IN BANKRUPTCY.

§38-10-4. Exemptions of property in bankruptcy proceedings.

Pursuant to the provisions of 11 U. S. C. §522(b)(1), this state specifically does not authorize debtors who are domiciled

in this state to exempt the property specified under the provisions of 11 U. S. C. §522(d).

Any person who files a petition under the federal bankruptcy law may exempt from property of the estate in a bankruptcy proceeding the following property:

(a) The debtor's interest, not to exceed twenty-five thousand dollars in value, in real property or personal property that the debtor or a dependent of the debtor uses as a residence, in a cooperative that owns property that the debtor or a dependent of the debtor uses as a residence or in a burial plot for the debtor or a dependent of the debtor: *Provided*, That when the debtor is a physician licensed to practice medicine in this state under article three or article fourteen, chapter thirty of this code, and has commenced a bankruptcy proceeding in part due to a verdict or judgment entered in a medical professional liability action, if the physician has current medical malpractice insurance in the amount of at least one million dollars for each occurrence, the debtor physician's interest that is exempt under this subsection may exceed twenty-five thousand dollars in value but may not exceed two hundred fifty thousand dollars per household.

(b) The debtor's interest, not to exceed two thousand four hundred dollars in value, in one motor vehicle.

(c) The debtor's interest, not to exceed four hundred dollars in value in any particular item, in household furnishings, household goods, wearing apparel, appliances, books, animals, crops or musical instruments that are held primarily for the personal, family or household use of the debtor or a dependent of the debtor: *Provided,* That the total amount of personal property exempted under this subsection may not exceed eight thousand dollars.

(d) The debtor's interest, not to exceed one thousand dollars in value, in jewelry held primarily for the personal, family or household use of the debtor or a dependent of the debtor.

(e) The debtor's interest, not to exceed in value eight hundred dollars plus any unused amount of the exemption provided under subsection (a) of this section in any property.

(f) The debtor's interest, not to exceed one thousand five hundred dollars in value, in any implements, professional books or tools of the trade of the debtor or the trade of a dependent of the debtor.

(g) Any unmeasured life insurance contract owned by the debtor, other than a credit life insurance contract.

(h) The debtor's interest, not to exceed in value eight thousand dollars less any amount of property of the estate transferred in the manner specified in 11 U. S. C. §542(d), in any accrued dividend or interest under, or loan value of, any unmeasured life insurance contract owned by the debtor under which the insured is the debtor or an individual of whom the debtor is a dependent.

(i) Professionally prescribed health aids for the debtor or a dependent of the debtor.

(j) The debtor's right to receive:

(1) A social security benefit, unemployment compensation or a local public assistance benefit;

(2) A veterans' benefit;

(3) A disability, illness or unemployment benefit;

(4) Alimony, support or separate maintenance, to the extent reasonably necessary for the support of the debtor and any dependent of the debtor;

(5) A payment under a stock bonus, pension, profit sharing, annuity or similar plan or contract on account of illness, disability, death, age or length of service, to the extent reasonably necessary for the support of the debtor and any dependent of the debtor, and funds on deposit in an individual retirement account (IRA), including a simplified employee pension (SEP) regardless of the amount of funds, unless:

(A) The plan or contract was established by or under the auspices of an insider that employed the debtor at the time the debtor's rights under the plan or contract arose;

(B) The payment is on account of age or length of service;

(C) The plan or contract does not qualify under Section 401(a), 403(a), 403(b), 408 or 409 of the Internal Revenue Code of 1986; and

(D) With respect to an individual retirement account, including a simplified employee pension, the amount is subject to the excise tax on excess contributions under Section 4973 and/or Section 4979 of the Internal Revenue Code of 1986, or any successor provisions, regardless of whether the tax is paid.

