WEST VIRGINIA LEGISLATURE  
Sixth Extraordinary Session, 2001

ENROLLED
Committee Substitute for Committee Substitute for
SENATE BILL NO. 6014

(By Senators Tomblin, Mr. President, and Sprouse, by Request of the Executive)

PASSED November 4, 2001

In Effect from Passage
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COMMITTEE SUBSTITUTE
FOR
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Senate Bill No. 6014
(BY SENATORS TOMBLIN, MR. PRESIDENT, AND SPROUSE,
BY REQUEST OF THE EXECUTIVE)

[Passed November 6, 2001; in effect from passage.]

AN ACT to amend and reenact sections two, three, six and eight, article twenty-b, chapter thirty-three of the code of West Virginia, one thousand nine hundred thirty-one, as amended; and to amend and reenact sections two, three and four, article twenty-c of said chapter, all relating to medical malpractice liability insurance; modifying factors considered for establishing insurance rates; creating a prohibition for the use of certain nonapproved rates; prohibiting insurers from requiring execution of certain rate endorsements and creating exceptions thereto; extending waiting period for certain filings; modifying methodology for determining when subsequent reporting violations occur; expanding entities required to report claims made against health care
providers; extending the time frame to report certain claims; adding information relating to certain claims which must be reported to the insurance commissioner; modifying the method that insurance commissioner may assess and dispose of civil penalties; removing a reason an insurer may use to cancel an existing insurance policy; and extending date of notice required of an insurer for nonrenewal of an insurance policy or contract.

Be it enacted by the Legislature of West Virginia:

That sections two, three, six and eight, article twenty-b, chapter thirty-three of the code of West Virginia, one thousand nine hundred thirty-one, as amended, be amended and reenacted; and that sections two, three and four, article twenty-c of said chapter be amended and reenacted, all to read as follows:

ARTICLE 20B. RATES AND MALPRACTICE INSURANCE POLICIES.

§33-20B-2. Ratemaking.

1 Any and all modifications of rates shall be made in accordance with the following provisions:

2 (a) Due consideration shall be given to the past and prospective loss experience within and outside this state.

3 (b) Due consideration shall be given to catastrophe hazards, if any, to a reasonable margin for underwriting profit and contingencies, to dividends, savings or unab- sorbed premium deposits allowed or returned by insurers to their policyholders, members or subscribers and actual past expenses and demonstrable prospective or projected expenses applicable to this state.

4 (c) Rates shall not be excessive, inadequate or unfairly discriminatory.

5 (d) Risks may not be grouped by territorial areas for the establishment of rates and minimum premiums.

6 (e) An insurer may use guide “A” rates and other nonapproved rates, also known as “consent to rates”:
Provided, That the insurer shall, prior to entering into an agreement with an individual provider or any health care entity, submit guide “A” rates and other nonapproved rates to the commissioner for review and approval: Provided, however, That the commissioner shall propose legislative rules for promulgation in accordance with the provisions of article three, chapter twenty-nine-a of this code, which set forth the standards and procedure for reviewing and approving guide “A” rates and other nonapproved rates. No insurer may require execution of a consent to rate endorsement for the purpose of offering to issue or issuing a contract or coverage to an insured or continuing an existing contract or coverage at a rate in excess of that provided by a filing otherwise applicable.

(f) Except to the extent necessary to meet the provisions of subdivision (c) of this section, uniformity among insurers, in any matters within the scope of this section, is neither required nor prohibited.

(g) Rates made in accordance with this section may be used subject to the provisions of this article.

§33-20B-3. Rate filings.

(a) Every filing for malpractice insurance made pursuant to subsection (a), section four, article twenty of this chapter shall state the proposed effective date of the filing, the character and extent of the coverage contemplated and information in support of the filing. The information furnished in support of a filing shall include: (i) The experience or judgment of the insurer or rating organization making the filing; (ii) its interpretation of any statistical data the filing relies upon; (iii) the experience of other insurers or rating organizations; and (iv) any other relevant factors required by the commissioner. When a filing is not accompanied by the information required by this section upon which the insurer supports the filing, the commissioner shall require the insurer to furnish the information and, in that event, the waiting period pre-
A filing and any supporting information shall be open to public inspection as soon as the filing is received by the commissioner. Any interested party may file a brief with the commissioner supporting his or her position concerning the filing. Any person or organization may file with the commissioner a signed statement declaring and supporting his or her or its position concerning the filing. Upon receipt of any such statement prior to the effective date of the filing, the commissioner shall mail or deliver a copy of the statement to the filer, which may file a reply. This section is not applicable to any memorandum or statement of any kind by any employee of the commissioner.

