WEST VIRGINIA LEGISLATURE
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ENROLLED

House Bill No. 4581
(By Delegates Michael, Doyle, Frederick, Warner and Stalnaker)

Passed March 7, 2002
In Effect from Passage
ENROLLED

H. B. 4581

(BY DELEGATES MICHAEL, DOYLE, FREDERICK, WARNER AND STALNAKER)

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AN ACT to repeal section five-c, article twelve, chapter twenty-nine of the code of West Virginia, one thousand nine hundred thirty-one, as amended; to amend and reenact sections two and five, article twelve of said chapter; and to amend and reenact sections six and ten, article twelve-b, of said chapter, all relating to repealing the section relating to coverage of obstetricians providing Medicaid coverage, redefining certain terms, including emergency services agencies as an entity eligible for board of risk and insurance management coverage, removing the payment of money into the guarantee fund by the medical liability program, allowing general liability coverage to be provided through the medical liability program, allowing audits to be done according to generally accepted accounting principles and allowing the medical liability program to capitalize its program through a loan from the liability insurance trust fund.

Be it enacted by the Legislature of West Virginia:
That section five-c, article twelve, chapter twenty-nine of the code of West Virginia, one thousand nine hundred thirty-one, as amended, be repealed; and that sections two and five, article twelve of said chapter be amended and reenacted; and that sections six and ten, article twelve-b, of said chapter, be amended and reenacted, all to read as follows:

ARTICLE 12. STATE INSURANCE.

§29-12-2. Definitions.

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.

(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.

§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 insurance.

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, a charitable or public service organization, or an emergency medical services
agency, the board is authorized to provide property and liability
insurance to insure their property, activities and responsibilities.
The 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, a charitable or public
service organization or an emergency medical services agency
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, the charitable or public
service organization or the emergency medical services agency
and may include administrative expenses. For purposes of this
section: Provided, That if an emergency medical services
agency is a for-profit entity its claims history may not adversely
affect other participants rates in the same class. All funds
received by the board, (including, but not limited to, state
agency premiums, mine subsidence premiums, and political
subdivision premiums) 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,
benefvolent, 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 promoting the campaign of any candidate for public office.

“Emergency medical service agency” as used in this subsection shall have the same meaning as in section three, article four-c, chapter sixteen of this code.

(c) (1) The board shall have general supervision and control over the optional medical liability insurance programs providing 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 be included in the Board of Risk and Insurance Management audited financial statements as “other financial information”, 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 statement based on generally accepted accounting practices (GAAP) and which shall include allowances for incurred but not reported claims: Provided, That the financial statement 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, expendi-
tures 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. Notwithstanding 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 insurance carrier, and the board otherwise has no covered participants, 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 Legislature 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-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, article seven-b, 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
delays 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.
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.

General liability coverage that may be required by a health care provider may be offered as determined by the board.

§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, notwithstanding any other provision of this code to the contrary, a portion of the initial capitalization of the pool may be provided through a transfer of no greater than four million dollars from the state special
insurance fund established in section five, article twelve of this chapter. All funds transferred pursuant to this section are to be repaid by transfer from the medical liability fund to the state special insurance fund, together with interest that would have accrued in the state special insurance fund, by the first day of July, two thousand six. Funds are to be transferred only as needed for expenditures from the medical liability fund created in this section. The treasurer shall effect these transfers pursuant to this section upon written request of the director of the board of risk and insurance management.
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 18th day of March, 2002.

Governor