(k) The debtor's right to receive or property that is traceable to:

(1) An award under a crime victim's reparation law;

(2) A payment on account of the wrongful death of an individual of whom the debtor was a dependent, to the extent reasonably necessary for the support of the debtor and any dependent of the debtor;

(3) A payment under a life insurance contract that insured the life of an individual of whom the debtor was a dependent on the date of the individual's death, to the extent reasonably necessary for the support of the debtor and any dependent of the debtor;

(4) A payment, not to exceed fifteen thousand dollars on account of personal bodily injury, not including pain and suffering or compensation for actual pecuniary loss, of the debtor or an individual of whom the debtor is a dependent;

(5) A payment in compensation of loss of future earnings of the debtor or an individual of whom the debtor is or was a dependent, to the extent reasonably necessary for the support of the debtor and any dependent of the debtor;

(6) Payments made to the prepaid tuition trust fund or to the savings plan trust fund, including earnings, in accordance with article thirty, chapter eighteen of this code on behalf of any beneficiary.

CHAPTER 55. ACTIONS, SUITS AND ARBITRATION; JUDICIAL SALE.

ARTICLE 7B. MEDICAL PROFESSIONAL LIABILITY.

§55-7B-1. Legislative findings and declaration of purpose.

The Legislature hereby finds and declares that the citizens of this state are entitled to the best medical care and facilities available and that health care providers offer an essential and basic service which requires that the public policy of this state encourage and facilitate the provision of such service to our citizens;

That as in every human endeavor the possibility of injury or death from negligent conduct commands that protection of

the public served by health care providers be recognized as an important state interest;

That our system of litigation is an essential component of this state's interest in providing adequate and reasonable compensation to those persons who suffer from injury or death as a result of professional negligence, and any limitation placed on this system must be balanced with and considerate of the need to fairly compensate patients who have been injured as a result of negligent and incompetent acts by health care providers;

That liability insurance is a key part of our system of litigation, affording compensation to the injured while fulfilling the need and fairness of spreading the cost of the risks of injury;

That a further important component of these protections is the capacity and willingness of health care providers to monitor and effectively control their professional competency, so as to protect the public and insure to the extent possible the highest quality of care;

That it is the duty and responsibility of the Legislature to balance the rights of our individual citizens to adequate and reasonable compensation with the broad public interest in the provision of services by qualified health care providers and health care facilities who can themselves obtain the protection of reasonably priced and extensive liability coverage;

That in recent years, the cost of insurance coverage has risen dramatically while the nature and extent of coverage has diminished, leaving the health care providers, the health care facilities and the injured without the full benefit of professional liability insurance coverage;

That many of the factors and reasons contributing to the increased cost and diminished availability of professional

liability insurance arise from the historic inability of this state to effectively and fairly regulate the insurance industry so as to guarantee our citizens that rates are appropriate, that purchasers of insurance coverage are not treated arbitrarily and that rates reflect the competency and experience of the insured health care providers and health care facilities;

That the unpredictable nature of traumatic injury health care services often result in a greater likelihood of unsatisfactory patient outcomes, a higher degree of patient and patient family dissatisfaction and frequent malpractice claims, creating a financial strain on the trauma care system of our state, increasing costs for all users of the trauma care system and impacting the availability of these services, requires appropriate and balanced limitations on the rights of persons asserting claims against trauma care health care providers, this balance must guarantee availability of trauma care services while mandating that these services meet all national standards of care, to assure that our health care resources are being directed towards providing the best trauma care available; and

That the cost of liability insurance coverage has continued to rise dramatically, resulting in the state's loss and threatened loss of physicians, which, together with other costs and taxation incurred by health care providers in this state, have created a competitive disadvantage in attracting and retaining qualified physicians and other health care providers.

The Legislature further finds that medical liability issues have reached critical proportions for the state's long-term health care facilities, as: (1) Medical liability insurance premiums for nursing homes in West Virginia continue to increase and the number of claims per bed has increased significantly; (2) the cost to the state medicaid program as a result of such higher premiums has grown considerably in this period; (3) current medical liability premium costs for some

nursing homes constitute a significant percentage of the amount of coverage; (4) these high costs are leading some facilities to consider dropping medical liability insurance coverage altogether; and (5) the medical liability insurance crisis for nursing homes may soon result in a reduction of the number of beds available to citizens in need of long-term care.

