

FLAHERTY, SENSABAUGH & BONASSO, P.L.L.C.
Attorneys at Law

Morgantown
7000 Hampton Center, Suite I
Morgantown, WV 26505
Telephone (304) 598-0788
Telecopier (304) 598-0790

200 Capitol Street
P.O. Box 3843
Charleston, WV 25338-3843

Wheeling
1225 Market Street
P.O. Box 6545
Wheeling, WV 26003
Telephone (304) 230-6600
Telecopier (304) 230-6610

Telephone (304) 345-0200
Telecopier (304) 345-0260
Web Page: www.fsbwv.com

Don R. Sensabaugh, Jr.
E-Mail: dsensabaugh@fsbwv.com
Direct Dial: (304) 347-4212

March 5, 2003

Michele Grinberg
E-Mail: mgrinberg@fsbwv.com
Direct Dial: (304) 347-4266

TO: ALL INTERESTED CLIENTS & FRIENDS

FROM: DON R. SENSABAUGH, JR. & MICHELE GRINBERG

RE: H.B. 2122: MEDICAL PROFESSIONAL LIABILITY REFORM & ENHANCEMENTS TO ASSIST IN CREATION OF THE PHYSICIANS' MUTUAL (**Full text of H.B. 2122, as signed by the Joint Conference Committee, can be found on our website: www.fsblaw.com**)

Because of the incredible efforts of the CARE Coalition, individual lobbyists, and leadership in both houses as exemplified by Speaker Bob Kiss, Delegate Jon Amores, Senator Jeff Kessler and others, the Legislature took a step forward and passed significant tort reform on March 5, 2003. The Legislature also made changes to the existing physicians' mutual insurance company statute and funded the start-up of the mutual to assist in creating a fiscally sound new entity that will provide insurance to physicians in the private sector. The bill now goes to the Governor for his signature. It seems that the legislature is learning that if it wants a vibrant health care industry in this State, it must take steps to create a marketplace that provides some economic certainty by limiting the scope of risks underwritten so that insurance can be provided for the public's benefit. It is hoped that this economically motivated legislation will be a first step in improving the business climate in this state for all industries.

Summary of major tort reform provisions:

- **Cap on non-economic damages at \$250,000 per occurrence (§55-7B-8)**

Lowers the existing one million dollar cap on awards for pain and suffering and other intangible losses to \$250,000 per occurrence, regardless of the number of plaintiffs and defendants or distributees of an estate.

In cases where plaintiff proves malpractice which results in (1) wrongful death or (2) permanent and substantial physical deformity or loss of use of limb or loss of a bodily organ system or (3) permanent physical or mental functional injuries that permanently prevent the injured person from being independently able to care for himself and perform life sustaining activities, the cap is lowered from one million dollars to a maximum of \$500,000 per occurrence.

To qualify for this cap, a defendant must have at least one million dollars of professional liability coverage.

To account for inflation, the cap can be adjusted yearly by an amount equal to the CPI. The cap's increase over time cuts off at an amount equal to 50% greater than the original cap; i.e., \$375,000 per occurrence or \$750,000 in cases of severe injury.

- **Cap on all trauma damages of \$500,000.00 (§55-7B-9c)**

Lawsuits filed as a result of good faith care for an emergency condition provided at designated trauma centers are subject to a \$500,000.00 total cap on damages, exclusive of interest. Emergency condition is defined as: any acute traumatic injury or acute medical condition which, according to standardized criteria for triage, involves a significant risk of death or the precipitation of significant complications or disabilities, impairment of bodily functions or with respect to a pregnant woman, significant risk to the health of the unborn child. The cap includes trauma care rendered by a licensed EMS agency. The cap does not protect medical care that is rendered in reckless disregard of risk of harm or in clear violation of established protocols. There is a rebuttable presumption that a medical condition that occurs during the follow-up care is related to the original emergency condition and therefore subject to the cap. The Office of Emergency Medical Services designates the trauma centers and may grant provisional status to a health care facility as it works through obtaining approval to be an officially designated trauma center. OEMS is also charged with developing written protocols specifying accepted triage standards.

