WEST VIRGINIA CODE CHAPTER 55 ARTICLE 7B

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

The Legislature 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;

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;

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;

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;

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 ensure to the extent possible the highest quality of care;

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;

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;

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;

The unpredictable nature of traumatic injury health care services often results 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

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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;

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;

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; and

The modernization and structure of the health care delivery system necessitate an update of provisions of this article in order to facilitate and continue the objectives of this article which are to control the increase in the cost of liability insurance and to maintain access to affordable health care services for our citizens.

Therefore, the purpose of this article is to provide 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.

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§55-7B-2. Definitions.

For the purposes of this article, the following words shall have the meanings ascribed to them in this section unless the context clearly indicates a different meaning:

(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 and Medicare 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, but excluding any amount that a group, organization, partnership, corporation, or health care provider agrees to reduce, discount, or write off of a medical bill;

(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:

(1) Any act, service, or treatment provided under, pursuant to, or in the furtherance of a physician's plan of care, a health care facility's plan of care, medical diagnosis, or treatment;

(2) Any act, service, or treatment performed or furnished, or which should have been

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performed or furnished, by any health care provider or person supervised by or acting under the direction of a health care provider or licensed professional for, to, or on behalf of a patient during the patient's medical care, treatment, or confinement, including, but not limited to, staffing, medical transport, custodial care, or basic care, infection control, positioning, hydration, nutrition, and similar patient services; and

(3) The process employed by health care providers and health care facilities for the appointment, employment, contracting, credentialing, privileging, and supervision of health care providers.

(f) "Health care facility" means any clinic, hospital, pharmacy, nursing home, assisted living facility, residential care community, end-stage renal disease facility, home health agency, child welfare agency, group residential facility, behavioral health care facility or comprehensive community mental health center, intellectual/developmental disability center or program, or other ambulatory health care facility, in and licensed, regulated, or certified by the State of West Virginia under state or federal law and any state-operated institution or clinic providing health care and any related entity to the health care facility.

(g) "Health care provider" means a person, partnership, corporation, professional limited liability company, health care facility, entity, 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, physician assistant, advanced practice registered nurse, hospital, health care facility, dentist, registered or licensed practical nurse, optometrist, podiatrist, chiropractor, physical therapist, speech-language pathologist, audiologist, occupational therapist, psychologist, pharmacist, technician, certified nursing assistant, emergency medical service personnel, emergency medical services authority or agency, any person supervised by or acting under the direction of a licensed professional, any person taking actions or providing service or treatment pursuant to or in furtherance of a physician's plan of care, a health care facility's plan of care, medical diagnosis or treatment; or an officer, employee, or agent of a health care provider acting in the course and scope of the officer's, employee's or agent's employment.

(h) "Injury" or "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. It also means other claims that may be contemporaneous to or related to the alleged tort or breach of contract or otherwise provided, all in the context of rendering health care services.

(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. In order to qualify as

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medical professional liability insurance for purposes of this article, a self-funding program for an individual physician must meet the requirements and minimum standards set forth in §55-7B-12 of this code.

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

(l) "Occurrence" means any and all injuries to a patient arising from health care rendered by a health care facility or a health care provider and includes any continuing, additional, or follow-up care provided to that patient for reasons relating to the original health care provided, regardless if the injuries arise during a single date or multiple dates of treatment, single or multiple patient encounters, or a single admission or a series of admissions.

(m) "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.

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

(o) "Related entity" means any corporation, foundation, partnership, joint venture, professional limited liability company, limited liability company, trust, affiliate, or other entity under common control or ownership, whether directly or indirectly, partially or completely, legally, beneficially, or constructively, with a health care provider or health care facility; or which owns directly, indirectly, beneficially, or constructively any part of a health care provider or health care facility.

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

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§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.

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§55-7B-4. Health care injuries; limitations of actions; exceptions; venue.

(a) A cause of action for medical injury to a person alleging medical professional liability against a health care provider, except a nursing home, assisted living facility, their related entities or employees, or a distinct part of an acute care hospital providing intermediate care or skilled nursing care or its employees, arises as of the date of medical injury, except as provided in subsection (c) of this section, and must be commenced within two years of the date of such injury or death, or within two years of the date when such person discovers, or with the exercise of reasonable diligence, should have discovered such medical injury, whichever last occurs: *Provided*, That in no event shall any such action be commenced more than 10 years after the date of medical injury.

