WEST VIRGINIA LEGISLATURE
SIXTH EXTRAORDINARY SESSION, 2001

ENROLLED

House Bill No. 601
(By Mr. Speaker, Mr. Kiss, and Delegate Trump)
[By Request of the Executive]

Passed December 1, 2001
In Effect from Passage
AN ACT to amend chapter eleven of the code of West Virginia, one thousand nine hundred thirty-one, as amended, by adding thereto a new article, designated article thirteen-p; to amend and reenact sections two, three and five, article twelve, chapter twenty-nine of said code; and to further amend said chapter by adding thereto a new article, designated article twelve-b; to amend chapter thirty-three of said code by adding thereto two new articles, designated articles twenty-e and twenty-f; to amend and reenact sections five, six, ten and eleven, article seven-b, chapter fifty-five of said code; and to further amend said article by adding thereto four new sections, designated sections six-a, six-b, six-c and six-d; to amend and reenact section eleven, article six, chapter fifty-six of said code; and to amend and reenact sections eleven and twenty-eight-a, article one, chapter fifty-nine of said code, all relating to medical professional liability generally; providing certain tax credits for certain health care providers; setting forth legislative findings and purpose; defining terms; creating tax credit and providing eligibility therefor; establishing amount of
credit; providing for the forfeiture of excess credit; providing for the application of the tax credit; requiring annual schedule; effect of credit on estimated taxes; providing for the computation and application of credit; authorizing tax commissioner to promulgate legislative rules; providing for the construction of article; establishing burden of proof; relating to claiming the credit; establishing effective date for credit; providing for termination of tax credit; modifying definitions; continuing, reestablishing and reconstituting board of risk and insurance management; establishing qualifications, terms and compensation of members of the board; clarifying and expanding powers and duties of board; increasing salary of executive director; authorizing the board to employ certain employees, including legal counsel; eliminating requirement for attorney general’s knowledge and consent to settlements and releases; making technical revisions; providing that board of risk and insurance management shall administer the optional medical liability insurance programs; establishing duties and reporting requirements of the board; establishing procedure for approval of board financial plans; providing rule-making authority; providing for the establishment and operation of medical professional liability insurance programs for certain physicians through the board of risk and insurance management as an alternative to commercial coverage for malpractice claims when comparable commercial coverage is not available; setting short title and legislative findings; defining terms; establishing a state medical malpractice advisory panel; establishing qualifications, terms and compensation of panel members; providing for the organization and reporting requirements of the panel; establishing medical professional liability insurance programs, including a preferred medical liability insurance program and a high-risk medical liability insurance program and exceptions to participation; establishing criteria for eligibility to participate in program; specifying powers and duties of the board of risk and insurance management relating to medical malpractice insurance; establishing special revenue account in state treasury for deposit
of collected premiums and for expenditure and investment of funds in the account; providing for payment of start-up operating expenses of the program and a pool from which claims may be paid and for amounts so paid to be reimbursed from collected premiums; authorizing the board to establish procedures for payment of claims; requiring certain documentation for payment of a medical malpractice settlement or judgment; exempting specific claim reserve information from disclosure under freedom of information act; authorizing board to post supersedeas bond when it appeals a medical malpractice judgment against a health care provider; specifying effective date; allowing policies written after the effective date to be retroactive to the effective date; providing for the establishment and operation of a medical professional liability insurance joint underwriting association; providing short title, legislative findings and stating intent and purpose; defining terms; creating medical professional liability insurance joint underwriting association and providing for the state board of risk and insurance management to exercise the powers of the association temporarily; creating a board of directors; qualifications and compensation of board members; specifying powers and duties of the association; providing for an interim plan of operation to be administered by the state board of risk and insurance management; providing for a final plan of operation to be administered by the board of directors; specifying the duties and powers of the insurance commissioner; establishing eligibility requirements for policyholders; providing for issuance of policies and guidelines for setting rates and premiums; creating a special revenue account in state treasury for deposit of initial capital, surplus and collected premiums, and for expenditure and investment of funds in the account; providing for assumption of assets and administrative control by the board of directors and a pool from which claims may be paid; clarifying premium tax liability of association; absolving state from responsibility for obligations of association; establishing methods by which a deficit in the association's accounts may be recouped and
reimbursed; requiring the commissioner to report to the board of
directors when any member insurer's authority to transact
insurance in this state has been terminated; providing that the
association is subject to examination and regulation by the
commissioner; requiring the association to submit to the commis­sioner an annual statement; providing that the association is
immune from suit; specifying operative date; allowing policies
written after the operative date to be retroactive to the effective
date; authorizing the formation of a physicians mutual insurance
company; setting forth a short title; establishing legislative
findings and purpose; defining terms; authorizing the creation of
a company; establishing the requirements and limitations of a
company; establishing the immunity of the state from all debts,
claims, obligations and liabilities of a company; providing for
governance and organization of a company; providing for the
management and administration of a company; providing for the
funding of the initial policyholders' surplus; authorizing a one­
time assessment against physicians to assist in funding the initial
capital surplus; providing for licensure application and approval
of the commissioner; setting forth the authority of the commis­sioner; authorizing the company to issue certain policies of
insurance; providing for the transfer of policies from the state
board of risk and insurance management; authorizing risk
management practices; providing for the controlling law, liberal
construction and severability of this article; providing for medical
professional liability actions; eliminating certain third party
causes of action against insurers; prescribing time when health
care provider may file certain causes of action against insurer;
establishing certain prerequisites for filing an action against a
health care provider and providing exceptions; providing for pre­litigation mediation upon request of health care provider;
providing for the tolling of the statute of limitations; establishing
confidentiality of certain documents; providing parties with
access to medical records and establishing procedures therefor;
providing for an expedited resolution of cases against health care
providers; requiring court to convene a mandatory status confer­
ence; providing for mandatory mediation; establishing trial date;
authorizing court to order a summary jury trial upon joint motion;
when counsel and parties are subject to sanctions; authorizing
court to direct payment of costs in certain instances; establishing
summary jury trial procedures; providing for a twelve-member
jury and allowing a verdict to be rendered by nine-member jury;
establishing operative date of revisions; establishing severability
and nonseverability of certain provisions; and increasing the
filing fee for medical professional liability actions and providing
for the disposition thereof.

