WEST VIRGINIA CODE CHAPTER 33 ARTICLE 20E

§33-20E-1. Short title.

This article may be cited as the "West Virginia Medical Professional Liability Insurance Joint Underwriting Association Act."

§33-20E-2. Legislative findings.

The Legislature finds and declares:

(a) That recent developments in the voluntary insurance market have made it impossible for certain West Virginia health care providers to obtain professional liability insurance coverage from insurers licensed to transact insurance in this state;

(b) That the unavailability of such insurance will have a deleterious effect on the quality and availability of public health programs and services to the citizens of this state;

(c) That it is in the best interests of the citizens of this state to preserve the quality and availability of public health programs and services; and,

(d) That the establishment and funding of a joint underwriting association will make available medical professional liability insurance to health care providers, thus preserving public health programs and services for the citizens of this state.

§33-20E-3. Intent and purpose.

The purpose of this article is to create a mechanism to provide medical professional liability insurance to health care providers who are unable to secure such coverage at approved rates through the voluntary market, in order to preserve public health programs and services for the citizens of this state.

§33-20E-4. Definitions.

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

(a) "Association" means the joint underwriting association created by this article.

(b) "Board" means the board of directors established pursuant to section six of this article.

(c) "Commissioner" means the Insurance Commissioner of West Virginia.

(d) "Health care provider" means a person, partnership, corporation, 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, or psychologist.

(e) "Medical professional liability insurance", commonly known as "medical malpractice insurance", means insurance coverage for any claim for damage or loss against a health care provider arising out of the death or injury of any person proximately caused by negligence in the rendering, or the failure to render, professional services by a health care provider.

(f) "Member insurer" means every insurer authorized to write and engaged in writing, within this state, casualty insurance, as defined in section ten, article one of this chapter.

(g) "Net direct written premiums" means, for purposes of this article, direct gross premiums written in this state on casualty insurance policies, less return premiums thereon, but does not include premiums on contracts between insurers or reinsurers.

(h) "State board" means the state Board of Risk and Insurance Management.

§33-20E-5. Joint underwriting association.

(a) There is hereby created a nonprofit unincorporated legal entity to be known as the West Virginia medical professional liability insurance joint underwriting association composed of member insurers. Every insurer authorized to write and engaged in writing, within this state, casualty insurance, on a direct basis, is and shall remain a member insurer, as a condition of its authority to transact insurance in this state.

(b) Each member insurer shall participate in the association in the proportion that its net direct written premiums during the preceding calendar year, as reported in the annual statements and other reports filed by the member with the commissioner, bear to the aggregate net direct premiums written in this state by all members of the association.

(c) The association shall perform its functions under a plan of operation approved by the commissioner under section nine of this article.

§33-20E-6. Board of directors.

(a) The administrative powers of the association shall be vested in a board of directors, which shall consist of nine persons serving terms established in the plan of operation. Seven of the board members shall be representatives of the member insurers and shall be appointed by the commissioner, with consideration given to whether all member insurers are fairly represented. One member shall be a health care provider, and another shall be a citizen, both appointed by the Governor with the advice and consent of the Senate.

(b) The citizen and health care provider members of the board shall receive the same compensation authorized by law for members of the Legislature for their interim duties for each day, or portion thereof, the member is engaged in the discharge of official duties. All board members shall be reimbursed for their actual and necessary expenses incurred in the discharge of official duties, except that mileage shall be reimbursed at the same rate as that authorized for members of the Legislature. All payments for compensation and expenses shall be made from the assets of the association.

§33-20E-7. Association's powers and duties.

(a) The association has, for purposes of this article and to the extent approved by the commissioner, the general powers and authority granted under the laws of this state to insurers licensed to transact insurance as defined in article one, chapter thirty-three of this code.

(b) The association may take any necessary action to make medical professional liability insurance available including, but not limited to:

(1) Assessing member insurers amounts necessary to pay the obligations of the association, administration expenses, the cost of examinations and other expenses authorized under this article.