(b) A cause of action for medical injury to a person alleging medical professional liability against a nursing home, assisted living facility, their related entities or employees, or a distinct part of an acute care hospital providing intermediate care or skilled nursing care or its employees arises as of the date of medical injury, except as provided in subsection (c) of this section, and must be commenced within one year of the date of such medical injury, or within one year of the date when such person discovers, or with the exercise of reasonable diligence, should have discovered such injury or death, whichever last occurs: *Provided*, That in no event shall any such action be commenced more than 10 years after the date of medical injury. With the amendments to this subsection enacted in the regular session of the Legislature, 2022, that intends to reinstate and codify a one-year statute of limitations for any cause of action for medical injury resulting in injury or death to a person alleging medical professional liability against a nursing home, assisted living facility, their related entities or employees or a distinct part of an acute care hospital providing intermediate care or skilled nursing care or its employees.

(c) A cause of action for injury to a minor, brought by or on behalf of a minor who was under the age of 10 years at the time of such injury, shall be commenced within two years of the date of such injury, or prior to the minor's 12th birthday, whichever provides the longer period.

(d) The periods of limitation set forth in this section shall be tolled for any period during which the health care provider or its representative has committed fraud or collusion by concealing or misrepresenting material facts about the injury.

(e) Any medical professional liability action against a nursing home, assisted living facility, related entity or employee, or a distinct part of an acute care hospital providing intermediate care or skilled nursing care or its employees shall be brought in the circuit court of the county in which the nursing home, assisted living facility, or acute care hospital providing intermediate care or skilled nursing care, at which the alleged act of medical professional liability occurred is located, unless otherwise agreed upon by the nursing home, assisted living facility, related entity, or a distinct part of an acute care hospital providing intermediate care or skilled nursing care, and the plaintiff. Nothing in this subsection shall prohibit a party from removing the action to federal court.

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§55-7B-5. Health care actions; complaint; specific amount of damages not to be stated; limitation on bad faith claims; filing of first party bad faith claims; when plaintiff's criminal conduct bars recovery.

(a) In any medical professional liability action against a health care provider no specific dollar amount or figure may be included in the complaint, but the complaint may include a statement reciting that the minimum jurisdictional amount established for filing the action is satisfied. However, any party defendant may at any time request a written statement setting forth the nature and amount of damages being sought. The request shall be served upon the plaintiff who shall serve a responsive statement as to the damages sought within thirty days thereafter. If no response is served within the thirty days, the party defendant requesting the statement may petition the court in which the action is pending to order the plaintiff to serve a responsive statement.

(b) Notwithstanding any other provision of law, absent privity of contract, no plaintiff who files a medical professional liability action against a health care provider may file an independent cause of action against any insurer of the health care provider alleging the insurer has violated the provisions of subdivision (9), section four, article eleven, chapter thirty-three of this code. Insofar as the provisions of section three of said article prohibit the conduct defined in subdivision (9), section four of said article, no plaintiff who files a medical professional liability action against a health care provider may file an independent cause of action against any insurer of the health care provider alleging the insurer has violated the provisions of section three of said article.

(c) No health care provider may file a cause of action against his or her insurer alleging the insurer has violated the provisions of subdivision (9), section four, article eleven, chapter thirty-three of this code until the jury has rendered a verdict in the underlying medical professional liability action or the case has otherwise been dismissed, resolved or disposed of.

(d) No action related to the prescription or dispensation of controlled substances may be maintained against a health care provider pursuant to this article by or on behalf of a person whose damages arise as a proximate result of a violation of the Uniform Controlled Substances Act, as set forth in chapter sixty-a of this code, the commission of a felony, a violent crime which is a misdemeanor, or any other state or federal law related to controlled substances: *Provided*, That an action may be maintained pursuant to this article if the plaintiff alleges and proves by a preponderance of the evidence that the health care provider dispensed or prescribed a controlled substance or substances in violation of state or federal law, and that such prescription or dispensation in violation of state or federal law was a proximate cause of the injury or death.