- **Individual liability equal to percent of fault (55-7B-9)**

Eliminates the present rule where any defendant who is greater than 25% at fault can be required to pay the entire verdict (joint liability) and replaces it with individual defendant liability equal to their percentage of fault (several liability). The new rule takes effect upon creation of the patient injury compensation fund. The Fund will not be in place before the 2004 legislative session; therefore, this change in exposure of a defendant from paying the whole verdict to paying only the individual's percentage of fault will be in abeyance.

- **Collateral payments to plaintiffs reduce awards by amounts paid (§55-7B-9a)**

Collateral sources include both private and governmental payers of medical and hospital expenses, etc. such as workers compensation, PEIA, health and accident insurance, casualty or property insurance, disability income, and Social Security Disability benefits which are obtained for the same injury as alleged in the medical malpractice litigation. Collateral sources will be offset from the verdict before final judgment is entered. There is no offset if plaintiff individually purchased an individual disability or income replacement insurance policy or if the collateral source has a statutory or contractual right of subrogation. Plaintiffs can be compensated for the premiums paid to secure benefits which are collateral sources. Collateral sources include both past and future benefits, as long as the future benefits are reasonably certain to be paid and are reducible to a sum certain.

- **Patient Injury Compensation Fund (§29-12C-1)**

The legislation establishes a Patient Injury Compensation Fund Study. A committee comprised of the director of the Board of Risk and Insurance Management (BRIM), the insurance commissioner and a governor's appointee will develop recommendations on the feasibility of creating a patient injury fund and will report back to the legislature in December 2003. This fund would cover only economic damages awarded by the jury but unpaid to plaintiff because either: 1) the economic damages exceed the trauma cap of \$500,000.00 or 2) because the elimination of joint liability in favor of liability only to the extent an individual is found to be at fault means some portion of the economic damages awarded remains unfunded. The fund will not provide for non-economic damages.

- **Medical injury litigation limited to injured patients (§55-7B-2 and §55-7B-9b)**

Prior statutory language was interpreted by the West Virginia Supreme Court to permit persons injured by patients to sue the patients' health care

professionals. The new language limits injured persons or their legal representatives (who are not patients) to suits against health care professionals only when the health care services provided are proven to have been done in a willful and wanton manner or with reckless disregard of a foreseeable risk of harm.

- **Qualifications for Experts strengthened (§55-7B-7)**

Witnesses, who parties want to call as experts at trial, must spend 60% of their time in active practice in the field or in teaching, in the same specialty for which they wish to render opinions when testifying. Expert witnesses must be licensed and in good standing by the licensing authority of a state and must have education and training in the particular area of medicine for which they intend to render opinions.

- **"Loss of Chance" Theory Requires Reasonable Proof (§55-7B-3(b))**

Plaintiffs, pursuant to case law, can recover on a theory that a deviation from the medical standard of care decreased their chances of an improved recovery or survival. The statutory provision clarifies the proof required. Plaintiff must prove to a reasonable degree of medical probability that if the physician had followed the standard of care, it would have resulted in a greater than 25% chance that the patient would have had an improved recovery or survived. In addition, it requires the acts of the physician to be a substantial factor in increasing the risk of harm to a patient.

- **Imputing liability through theory of "ostensible agency" eliminated (§55-7B-9(g))**

Health care entities, pursuant to case law, can be held financially responsible for those whom the court found appeared to be the agents ("ostensible agents") of the entities or providers, in addition to the ostensible agents also being responsible. This provision eliminates the doctrine of "ostensible agency" as long as the "ostensible agents" carry \$1 million in professional liability coverage.

OTHER IMPORTANT PROVISIONS OF THE ACT

- **Homestead exemption increased (§38-10-4)**

A homestead exemption is allowed up to \$250,000 for a physician who has to declare bankruptcy because of a medical settlement or payout. In order to qualify for the exemption the physician must have \$1 million in medical liability insurance coverage.

- **WV Board of Medicine/Board of Osteopathy supervision strengthened (§30-3-14 and §30-14-12a)**

The Board is mandated to investigate any physician (MD or DO) or podiatrist who has three or more judgments, or five or more judgments and settlements with five or more unfavorable outcomes. Further, if a physician/podiatrist has had three or more incidents that subject the physician to disciplinary actions by any state or hospital in five years, the Board must require the doctor to practice under the direction of a physician chosen by the board for a discrete period of time.