Be it enacted by the Legislature of West Virginia:

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

CHAPTER 11. TAXATION.

ARTICLE 13P. TAX CREDIT FOR MEDICAL LIABILITY INSURANCE
PREMIUMS.

§11-13P-1. Legislative finding and purpose.
The Legislature finds that the retention of physicians practicing in this state is in the public interest and promotes the general welfare of the people of this state. The Legislature further finds that the promotion of stable and affordable medical malpractice liability insurance premium rates will induce retention of physicians practicing in this state.

In order to effectively decrease the cost of medical liability insurance premiums paid in this state on physicians’ services, there is hereby provided a tax credit for certain medical liability insurance premiums paid.


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

(b) Terms defined. –

(1) “Adjusted annual medical liability premium” means statewide average of medical liability insurance premiums by specialty and sub-specialty groups directly paid by eligible taxpayers in those specialty and subspecialty groups during the taxable year to cover physicians’ services performed during the year reduced by the sum of ten thousand dollars.

(2) “Eligible taxpayer” means any person subject to tax under section sixteen, article twenty-seven of this chapter or a physician who is a partner, member, shareholder or employee of an eligible taxpayer.

(3) “Person” means and includes any natural person, corporation, limited liability company, trust or partnership.
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(4) “Physicians’ services” means health care providers services taxable under section sixteen, article twenty-seven of this chapter performed in this state by physicians licensed by the state board of medicine or the state board of osteopathic medicine.

24 (5) “Statewide average medical liability insurance premiums” are the average of premiums for each specialty and subspecialty group as determined by the state insurance commission.

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

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

§11-13P-4. Amount of credit allowed.

The amount of annual credit allowable under this article to an eligible taxpayer shall be equal to ten percent of the adjusted annual medical liability insurance premium for the taxpayer's specialty or subspecialty group or ten percent of the taxpayer's actual annual medical liability insurance premium, whichever is less: Provided, That no credit shall be allowed for any medical liability insurance premium paid on behalf of an eligible taxpayer employed by the state, its agencies or subdivisions or an eligible taxpayer organization pursuant to coverage provided under article twelve, chapter twenty-nine of this code.

§11-13P-5. Excess credit forfeited.

If after application of the credit against tax under this article, any credit remains for the taxable year, the amount remaining and not used is forfeited. Unused credit may not be
§11-13P-6. Application of credit; schedules; estimated taxes.

(a) The credit allowed under this article shall be applied against the tax payable under section sixteen, article twenty-seven of this chapter.

(b) To assert this credit against tax, the eligible taxpayer shall prepare and file with its annual tax return filed under article twenty-seven of this chapter, and for information purposes, a schedule showing the amount paid for medical liability coverage for the taxable year, the amount of credit allowed under this article, the taxes against which the credit is being applied and other information that the tax commissioner may require. This annual schedule shall set forth the information and be in the form prescribed by the tax commissioner.

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

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

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

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

(1) Qualification for credit.

(A) For purposes of this section the term “eligible taxpayer organization” means a partnership, limited liability company, or corporation that is an eligible taxpayer.

(B) For purposes of this section the term “payor” means a natural person who is a partner, member, shareholder or owner, in whole or in part, of an eligible taxpayer organization and who pays medical liability insurance premiums for or on behalf of the eligible taxpayer organization.

(C) Medical liability insurance premiums paid by a payor (as defined in this section) qualify for tax credit under this article, provided that such payments are made to insure against medical liabilities arising out of or resulting from physicians’ services provided by a physician while practicing in service to or under the organizational identity of an eligible taxpayer organization or as an employee of such eligible taxpayer organization where such insurance covers the medical liability of:

(i) the eligible taxpayer organization, or

(ii) one or more physicians practicing in service to or under the organizational identity of the eligible taxpayer organization or as an employee of the eligible taxpayer organization, or

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

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

(4) Apportionment among multiple eligible taxpayer organizations. - Where a payor described in subdivision (1) of this subsection pays medical liability insurance premiums for and provides services to or under the organizational identity of two or more eligible taxpayer organizations described in this section or as an employee of two or more such eligible taxpayer organizations, the tax credit shall, for purposes of subdivision (3) of this subsection, be allocated among such eligible taxpayer organizations in proportion to the medical liability insurance premiums paid directly by the payor during the taxable year to cover physicians' services during such year for, or on behalf of, each eligible taxpayer organization. In no event may the total credit claimed by all eligible taxpayers and eligible taxpayer organizations exceed the credit which would be allowable if the payor had paid all such medical liability insurance premiums for or on behalf of one eligible taxpayer organization, and if all physician's services had been performed for, or under the organizational identity of, or by employees of, one eligible taxpayer organization.

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

§11-13P-9. Construction of article; burden of proof.

1 The provisions of this article shall be reasonably construed.
2 The burden of proof is on the person claiming the credit allowed by this article to establish by clear and convincing evidence that the person is entitled to the amount of credit asserted for the taxable year.

§11-13P-10. Effective date.

1 This article shall be effective for taxable years beginning after the thirty-first day of December, two thousand one: Providing, That the assertion of the credit by an eligible taxpayer shall not be allowed prior to the first day of July, two thousand two.

§11-13P-11. Termination of tax credit.

1 No credit shall be allowed under this article for any taxable year ending after the thirty-first day of December, two thousand four.

CHAPTER 29. MISCELLANEOUS BOARDS AND OFFICERS.

ARTICLE 12. STATE INSURANCE.

§29-12-2. Definitions.

1 As used in this article, unless the context otherwise clearly requires:
(a) "Board" means the state board of risk and insurance management.

