Report and Recommendations on the Feasibility of a West Virginia Patient Injury Compensation Fund

Submitted to the Joint Committee on Government and Finance
By the Patient Injury Compensation Fund Study Board

December 1, 2003

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Honorable Earl Ray Tomblin
Senate President
WV Senate
Room 227M, Building 1
1900 Kanawha Blvd., E.
Charleston, WV 25305

Honorable Robert S. Kiss
Speaker of the House
WV House of Delegates
Room 234M, Building 1
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Gentlemen:

Pursuant to House Bill 2122, a study has been conducted to examine the feasibility of establishing a patient injury compensation fund.

West Virginia Code § 29-12C-1(d) provides:

> *"The patient injury compensation fund study board's report and recommendations shall be completed no later than the first day of December, two thousand three, and shall be presented to the joint committee of government and finance during the legislative interim meetings to be held in December, two thousand three."*

Accordingly, attached are the Report and Recommendations on the Feasibility of a West Virginia Patient Injury Compensation Fund.

This Report will be formally presented to the Joint Committee on Government and Finance at the December 9, 2003 interim committee meeting.

Should you have any questions, please feel free to contact any member of the Study Board.

Respectfully submitted,

PATIENT INJURY COMPENSATION FUND STUDY BOARD

Charles E. Jones, Jr., Executive Director
West Virginia Board of Risk and Insurance Management

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Office of the Insurance Commissioner

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By: ________________________________
Chairman

CEJ/cjs

cc: Bob Wise, Governor
Tom Susman, Acting Cabinet Secretary, DOA
John R. Lukens, BRIM Board Chairman

Attachment

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Report and Recommendations on the Feasibility of a West Virginia Patient Injury Compensation Fund

Executive Summary and Recommendations

Purpose of the PICF Study Board

House Bill 2122, passed by the West Virginia Legislature during the regular session of 2003, was enacted to address significant concerns regarding the availability and affordability of professional medical liability insurance (medical malpractice insurance) for West Virginia health care providers and problems with retaining and recruiting physicians to West Virginia. Chapter 29, Article 12C, Section 1 of the Bill addresses the formation of a patient injury compensation plan study board, hereinafter referred to as the "PICF Study Board" or simply the "Study Board." The purpose of the PICF Study Board is to examine the feasibility of establishing a patient injury compensation fund to reimburse claimants in medical malpractice actions for any portion of "economic damages awarded" which are uncollectible due to statutory limitations on damage awards for trauma care and/or the elimination of joint and several liability of tortfeasor health care providers and health care facilities.

PICF Guidelines

H.B. 2122 requires the Study Board to identify funding methods for a Patient Injury Compensation Fund ("PICF"), and to also identify options for the operation and administration of the Fund within certain guidelines.[1] The guidelines call for the Board of Risk and Insurance Management to implement, administer and operate the PICF; require the PICF to be actuarially sound and fully funded; and require eligibility for reimbursement from the fund to be limited to

[1] W.Va. Code § 29-12C-1(c).

claimants who have been awarded economic damages in medical malpractice actions but have been certified by BRIM as being unable, after exhausting all reasonable means to recover the award, to collect all or part of the economic damages due to the Legislature's enactment of two specific legal reforms. Those reforms affect joint liability of multiple defendants in medical malpractice actions,[2] and place a cap on total damages (including both economic and non-economic damages) resulting from health care services necessitated by an emergency condition for which the patient receives treatment at a designated trauma center.[3]

Pertinent issues for consideration within the scope of the Study Board's charge under Article 12C include:

- The amount, nature and source of the funding for the PICF;
- Whether, and under what circumstances, should claimants have access to the Fund if the underlying medical liability action is settled;
- Whether medical liability insurance should be required of health care providers in order to limit the potential exposure of the PICF especially in the area of the joint and several liability reform;
- Whether and to what extent should plaintiff attorneys fees be payable from the Fund;
- And, in what manner should the financial assets of the PICF be protected.

The legislation directed the PICF Board to propose emergency legislative rules relating to the establishment, implementation and operation of the patient injury compensation fund in conjunction with its Report and Recommendations. Without enabling legislation resolving fundamental policy considerations, proposed emergency rules could not be completed.