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§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 30 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. For the purposes of this section, where the medical professional liability claim against a health care facility is premised upon the act or failure to act of agents, servants, employees, or officers of the health care facility, such agents, servants, employees, or officers shall be identified by area of professional practice or role in the health care at issue. 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 who:

(1) Is qualified as an expert under the West Virginia rules of evidence;

(2) Meets the requirements of §55-7B-7(a)(5) and §55-7B-7(a)(6) of this code; and

(3) Devoted, at the time of medical injury, 60 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 specialty in an accredited university.

If the health care provider executing the screening certificate of merit meets the qualifications of subdivisions (1), (2), and (3) of this subsection, there shall be a presumption that the health care provider is qualified as an expert for the purpose of executing a screening certificate of merit. The screening certificate of merit shall state with particularity, and include: (A) The basis for the expert's familiarity with the applicable standard of care at issue; (B) the expert's qualifications; (C) the expert's opinion as to how the applicable standard of care was breached; (D) the expert's opinion as to how the breach of the applicable standard of care resulted in injury or death; and (E) a list of all medical records and other information reviewed by the expert executing the screening certificate of merit. A separate screening certificate of merit must be provided for each health care provider against whom a claim is asserted. The health care provider 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 limits the application of Rule 15 of the Rules of Civil Procedure. No challenge to the notice of claim may be raised prior to receipt of the notice of claim and the executed screening certificate of merit.

(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. The statement shall be accompanied by the list of medical records and other information otherwise required to be provided pursuant to subsection (b) of this section.

(d) Except for medical professional liability actions against a nursing home, assisted living facility, their related entities or employees, or a distinct part of an acute care hospital providing intermediate care or skilled nursing care or its employees, 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 60 days of the date the health care provider receives the notice of claim. The screening certificate of merit shall be accompanied by a list of the medical records otherwise required to be provided pursuant to subsection (b) of this section.

(e) In medical professional liability actions against a nursing home, assisted living facility, their related entities or employees, or a distinct part of an acute care hospital providing intermediate care or skilled nursing care or its employees, 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 120 days of the date the health care provider receives the notice of claim.

(f) 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 30 days of receipt of the claim or within 30 days of receipt of the screening certificate of merit if the claimant is proceeding pursuant to the provisions of subsection (d) or (e) 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.

(g) 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) or (e) of this section, the health care provider is entitled to prelitigation mediation before a qualified mediator upon written demand to the claimant.

(h) If the health care provider demands mediation pursuant to the provisions of subsection (g) of this section, the mediation shall be concluded within 45 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.

(i)(1) Except for medical professional liability actions against a nursing home, assisted living facility, their related entities or employees, or a distinct part of an acute care hospital providing intermediate care or skilled nursing care or its employees, and 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 30 days following receipt of a response to the notice of claim, 30 days from the date a response to the notice of claim would be due, or 30 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.

(2) In medical professional liability actions against a nursing home, assisted living facility, their related entities or employees, or a distinct part of an acute care hospital providing intermediate care or skilled nursing care or its employees, 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 120 days from the date of mail of a notice of claim to 30 days following receipt of a response to the notice of claim, 30 days from the date a response to the notice of claim would be due, or 30 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.

(3) 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 30 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.

(j) 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.

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§55-7B-6a. Access to medical records.

(a) Within thirty days of the filing of an answer by a defendant in a medical professional liability action or, if there are multiple defendants, within thirty days following the filing of the last answer, the plaintiff shall provide each defendant and each defendant shall provide the plaintiff with access, as if a request had been made for production of documents pursuant to rule 34 of the rules of civil procedure, to all medical records pertaining to the alleged act or acts of medical professional liability which: (1) Are reasonably related to the plaintiff's claim; and (2) are in the party's control. The plaintiff shall also provide releases for such other medical records known to the plaintiff but not under his or her control but which relate to the plaintiff's claim. If the action is one alleging wrongful death, the records shall be for the deceased except inasmuch as the plaintiff alleges injury to himself or herself.

