WEST VIRGINIA CODE CHAPTER 29 ARTICLE 12B

WV Legislature

§29-12B-1. Short title.

This article may be cited as the "West Virginia Health Care Provider Professional Liability Insurance Availability Act."

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§29-12B-2. Legislative findings.

The Legislature finds and declares that there is a need for the State of West Virginia to assist in making professional liability insurance available for certain necessary health care providers in West Virginia to assure that quality medical care is available for the citizens of the state.

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§29-12B-3. Definitions.

As used in this article, the following terms have the meanings set forth herein:

(a) "Board" means the state Board of Risk and Insurance Management.

(b) "Health care provider" means:

(1) A person licensed by the West Virginia Board of Medicine to practice medicine in this state;

(2) A person licensed by the West Virginia board of osteopathy to practice medicine in this state;

(3) A podiatrist licensed by the West Virginia Board of Medicine;

(4) An optometrist licensed by the West Virginia board of optometry;

(5) A pharmacist licensed by the West Virginia Board of Pharmacy;

(6) A registered nurse holding an advanced practice announcement from the West Virginia board of examiners for registered professional nurses;

(7) A physician's assistant licensed by either the West Virginia Board of Medicine or the West Virginia board of osteopathy;

(8) A dentist licensed by the West Virginia board of dental examiners;

(9) A physical therapist licensed by the West Virginia board of physical therapy;

(10) A chiropractor licensed by the West Virginia board of chiropractic;

(11) A professional limited liability company or medical corporation certified by the state Board of Medicine;

(12) An association, partnership or other entity organized for the purpose of rendering professional services by persons who are health care providers;

(13) A hospital, medical clinic, psychiatric hospital or other medical facility authorized by law to provide professional medical services; and

(14) Such other health care provider as the board may from time to time approve, and for whom an adequate rate can be established.

"Health care provider" does not include any provider of professional medical services that has medical malpractice insurance pursuant to article twelve of this chapter.

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(b) "Sexual acts" means that sexual conduct which constitutes a criminal or tortious act under the laws of West Virginia.

(c) "Prior acts" coverage means coverage for claims arising out of the providing of medical services, including medical treatment, which are first reported to the board during the effective policy period, but which occurred on or after the retroactive date reported in the policy declarations.

(d) "High risk" means the probability of loss is greater than average based on criteria specified in this article and established by the board.

(e)"Retroactive date" means the date designated in the policy declarations, before which coverage is not applicable.

(f) "Tail coverage" or "extended reporting coverage" is coverage that protects the health care provider against all claims arising from professional services performed while the claims-made policy was in effect and included in the policy but reported after the termination of the policy.

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§29-12B-4.

Repealed.

Acts, 2015 Reg. Sess., Ch. 53.

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§29-12B-5.

Repealed.

Acts, 2015 Reg. Sess., Ch. 53.

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§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 $1 million per claim, including repeated exposure to the same event or series of events, and all derivative claims, and $3 million in the annual aggregate. Health care providers have the option to purchase higher limits of up to $2 million per claim, including repeated exposure to the same event or series of events, and all derivative claims, and up to $4 million in the annual aggregate. In addition, hospitals covered by the plan shall have available limits of $3 million per claim, including repeated exposure to the same event or series of events, and all derivative claims, and $5 million 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

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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.

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§29-12B-7. Eligibility criteria for participation in health care provider professional liability insurance programs.

(a) Only those health care providers unable to obtain medical professional liability insurance because it is not available through the voluntary insurance market from insurers licensed to transact insurance in West Virginia at rates approved by the commissioner are eligible to obtain coverage pursuant to the provisions of this article: Provided, That any health care provider who can obtain medical professional liability insurance only pursuant to a "consent to" or "guide A" rate agreement is eligible to obtain coverage. Any health care provider who has medical professional liability insurance pursuant to the provisions of article twelve, chapter twenty-nine of this code is not eligible to obtain insurance pursuant to the provisions of this article.

(b) In addition to other eligibility criteria for participation in the health care provider professional liability insurance program established by the provisions of this article or criteria imposed by the board, every participant in the programs shall:

(1) Maintain a policy of not excluding patients whose health care coverage is provided through the West Virginia public employees insurance plan, the West Virginia Children's Health Insurance Program, West Virginia Medicaid or the West Virginia worker's compensation fund based solely on the fact that the person's health care coverage is provided by any of the aforementioned entities;

(2) Annually participate, at his or her own expense, in a risk management program approved by the board relating to risk management; and

(3) Agree in writing to the board's authority to assign his or her policy, individually or collectively, to a third party if the third party coverage is comparable, as determined by the board.

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§29-12B-8. Preferred professional liability insurance program.