Therefore, the purpose of this article is to provide for a comprehensive resolution of the matters and factors which the Legislature finds must be addressed to accomplish the goals set forth in this section. In so doing, the Legislature has determined that reforms in the common law and statutory rights of our citizens must be enacted together as necessary and mutual ingredients of the appropriate legislative response relating to:

(1) Compensation for injury and death;

(2) The regulation of rate making and other practices by the liability insurance industry, including the formation of a physicians' mutual insurance company and establishment of a fund to assure adequate compensation to victims of malpractice; and

(3) The authority of medical licensing boards to effectively regulate and discipline the health care providers under such board.

§55-7B-2. Definitions.

(a) "Board" means the state board of risk and insurance management;

(b) "Collateral source" means a source of benefits or advantages for economic loss that the claimant has received from:

(1) Any federal or state act, public program or insurance which provides payments for medical expenses, disability benefits, including workers' compensation benefits, or other similar benefits. Benefits payable under the Social Security Act are not considered payments from collateral sources except for Social Security disability benefits directly attributable to the medical injury in question;

(2) Any contract or agreement of any group, organization, partnership or corporation to provide, pay for or reimburse the cost of medical, hospital, dental, nursing, rehabilitation, therapy or other health care services or provide similar benefits;

(3) Any group accident, sickness or income disability insurance, any casualty or property insurance (including automobile and homeowners' insurance) which provides medical benefits, income replacement or disability coverage, or any other similar insurance benefits, except life insurance, to the extent that someone other than the insured, including the insured's employer, has paid all or part of the premium or made an economic contribution on behalf of the plaintiff; or

(4) Any contractual or voluntary wage continuation plan provided by an employer or otherwise, or any other system intended to provide wages during a period of disability.

(c) "Consumer price index" means the most recent consumer price index for all consumers published by the United States department of labor.

(d) "Emergency condition" means any acute traumatic injury or acute medical condition which, according to standardized criteria for triage, involves a significant risk of death or the precipitation of significant complications or disabilities, impairment of bodily functions, or, with respect to a pregnant woman, a significant risk to the health of the unborn child.

(e)"Health care" means any act or treatment performed or furnished, or which should have been performed or furnished, by any health care provider for, to or on behalf of a patient during the patient's medical care, treatment or confinement.

(f) "Health care facility" means any clinic, hospital, nursing home, or assisted living facility, including personal care home, residential care community and residential board and care home, or behavioral health care facility or comprehensive community mental health/mental retardation center, in and licensed by the state of West Virginia and any state operated institution or clinic providing health care.

(g) "Health care provider" means a person, partnership, corporation, professional limited liability company, health care facility or institution licensed by, or certified in, this state or another state, to provide health care or professional health care services, including, but not limited to, a physician, osteopathic physician, hospital, dentist, registered or licensed practical nurse, optometrist, podiatrist, chiropractor, physical therapist , psychologist, emergency medical services authority or agency, or an officer, employee or agent thereof acting in the course and scope of such officer's, employee's or agent's employment.

(h) "Medical injury" means injury or death to a patient arising or resulting from the rendering of or failure to render health care.

(i) "Medical professional liability" means any liability for damages resulting from the death or injury of a person for any tort or breach of contract based on health care services rendered, or which should have been rendered, by a health care provider or health care facility to a patient.

(j) "Medical professional liability insurance" means a contract of insurance or any actuarially sound self-funding

program that pays for the legal liability of a health care facility or health care provider arising from a claim of medical professional liability.

(k) "Noneconomic loss" means losses, including, but not limited to, pain, suffering, mental anguish and grief.

(l) "Patient" means a natural person who receives or should have received health care from a licensed health care provider under a contract, expressed or implied.

(m) "Plaintiff" means a patient or representative of a patient who brings an action for medical professional liability under this article.

(n) "Representative" means the spouse, parent, guardian, trustee, attorney or other legal agent of another.

§55-7B-3. Elements of proof.

(a) The following are necessary elements of proof that an injury or death resulted from the failure of a health care provider to follow the accepted standard of care:

(1) The health care provider failed to exercise that degree of care, skill and learning required or expected of a reasonable, prudent health care provider in the profession or class to which the health care provider belongs acting in the same or similar circumstances; and

(2) Such failure was a proximate cause of the injury or death.