(b) Upon receipt and review of the records referred to in subsection (a) of this section, any party may make a written request to any other party for medical records of the plaintiff or the deceased related to his or her medical care and which are reasonably related to the plaintiff's claim. Such request shall be specific as to the type of record requested and shall be accompanied by a brief statement as to why its disclosure would be relevant to preparation of a claim or of a defense. The party receiving the request shall provide access to any such records under his or her control or a release for medical records for such records not under his or her control unless the party receiving the request believes that the records requested are not reasonably related to the claim.

(c) If a party receives a request for existing records he or she believes are not reasonably related to the claim, he or she shall provide written notice to the requesting party of the existence of such records and schedule a hearing before the court to determine whether access should be provided.

(d) If a party has reasonable cause to believe that medical records reasonably related to the claim of medical negligence exist and access have not been provided or a release has not been provided therefor, he or she shall give written notice thereof to the party upon whom the request is made, and if said records are not received within fourteen days of the written notice, obtain a hearing on the matter before the court.

(e) In the event a hearing is required pursuant to the provisions of subsection (c) or (d) of this section, the court at the conclusion thereof shall make a finding as to the reasonableness of the parties' request for or refusal to provide records and may assess costs pursuant to the rules of civil procedure.

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§55-7B-6b. Expedited resolution of cases against health care providers; time frames.

(a) In each professional liability action filed against a health care provider, the court shall convene a mandatory status conference within sixty days after the appearance of the defendant. It shall be the duty of the defendant to schedule the conference with the court upon proper notice to the plaintiff.

(b) During the status conference the parties shall inform the court as to the status of the action, the identification of contested facts and issues, the progress of discovery and the time necessary to complete discovery. The plaintiff shall advise the court whether the plaintiff intends to proceed without an expert, whether the expert who signed the screening certificate of merit will testify upon trial or whether additional experts will be offered by plaintiff. The court shall determine whether the plaintiff may proceed without an expert or otherwise establish dates for the disclosure of expert witnesses by both the plaintiff and all defendants. The court shall also order the parties to participate in mandatory mediation. The mediation shall be conducted pursuant to the provisions of trial court rule 25.

(c) Absent an order expressly setting forth reasons why the interests of justice would otherwise be served, the court shall enter a scheduling order which sets a trial date within twenty-four months from the date the defendant made an appearance, or if there is more than one defendant, twenty-four months from the date the last defendant makes an appearance in the proceeding. The trial date shall be adhered to unless, for good cause shown, the court enters an order continuing the trial date.

(d) The court may order a summary jury trial of the case if all parties represent a case is ready for trial and jointly move the court for a summary jury trial, as provided in section six-c of this article.

(e) Counsel and parties are subject to sanctions for failures and lack of preparation specified in rule 16(f) of the rules of civil procedure respecting pretrial conferences or orders and are subject to the payment of reasonable expenses, including attorneys fees, for failure to participate in good faith in the development and submission of a proposed discovery plan as required by the rules of civil procedure.

(f) In the event that the court determines prior to trial that either party is presenting or relying upon a frivolous or dilatory claim or defense, for which there is no reasonable basis in fact or at law, the court may direct in any final judgment the payment to the prevailing party of reasonable litigation expenses, including deposition and subpoena expenses, travel expenses incurred by the party, and such other expenses necessary to the maintenance of the action, excluding attorney's fees and expenses.

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§55-7B-6c. Summary jury trial.

(a) The court must determine the date of the summary jury trial, the length of presentations by counsel, and the length of deliberations by the jury, so that the proceeding can be completed in no more than one day.

(b) Unless the court orders otherwise, the parties or representatives of the parties must be present at the summary jury trial.

(c) The trial shall be conducted before a six-member jury selected from the regular jury panel. The court shall conduct a brief voir dire of the panel, and each party may exercise two challenges. No alternate jurors will be impaneled.

(d) All evidence shall be presented by the attorneys for the parties. The attorneys may summarize, quote from, and comment on pleadings, depositions, or other discovery requests and responses, exhibits and statements of potential witnesses. No potential testimony of a witness may be referred to unless the reference is based on: (i) The product of discovery procedures; (ii) a written sworn statement of the witness; or (iii) an affidavit of counsel stating that although an affidavit of the witness is not available and cannot be obtained by the exercise of reasonable diligence, the witness would be called at trial and counsel has been told the substance of the testimony of the witness. The substance of the witness' testimony must also be included in the affidavit of counsel.