(2) Establishing underwriting standards and criteria.

(3) Requiring an eligible health care provider to purchase an extended reporting endorsement, if available, from his or her previous primary medical professional liability carrier with respect to claims arising during previous policy periods.

(4) Entering into such contracts as are necessary or proper to carry out the provisions and purposes of this article, including contracts authorizing competent third parties with experience with joint underwriting associations or the medical professional liability line of insurance to administer the plan of operation, issue policies, oversee risk management, oversee investment management, set rates, underwrite risk or process claims or any combination thereof. Any such third-party contract must be approved by the commissioner. The provisions of article three, chapter five-a of this code, relating to purchasing procedures, do not apply to any contracts or agreements executed by or on behalf of the association under this subsection.

(5) Suing, including taking legal action necessary to recover any assessments for, on behalf of, or against member insurers.

(6) Investigating claims brought against the association and adjusting, compromising, defending, settling, and paying covered claims, to the extent of the association's obligation, and denying all other claims.

(7) Classifying risks as may be applicable and equitable.

(8) Establishing actuarially sound rates, rate classifications and rating adjustments, subject to approval by the commissioner.

(9) Purchasing reinsurance in an amount as it may from time to time consider appropriate.

(10) Issuing and marketing policies of insurance providing coverage required by this article in its own name.

(11) Investing, reinvesting and administering all funds and moneys held by the association.

(12) Establishing accounts and funds, including a reserve fund, to effectuate the purposes of this article.

(13) Developing, effectuating and promulgating any loss prevention programs aimed at the best interests of the association and the insured public.

§33-20E-8. State Board of Risk and Insurance Management to exercise board of directors' powers temporarily; interim plan of operation.

(a) Prior to the commissioner's approval of the final plan of operation in accordance with section nine of this article, the administrative powers of the association will be exercised by the state Board of Risk and Insurance Management.

(b) The state board shall submit to the commissioner an interim plan of operation consistent with the provisions of this article, to become effective and operative upon approval in writing by the commissioner.

(c) If the state board fails to submit a suitable interim plan of operation within thirty days, the commissioner shall adopt an interim plan which shall continue in force until superceded by a final plan of operation, submitted by the board and approved by the commissioner in accordance with section nine of this article.

(d) The interim plan of operation shall provide for economic, fair, and nondiscriminatory administration and for the prompt and efficient provision of professional liability insurance, and shall:

(1) Establish actuarially sound rates and premiums;

(2) Establish procedures for handling assets of the association;

(3) Establish procedures by which claims may be filed with the association and acceptable forms for filing claims;

(4) Establish procedures for records to be kept of all financial transactions of the association;

(5) Establish a procedure by which any member insurer or policyholder aggrieved by a final action or decision of the state board or the board of directors may appeal to the commissioner within thirty days after the action or decision; and,

(6) Contain additional provisions necessary or proper for the execution of the powers and duties of the association.

(e) The interim plan may also provide for:

(1) Assessments of members to defray losses and expenses;

(2) Creation and administration of a reserve fund;

(3) Commission arrangements;

(4) Reasonable and objective underwriting standards; and

(5) Purchase and cession of reinsurance.

(f) A health care provider is not eligible to obtain coverage under the interim plan if he or she refuses, on a regular basis, to accept patients solely because their health care coverage is provided pursuant to the West Virginia public employees insurance act, the West Virginia children's health program, West Virginia Medicaid, or the West Virginia workers' compensation fund.

(g) All member insurers shall comply with the interim plan of operation.

§33-20E-9. Final plan of operation.

(a) Once the commissioner has approved the selection of the initial board members, the board shall, within thirty days, submit to the commissioner a final plan of operation consistent with the provisions of this article.

(b) If the board fails to submit a suitable final plan of operation within the time provided in subsection (a) of this section, the commissioner shall adopt a final plan of operation as necessary or advisable to effectuate the provisions of this article.

(c) The board shall not assume administrative control of the association until the commissioner approves the final plan of operation.