(b) "Company" means and includes corporations, associations, partnerships and individuals.

(c) "Insurance" means all forms of insurance and bonding services available for protection and indemnification of the state and its officials, employees, properties, activities and responsibilities against loss or damage or liability, including fire, marine, casualty, and surety insurance.

(d) "Insurance company" means all insurers or insurance carriers, including, but not limited to, stock insurance companies, mutual insurance companies, reciprocal and interinsurance exchanges, and all other types of insurers and insurance carriers, including life, accident, health, fidelity, indemnity, casualty, hospitalization and other types and kinds of insurance companies, organizations and associations, but excepting and excluding workers' compensation coverage.

(e) "State property activities" and "state responsibilities" means and includes all operations, boards, commission, works, projects and functions of the state, its properties, officials, agents and employees which, within the scope and in the course of governmental employment, may be subject to liability, loss, damage, risks and hazards recognized to be and normally included within insurance and bond coverages. "State property activities" includes ambulances, as defined in section three, article sixteen, chapter four of this code.

(f) "State property" means all property belonging to the state of West Virginia and any boards or commissions thereof wherever situated and which is the subject of risk or reasonably considered to be subject to loss or damage or liability by any single occurrence of any event insured against."State property"
§29-12-3. State board of risk and insurance management; creation, composition, qualifications, and compensation.

(a) (1) The "state board of insurance of West Virginia" is hereby reestablished, reconstituted and continued as the state board of risk and insurance management. The board shall be composed of five members. One member shall be the vice chancellor of health sciences of the West Virginia higher education policy commission. The remaining four members shall be appointed by the governor with the advice and consent of the Senate. One member shall be appointed by the governor from a list of three eligible persons submitted to the governor by the president of the senate, and one member shall be appointed by the governor from a list of three eligible persons submitted to the governor by the speaker of the house of delegates. Each member shall be a resident of West Virginia and shall have experience in one or more of the following areas: law, accounting, business, insurance or actuarial science.

(2) Initial appointment of the members other than the vice chancellor for health sciences shall be for the following terms:

One member shall be appointed for a term ending the thirtieth day of June, two thousand three;

One member shall be appointed for a term ending the thirtieth day of June, two thousand four;

One member shall be appointed for a term ending the thirtieth day of June, two thousand five; and

One member shall be appointed for a term ending the thirtieth day of June, two thousand six.
(3) Except for appointments to fill vacancies, each subsequent appointment shall be for a term ending the thirtieth day of June of the fourth year following the year the preceding term expired. In the event a vacancy occurs it shall be filled by appointment for the unexpired term. A member whose term has expired shall continue in office until a successor has been duly appointed and qualified. No member of the board may be removed from office by the governor except for official misconduct, incompetency, neglect of duty, or gross immorality.

(4) Members of the board appointed prior to the reenactment of this article during the sixth extraordinary session of the Legislature, two thousand one, shall serve until the fifteen day of December two thousand one.

(b) The insurance commissioner of West Virginia shall serve as secretary of the board without vote and shall make available to the board the information, facilities and services of the office of the state insurance commissioner.

c) The members of the board shall receive from the executive director of the board the same compensation authorized by law for members of the Legislature for the 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.

d) Notwithstanding any provision of this section to the contrary, the board is subject to the provisions of section twelve of this article.

§29-12-5. Powers and duties of board.
(a) The board shall have general supervision and control over the insurance of all state property, activities and responsibilities, including the acquisition and cancellation thereof; determination of amount and kind of coverage, including, but not limited to, deductible forms of insurance coverage, inspections or examinations relating thereto, reinsurance, and any and all matters, factors and considerations entering into negotiations for advantageous rates on and coverage of all such state property, activities and responsibilities. The board shall have the authority to employ an executive director for an annual salary of seventy thousand dollars and such other employees, including legal counsel, as may be necessary to carry out its duties. The legal counsel may represent the board before any judicial or administrative tribunal and perform such other duties as may be requested by the board. Any policy of insurance purchased or contracted for by the board shall provide that the insurer shall be barred and estopped from relying upon the constitutional immunity of the state of West Virginia against claims or suits: Provided, That nothing herein shall bar the insurer of political subdivisions from relying upon any statutory immunity granted such political subdivisions against claims or suits. The board may enter into any contracts necessary to the execution of the powers granted to it by this article. It shall endeavor to secure the maximum of protection against loss, damage or liability to state property and on account of state activities and responsibilities by proper and adequate insurance coverage through the introduction and employment of sound and accepted methods of protection and principles of insurance. It is empowered and directed to make a complete survey of all presently owned and subsequently acquired state property subject to insurance coverage by any form of insurance, which survey shall include and reflect inspections, appraisals, exposures, fire hazards, construction, and any other objectives or factors affecting or which might affect the insurance protection and coverage required. It shall keep itself currently informed on
new and continuing state activities and responsibilities within
the insurance coverage herein contemplated. The board shall
work closely in cooperation with the state fire marshal's office
in applying the rules of that office insofar as the appropriations
and other factors peculiar to state property will permit. The
board is given power and authority to make rules governing its
functions and operations and the procurement of state insur-
ance.

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

(b) If requested by a political subdivision or by a charitable
or public service organization, the board is authorized to
provide property and liability insurance to the political subdivi-
sions or such organizations to insure their property, activities
and responsibilities. Such board is authorized to enter into any
necessary contract of insurance to further the intent of this
subsection.

The property insurance provided by the board, pursuant to
this subsection, may also include insurance on property leased
to or loaned to the political subdivision or such organization
which is required to be insured under a written agreement.

The cost of this insurance, as determined by the board, shall
be paid by the political subdivision or the organization and may
include administrative expenses. All funds received by the
board, (including, but not limited to, state agency premiums,
mine subsidence premiums, and political subdivision premi-
ums) shall be deposited with the West Virginia investment
management board with the interest income and returns on
investment a proper credit to such property insurance trust fund
or liability insurance trust fund, as applicable.