(e) Unless the court orders otherwise, presentations shall be limited to one hour for each party. In the case of multiple parties represented by separate counsel, the court shall make a reasonable adjustment of the time allowed.

(f) Opposing counsel may object during the course of a presentation if the presentation violates the provisions of subsection (d) of this section or goes beyond the limits of propriety in statements as to evidence or other comments.

(g) Following the presentations by counsel, the court shall give an abbreviated set of instructions to the jury on the applicable law. The jury will be encouraged to return a verdict that represents a unanimous verdict of the jurors. If after a reasonable time a unanimous verdict is not possible, the jury shall be directed to return a special verdict consisting of an anonymous statement of each juror's finding on liability and damages. Following the verdict, the court may invite, but may not require, the jurors to informally discuss the case with the attorneys and the parties.

(h) Unless the court orders otherwise, the proceedings will not be recorded. However, a party may arrange for recording at its own expense. Statements in briefs or summaries submitted in connection with the summary jury trial and statements by counsel at trial are not admissible in any evidentiary proceeding. The summary jury trial verdict is not admissible in any evidentiary proceeding.

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(i) Within thirty days following the jury verdict, each party must file a notice setting forth whether the party intends to accept the summary jury trial verdict or whether the party rejects the summary jury trial verdict and desires to proceed to trial. If all parties accept the summary jury trial verdict, the verdict will be deemed a final determination on the merits and judgment may be entered on the verdict by the court. If a verdict is rendered upon the subsequent trial of the case which is not more than twenty percent more favorable to a party who rejected the summary jury trial verdict and indicated a desire to proceed to trial, the rejecting party is liable for the costs incurred by the other party or parties subsequent to the summary jury trial, in a similar manner as is provided in rule 68(c) of the rules of civil procedure when a claimant rejects an offer of judgment, and is liable for attorneys' fees incurred after the summary jury trial.

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§55-7B-6d.

Repealed.

Acts, 2014 Reg. Sess., Ch. 99.

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§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. A proposed expert witness may only be found competent to testify if the foundation for his or her testimony 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's opinion is grounded on scientifically valid peer-reviewed studies if available; (5) 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's license has not been revoked or suspended in the past year in any state; and (6) 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's 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 limits 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.

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§55-7B-7a. Admissibility and use of certain information.

(a) In an action brought, there is a rebuttable presumption that the following information may not be introduced unless it applies specifically to the injured person or it involves substantially similar conduct that occurred within one year of the particular incident involved:

(1) A state or federal survey, audit, review or other report of a health care provider or health care facility;

(2) Disciplinary actions against a health care provider's license, registration or certification;

(3) An accreditation report of a health care provider or health care facility; and

(4) An assessment of a civil or criminal penalty.

(b) In any action brought alleging inappropriate staffing or inadequate supervision, if the health care facility or health care provider demonstrates compliance with the minimum staffing requirements under state law, the health care facility or health care provider is entitled to a rebuttable presumption that appropriate staffing and adequate supervision of patients to prevent accidents were provided, and the jury shall be instructed accordingly.

(c) In any action brought alleging inappropriate staffing or inadequate supervision, if staffing is less than the minimum staffing requirements under state law, then there is a rebuttable presumption that there was inadequate supervision of patients and that inadequate staffing or inadequate supervision was a contributing cause of the patient's fall and injuries or death arising therefrom, and the jury shall be instructed accordingly.

(d) Information under this section may only be introduced in a proceeding if it is otherwise admissible under the West Virginia Rules of Evidence.

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§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 may not exceed $250,000 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, except as provided in subsection (b) of this section.

(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 $500,000 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 January 1, 2004, 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, not to exceed one hundred fifty percent of the amounts specified in said subsections. (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 aggregate amount of at least $1 million for each 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 2003 regular session of the Legislature, 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 $1 million.

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§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) 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 prejudgment interest recoverable by the plaintiff, 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. To determine the amount of judgment to be entered against each defendant when there is no preverdict settlement, the court shall first, after adjusting the verdict as provided in section nine-a of this article, multiply the total amount of damages remaining with any prejudgment interest recoverable by the plaintiff, 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 amount recoverable damages against each defendant.