(b) If the plaintiff proceeds on the "loss of chance" theory, *i.e.*, that the health care provider's failure to follow the accepted standard of care deprived the patient of a chance of recovery or increased the risk of harm to the patient which was a substantial

factor in bringing about the ultimate injury to the patient, the plaintiff must also prove, to a reasonable degree of medical probability, that following the accepted standard of care would have resulted in a greater than twenty-five percent chance that the patient would have had an improved recovery or would have survived.

§55-7B-6. Prerequisites for filing an action against a health care provider; procedures; sanctions.

(a) Notwithstanding any other provision of this code, no person may file a medical professional liability action against any health care provider without complying with the provisions of this section.

(b) At least thirty days prior to the filing of a medical professional liability action against a health care provider, the claimant shall serve by certified mail, return receipt requested, a notice of claim on each health care provider the claimant will join in litigation. The notice of claim shall include a statement of the theory or theories of liability upon which a cause of action may be based, and a list of all health care providers and health care facilities to whom notices of claim are being sent, together with a screening certificate of merit. The screening certificate of merit shall be executed under oath by a health care provider qualified as an expert under the West Virginia rules of evidence and shall state with particularity: (1) The expert's familiarity with the applicable standard of care in issue; (2) the expert's qualifications; (3) the expert's opinion as to how the applicable standard of care was breached; and (4) the expert's opinion as to how the breach of the applicable standard of care resulted in injury or death. A separate screening certificate of merit must be provided for each health care provider against whom a claim is asserted. The person signing the screening certificate of merit shall have no financial interest in the underlying claim, but may participate as an expert witness in

any judicial proceeding. Nothing in this subsection may be construed to limit the application of rule 15 of the rules of civil procedure.

(c) Notwithstanding any provision of this code, if a claimant or his or her counsel, believes that no screening certificate of merit is necessary because the cause of action is based upon a well-established legal theory of liability which does not require expert testimony supporting a breach of the applicable standard of care, the claimant or his or her counsel, shall file a statement specifically setting forth the basis of the alleged liability of the health care provider in lieu of a screening certificate of merit.

(d) If a claimant or his or her counsel has insufficient time to obtain a screening certificate of merit prior to the expiration of the applicable statute of limitations, the claimant shall comply with the provisions of subsection (b) of this section except that the claimant or his or her counsel shall furnish the health care provider with a statement of intent to provide a screening certificate of merit within sixty days of the date the health care provider receives the notice of claim.

(e) Any health care provider who receives a notice of claim pursuant to the provisions of this section may respond, in writing, to the claimant or his or her counsel within thirty days of receipt of the claim or within thirty days of receipt of the screening certificate of merit if the claimant is proceeding pursuant to the provisions of subsection (d) of this section. The response may state that the health care provider has a bona fide defense and the name of the health care provider's counsel, if any.

(f) Upon receipt of the notice of claim or of the screening certificate of merit, if the claimant is proceeding pursuant to the provisions of subsection (d) of this section, the health care

provider is entitled to pre-litigation mediation before a qualified mediator upon written demand to the claimant.

(g) If the health care provider demands mediation pursuant to the provisions of subsection (f) of this section, the mediation shall be concluded within forty-five days of the date of the written demand. The mediation shall otherwise be conducted pursuant to rule 25 of the trial court rules, unless portions of the rule are clearly not applicable to a mediation conducted prior to the filing of a complaint or unless the supreme court of appeals promulgates rules governing mediation prior to the filing of a complaint. If mediation is conducted, the claimant may depose the health care provider before mediation or take the testimony of the health care provider during the mediation.

(h) Except as otherwise provided in this subsection, any statute of limitations applicable to a cause of action against a health care provider upon whom notice was served for alleged medical professional liability shall be tolled from the date of mail of a notice of claim to thirty days following receipt of a response to the notice of claim, thirty days from the date a response to the notice of claim would be due, or thirty days from the receipt by the claimant of written notice from the mediator that the mediation has not resulted in a settlement of the alleged claim and that mediation is concluded, whichever last occurs. If a claimant has sent a notice of claim relating to any injury or death to more than one health care provider, any one of whom has demanded mediation, then the statute of limitations shall be tolled with respect to, and only with respect to, those health care providers to whom the claimant sent a notice of claim to thirty days from the receipt of the claimant of written notice from the mediator that the mediation has not resulted in a settlement of the alleged claim and that mediation is concluded.