(b) Every filing shall be on file for a waiting period of ninety days before it becomes effective. The commissioner may extend the waiting period for an additional period not to exceed thirty days if he or she gives written notice within the waiting period to the insurer or rating organization which made the filing that he or she needs the additional time for the consideration of the filing. Upon written application by the insurer or rating organization, the commissioner may authorize a filing which he or she has reviewed to become effective before the expiration of the waiting period or any extension of the waiting period. A filing shall be deemed to meet the requirements of this article unless disapproved by the commissioner within the waiting period or any extension thereof.

(c) No insurer shall make or issue a contract or policy of malpractice insurance except in accordance with the filings which are in effect for the insurer as provided in this article.

§33-20B-6. Rate review and reporting.

(a) The commissioner shall review annually the rules, rates and rating plans filed and in effect for each insurer
providing five percent or more of the malpractice insurance coverage in this state in the preceding calendar year to determine whether the filings continue to meet the requirements of this article and whether the filings are unfair or inappropriate given the loss experience in this state in the preceding year.

The commissioner shall promulgate legislative rules pursuant to article three, chapter twenty-nine-a of this code establishing procedures for the fair and appropriate evaluation and determination of the past loss experience and prospective or projected loss experience of insurers within and outside this state, actual past expenses incurred in this state and demonstrable prospective or projected expenses applicable to this state.

(b) The commissioner shall promulgate legislative rules pursuant to article three, chapter twenty-nine-a of this code establishing procedures whereby each insurer providing five percent or more of the malpractice insurance coverage in this state annually shall submit to the commissioner the following information:

(1) The number of claims filed per category;

(2) The number of civil actions filed;

(3) The number of civil actions compromised or settled;

(4) The number of verdicts in civil actions;

(5) The number of civil actions appealed;

(6) The number of civil actions dismissed;

(7) The total dollar amount paid in claims compromised or settled;

(8) The total dollar amount paid pursuant to verdicts in civil actions;

(9) The number of claims closed without payment and the amount held in reserve for all such claims;

(10) The total dollar amount expended for loss adjustment expenses, commissions and brokerage expenses;

(11) The total dollar amount expended in defense and litigation of claims;

(12) The total dollar amount held in reserve for anticipated claims;

(13) Net profit or loss;

(14) Investment and other income on net realized capital gains and loss reserves and unearned premiums; and

(15) The number of malpractice insurance policies canceled for reasons other than nonpayment of premiums.

The commissioner shall establish, in the rules, methods of allocating investment and other income among capital gains, loss reserves, unearned premiums and other assets if an insurer does not separately account for and allocate that income.

Any insurer who fails to submit any information to the commissioner, as required by this subsection, in accordance with the rules promulgated under this subsection, shall be fined ten thousand dollars for each of the first five failures and shall be fined one hundred thousand dollars for the sixth and each subsequent failure.

(c) The commissioner shall report annually, during the month of November, to the joint standing committee on the judiciary the following information pertaining to each insurer providing five percent or more of the malpractice insurance coverage in this state:

(1) The loss experience within the state during the preceding calendar year;

(2) The rules, rates and rating plans in effect on the date of the report;

(3) The investment portfolio, including reserves, and the annual rate of return on the investment portfolio; and
(4) The information submitted to the commissioner pursuant to the rules promulgated by authority of subsection (b) of this section.

§33-20B-8. Insurers required to report results of civil actions against physicians or podiatrists; penalties for failure to report; notice and hearing.

(a) Every insurer issuing, or issuing for delivery in this state, a professional liability policy or providing professional liability insurance to health care providers, including, but not limited to, physicians, osteopathic physicians or surgeons, podiatrists or chiropractors, hospitals, medical clinics, professional limited liability companies, medical corporations or partnerships in this state shall submit to the commissioner, within sixty days from the date of entry of any judgment or dismissal without payment, the date a release is executed in connection with a settlement or the date a file is closed on any claim in which a law suit has not been filed involving the insured, the following information:

(1) The date of any judgment, dismissal or settlement;
(2) Whether any appeal has been taken on the judgment and, if so, by which party;
(3) The amount of any settlement or judgment against the insured;
(4) Whether the claim was the subject of mediation;
(5) Whether any settlement of a claim was made in a lump sum payment, a structured settlement or a combination of the two; and
(6) Any other information required by the commissioner.