(e) When any defendant's percentage of the verdict exceeds the remaining amounts due the 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.

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(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 $1 million for each occurrence.

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§55-7B-9a. Reduction in compensatory damages for economic losses for payments from collateral sources for 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 a hearing held 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 a hearing held 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

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damages awarded the plaintiff by the trier of fact for that category of economic loss to arrive at the adjusted verdict.

(g) The court may 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 of this article.

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§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.

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§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 emergency medical services authority or agency, certified emergency medical service personnel or an employee of a licensed emergency medical services authority or agency, the total amount of civil damages recoverable may not exceed $500,000, for each occurrence, exclusive of interest computed from the date of judgment, and regardless of the number of plaintiffs or the number of defendants or, in the case of wrongful death, regardless of the number of distributees.

(b) On January 1, 2016, and in each year thereafter, the limitation on the total amount of civil damages contained in subsection (a) of this section shall increase to account for inflation as determined by the Consumer Price Index published by the United States Department of Labor: *Provided*, That increases on the limitation of damages shall not exceed one hundred fifty percent of the amounts specified in said subsection.

(c) Beginning July 1, 2016, a plaintiff who, as a result of an injury suffered prior to or after said date, suffers or has suffered economic damages, as determined by the trier of fact or the agreement of the parties, in excess of the limitation of liability in section (a) of this section and for whom recovery from the Patient Injury Compensation Fund is precluded pursuant to section one, article twelve-d, chapter twenty-nine of this code may recover additional economic damages of up to $1 million. This amount is not subject to the adjustment for inflation set forth in subsection (b) of this section.

(d) 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.

(e) 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.

(f) 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

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subsection, 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.

(g) 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.

(h) 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 for triage and emergency health care procedures.

(i) 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.

(j) 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 (i) 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 is no longer eligible for the limitation on liability provided in subsection (a) of this section.

(k) 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 no longer has the protection of the limitation on liability provided in subsection (a) of this section.

(l) If the Office of Emergency Medical Services determines that a health care facility no

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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 ceases to apply to that health care facility for services or treatment rendered thereafter.

(m) 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 to file, on or before July 1, 2003, 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.

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§55-7B-9d. Adjustment of verdict for past medical expenses.

A verdict for past medical expenses is limited to:

(1) The total amount of past medical expenses paid by or on behalf of the plaintiff; and

(2) The total amount of past medical expenses incurred but not paid by or on behalf of the plaintiff for which the plaintiff or another person on behalf of the plaintiff is obligated to pay.

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§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 of the Legislature, 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 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, 2001, apply to all causes of action alleging medical professional liability which are filed on or after March 1, 2002.

The amendments to this article provided in Enrolled Committee Substitute for House Bill 2122 during the regular session of the Legislature, 2003, apply to all causes of action alleging medical professional liability which are filed on or after July 1, 2003.

(b) The amendments to this article provided in Enrolled Committee Substitute for Senate Bill 6 during the regular session of the Legislature, 2015, apply to all causes of action alleging medical professional liability which are filed on or after July 1, 2015.

(c) The amendments to this article provided in Enrolled Committee Substitute for Senate Bill 338 during the regular session of the Legislature, 2017, apply to all causes of action alleging medical professional liability which arise or accrue on or after July 1, 2017.

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§55-7B-11. Severability.

(a) If any provision of this article as enacted during the first extraordinary session of the Legislature, 1986, in House Bill 149, or as enacted during the regular session of the Legislature, 1986, in Senate Bill 714, or as enacted during the regular session of the Legislature, 2015, or in Senate Bill 338, as enacted during the regular session of the Legislature, 2017, or the application thereof to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of this article, and to this end, the provisions of this article are declared to be severable.

(b) If any provision of the amendments to section five of this article, any provision of section six-d of this article or any provision of the amendments to section eleven, article six, chapter fifty-six of this code as provided in House Bill 601, enacted during the sixth extraordinary session of the Legislature, 2001, is held invalid, or the application thereof to any person is held invalid, then, notwithstanding any other provision of law, every other provision of said House Bill 601 shall be deemed invalid and of no further force and effect.