(a) Eligibility to participate in the preferred professional liability insurance program shall be determined by underwriting criteria approved by the board and set forth in a written underwriting manual, and shall be subject to rates approved by the board and set forth in a written rating manual. Participation in the preferred professional liability insurance program shall not be limited based on geographic location or specialty, but may be limited based upon indemnity loss history, number of patient exposures, refusal to participate in risk management/loss control programs or any other grounds the board may approve, as set forth in a written underwriting manual. The board shall periodically review its underwriting manual and make any changes it considers necessary or appropriate.

(b) Qualification for participation in the preferred professional liability insurance program shall be reviewed each year, and any participant may be transferred to the high risk professional liability insurance program, as set forth in the written underwriting manual approved by the board.

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§29-12B-9. High risk professional liability insurance program.

(a) The rate charged participants in the high risk professional liability insurance program may be higher than those established and approved by the board for participants in the preferred professional insurance program as set forth in a written rating manual. Risks may be refused coverage under criteria approved by the board, as set forth in its underwriting manual. The Board of Risk and Insurance Management shall periodically review its underwriting manual and make any changes it deems necessary or appropriate.

(b) If a majority of the board determines that a health care provider covered by one of the programs created by this article presents an extreme risk because of the number of claims filed against him or her or the outcome of such claims, said board may, after notice and a hearing in accordance with the provisions of the West Virginia administrative procedures act, chapter twenty-nine-a of this code, terminate coverage for all claims against that health care provider. Coverage shall terminate thirty days after the board's decision. Upon termination of coverage under this subsection, the board shall notify the licensing or disciplinary board having jurisdiction over the health care provider of said provider's name and of the reasons for termination of the coverage.

(c) The board may terminate coverage for a health care provider's failure to pay premiums by providing written notice of such termination by first-class mail no less than thirty days prior to termination of coverage.

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§29-12B-10. Deposit, expenditure and investment of premiums.

(a) The premiums charged and collected by the board under this article shall be deposited into a special revenue account hereby created in the state Treasury known as the "Medical Liability Fund", and shall not be part of the general revenues of the state. Disbursements from the special revenue fund shall be upon requisition of the executive director and in accordance with the provisions of chapter five-a of this code. Disbursements shall pay operating expenses of the board attributed to these programs and the board's share of any judgments or settlements of medical malpractice claims. Funds shall be invested with the consolidated fund managed by the West Virginia Investment Management Board and interest earned shall be used for purposes of this article.

(b) Start-up operating expenses of the medical liability fund, not to exceed $500,000, may be transferred to the medical liability fund pursuant to an appropriation by the Legislature from any special revenue funds available. The medical liability fund shall reimburse the board within twenty-four months of the date of the transfer.

(c) For purposes of establishing a pool from which settlements and judgments may be paid, notwithstanding any other provision of this code to the contrary, a portion of the initial capitalization of the pool may be provided through a transfer of no greater than $4,000,000 from the State Special Insurance Fund established in section five, article twelve of this chapter. All funds transferred pursuant to this section are to be repaid by transfer from the Medical Liability Fund to the State Special Insurance Fund, together with interest that would have accrued in the State Special Insurance Fund, by July 1, 2006. Funds are to be transferred only as needed for expenditures from the Medical Liability Fund created in this section. The Treasurer shall effect these transfers pursuant to this section upon written request of the Director of the Board of Risk and Insurance Management.

(d) On July 1, 2016, all funds in the Medical Liability Fund, including all funds currently invested pursuant to the terms of subsection (a) of this section, shall be transferred to the West Virginia Patient Injury Compensation Fund established by section one, article twelve-d of this chapter. Thereafter, the Medical Liability Fund established pursuant to this section shall be closed.

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§29-12B-11. Payments for settlement or judgment.

All payments made in satisfaction of any settlement or judgment shall be in accordance with the procedures established by the board. No settlement or judgment may be paid until there is recorded in the office of the executive director: (1) A certified copy of a final judgment against a health care provider insured by either of the medical liability programs created pursuant to this article, or a certified copy of an order approving settlement in a summary proceeding; or (2) appropriate settlement documentation to include a written settlement determination issued by or on behalf of the board.

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§29-12B-12. Information exempt from disclosure.

Any specific claim reserve information is exempt from public disclosure under the freedom of information act set forth in article one, chapter twenty-nine-b of this code.

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§29-12B-13. Appeal bond.

In the event of a judgment against a health care provider from which the health care provider or the board wishes to appeal, the board is not liable for more than its share of the coverage and, as to that portion, a supersedeas bond signed by the board's administrator or his or her designee, shall suffice without further surety or other security.

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§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 July 1, 2004, 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.

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