Recommendations

In arriving at our recommendations, we reviewed and analyzed other patient compensation funds. Based upon a careful review and study of the situation, the Study Board

[2] W.Va. Code § 55-7B-9.
[3] W.Va. Code § 55-7B-9c.

recommends that the Patient Injury Compensation Fund be established with the following considerations:

- The PICF should be fully funded, actuarially sound, and have a source of funding that is continuous;
- The PICF should be a segregated and protected state fund;
- In order to stabilize the financial condition of the Fund, the total Fund payment for any one occurrence should be limited to $1,000,000;
- The Fund should be permitted to pay future economic damages periodically (i.e. structured settlements) in appropriate cases;
- Reasonable and appropriate limits should be placed on attorney fees paid out of the Fund; and
- The potential liability of the Fund should be protected by requiring that health care providers carry appropriate amounts of medical liability insurance.
- Other Considerations[4]:
  - Settlement authority should be carefully considered in appropriate and limited circumstances;
  - The funding of the PICF come from a ‘broad-based” source.

It is anticipated that this Report will serve as an information source to assist state policy makers in making informed decisions regarding the implementation of a PICF.

Background

A number of states have established funds to provide compensation to claimants suffering loss, damages or expenses as a result of medical malpractice. In those states, the liability of the health care provider (and the primary insurer) is capped by statute, and a fund is available to pay any excess damages that have been properly established by the claimant. Patient compensation funds are typically funded through a surcharge on insurance premiums or other type of fee or

[4] Article 12C authorized the PICF Study Board in its proposed emergency rules to “[e]stablish any additional requirements and criteria consistent with and necessary to effectuate the provisions of this article.” W. Va. Code § 29-12C-2(a)(8).

assessment imposed on health care providers. Many such funds serve as an excess layer of insurance coverage having a monetary limit per occurrence for which it will be responsible, as well as an aggregate annual limit for each participating provider.

At least ten states[5] have a law that authorizes the establishment of a patient compensation fund. These funds were established during the 1970s liability insurance crisis in an attempt to increase the availability and reduce the cost of medical malpractice insurance by creating a more attractive market for medical malpractice insurers. These statutes in effect created a guaranteed source of “excess insurance” for health care providers, redistributed the costs of maintaining the availability of insurance, and attempted to provide a more reliable and efficient compensation mechanism for persons negligently injured through malpractice.[6] A summary and comparison of the Patient Compensation Funds is attached to the Report as Exhibit 1. These “excess coverage” patient compensation funds provide another layer of coverage for settlements and judgments in a medical liability action above a defined amount. Eight of the funds are currently active and have been in operation since the mid-1970s. Florida and Wyoming patient compensation funds are currently inactive and the Pennsylvania Fund is scheduled to be phased out by 2009.[7]

Two states, Florida and Virginia, have established limited purpose funds that compensate families whose babies are born with neurological impairment due to oxygen deprivation or by mechanical injury at birth. If the health care provider participates in these funds, a plaintiff’s exclusive remedy is to seek recovery from the fund for injuries subject to fund coverage. The Virginia Birth-Related Neurological Injury Compensation Act was enacted in 1987 in response to medical liability insurance availability problems for obstetricians. The Florida legislature

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[5] Florida, Indiana, Kansas, Louisiana, Nebraska, New Mexico, Pennsylvania, South Carolina, Wisconsin and Wyoming.

[6] As contemplated under the provisions of Article 12C, the PICF would not necessarily serve to increase the “availability” of insurance from the primary market or necessarily reduce the cost of medical professional liability insurance since the Fund is accessible in only two rather narrow situations.

[7] Due to a deficit of more than $2 Billion, the Pennsylvania Legislature is phasing out the CAT Fund and replacing the fund with the Medical Care Availability Reduction of Error Act (MCARE) fund.

created the Birth-Related Neurological Injury Compensation Association (NICA) in 1988 following the recommendations by a task force examining medical liability insurance and tort reform. NICA is modeled on Virginia's birth injury program.

In addition to West Virginia, at least two other states, Ohio and Connecticut, have recently studied the feasibility of establishing a patient compensation fund.

The PICF Board was created to "study the feasibility of establishing a patient injury compensation fund to reimburse claimants in medical malpractice actions for any portion of economic damages awarded which are uncollectible due to statutory limitations on damage awards for trauma care and/or the elimination of joint and several liability of tortfeasor health care providers and health care facilities."[8] The PICF Board is comprised of three members: the Director of the West Virginia Board of Risk and Insurance Management; the West Virginia Insurance Commissioner and the President of the West Virginia Hospital Association.