(c) If any provision of the amendments to section six or ten of this article or any provision of section six-a, six-b or six-c of this article as provided in House Bill 601, enacted during the sixth extraordinary session of the Legislature, 2001, is held invalid, the invalidity does not affect other provisions or applications of this article, and to this end, such provisions are deemed severable.

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§55-7B-12. Self-funding program; requirements; minimum standards.

(a) An irrevocable trust may be established by or for the benefit of the physician and funded by conveyance to the trustee of the sum of not less than $1 million, in cash or cash equivalents, subject to disbursement and replenishment from time to time, as described in this section, and exclusive of funds needed for maintenance, administration, legal defense and all other costs.

(b) A physician who has established a trust pursuant to this section may subsequently terminate the trust and elect to acquire coverage from a commercial medical professional liability insurance carrier. The assets of the trust may not be distributed to the physician settlor until the costs associated with the administration of the trust have been satisfied and the trustee receives certification that the physician has acquired medical professional liability insurance tail coverage or prior acts coverage, whichever is applicable. The tail coverage or prior acts coverage must cover the time period from the establishment of the trust to the effective date of the newly acquired medical professional liability insurance coverage or twelve years, whichever is shorter.

(c) For a period of not less than the applicable statute of limitations for medical professional liability, a physician who has established an actuarially sound physician self-funding insurance program under this section and has such a program in effect at the time of retirement shall, following his or her retirement, either maintain the trust in effect at funding levels required by this section, or purchase and maintain in force and effect tail insurance as required by article twenty-d, chapter thirty-three of this code.

(d) The trustee for the trust must be an independent professional, bank or other qualified institutional fiduciary. The trustee has all necessary and appropriate powers to fulfill the purposes of the trust, including, but not limited to, the powers to:

(1) Disburse funds for the maintenance and administration of the trust, and for defense costs, judgments, arbitration indemnity awards and settlements;

(2) Hire an actuary who is a member of the Casualty Actuarial Society and experienced in medical professional liability protection programs to provide a periodic opinion, but not less frequently than annually, as to the actuarial soundness of the fund, a copy of which opinion shall be provided upon request to any facility where the physician maintains clinical privileges;

(3) Hire a qualified, third-party claims manager experienced in handling medical professional liability claims, with the power and authority to set reserves and administer and oversee the defense of all claims; and

(4) Require that the physician replenish the trust so as to maintain at all times a funding level of no less than $1 million or such greater amount as set forth in the most current actuarial opinion as described in subdivision (2) of this subsection, exclusive of funds needed

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for maintenance, administration, defense or other costs.

(e) The trustee, acting directly or through its hired professionals, as appropriate, shall periodically, but not less frequently than annually, evaluate and set required trust funding levels for the trust; make assessments against the physician for payments into the trust in order to replenish and maintain the trust at levels required by this subsection and required to render the trust actuarially sound from time to time; and otherwise take such actions as may appear necessary, desirable or appropriate to fulfill the purposes and integrity of the trust. Should the physician fail to timely meet any of the requests or requirements of the trustee with regard to funding of the trust or otherwise, or should the trust at any time fail to meet all the requirements of this subsection, thereupon the trust arrangement will conclusively no longer qualify under this article as an actuarially sound self-funding program: Provided, That all assets of the trust at the time of any such disqualifying event or circumstance will remain trust assets and may not be distributed to the physician settlor of the trust until the latter of the date on which any and all medical professional liability claims asserted or pending against the physician at the time of such disqualifying event or circumstance or within the applicable statute of limitations for medical malpractice liability thereafter have been finally adjudicated or otherwise resolved and fully satisfied to the extent of trust assets available for such purpose.

(f) In the event that more than one claim arises within the period since the last annual evaluation, a new evaluation will be performed within sixty days or at the time of the next annual audit, whichever is shorter, in order to evaluate the trust and replenish funds to ensure that its assets total not less than $1 million, or such other amount that is actuarially determined necessary to satisfy the aggregate outstanding claims, whichever is greater, exclusive of funds needed for maintenance, administration, legal defense or other costs.

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