(d) In addition to the matters specified in subsection (d) of section eight of this article to be included in the interim plan of operation, the final plan of operation shall:

(1) Establish procedures for the transfer of all assets and liabilities of the association from the state board to the board of directors created by section six of this article.

(2) Establish the terms of office of the board of directors.

(3) Establish regular places and times for meetings of the board of directors.

(4) Establish procedures for records to be kept of all financial transactions of the association, its agents, and the board.

(5) Establish procedures for assessments of member insurers to defray losses and expenses;

(6) Establish reasonable and objective underwriting standards;

(7) Establish actuarially sound rates and premiums;

(8) Contain such additional provisions as are necessary or proper for the execution of the powers and duties of the association.

(d) All member insurers shall comply with the final plan of operation.

(e) Amendments to the plan of operation may be made by the commissioner or by the board of directors with the approval of the commissioner.

§33-20E-10. Duties and powers of commissioner.

(a) The commissioner shall, upon request of the board, provide the association with a statement of the net direct written premiums of each member insurer.

(b) The commissioner may suspend or revoke, after notice and hearing, the certificate of authority to transact insurance in this state of any member insurer which fails to comply with the plan of operation or fails to pay an assessment when due.

(c) Any final order of the commissioner under this article shall be subject to judicial review as provided by section fourteen, article two of this chapter.

§33-20E-11. Eligibility for coverage.

(a) Only those health care providers who are 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 through the association: Provided, That any health care provider who can obtain medical professional liability insurance only pursuant to a "consent to" or "guide A" rate agreement will remain eligible to obtain coverage through the association. Any health care provider who has medical professional liability insurance pursuant to article twelve of chapter twenty-nine of this code is not eligible to obtain insurance through the association.

(b) The commissioner shall designate, based upon market conditions, the categories of health care providers who are eligible to obtain coverage from the association.

§33-20E-12. Issuance of policy.

(a) If an eligible applicant meets the underwriting standards and other requirements and conditions of the association as set forth in the approved plan of operation and there is no unpaid, uncontested premium, charge or assessment due from the applicant for any prior insurance of the same kind, the association, upon receipt of the premium, charge or assessment or a portion thereof as prescribed by the plan of operation, shall cause to be issued a policy of medical professional liability insurance.

(b) The policy may not require as a condition precedent to settlement or compromise of any claim the consent or acquiescence of the policyholder.

§33-20E-13. Rates; initial filing; basis for rates and premiums.

(a) The rates, rating plans, rating rules and rating classifications applicable to insurance written by the association are subject to the provisions of article twenty-b of this chapter. Policy forms applicable to insurance written by the association must conform to the requirements of the provisions of section eight, article six of this chapter.

(b) Within such time as the commissioner shall direct, the association shall submit an initial filing, in proper form, of policy forms, classifications, rates, rating plans, and rating rules applicable to medical professional liability insurance. Rates approved by the state board pursuant to section eight of this article shall remain in effect until the association's initial filing is approved.

(c) In the event the commissioner disapproves the initial filing, in whole or in part, the association shall amend the filing, in whole or in part, in accordance with the direction of the commissioner.

(d) Initial rates and premiums are to be set in consideration of the past and prospective loss and expense experience for insurers writing medical professional liability insurance within this state.

(e) After the initial year of operation, the board shall 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 upon which premiums shall be based. The resultant premium rates must be arrived at on an actuarially sound basis and must be calculated to be self-supporting.

(f) The rates and premiums charged for insurance policies issued pursuant to this article shall not be deemed excessive because they contain an amount reasonably calculated to recoup a deficit of the association pursuant to section sixteen of this article.

§33-20E-14. The Medical Professional Liability Insurance Fund; capitalization; transfer of assets and liabilities to board of directors.

(a) There is hereby established a special revenue fund, to be known as the "medical professional liability insurance fund," into which any initial capital, surplus or premiums or assessments charged and collected by the state board under the provisions of the interim plan shall be deposited.