Guiding Principles

The PICF Study Board is charged with making a report and recommendations to the Joint Committee of Government and Finance of the West Virginia Legislature in December 2003. In fulfilling its charge the PICF Board developed the following guiding principles for consideration in developing a West Virginia Patient Injury Compensation Fund:

- An actuarial study is needed to support the PICF Study Board's recommendations and the results of this study should be included in the final Report.
- Initially, the PICF should be based on a funding plan that has a three-year time frame with a "look-back" mechanism that allows for the review and assessment of all initial assumptions to confirm whether the fund is based on actuarially sound and historically accurate information.
- The source of funding for the PICF should be continuous in nature and subject to an annual adjustment depending on the actuarially-determined needs of the PICF.

[8] W. Va. Code § 29-12C-1(a).

- PICF funding should be based on the principle that the tort system was created in response to societal issues and it requires that negligently injured persons be compensated in an adequate and reasonable manner. The source of funding can be similarly viewed, that is, the benefit of having a PICF accrues to all persons and not just the health care providers and health care facilities. Therefore, consideration should be given to the source of funding of the PICF as being as broad-based as possible. Payments from the PICF must be structured in a manner that prevents them from being open-ended and ensures a linkage to normal insurance policy limits. Payouts from the PICF in any given fiscal year should not exceed the available funds for that year.

- The PICF is specifically limited to provide compensation for economic damages in two situations – statutory limitations on damages awarded for trauma care and/or the elimination of joint and several liability. Accordingly, the potential exposure of the fund should be well defined and limited in terms of the potential risk of payments exceeding revenues.

- The date that a claimant becomes eligible to access the PICF for reimbursement should be when the award becomes final and all reasonable means available by law of recovering the award have been exhausted and not the date of the occurrence of the injury.

- The assets of the PICF must be fully protected from being diverted for any other purpose.

- The Study Board should consider the extent of enabling legislation that is necessary to implement the recommendations of the Study Board.

- Recommendations and proposed emergency rules should be completed and included in the Final Report submitted to the Joint Committee on Government and Finance on or before December 1, 2003, or, upon adoption of specific policy issues that have yet to be determined.

House Bill 2122

House Bill 2122, a comprehensive medical liability reform law, was passed on March 8, 2003 and signed into law by Governor Bob Wise on March 11, 2003. In addition to several important medical liability insurance reforms such as reducing the cap on non-economic damages to an inflation-adjusted cap, and establishing the initial funding and capitalization for a physicians' mutual insurance company, H.B. 2122 establishes a cap on total damages on treatment of an emergency condition when the patient is admitted to a designated trauma center including health care services or assistance rendered in good faith by a licensed EMS agency or

employee of a licensed EMS agency and generally abolishes joint and several liability in medical liability actions.

Patient Injury Compensation Fund Study

H.B. 2122 also creates a board to "study the feasibility of establishing a patient injury compensation fund to reimburse claimants in medical malpractice actions for **any portion of economic damages awarded** which are **uncollectible due to statutory limitations on damage awards** for trauma care and/or elimination of joint and several liability of tortfeasor health care providers and health care facilities."[9] [Emphasis supplied]. The legislation authorizes the PICF Study Board to consider all options for identifying funding methods and for the operation and administration of a PICF within the following guidelines[10]:

- BRIM is responsible for implementing, administering and operating the PICF;
- The PICF must be actuarially sound and fully-funded in accordance with GAAP;
- Eligibility for reimbursement is limited to claimants who have been awarded damages in a medical malpractice action but, as certified by BRIM, have been unable to collect all or part of economic damages awarded due to limitations on awards in W. Va. Codes §§ 55-7B-9 [several liability] and 55-7B-9c [emergency care trauma cap]; and
- BRIM may invest the moneys in the fund and use the earnings to pay administration expenses and claims.

Emergency Rules

The legislation further directs the PICF Board to develop proposed emergency rules addressing the following eight areas:

1. Provide the funding mechanism and methodology for processing and timely and accurately collecting funds;
2. Assure actuarial soundness and sufficient moneys to satisfy all foreseeable claims against the PICF;

[9] W. Va. Code § 29-12C-1.
[10] W. Va. Code § 29-12C-1(c).