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

Charitable or public service organization as used in this
subsection means a bona fide, not for profit, tax-exempt,
benevolent, educational, philanthropic, humane, patriotic, civic,
religious, eleemosynary, incorporated or unincorporated
association or organization or a rescue unit or other similar
volunteer community service organization or association, but
does not include any nonprofit association or organization,
whether incorporated or not, which is organized primarily for
the purposes of influencing legislation or supporting or promot-
ing the campaign of any candidate for public office.

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

(2) The board shall:

(A) Administer the preferred medical liability program and
the high risk medical liability program and exercise and
perform other powers, duties and functions specified in this
article;
(B) Obtain and implement, at least annually, from an independent outside source, such as a medical liability actuary or a rating organization experienced with the medical liability line of insurance, written rating plans for the preferred medical liability program and high risk medical liability program on which premiums shall be based;

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

(D) Prepare and publish, before each regular session of the Legislature, separate summaries for the preferred medical liability program and high risk medical liability program activity during the preceding fiscal year, each summary to include, but not be limited to, an audited financial statement which shall follow the accounting practices and procedures prescribed by the national association of insurance commissioners procedures manual, as amended, and which shall include a balance sheet, income statement and cash flow statement, an actuarial opinion addressing adequacy of reserves, the highest and lowest premiums assessed, the number of claims filed with the program by provider type, the number of judgments and amounts paid from the program, the number of settlements and amounts paid from the program and the number of dismissals without payment;

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

(F) Determine and annually review the criteria for transfer from the preferred medical liability program to the high risk medical liability program;
(G) Determine and annually review the role of independent agents, the amount of commission, if any, to be paid therefor, and agent appointment criteria;

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

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

For these purposes, the board shall:

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

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

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

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

(J) Meet on at least a quarterly basis to review implementation of its current financial plan in light of the actual experience of the medical liability programs established in article twelve-b of this chapter. The board shall review actual costs incurred, any revised cost estimates provided by the actuary, expenditures and any other factors affecting the fiscal stability of the plan and may make any additional modifications to the plan necessary to ensure that the total financial requirements of these programs for the current fiscal year are met;

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

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

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

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

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

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

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

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

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

(d) If, after the first day of September, two thousand two,
the board has assigned coverages or transferred all insurance
obligations and/or risks of existing or in-force contracts of
insurance to a third party medical professional liability insur-
ance carrier, and the board otherwise has no covered partici-
pants, then the board shall not thereafter offer or provide
professional liability insurance to any health care provider
pursuant to the provisions of subsection (c) of this section or the
provisions of article twelve-b of this chapter unless the Legisla-
ture adopts a concurrent resolution authorizing the board to
reestablish medical liability insurance programs.

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

§29-12B-1. Short title.

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

§29-12B-2. Legislative findings.

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

§29-12B-3. Definitions.

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

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

(b) "Health care provider" means:

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

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

(3) A podiatrist licensed by the West Virginia board of medicine;

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

(5) A pharmacist licensed by the West Virginia board of pharmacy;

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

(7) A physician’s assistant licensed by either the West Virginia board of medicine or the West Virginia board of osteopathy;

(8) A dentist licensed by the West Virginia board of dental examiners;
(9) A physical therapist licensed by the West Virginia board of physical therapy;

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

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

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

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

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

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

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

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

(d) “High risk” means the probability of loss is greater than average based on criteria specified in this article and established by the board.
(e) "Retroactive date" means the date designated in the policy declarations, before which coverage is not applicable.

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

§29-12B-4. State medical malpractice advisory panel; creation, composition, duties and compensation.

(a) (1) There is hereby created, under the direction and control of the board, the medical malpractice advisory panel. The panel shall be composed of seven members appointed by the governor with the advice and consent of the senate. Each member shall be a resident of West Virginia. No more than three members may reside in the same congressional district, no more than two members may reside in the same county, and no more than four members may belong to the same political party.

(2) Initial appointment of the members shall be for the following terms:

One member shall be appointed for a term ending the thirtieth day of June, two thousand two;

Two members shall be appointed for a term ending the thirtieth day of June, two thousand three;

Two members shall be appointed for a term ending the thirtieth day of June, two thousand four; and

Two members shall be appointed for a term ending the thirtieth day of June, two thousand five.
(3) Except for appointments to fill vacancies, each subsequent appointment shall be for a term ending the thirtieth day of June of the fourth year following the year the preceding term expired. In the event a vacancy occurs it shall be filled by appointment for the unexpired term. A member whose term has expired shall continue in office until a successor has been duly appointed and qualified. No member of the panel may be removed from office by the governor except for official misconduct, incompetency, neglect of duty, or gross immorality.

(4) The panel shall consist of the following:

(A) A physician licensed in this state by the state board of medicine recommended from a list of three candidates from a specialty area and three candidates from a non-specialty area submitted by the state medical association;

(B) A physician licensed by the state board of osteopathy recommended from a list of three candidates submitted by the state society of osteopathic medicine;

(C) A physician licensed by the state board of medicine from a specialty area recommended from the list of three candidates submitted by the West Virginia academy of family practitioners;

(D) A chief executive officer or chief financial officer of a hospital recommended from a list of three submitted by the state hospital association;

(E) One consumer or consumer representative;

(F) One person with training or experience in underwriting; and
(G) A person with training or experience in insurance industry management.

(b) The members of the panel shall receive from the executive director of the board 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 panel 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.

(c) The panel shall advise the board with regard to those duties imposed on the board by the provisions of this article and the provisions of subsection (c), section five, article twelve of this chapter relating to medical professional liability insurance.

§29-12B-5. Organization, meetings, records and reports of panel.

(a) The panel shall select one of its members as chairman and shall meet in the office of the board upon the call of the board. The panel shall keep records of all of its proceedings which shall be public and open to inspection: Provided, That any discussion or consideration of the financial or personal information of an insured may be held by the panel in executive session closed to the public, notwithstanding the provisions of article nine-a, chapter six of this code. The panel shall exercise and perform the duties prescribed by this article.