For purposes of this section, "claim" means a third-party request for indemnification.

(b) If there is any additional resolution, including appellate decision or other subsequent action, the insurer shall file a supplemental report to the commissioner.
(c) The West Virginia insurance guaranty association created pursuant to article twenty-six of this chapter and
the state board of risk and insurance management created pursuant to article twelve, chapter twenty-nine of this
code are subject to the reporting requirements of subsection (a) of this section.

(d) Any insurer or entity that fails to report any information required to be reported under this section is subject
to a civil money penalty to be imposed by the insurance commissioner. Upon a determination of the commissioner
that there is probable cause to believe that any insurer or entity has failed or refused to make a report required by
this section, the commissioner shall provide written notice to the alleged violator stating the nature of the alleged
violation. Upon written request of the alleged violator within thirty days of the date of the commissioner’s
written notice, the commissioner shall notify the alleged violator of the time and place of a hearing at which the
alleged violator may appear to show good cause why a civil penalty should not be imposed. The hearing shall be
conducted in accordance with the provisions of article five, chapter twenty-nine-a of this code.

(e) If the commissioner determines that a violation of this section has occurred, the commissioner shall assess a
civil penalty of not less than one thousand dollars nor more than ten thousand dollars per violation. Anyone so
assessed shall be notified of the assessment in writing and the notice shall specify the reasons for the assessment. If
the alleged violator requests a hearing, as provided in subsection (d) of this section, the commissioner may not
make his or her determination of violation and assessment until the conclusion of the hearing. The amount of penalty
collected shall be deposited in the general revenue fund.

(f) If any violator fails to pay the amount of the penalty assessment to the commissioner within thirty days after
issuance of notice of the penalty assessment, the commissioner may institute a civil action in the circuit court of
In any civil action, the court's review of the commissioner's action shall be conducted in accordance with the provisions of section four, article five, chapter twenty-nine-a of this code.

(g) No person or entity may be held liable in any civil action with respect to any report made pursuant to this section if the report was made without knowledge of any falsity of the information contained in the report.

ARTICLE 20C. CANCELLATION AND NONRENEWAL OF MALPRACTICE INSURANCE POLICIES.

§33-20C-2. Cancellation prohibited except for specified reasons; notice.

No insurer once having issued or delivered a policy providing malpractice insurance in this state may cancel the policy, except for one or more of the following reasons:

(a) The named insured fails to discharge any of his or her obligations to pay premiums for the policy or any installment of the policy within a reasonable time of the due date;

(b) The policy was obtained through material misrepresentation;

(c) The insured violates any of the material terms and conditions of the policy; or

(d) Reinsurance is unavailable. The insurers shall supply sufficient proof of the unavailability to the commissioner.

(e) Any purported cancellation of a policy providing malpractice insurance attempted in contravention of this section is void.

§33-20C-3. Insurer to specify reasons for cancellation.

In every instance in which a policy or contract of malpractice insurance is canceled by the insurer, the
insurer or its duly authorized agent shall cite within the written notice of the action the allowable reason in section two of this article for which the action was taken and shall state with specificity the circumstances giving rise to the allowable reason cited. The notice of the action shall further state that the insured has a right to request a hearing, pursuant to section five of this article, within thirty days.

§33-20C-4. Notice period for cancellation; ninety-day notice required for nonrenewal.

(a) No insurer shall fail to renew a policy or contract providing malpractice insurance unless written notice of the nonrenewal is forwarded to the insured by certified mail, return receipt requested, not less than ninety days prior to the expiration date of the policy.

(b) No insurer shall cancel a policy or contract providing malpractice insurance during the term of the policy unless written notice of the cancellation is forwarded to the insured by certified mail, return receipt requested, not more than thirty days after the reason for the cancellation, as provided in section two of this article, arose or occurred or the insurer learned that it arose or occurred and not less than thirty days prior to the effective cancellation date.
The Joint Committee on Enrolled Bills hereby certifies that the foregoing bill is correctly enrolled.

Chairman Senate Committee

Chairman House Committee

Originated in the Senate.

In effect from passage.

Clerk of the Senate

Clerk of the House of Delegates

President of the Senate

Speaker House of Delegates

The within bill is approved this the 16th Day of November, 2001.
PRESENTED TO THE
GOVERNOR
Date: 11/20/04
Time: 9:30 a.m.