3. Provide a reasonable reserve fund for unexpected contingencies, consistent with generally accepted accounting principles;

4. Establish appropriate procedures for notification of payment adjustments prior to any payment periods established in which a funding adjustment will be in effect;

5. Establish procedures for determining eligibility for and distribution of funds to claimants seeking reimbursement;

6. Establish the requirements and procedure for certifying that a claimant has been unable to collect a portion of the economic damages recovered;

7. Establish the process for submitting a claim for payment from the PICF; and

8. Establish any additional requirements and criteria consistent with and necessary to effectuate the provisions of the article.[11]

Several Liability

The Medical Professional Liability Act ("MPLA"), passed in 1986 by the West Virginia Legislature, contained limited civil justice reform related to joint and several liability in medical malpractice actions. Under the MPLA, as it existed prior to House Bill 2122, West Virginia health care providers could be held jointly and severally liable[13] for the entire award in medical liability actions if their negligence was twenty-five percent (25%) or more of the negligence attributable to all defendants.[14] The 25% rule only applied to the defendants in the medical liability action at time of verdict.[15] Case law severely restricted the ability of the remaining trial defendants to argue the negligence of an absent tortfeasor, e.g. the so-called "empty chair"

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[11] W. Va. Code § 29-12C-2.
[12] W. Va. Code § 29-12C-2.
[13] The common law rule of joint and several liability allows any defendant in a lawsuit to be held liable for the entire amount of damages, regardless of that defendant's proportion of fault for the injury. Under this rule, defendants who have been determined to be 1% at fault for the cause of the injury can be responsible for 100% of the damages. Joint and several liability separates the responsibility for causing an injury from the responsibility to compensate for that injury. It encourages trial lawyers to focus on any deep pocket defendant that is tangentially-related to a case for payment of all damages.
[14] W. Va. Code § 55-7B-9(b) [1986], repealed by Acts 2003, c. 147.
[15] *Rowe v. Sisters of Pallotine Missionary Soc.*, 560 S.E.2d 491, 500 (W. Va. 2001).

defense.[16] Under these rules, it was not uncommon in medical liability actions for the plaintiff to choose who to settle with prior to trial and then proceed against the other defendants, without limitation, thereby increasing the pressure on the remaining defendants to settle. The 25% rule did not apply to non-party tortfeasors unless there was evidence of contributory negligence by the plaintiff.[17]

House Bill 2122 generally abolishes joint liability in medical professional liability civil actions.[18] For all civil actions filed in West Virginia alleging medical professional liability filed on or after July 1, 2003, courts may only enter judgments of several liability against each defendant in accordance with the percentages of fault attributable to each defendant.[19] Unless otherwise agreed to by all parties, the fact finder is required to answer special interrogatories in such actions involving multiple defendants as to the following:

- The total amount of compensatory damages recoverable;
- The portion of the damages representing noneconomic damages;
- The portion of the damages representing each category of economic loss;
- The percentage of fault attributable to each plaintiff; and
- The percentage of fault attributable to each defendant.[20]

In applying the rule of several liability established in H.B. 2122, a special rule exists prior to the creation and funding of the WV PICF. Until the WV PICF is created, there is a modified several liability standard, in which all defendants at trial share responsibility for the jury award severally, without regard to the liability of any parties who may have settled before the verdict.

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[16] *See, Doe v. Wal-Mart Stores, Inc.* 558 S.E.2d 663 (W. Va. 2001). *But see, Matheny v. Fairmont General Hospital,* 212 W. Va. 740, 575 S.E.2d 350 (W. Va. 2002)("empty chair" prohibition did not prohibit defense closing argument based on causation).
[17] *Rowe v. Sisters of Pallotine Missionary Soc.*, 560 S.E.2d 491, 499 (W. Va. 2001).
[18] W. Va. Code § 55-7B-9.
[19] W. Va. Code § 55-7B-9(c).
[20] W. Va. Code § 55-7B-9(a).

Before the PICF is created, the fact finder may only consider the fault of the parties in litigation when the verdict is rendered and not the fault of any other person who has settled a claim arising out of the same medical injury.[21] The Court must first reduce the judgment based on collateral source payments [W. Va. Code § 55-7B-9a], then reduce it again by any pre-verdict settlements. For each defendant, the Court multiplies the total damages remaining by the percentage of fault attributed to each defendant. The resulting amount of damages is the maximum amount recoverable against each defendant.

After the PICF is created, the fact finder will consider the fault of the parties who have settled before trial in assessing the percentages of fault. In computing the maximum amount recoverable against each defendant, the court multiplies the total amount of damages recoverable by the plaintiff by the percentage of each defendant's fault. However, before entry of judgment as to each defendant, the court must reduce the total verdict by any amounts received by the plaintiff as settlements. If after such mandatory reductions, any defendant's percentage of the verdict is greater than the remaining amounts due the plaintiff, each defendant is liable only for the defendant's pro rata share of the remainder of the verdict.