(b) The panel shall report in writing to the board and the legislative auditor on or before the thirty-first day of August of each year. Such report shall contain a summary of the panel’s proceedings during the preceding fiscal year.

§29-12B-6. Health care provider professional liability insurance programs.
(a) There is hereby established through the board of risk and insurance management optional insurance for health care providers consisting of a preferred professional liability insurance program and a high risk professional liability insurance program.

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

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

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

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

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

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

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

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

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

(k) The premiums for each of the programs described in subsection (a) of this section are subject to premium taxes imposed by article three, chapter thirty-three of this code, assessments pursuant to the West Virginia insurance guaranty association act set forth in article twenty-six, chapter thirty-three of this code, and any other assessment against premiums.

(l) Nothing in this article shall be construed to preclude a health care provider from obtaining professional liability insurance coverage for claims in excess of the coverage made available by the provisions of this article.
§29-12B-7. Eligibility criteria for participation in health care provider professional liability insurance programs.

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

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

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

(2) Annually participate, at his or her own expense, in a risk management program approved by the board relating to risk management; and
(3) Agree in writing to the board’s authority to assign his or her policy, individually or collectively, to a third party if the third party coverage is comparable, as determined by the board.

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

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

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

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

(a) The rate charged participants in the high risk professional liability insurance program may be higher than those established and approved by the board for participants in the preferred professional insurance program as set forth in a written rating manual. Risks may be refused coverage under criteria approved by the board, as set forth in its underwriting manual. The board of risk and insurance management shall periodically review its underwriting manual and make any changes it deems necessary or appropriate.
(b) If a majority of the board determines that a health care provider covered by one of the programs created by this article presents an extreme risk because of the number of claims filed against him or her or the outcome of such claims, said board may, after notice and a hearing in accordance with the provisions of the West Virginia administrative procedures act, chapter twenty-nine-a of this code, terminate coverage for all claims against that health care provider. Coverage shall terminate thirty days after the board’s decision. Upon termination of coverage under this subsection, the board shall notify the licensing or disciplinary board having jurisdiction over the health care provider of said provider’s name and of the reasons for termination of the coverage.

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

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

(a) The premiums charged and collected by the board under this article shall be deposited into a special revenue account hereby created in the state treasury known as the "Medical Liability Fund", and shall not be part of the general revenues of the state. Disbursements from the special revenue fund shall be upon requisition of the executive director and in accordance with the provisions of chapter five-a of this code. Disbursements shall pay operating expenses of the board attributed to these programs and the board's share of any judgments or settlements of medical malpractice claims. Funds shall be invested with the consolidated fund managed by the West Virginia investment management board and interest earned shall be used for purposes of this article.
(b) Start-up operating expenses of the medical liability fund, not to exceed five hundred thousand dollars, may be transferred to the medical liability fund pursuant to an appropriation by the Legislature from any special revenue funds available. The medical liability fund shall reimburse the board within twenty-four months of the date of the transfer.

(c) For purposes of establishing a pool from which settlements and judgments may be paid, a portion of the initial capitalization of the pool 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.

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

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

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

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


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

§29-12B-14. Effective date.

1 The provisions of this article are effective from passage.
2 Any policies written under this article may have an effective
3 date retroactive to the effective date of this article.

CHAPTER 33. INSURANCE.

ARTICLE 20E. WEST VIRGINIA MEDICAL PROFESSIONAL LIABILITY
INSURANCE JOINT UNDERWRITING ASSOCIATION
ACT.

§33-20E-1. Short title.

1 This article may be cited as the “West Virginia Medical
2 Professional Liability Insurance Joint Underwriting Association
3 Act.”

§33-20E-2. Legislative findings.

1 The Legislature finds and declares:

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

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

9 (c) That it is in the best interests of the citizens of this state
10 to preserve the quality and availability of public health pro-
11 grams and services; and,
§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
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18 coverage for any claim for damage or loss against a health care
19 provider arising out of the death or injury of any person
20 proximately caused by negligence in the rendering, or the
21 failure to render, professional services by a health care pro-
22 vider.

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

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

31 (h) “State board” means the state board of risk and insur-
32 ance management.

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

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

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


(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.
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10  (b) The policy may not require as a condition precedent to
11 settlement or compromise of any claim the consent or acquies-
12 cence of the policyholder.

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

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

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

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

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

22  (e) After the initial year of operation, the board shall obtain
23 and implement, at least annually, from an independent outside
24 source, such as a medical liability actuary or a rating organiza-
25 tion experienced with the medical liability line of insurance,
26 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 the thirtieth day of March 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.


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.


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.
ARTICLE 20F. PHYSICIANS' MUTUAL INSURANCE COMPANY.

§33-20F-1. Short title.

This article shall be known and may be cited as the "Physicians' Mutual Insurance Company Act."

§33-20F-2. Findings and purpose.

(a) The Legislature finds that:

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

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

3. Physicians in West Virginia find it increasingly difficult, if not impossible, to obtain medical liability insurance either because coverage is unavailable or unaffordable;

4. The difficulty or impossibility in obtaining medical liability insurance may result in many qualified physicians leaving the state;

5. Access to health care is of utmost importance to the citizens of West Virginia;

6. A mechanism is needed to remedy this recurring medical liability crisis; and

7. A physicians' mutual insurance company or a similar entity has proven to be a successful mechanism in other states for helping physicians secure insurance and for stabilizing the insurance market.
(b) The purpose of this article is to create a mechanism for the formation of a physicians' mutual insurance company that will provide:

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

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

§33-20F-3. Definitions.

For purposes of this article, the term:

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

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

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

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

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

§33-20F-4. Authorization for creation of company; requirements and limitations.
(a) Subject to the provisions of this article, a company is hereby authorized to be created as a domestic, private, nonstock, nonprofit corporation. As an incentive for its creation, any company that meets the requirements set forth in this article may be eligible for funds from the Legislature in accordance with the provisions of section seven of this article. A company must remain for the duration of its existence a domestic mutual insurance company owned by its policyholders and may not be converted into a stock corporation, a for-profit corporation or any other entity not owned by its policyholders.

