WEST VIRGINIA CODE: §29-12D-1A

§29-12D-1a. Additional funding for Patient Injury Compensation Fund; assessment on licensed physicians; assessment on hospitals; assessment on certain awards.

(a) Annual assessment on licensed physicians. —

(1) The Board of Medicine and the Board of Osteopathic Medicine shall collect a biennial assessment in the amount of $125 from every physician licensed by each board for the privilege of practicing medicine in this state. The assessment is to be imposed and collected on forms prescribed by each licensing board. The assessment shall be collected as part of licensure or license renewal beginning July 1, 2016, for licenses issued or renewed through December 31, 2021: Provided, That the following physicians shall be exempt from the assessment:

(A) 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;

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

(C) A physician who practices solely under a special volunteer medical license authorized by §30-3-10a or §30-14-12b of this code;

(D) A physician who holds an inactive license pursuant to §30-3-12(j) or §30-14-10 of this code, or a physician who voluntarily surrenders his or her license: Provided, That a retired osteopathic physician who submits to the Board of Osteopathic Medicine an affidavit asserting that he or she receives no monetary remuneration for any medical services provided, executed under the penalty of perjury and if executed outside the State of West Virginia, verified, may be considered to be licensed on an inactive basis: Provided, however, That if a physician or osteopathic physician elects to resume an active license to practice in the state and the physician or osteopathic physician has not paid the assessments during his or her inactive status, then as a condition of receiving an active status license, the physician or osteopathic physician shall pay the assessment due in the year in which physicians or the osteopathic physician resumes an active license; and

(E) A physician who practices less than 40 hours a year providing medical genetic services to patients within this state.

(2) The entire proceeds of the annual assessment collected pursuant to §29-12D-1a(a) of this code shall be dedicated to the Patient Injury Compensation Fund. The Board of Medicine and

the Board of Osteopathic Medicine shall promptly pay over to the Board of Risk and Insurance Management all amounts collected pursuant to this subsection for deposit in the fund.

(3) Notwithstanding any provision of the code to the contrary, a physician required to pay the annual assessment who fails to do so shall not be granted a license or renewal of an existing license by the Board of Medicine or the Board of Osteopathic Medicine. Any license which expires as a result of a failure to pay the required assessment shall not be reinstated or reactivated until the assessment is paid in full.

(b) Assessment on trauma centers. —The Board of Risk and Insurance Management shall levy an assessment of $25 for each trauma patient treated at a health care facility designated by the Office of Emergency Medical Services as a trauma center, as reported to the West Virginia Trauma Registry, from January 1, 2016, through June 30, 2021. The assessment is due June 30 following each calendar year for which assessments are levied: Provided, That the assessment for the period January 1, 2021, through June 30, 2021, shall be due by December 31, 2021.

(c) Assessment on claims filed under the Medical Professional Liability Act. — From July 1, 2016, through December 31, 2021, an assessment of one percent of the gross amount of any settlement or judgment in a qualifying claim shall be levied.

(1) For purposes of this subsection, a qualifying claim is any claim for which a screening certificate of merit is required, or for which a statement setting forth the basis of the alleged liability of the health care provider is allowed in lieu of the screening certificate of merit, as defined in §55-7B-6 of this code.

(2) For any assessment levied pursuant to this subsection for which a judgment is entered by a court, the date of the entry of judgment shall be used to determine applicability of this provision. The defendant or defendants shall remit the assessment to the clerk of the court in which the qualified claim was filed. The clerk of the court shall then remit the assessment monthly to the State Treasury to be deposited in the fund.

(3) For any assessment levied pursuant to this subsection on a settlement entered into by the parties, the date on which the agreement is formalized in writing by the parties shall be used to determine applicability of this provision. At the time that an action alleging a qualified claim is dismissed by the parties, the assessment shall be remitted by the plaintiff or his or her counsel to the clerk of the court, who shall then remit the assessment to the State Treasury to be deposited in the fund. Collected assessments shall be remitted no less often than monthly. If a qualifying claim is settled prior to the filing of an action, the claimant, or his or her counsel, shall remit the payment to the Board of Risk and Insurance Management within 60 days of the date of the settlement agreement to be paid into the fund.

(d) Annual Report; transfer of fund balance. — The requirements of this section shall terminate on the dates set forth in this section or sooner if the liability of the Patient Injury

Compensation Fund has been paid or has been funded in its entirety. The Board of Risk and Insurance Management shall submit a report to the Joint Committee of Government and Finance each year beginning January 1, 2018, giving recommendations based on actuarial analysis of the fund's liability. The recommendations shall include, but not be limited to, discontinuance of the assessments provided for in this section, closure of the fund and transfer of the fund's liability. Any funds remaining in the fund on June 30, 2022, and determined by the Board of Risk and Insurance Management to not be necessary for claim payments or administrative costs of the fund, shall be transferred to the General Revenue Fund.