?? **Effective date (§55-7B-10)**

The tort reforms apply to all causes of action that are filed on or after July 1, 2003.

STATUTORY CHANGES AND AMENDMENTS TO STRENGTHEN PHYSICIANS' MUTUAL INSURANCE COMPANY, PROVIDES CREDITS TO PARTIALLY OFFSET PHYSICIANS' DRAMATIC INCREASES IN PROFESSIONAL LIABILITY INSURANCE AND ELIMINATES BRIM II INSURANCE

- **Creates funding to assist in proper capitalization of Physicians' Mutual**
 - ? **\$24 million dollars** will be loaned from the WV tobacco settlement medical trust fund. (§4-11A-2) This amount will be restored over time from premium taxes due from the Mutual and other insurers offering medical liability insurance. (§33-3-14; §33-20F-4). The Mutual will also be required to execute a surplus note to replay the loan with interest when the Mutual becomes profitable.
 - ? Each insurance carrier shall be one-time assessed \$2500. This is expected to raise **\$3 million dollars**. (§33-2-9a)
 - ? All physicians must contribute a one-time assessment of \$1000. This is expected to raise approximately **\$3.2 million dollars**. (§33-20F-7). Exempted from this assessment are faculty physicians not in private practice, physicians in the armed services, physicians who receive more than 50% of income from FQHCs (federally-funded clinics), and physicians working under a special volunteer license.

- **TOTAL CAPITALIZATION: \$30.2 MILLION DOLLARS.**

? Capitalization must be in compliance with insurance commissioner requirements within forty months. (§33-20F-7(d))

- **Tax credit against provider tax for premiums paid for claims made policies and for "tail insurance" (§11-13T-1 et seq.)**

Physicians who purchase medical liability insurance which may include tail insurance will be entitled to a credit against their provider taxes equal to either 10% of premiums in excess of \$30 thousand dollars OR 20% of premiums paid in excess of \$70 thousand dollars. The taxpayer elects. The credit is available for the years 2002 and 2003 only. However, any credit remaining in a taxable year can be carried forward and applied against provider taxes up to 2010, at which time the credit and the provider tax expire. It is estimated that this will save West Virginia physicians' five million dollars per year for each of two years.

- **BRIM II (The State's insurance plan for physicians) to end by July 1, 2004. (§29-12B et seq. and §33-20F)**

BRIM II will expire on July 1, 2004, except for hospitals who have not obtained coverage elsewhere. Those policies shall remain in force until their expiration date. BRIM II is authorized to provide coverage for run out of policies and tail coverage for policies that are not transferred to the Mutual. Premiums for tail coverage can be financed for five years.

- **Physicians' Mutual governance and organization (§33-20F-5)**

The provisional board which is charged with creating the Mutual shall be created July 1, 2003 and serve until June 30, 2004. The Mutual does not include hospitals. (§33-20F-9(b)(1)). The provisional board is comprised of the members of BRIM (J. Michael Mullen, John Lukens, Sherry Cunningham, Bruce Martin and Martin Glasser), Dean of the W.V.U. School of Medicine, and five physicians elected by the physician policyholders in BRIM II. One of the physician members shall be selected from three nominees provided by the WVSMA. The election for the first five physician directors will be organized by BRIM and shall occur no later than June 1, 2003.

? Beginning July 2004, the Board shall have eleven directors including five physicians, three persons with substantial experience as an officer or employee of insurance business, two persons with business management experience, and the dean of one of the medical schools. At the time the tobacco settlement fund money is repaid, the dean's seat shall be replaced with another

physician director. Terms shall initially be staggered from four to one year terms. Ultimately, the term shall be four years.

? The provisional board is authorized to enter into management contracts with those experienced to run the company for a period to end June 30, 2005. Competitive bidding is required for this contract and other contracts.

- **Transfer of Risks (§33-20F-9)**

Initially, the Mutual must take all physician, physician corporation and physician-operated clinic insureds from BRIM II. It also takes all assets and liabilities attributed to these insureds as determined from an independent actuarial study.