(i) Notwithstanding any other provision of this code, a notice of claim, a health care provider's response to any notice claim, a screening certificate of merit and the results of any mediation conducted pursuant to the provisions of this section are confidential and are not admissible as evidence in any court proceeding unless the court, upon hearing, determines that failure to disclose the contents would cause a miscarriage of justice.

§55-7B-7. Testimony of expert witness on standard of care.

(a) The applicable standard of care and a defendant's failure to meet the standard of care, if at issue, shall be established in medical professional liability cases by the plaintiff by testimony of one or more knowledgeable, competent expert witnesses if required by the court. Expert testimony may only be admitted in evidence if the foundation therefor is first laid establishing that: (1) The opinion is actually held by the expert witness; (2) the opinion can be testified to with reasonable medical probability; (3) the expert witness possesses professional knowledge and expertise coupled with knowledge of the applicable standard of care to which his or her expert opinion testimony is addressed; (4) the expert witness maintains a current license to practice medicine with the appropriate licensing authority of any state of the United States: *Provided,* That the expert witness' license has not been revoked or suspended in the past year in any state; and (5) the expert witness is engaged or qualified in a medical field in which the practitioner has experience and/or training in diagnosing or treating injuries or conditions similar to those of the patient. If the witness meets all of these qualifications and devoted, at the time of the medical injury, sixty percent of his or her professional time annually to the active clinical practice in his or her medical field or specialty, or to teaching in his or her medical field or speciality in an accredited university, there shall be a rebuttable presumption that the witness is qualified as an expert. The

parties shall have the opportunity to impeach any witness' qualifications as an expert. Financial records of an expert witness are not discoverable or relevant to prove the amount of time the expert witness spends in active practice or teaching in his or her medical field unless good cause can be shown to the court.

(b) Nothing contained in this section may be construed to limit a trial court's discretion to determine the competency or lack of competency of a witness on a ground not specifically enumerated in this section.

§55-7B-8. Limit on liability for noneconomic loss.

(a) In any professional liability action brought against a health care provider pursuant to this article, the maximum amount recoverable as compensatory damages for noneconomic loss shall not exceed two hundred fifty thousand dollars per occurrence, regardless of the number of plaintiffs or the number of defendants or, in the case of wrongful death, regardless of the number of distributees, except as provided in subsection (b) of this article.

(b) The plaintiff may recover compensatory damages for noneconomic loss in excess of the limitation described in subsection (a) of this section, but not in excess of five hundred thousand dollars for each occurrence, regardless of the number of plaintiffs or the number of defendants or, in the case of wrongful death, regardless of the number of distributees, where the damages for noneconomic losses suffered by the plaintiff were for: (1) Wrongful death; (2) permanent and substantial physical deformity, loss of use of a limb or loss of a bodily organ system; or (3) permanent physical or mental functional injury that permanently prevents the injured person from being able to independently care for himself or herself and perform life sustaining activities.

(c) On the first of January, two thousand four, and in each year thereafter, the limitation for compensatory damages contained in subsections (a) and (b) of this section shall increase to account for inflation by an amount equal to the consumer price index published by the United States department of labor, up to fifty percent of the amounts specified in subsections (b) and (c) as a limitation of compensatory noneconomic damages.

(d) The limitations on noneconomic damages contained in subsections (a), (b), (c) and (e) of this section are not available to any defendant in an action pursuant to this article which does not have medical professional liability insurance in the amount of at least one million dollars per occurrence covering the medical injury which is the subject of the action.

(e) If subsection (a) or (b) of this section, as enacted during the regular session of the Legislature, two thousand three, or the application thereof to any person or circumstance, is found by a court of law to be unconstitutional or otherwise invalid, the maximum amount recoverable as damages for noneconomic loss in a professional liability action brought against a health care provider under this article shall thereafter not exceed one million dollars.

§55-7B-9. Several liability.

(a) In the trial of a medical professional liability action under this article involving multiple defendants, the trier of fact shall report its findings on a form provided by the court which contains each of the possible verdicts as determined by the court. Unless otherwise agreed by all the parties to the action, the jury shall be instructed to answer special interrogatories, or the court, acting without a jury, shall make findings as to:

(1) The total amount of compensatory damages recoverable by the plaintiff;

(2) The portion of the damages that represents damages for noneconomic loss;

(3) The portion of the damages that represents damages for each category of economic loss;

(4) The percentage of fault, if any, attributable to each plaintiff; and

(5) The percentage of fault, if any, attributable to each of the defendants.