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

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

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

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

(a) A company is to be governed by a board of directors consisting of eleven directors, as follows:

(1) At least, but not more than, four directors who are physicians licensed by the board of medicine or the board of
osteopathy and who represent the various physician organizations within the state;

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

(3) At least two directors who are officers and employees of the company and are responsible for the daily management of the company; and

(4) Two directors with general knowledge and experience in business management.

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

(c) Relating to the directors provided for in subsection (a) of this section and to the extent possible, the directors are to reside in different geographical areas of the state. The number of such directors from any one congressional district in the state may not exceed the number of directors from any other congressional district in the state by more than two.

(d) The directors and officers of a company are to be chosen in accordance with the articles of incorporation and bylaws of the company. The initial directors shall serve for the following terms: (1) Three for four year terms; (2) three for three year terms; (3) three for two year terms; and (4) two for one year terms. Thereafter, the directors shall serve staggered terms of four years. If additional directors are added to the board as provided in subsection (b) of this section, the initial term for those directors is four years. No director chosen pursuant to subsection (a) of this section may serve more than two consecutive terms.
36 (e) The incorporators are to prepare and file articles of
37 incorporation and bylaws in accordance with the provisions of
38 this article and the provisions of chapters thirty-one and thirty-
39 three of this code.

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

1 (a) If the board of directors determines that the affairs of a
2 company may be administered suitably and efficiently, the
3 company may enter into a contract with a licensed insurer,
4 licensed health service plan, insurance service organization,
5 third party administrator, insurance brokerage firm or other firm
6 or company with suitable qualifications and experience to
7 administer some or all of the affairs of the company, subject to
8 the continuing direction of the board of directors as required by
9 the articles of incorporation and bylaws of the company, and
10 the contract.
11
12 (b) The company shall file a true copy of the contract with
13 the commissioner as provided in section twenty-one, article five
14 of this chapter.

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

1 (a) A portion of the initial capital and surplus of a company
2 may be provided by direction of the Legislature, in an amount,
3 upon terms and conditions, and from sources as may deter-
4 mined by the Legislature in its sole discretion.
5
6 (b) In the event that a portion of the initial capital and
7 surplus of a company is provided by direction of the Legislature
8 pursuant to subsection (a) of this section, a special one time
9 assessment for the privilege of practicing in West Virginia may
10 be assessed on every physician licensed by the board of
11 medicine and every physician licensed by the board of osteopa-
12 thy to practice medicine in this state. The executive director of
13 the medical licensing board shall establish the amount of the
assessment, in consultation with the board of directors of the company or their designee. The amount of the assessment may not exceed one thousand dollars. The assessment is to be assessed and collected by the board of medicine and the board of osteopathy, on forms as the board of medicine and the board of osteopathy may prescribe.

(c) If the special assessment is collected pursuant to subsection (b) of this section, the Legislature hereby dedicates the entire proceeds of the special assessment to the company. The board of medicine and the board of osteopathy shall promptly pay over to the company all amounts collected pursuant to this section.

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

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

(b) In recognition of the medical liability insurance crisis in this state at the time of enactment of this article, and the critical need to expedite the initial operation of a company, the Legislature hereby authorizes the commissioner to review the documentation submitted by a company and to determine the initial capital and surplus requirements of a company, notwithstanding the provisions of section five-b, article three of this chapter. The commissioner has the sole discretion to determine the capital and surplus funds of a company and to monitor the economic viability of the company during its initial operation and duration on not less than a monthly basis. A company shall furnish the commissioner with all information and cooperate in all respects as may be necessary for the commissioner to
perform the duties set forth in this section and in other provisions of this chapter.

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

(d) Within thirty-six months of the date of the issuance of its license to transact insurance, a company must comply with the capital and surplus requirements set forth in section five-b, article three of this chapter and with all other requirements imposed upon mutual insurance companies by the provisions of this chapter.

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

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

(b) A company must accept the transfer of medical malpractice insurance obligations and risks of existing or in force contracts of insurance on physicians from the state board of risk and insurance. Subject to approval by the commissioner, a company may impose reasonable terms and conditions upon any transfer from the state board of risk and insurance management, but the terms and conditions may not be designed or construed to prohibit or unduly restrict such transfers.
(c) A company shall make policies of insurance available to physicians in this state, regardless of practice type or specialty. Policies issued by a company to each class of physicians are to be essentially uniform in terms and conditions of coverage.

(d) Notwithstanding the provisions of subsections (b) or (c) of this section, a company may:

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

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

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

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

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

§33-20F-10. Controlling law.

To the extent applicable, and when not in conflict with the provisions of this article, the provisions of chapters thirty-one and thirty-three of this code apply to any company created pursuant to the provisions of this article. If a provision of this
§33-20F-11. Liberal construction.

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

§33-20F-12. Severability.

If any provision of this article or the application thereof to any person or circumstance is held invalid, such invalidity may not affect other provisions or applications of this article and to this end, the provisions of this article are declared to be severable.

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

ARTICLE 7B. MEDICAL PROFESSIONAL LIABILITY.

§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.

(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, article
eleven, chapter thirty-three of this code prohibit the conduct
defined in subdivision (9), section four, article eleven, chapter
thirty-three of this code, 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 said section three.

(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.