(b) A portion of the association's initial capital and surplus may be provided by the Legislature, in an amount, upon terms and conditions, and from sources as may be determined by the Legislature in its sole discretion.

(c) Upon approval of the final plan of operation by the commissioner, the state board shall transfer the assets and liabilities of the association to the board of directors.

§33-20E-15. Deposit of funds; investments; premium tax liability; state not responsible for liabilities or expenses of association.

(a) The board shall deposit all sums transferred from the state board into an account of the association as specified in the final plan of operation.

(b) The board may invest sums from the association's account. Any interest earned on investments or any profit generated by collection of premiums or other means shall be returned to the association's account for the purpose of implementing this article.

(c) The association is liable for premium taxes to the same extent and in the same manner as a licensed insurer engaged in transacting insurance in this state.

(d) The state is not responsible for any costs, expenses, liabilities, judgments, or other obligations of the association.

§33-20E-16. Deficit; recoupment; assessments; reimbursement of members.

(a) A deficit sustained by the association in any one calendar year may be recouped, pursuant to the plan of operation then in effect, by one or more of the following procedures:

(1) A contribution from a reserve fund, if any, until the same is exhausted;

(2) An assessment upon the member insurers;

(3) A prospective rate increase.

(b) In the event the board opts to assess the member insurers, each member shall be responsible for the proportion of the deficit its net direct written premiums for the preceding year bear to the aggregate net direct premiums written by all members in the preceding calendar year. Net direct written premiums subject to the provisions of article twenty-a of this chapter shall not be considered in determining a member insurer's proportional share of the deficit. A member insurer may not be assessed in any year an amount greater than two percent of its net direct written premiums for the preceding calendar year.

(c) The assessment of a member insurer may be ordered deferred, in whole or in part, upon application by the insurer if the commissioner determines that payment of the assessment may render the insurer insolvent or in danger of insolvency or otherwise seriously impair the financial stability of the member insurer.

(d) After the deficit which necessitated the assessment has been recouped, each member insurer shall be entitled to reimbursement of any assessment through a credit against the premium taxes imposed by sections fourteen and fourteen-a, article three of this chapter, in equal amounts per year for three successive years following the assessment. At the option of the member insurer, the premium tax credit may be taken over an additional number of years. The tax credit established under this subsection shall be applicable only to General Revenue Funds.

(e) A member insurer may not impose a policy surcharge on any policyholder of the member insurer for any assessment paid by the member insurer pursuant to subsection (b) of this section or otherwise refer to the assessment paid by the member insurer in any billing statement or notice provided to any policyholder of the member insurer. Nothing in this section shall prohibit a member insurer from treating any assessment payments as an expense of the member insurer for all purposes.

§33-20E-17. Commissioner to report to board termination of authority to transact insurance.

If the authority of a member to transact insurance in this state terminates for any reason, the commissioner shall notify the board.

§33-20E-18. Examination of association.

The association shall be subject to examination and regulation by the commissioner.

§33-20E-19. Annual statements.

The association shall file in the office of the commissioner, on or before March 30 of each year, a statement containing information with respect to its transactions, condition, operations, and affairs during the preceding calendar year. The commissioner shall prescribe the matters and information to be contained in and the form of the annual statement. The commissioner may, at any time, require the association to furnish additional information with respect to its transactions, condition, or any matter connected therewith considered to be material and of assistance in evaluating the scope, operation, and experience of the association.

§33-20E-20. Immunity.

There shall be no liability on the part of and no cause of action of any nature shall arise against any member insurer, the association, the board, the commissioner or their agents or employees for any action taken by them in the exercise and performance of their powers and duties under this article or for any statements made in good faith by them in any reports or communications, concerning risks insured or to be insured by the association, or at any administrative hearings conducted in connection therewith.

§33-20E-21. Operative date.

The provisions of this article may only become operable upon the passage of a resolution by the Legislature. Any policies written under this article may have an effective date retroactive to the operative date.