(b) In assessing percentages of fault, the trier of fact shall consider only the fault of the parties in the litigation at the time the verdict is rendered and shall not consider the fault of any other person who has settled a claim with the plaintiff arising out of the same medical injury. *Provided,* That, upon the creation of the patient injury compensation fund provided for in article twelve-c, chapter twenty-nine of this code, or of some other mechanism for compensating a plaintiff for any amount of economic damages awarded by the trier of fact which the plaintiff has been unable to collect, the trier of fact shall, in assessing percentages of fault, consider the fault of all alleged parties, including the fault of any person who has settled a claim with the plaintiff arising out of the same medical injury.

(c) If the trier of fact renders a verdict for the plaintiff, the court shall enter judgment of several, but not joint, liability against each defendant in accordance with the percentage of fault attributed to the defendant by the trier of fact.

(d) To determine the amount of judgment to be entered against each defendant, the court shall first, after adjusting the verdict as provided in section nine-a of this article, reduce the

adjusted verdict by the amount of any pre-verdict settlement arising out of the same medical injury. The court shall then, with regard to each defendant, multiply the total amount of damages remaining, with interest, by the percentage of fault attributed to each defendant by the trier of fact. The resulting amount of damages, together with any post-judgment interest accrued, shall be the maximum recoverable against the defendant.

(e) Upon the creation of the patient injury compensation fund provided for in article twelve-c, chapter twenty-nine of this code, or of some other mechanism for compensating a plaintiff for any amount of economic damages awarded by the trier of fact which the plaintiff has been unable to collect, the court shall, in determining the amount of judgment to be entered against each defendant, first multiply the total amount of damages, with interest, recoverable by the plaintiff by the percentage of each defendant's fault and that amount, together with any post-judgment interest accrued, is the maximum recoverable against said defendant. Prior to the court's entry of the final judgment order as to each defendant against whom a verdict was rendered, the court shall reduce the total jury verdict by any amounts received by a plaintiff in settlement of the action. When any defendant's percentage of the verdict exceeds the remaining amounts due plaintiff after the mandatory reductions, each defendant shall be liable only for the defendant's pro rata share of the remainder of the verdict as calculated by the court from the remaining defendants to the action. The plaintiff's total award may never exceed the jury's verdict less any statutory or court-ordered reductions.

(f) Nothing in this section is meant to eliminate or diminish any defenses or immunities which exist as of the effective date of this section, except as expressly noted in this section.

(g) Nothing in this article is meant to preclude a health care provider from being held responsible for the portion of fault attributed by the trier of fact to any person acting as the health care provider's agent or servant or to preclude imposition of fault otherwise imputable or attributable to the health care provider under claims of vicarious liability. A health care provider may not be held vicariously liable for the acts of a nonemployee pursuant to a theory of ostensible agency unless the alleged agent does not maintain professional liability insurance covering the medical injury which is the subject of the action in the aggregate amount of at least one million dollars.

§55-7B-9a. Reduction in compensatory damages for economic losses for payments from collateral sources the same injury.

(a) In any action arising after the effective date of this section, a defendant who has been found liable to the plaintiff for damages for medical care, rehabilitation services, lost earnings or other economic losses may present to the court, after the trier of fact has rendered a verdict, but before entry of judgment, evidence of payments the plaintiff has received for the same injury from collateral sources.

(b) In any hearing pursuant to subsection (a) of this section, the defendant may present evidence of future payments from collateral sources if the court determines that: (1) There is a preexisting contractual or statutory obligation on the collateral source to pay the benefits; (2) the benefits, to a reasonable degree of certainty, will be paid to the plaintiff for expenses the trier of fact has determined the plaintiff will incur in the future; and (3) the amount of the future expenses is readily reducible to a sum certain.

(c) In the hearing pursuant to subsection (a) of this section, the plaintiff may present evidence of the value of payments or contributions he or she has made to secure the right to the benefits paid by the collateral source.