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

(a) Notwithstanding any other provision of this code, no
person may file a medical professional liability action against
any health-care provider without complying with the provisions
of this section.
(b) At least thirty days prior to the filing of a medical professional liability action against a health-care provider, the claimant shall serve by certified mail, return receipt requested, a notice of claim. The notice of claim shall include a statement of the theory or theories of liability upon which a cause of action may be based, together with a screening certificate of merit. The certificate of merit shall be executed under oath by a health care provider qualified as an expert under the West Virginia rules of evidence and shall state with particularity: (1) the expert’s familiarity with the applicable standard of care in issue; (2) the expert’s qualifications; (3) the expert’s opinion as to how the applicable standard of care was breached; and (4) the expert’s opinion as to how the breach of the applicable standard of care resulted in injury or death. A separate screening certificate of merit must be provided for each health care provider against whom a claim is asserted. The person signing the screening certificate shall have no financial interest in the underlying claim, but may participate as an expert witness in any judicial proceeding. Nothing in this subsection may be construed to limit the application of rule fifteen of the rules of civil procedure.

(c) Notwithstanding any provision of this code, if a claimant or if represented by counsel, the claimant’s 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 if represented by counsel, the claimant’s counsel, shall file a statement specifically setting forth the basis of the alleged liability of the health care provider in lieu of a screening certificate of merit.

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

(e) Any health care provider who receives a notice of claim pursuant to the provisions of this section must respond, in writing, to the claimant within thirty days of receipt of the claim or within thirty days of receipt of the certificate of merit if the claimant is proceeding pursuant to the provisions of subsection (d) of this section.

(f) Upon receipt of the notice of claim or of the screening certificate, if the claimant is proceeding pursuant to the provisions of subsection (d) of this section, the health care provider is entitled to pre-litigation mediation before a qualified mediator upon written demand to the claimant.

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

(h) The failure of a health care provider to timely respond to a notice of claim, in the absence of good cause shown, constitutes a waiver of the right to request pre-litigation mediation. 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 the mailing of a notice of claim to thirty days following receipt of a response to the notice of claim, thirty days from the date a response to the notice of claim would be due, or thirty days from the receipt by the claimant of written notice from the mediator that the mediation has not resulted in a settlement of the alleged claim and that mediation is concluded, whichever last occurs. If a claimant has sent a notice of claim relating to any injury or death to more than one health care provider, any one of whom has demanded mediation, then the statute of limitations shall be tolled with respect to, and only with respect to, those health care providers to whom the claimant sent a notice of claim to thirty days from the receipt of the claimant of written notice from the mediator that the mediation has not resulted in a settlement of the alleged claim and that mediation is concluded.

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

§55-7B-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.

§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 proceed-
ing. 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 section.

(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.

§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.

(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.

§55-7B-6d. Twelve-member jury trial.

Notwithstanding any other provision of this code, the jury in any trial of an action for medical professional liability shall consist of twelve members. The judge shall instruct the jury that they should endeavor to reach a unanimous verdict but, if they cannot reach a unanimous verdict, they may return a majority
verdict of nine of the twelve members of the jury. The judge shall accept and record any verdict reached by nine members of the jury. The verdict shall bear the signatures of all jurors who have concurred in the verdict. The verdict shall be announced in open court, either by the jury foreperson or by any of the jurors concurring in the verdict. After a verdict has been returned and before the jury has been discharged, the jury shall be polled at the request of any party or upon the court’s own motion. The poll shall be conducted by the clerk of the court asking each juror individually whether the verdict announced is such juror’s verdict. If, upon the poll, a majority of nine members of the jury has not concurred in the verdict, the jury may be directed to retire for further deliberations or the jury may be discharged.

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

(a) The provisions of House Bill 149, enacted during the first extraordinary session of the Legislature, 1986, shall be effective at the same time that the provisions of Enrolled Senate Bill 714, enacted during the Regular session, 1986, become effective, and the provisions of said House Bill 149 shall be deemed to amend the provisions of Enrolled Senate Bill 714. The provisions of this article shall not apply to injuries which occur before the effective date of this said Enrolled Senate Bill 714.

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


(a) If any provision of this article as enacted during the first extraordinary session of the Legislature, 1986, in House Bill
(b) If any provision of the amendments to section five of
this article, any provision of new 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, two thousand one, 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 sections six or ten of this article or any provision of new sections 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, two thousand one, is held invalid, such invalidity shall not affect other provisions or applications of this article, and to this end, such provisions are deemed severable.

CHAPTER 56. PLEADING AND PRACTICE.

ARTICLE 6. TRIAL.

§56-6-11. Execution of order of inquiry and trial of case by court;
six member jury in civil trials; twelve member jury in eminent domain, medical professional liability and criminal trials.

(a) The court, in an action at law, if neither party requires a jury, or if the defendant has failed to appear and the plaintiff does not require a jury, shall ascertain the amount the plaintiff is entitled to recover in the action, if any, and render judgment
accordingly. In any case, in which a trial by jury would be
otherwise proper, the parties or their counsel, by consent
entered of record, may waive the right to have a jury, and
thereupon the whole matter of law and fact shall be heard and
determined, and judgment given by the court. Absent such
waiver, in any civil trial a jury shall consist of six members and
in any criminal trial a jury shall consist of twelve members.

(b) The provisions of this section do not apply to any
proceeding had pursuant to article two, chapter fifty-four of this
code, the provisions of which apply to all cases involving the
taking of property for a public use.

(c) The provisions of this section providing for a six
member jury trial do not apply to any proceeding had pursuant
to article seven-b, chapter fifty-five of this code, the provisions
of which apply to all cases involving a medical professional
liability action.

CHAPTER 59. FEES, ALLOWANCES AND COSTS;
NEWSPAPERS; LEGAL ADVERTISEMENTS.

ARTICLE 1. FEES AND ALLOWANCES.

§59-1-11. Fees to be charged by clerk of circuit court.

(a) The clerk of a circuit court shall charge and collect for
services rendered as such clerk the following fees, and such
fees shall be paid in advance by the parties for whom such
services are to be rendered:

(1) For instituting any civil action under the rules of civil
procedure, any statutory summary proceeding, any extraordi-
nary remedy, the docketing of civil appeals, or any other action,
cause, suit or proceeding, eighty-five dollars;
(2) Beginning on and after the first day of January, two
thousand two, for instituting an action for medical professional
liability, two hundred fifty dollars;

(3) Beginning on and after the first day of July, one
thousand nine hundred ninety-nine, for instituting an action for
divorce, separate maintenance or annulment, one hundred
thirty-five dollars;

(4) For petitioning for the modification of an order involv-
ing child custody, child visitation, child support or spousal
support, eighty-five dollars; and

(5) For petitioning for an expedited modification of a child
support order, thirty-five dollars.