(d) After hearing the evidence presented by the parties, the court shall make the following findings of fact:

(1) The total amount of damages for economic loss found by the trier of fact;

(2) The total amount of damages for each category of economic loss found by the trier of fact;

(3) The total amount of allowable collateral source payments received or to be received by the plaintiff for the medical injury which was the subject of the verdict in each category of economic loss; and

(4) The total amount of any premiums or contributions paid by the plaintiff in exchange for the collateral source payments in each category of economic loss found by the trier of fact.

(e) The court shall subtract the total premiums the plaintiff was found to have paid in each category of economic loss from the total collateral source benefits the plaintiff received with regard to that category of economic loss to arrive at the net amount of collateral source payments.

(f) The court shall then subtract the net amount of collateral source payments received or to be received by the plaintiff in each category of economic loss from the total amount of damages awarded the plaintiff by the trier of fact for that category of economic loss to arrive at the adjusted verdict.

(g) The court shall not reduce the verdict rendered by the trier of fact in any category of economic loss to reflect:

(1) Amounts paid to or on behalf of the plaintiff which the collateral source has a right to recover from the plaintiff through subrogation, lien or reimbursement;

(2) Amounts in excess of benefits actually paid or to be paid on behalf of the plaintiff by a collateral source in a category of economic loss;

(3) The proceeds of any individual disability or income replacement insurance paid for entirely by the plaintiff;

(4) The assets of the plaintiff or the members of the plaintiff's immediate family; or

(5) A settlement between the plaintiff and another tortfeasor.

(h) After determining the amount of the adjusted verdict, the court shall enter judgment in accordance with the provisions of section nine.

§55-7B-9b. Limitations on third-party claims.

An action may not be maintained against a health care provider pursuant to this article by or on behalf of a third-party nonpatient for rendering or failing to render health care services to a patient whose subsequent act is a proximate cause of injury or death to the third party unless the health care provider rendered or failed to render health care services in willful and wanton or reckless disregard of a foreseeable risk of harm to third persons. Nothing in this section shall be construed to prevent the personal representative of a deceased patient from maintaining a wrongful death action on behalf of such patient pursuant to article seven of this chapter or to prevent a derivative claim for loss of consortium arising from injury or death to the patient arising from the negligence of a health care provider within the meaning of this article.

§55-7B-9c. Limit on liability for treatment of emergency conditions for which patient is admitted to a designated trauma center; exceptions; emergency rules.

(a) In any action brought under this article for injury to or death of a patient as a result of health care services or assistance rendered in good faith and necessitated by an emergency condition for which the patient enters a health care facility designated by the office of emergency medical services as a trauma center, including health care services or assistance rendered in good faith by a licensed EMS agency or an employee of an licensed EMS agency, the total amount of civil damages recoverable shall not exceed five hundred thousand dollars, exclusive of interest computed from the date of judgment.

(b) The limitation of liability in subsection (a) of this section also applies to any act or omission of a health care provider in rendering continued care or assistance in the event that surgery is required as a result of the emergency condition within a reasonable time after the patient's condition is stabilized.

(c) The limitation on liability provided under subsection (a) of this section does not apply to any act or omission in rendering care or assistance which: (1) Occurs after the patient's condition is stabilized and the patient is capable of receiving medical treatment as a nonemergency patient; or (2) is unrelated to the original emergency condition.

(d) In the event that: (1) A physician provides follow-up care to a patient to whom the physician rendered care or assistance pursuant to subsection (a) of this section; and (2) a medical condition arises during the course of the follow-up care that is directly related to the original emergency condition for which care or assistance was rendered pursuant to said subsec-

tion, there is rebuttable presumption that the medical condition was the result of the original emergency condition and that the limitation on liability provided by said subsection applies with respect to that medical condition.

(e) There is a rebuttable presumption that a medical condition which arises in the course of follow-up care provided by the designated trauma center health care provider who rendered good faith care or assistance for the original emergency condition is directly related to the original emergency condition where the follow-up care is provided within a reasonable time after the patient's admission to the designated trauma center.

(f) The limitation on liability provided under subsection (a) of this section does not apply where health care or assistance for the emergency condition is rendered:

(1) In willful and wanton or reckless disregard of a risk of harm to the patient; or

(2) In clear violation of established written protocols for triage and emergency health care procedures developed by the office of emergency medical services in accordance with subsection (e) of this section. In the event that the office of emergency medical services has not developed a written triage or emergency medical protocol by the effective date of this section, the limitation on liability provided under subsection (a) of this section does not apply where health care or assistance is rendered under this section in violation of nationally recognized standards national standards for triage and emergency health care procedures.

(g) The office of emergency medical services shall, prior to the effective date of this section, develop a written protocol specifying recognized and accepted standards for triage and

emergency health care procedures for treatment of emergency conditions necessitating admission of the patient to a designated trauma center.

(h) In its discretion, the office of emergency medical services may grant provisional trauma center status for a period of up to one year to a health care facility applying for designated trauma center status. A facility given provisional trauma center status is eligible for the limitation on liability provided in subsection (a) of this section. If, at the end of the provisional period, the facility has not been approved by the office of emergency medical services as a designated trauma center, the facility will no longer be eligible for the limitation on liability provided in subsection (a) of this section.

(i) The commissioner of the bureau for public health may grant an applicant for designated trauma center status a one-time only extension of provisional trauma center status, upon submission by the facility of a written request for extension, accompanied by a detailed explanation and plan of action to fulfill the requirements for a designated trauma center. If, at the end of the six-month period, the facility has not been approved by the office of emergency medical services as a designated trauma center, the facility will no longer have the protection of the limitation on liability provided in subsection (a) of this section.

(j) If the office of emergency medical services determines that a health care facility no longer meets the requirements for a designated trauma center, it shall revoke the designation, at which time the limitation on liability established by subsection (a) of this section shall cease to apply to that health care facility for services or treatment rendered thereafter.

(k) The Legislature hereby finds that an emergency exists compelling promulgation of an emergency rule, consistent with

the provisions of this section, governing the criteria for designation of a facility as a trauma center or provisional trauma center and implementation of a statewide trauma/emergency care system. The Legislature therefore directs the secretary of the department of health and human resources to file, on or before the first day of July, two thousand three, emergency rules specifying the criteria for designation of a facility as a trauma center or provisional trauma center in accordance with nationally accepted and recognized standards and governing the implementation of a statewide trauma/emergency care system. The rules governing the statewide trauma/emergency care system shall include, but not be limited to:

(1) System design, organizational structure and operation, including integration with the existing emergency medical services system;

(2) Regulation of facility designation, categorization and credentialing, including the establishment and collection of reasonable fees for designation; and

(3) System accountability, including medical review and audit to assure system quality. Any medical review committees established to assure system quality shall include all levels of care, including emergency medical service providers, and both the review committees and the providers shall qualify for all the rights and protections established in article three-c, chapter thirty of this code.

§55-7B-10. Effective date; applicability of provisions.

(a) The provisions of House Bill 149, enacted during the first extraordinary session of the Legislature, 1986, shall be effective at the same time that the provisions of Enrolled Senate Bill 714, enacted during the Regular session, 1986, become effective, and the provisions of said House Bill 149 shall be

deemed to amend the provisions of Enrolled Senate Bill 714. The provisions of this article shall not apply to injuries which occur before the effective date of this said Enrolled Senate Bill 714.

The amendments to this article as provided in House Bill 601, enacted during the sixth extraordinary session of the Legislature, two thousand one, apply to all causes of action alleging medical professional liability which are filed on or after the first day of March, two thousand two.

(b) The amendments to this article provided in Enrolled Committee Substitute for House bill No. 2122 during the regular session of the Legislature, two thousand three, apply to all causes of action alleging medical professional liability which are filed on or after the first day of July, two thousand three.

That Joint Committee on Enrolled Bills ~~hereby~~ certifies that the foregoing bill is correctly enrolled.

~~Chairman~~ *Senate Committee*
Member

Chairman House Committee

Originating in the House.

In effect from passage

Clerk of the Senate

Clerk of the House of Delegates

President of the Senate

Speaker of the House of Delegates

The within is approved this the 11th day of March, 2003.

Governor

PRESENTED TO THE
GOVERNOR
Date 3/11/03
Time 5:45pm