(b) In addition to the foregoing fees, the following fees
shall likewise be charged and collected:

(1) For preparing an abstract of judgment, five dollars;

(2) For any transcript, copy or paper made by the clerk for
use in any other court or otherwise to go out of the office, for
each page, fifty cents;

(3) For action on suggestion, ten dollars;

(4) For issuing an execution, ten dollars;

(5) For issuing or renewing a suggestee execution, includ-
ing copies, postage, registered or certified mail fees and the fee
provided by section four, article five-a, chapter thirty-eight of
this code, three dollars;

(6) For vacation or modification of a suggestee execution,
one dollar;
(7) For docketing and issuing an execution on a transcript of judgment from magistrate's court, three dollars;

(8) For arranging the papers in a certified question, writ of error, appeal or removal to any other court, five dollars;

(9) For postage and express and for sending or receiving decrees, orders or records, by mail or express, three times the amount of the postage or express charges;

(10) For each subpoena, on the part of either plaintiff or defendant, to be paid by the party requesting the same, fifty cents; and

(11) For additional service (plaintiff or appellant) where any case remains on the docket longer than three years, for each additional year or part year, twenty dollars.

(c) The clerk shall tax the following fees for services in any criminal case against any defendant convicted in such court:

(1) In the case of any misdemeanor, fifty-five dollars; and

(2) In the case of any felony, sixty-five dollars.

(d) No such clerk shall be required to handle or accept for disbursement any fees, cost or amounts, of any other officer or party not payable into the county treasury, except it be on order of the court or in compliance with the provisions of law governing such fees, costs or accounts.

ARTICLE 1. FEES AND ALLOWANCES.

§59-1-28a. Disposition of filing fees in civil actions and fees for services in criminal cases.

(a) Except for those payments to be made from amounts equaling filing fees received for the institution of divorce
actions as prescribed in subsection (b) of this section, and
eXcept for those payments to be made from amounts equaling
filing fees received for the institution of actions for divorce,
separate maintenance and annulment as prescribed in subsec-
tion (b) of this section, for each civil action instituted under the
rules of civil procedure, any statutory summary proceeding, any
extraordinary remedy, the docketing of civil appeals, or any
other action, cause, suit or proceeding in the circuit court, the
clerk of the court shall, at the end of each month, pay into the
funds or accounts described in this subsection an amount equal
to the amount set forth in this subsection of every filing fee
received for instituting the action as follows:

(1) Into the regional jail and correctional facility authority
fund in the state treasury established pursuant to the provisions
of section ten, article twenty, chapter thirty-one of this code, the
amount of sixty dollars; and

(2) Into the court security fund in the state treasury estab-
lished pursuant to the provisions of section fourteen, article
three, chapter fifty-one of this code, the amount of five dollars.

(b) For each action for divorce, separate maintenance or
annulment instituted in the circuit court, the clerk of the court
shall, at the end of each month, report to the supreme court of
appeals, the number of actions filed by persons unable to pay,
and pay into the funds or accounts in this subsection an amount
equal to the amount set forth in this subsection of every filing
fee received for instituting the divorce action as follows:

(1) Into the regional jail and correctional facility authority
fund in the state treasury established pursuant to the provisions
of section ten, article twenty, chapter thirty-one of this code, the
amount of ten dollars;
(2) Into the special revenue account of the state treasury, established pursuant to section six hundred four, article two, chapter forty-eight of this code, an amount of thirty dollars;

(3) Into the family court fund established under section twenty-two, article two-a, chapter fifty-one of this code, an amount of seventy dollars; and

(4) Into the court security fund in the state treasury, established pursuant to the provisions of section fourteen, article three, chapter fifty-one of this code, the amount of five dollars.

(c) Notwithstanding any provision of subsection (a) or (b) of this section to the contrary, the clerk of the court shall, at the end of each month, pay into the family court fund established under section twenty-two, article two-a, chapter fifty-one of this code an amount equal to the amount of every fee received for petitioning for the modification of an order involving child custody, child visitation, child support or spousal support as determined by subdivision (3), subsection (a), section eleven of this article and for petitioning for an expedited modification of a child support order as provided in subdivision (4), subsection (a), section eleven of this article.

(d) The clerk of the court from which a protective order is issued shall, at the end of each month, pay into the family court fund established under section twenty-two, article two-a, chapter fifty-one of this code an amount equal to every fee received pursuant to the provisions of section five hundred eight, article twenty-seven, chapter forty-eight of this code.

(e) The clerk of each circuit court shall, at the end of each month, pay into the regional jail and correctional facility authority fund in the state treasury an amount equal to forty dollars of every fee for service received in any criminal case against any respondent convicted in such court and shall pay an
amount equal to five dollars of every such fee into the court security fund in the state treasury established pursuant to the provisions of section fourteen, article three, chapter fifty-one of this code.

(f) Beginning the first day of January, two thousand two, the clerk of the circuit court shall, at the end of each month, pay into the medical liability fund established under article twelve-b, chapter twenty-nine of this code an amount equal to one hundred sixty-five dollars of every filing fee received for instituting a medical professional liability action.
That Joint Committee on Enrolled Bills hereby certifies that the foregoing bill is correctly enrolled.

Chairman Senate Committee

Chairman House Committee

Originating in the House.

In effect from passage.

Clerk of the Senate

Clerk of the House of Delegates

President of the Senate

Speaker of the House of Delegates

The within is approved this the 12th day of December, 2001.

Governor
PRESENTED TO THE
GOVERNOR
Date 10/4/01
Time 4:30 PM