The new several liability law does not preclude a health care provider from being held responsible for the portion of fault attributable to the negligent acts of the health care provider's agents under claims of vicarious liability.[22] However, a health care provider may not be held liable for acts of a nonemployee under ostensible agency theory unless the alleged agent does not have medical professional liability coverage covering the injury in the aggregate of at least One Million Dollars ($1,000,000).[23] This provision protects a hospital or other health care facility from being sued solely on the basis of its relationship with non-employee health care providers.

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[21] W. Va. Code § 55-7B-9(b).
[22] W. Va. Code § 55-7B-9(g).
[23] W. Va. Code § 55-7B-9(g).

Emergency Condition Trauma Care

In H.B. 2122 the Legislature made legislative findings pertaining to trauma health care services. The Legislature found that:

> . . . the unpredictable nature of traumatic health care services often result in a greater likelihood of unsatisfactory patient outcomes, a higher degree of patient and patient family dissatisfaction and frequent malpractice claims, creating a strain on the trauma care system of our state, increasing costs for all users of the trauma care system and impacting the rights of persons asserting claims against trauma care health care providers, this balance must guarantee availability of trauma care services while mandating that these services meet all national standards of care, to assure that our health care resources are being directed towards providing the best trauma care available . . .[24]

House Bill 2122 establishes a Five Hundred Thousand Dollar ($500,000) limit on all civil damages recoverable in any medical professional liability action for any injury to or death of a patient as a result of health care services or assistance rendered in good faith and necessitated by an "emergency condition" for which the patient enters a health care facility designated as a "trauma center."[25] An "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 body functions, or, with respect to a pregnant woman, a significant risk to the health of the unborn child."[26] The trauma care limit also applies to:

- Health care services rendered by a licensed EMS agency or employee of an EMS agency;[27] and
- Any act or omission of a health care provider in rendering continued care or assistance in the event that surgery is required as a result of the patient's emergency condition within a reasonable time after the patient is stabilized.[28]

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[24] W. Va. Code § 55-7B-1.
[25] W. Va. Code § 55-7B-9c(a).
[26] W. Va. Code § 55-7B-2(d).
[27] W. Va. Code § 55-7B-9c(a).
[28] W. Va. Code § 55-7B-9c(b).

The legislation creates two rebuttable presumptions in favor of the applicability of the emergency treatment trauma center damage cap. First, if a physician provides follow-up care to a patient to whom the physician rendered care or assistance necessitated by an emergency condition for which the patient enters a trauma center and a medical condition arises during the course of the follow-up care that is directly related to the emergency condition, there is a rebuttable presumption that the medical condition was the result of the original emergency condition and that the limit of liability applies to that medical condition.[29]

There is also a rebuttable presumption that a medical condition that arises in the course of follow-up care provided by the designated trauma center health care provider is directly related to the original emergency condition if the follow-up care is provided within a "reasonable time" after the patient's admission to the designated trauma center.[30]

The trauma care damage limit does not apply where the health care or assistance for "emergency condition" is rendered:

- In willful and wanton or reckless disregard of a risk of harm to the patient; or
- In clear violation of established written protocols for triage and emergency health care procedures.[31]

Likewise, the limit does not apply to any act or omission in rendering health care or assistance that occurs after the patient's condition is stabilized **and** the patient is capable of receiving medical treatment as a non-emergency patient or any act or omission in rendering care or assistance that is **unrelated** to the original emergency condition.[32]

H.B. Bill 2122 directed the Secretary of the Department of Health and Human Resources to promulgate emergency rules before July 1, 2003, that specify criteria for the designation of a facility as a trauma center or provisional trauma center, and governing the implementation of a

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[29] W. Va. Code § 55-7B-9c(d).
[30] W. Va. Code § 55-7B-9c(e).
[31] W. Va. Code § 55-7B-9c(f).
[32] W. Va. Code § 55-7B-9c(c).

statewide trauma/emergency care system to include: system design and organization; regulation of facility designation and categorization; and system accountability.[33] On June 27, 2003, the Secretary of DHHR filed emergency rules with the West Virginia Secretary of State governing the administration of the statewide trauma/emergency care system.[34]

According to the Department of Health and Human Resources, there are currently thirteen designated trauma centers in West Virginia, designated as follows:

CAMC – General Division	Level 1
WVU Hospitals, Inc.	Level 1
Tri-State Trauma Center – Cabell-Huntington Hospital	Level II
Tri-State Trauma Center – St. Mary's Hospital	Level II
Weirton Medical Center	Level III
Wetzel County Hospital	Level III
Reynolds Memorial Hospital	Level III
Grant Memorial Hospital	Level III
Jefferson Memorial Hospital	Level III
Stonewall Jackson Memorial Hospital	Level III
Logan Regional Medical Center	Level III
St. Joseph's Hospital (Buckhannon)	Level III
Raleigh General Hospital	Level III

A list of designated trauma centers and emergency medical service (EMS) providers is attached as Exhibit 2.

The trauma reform provisions are designed both to protect existing trauma facilities and to encourage trauma facilities to seek a higher level of designation resulting in a more comprehensive trauma health care system in West Virginia.

Funding Options for the Patient Injury Compensation Fund

Actuarial Funding Determinations

The West Virginia PICF is required to be "actuarially sound" and "fully-funded."[35] BRIM retained the services of AON Risk Consultants, Inc. ("ARC") to review the effects of

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[33] W. Va. Code § 55-7B-9c(k).
[34] 64 C.S.R., Series 27 *Statewide Trauma / Emergency Care System (filed as an emergency rule).*
[35] W. Va. Code § 29-12C-(c) (2).

H.B. 2122 and to provide estimates of the amount of funding necessary for the PICF at two levels of coverage for economic damages: $1 Million and $2 Million. The reader of this Report is directed to the Actuarial Study for limitations on reliance of the findings.

The following table summarizes the actuary's determination of estimated losses covered by the PICF for a "mature" claim filing cycle:

Estimated Required Funding for PICF

Confidence Level	Limited to $1 Million	Limited to $2 Million
Mean	$3,172,753	$4,063,530
10%	$1,049,113	$1,049,113
30%	$2,070,941	$2,456,904
50%	$2,921,918	$3,621,973
75%	$4,239,883	$5,551,055
90%	$5,637,876	$7,582,305
95%	$6,550,921	$8,990,547

Due to the high degree of uncertainty in establishing initial funding requirements and the inherent uncertainty of the projections, it is the recommendation of the Study Board that the PICF be funded at the 95% confidence level. This requires initial funding of approximately $6.6 million dollars. If the Fund is funded at the 95% confidence level, this means that in 95 out of 100 times the PICF should have enough funds to pay total anticipated claims at a $1 Million limit per occurrence. In five out of 100 times, or 5% of the time, total claims paid out would be greater than the amount in the Fund.

The benefits of having a well funded and actuarially sound PICF serves the interests of all citizens of West Virginia and is an important part to maintaining access to quality health care services throughout the state. As envisioned in the Legislative guidelines, the Fund does not act

as an excess layer of insurance, as is the case for many of the compensation funds in other states. Rather, it is to be used in only two narrowly defined circumstances — economic damages awarded above the total trauma limits of $500,000, and the elimination of joint liability. Therefore, the value or benefit of the fund could be viewed in a larger societal context. Moreover, another important consideration is that the PICF complements the tort system and as such, was created in response to societal issues. The funding source, consequently, could be structured in a commensurate fashion and drawn from a wide range of sources. By spreading the funding across a range of groups, the fiscal impact on health care providers could be lessened, and by extension, could lessen the fiscal impact on the cost of health care services.

Principles for Determining the Funding Source

The PICF Study Board suggests consideration of the following principles in determining the mechanism and sources of funding for the Patient Injury Compensation Fund:

1. The sources of PICF funding could be broad-based taxes, surcharges and/or assessments. The goal is to ensure that the responsibility for funding the PICF be spread across a broad range of organizations and professional groups. This recommendation is in conformance with the belief that the benefit of the fund and the underlying legal reforms accrue to society and not any one particular group.

2. In order to avoid the kinds of fiscal crisis that have been faced by other states with similar mechanisms, the Study Board recommends that the funding sources that are ultimately chosen be permanent, continuous, and that it flow into the PICF on a regular basis.

3. Since one of the two provisions served by the fund pertains to trauma related injuries, the Study Board believes one of the sources for funding could be connected to the primary cause of the injuries that result in these patients being brought to the hospital emergency department for care relating to an emergency condition. Examples would include alcohol products (operating motor vehicles under the influence), ATVs (operating these vehicles in an unsafe manner), firearms (trauma related injuries) and automobiles (operating motor vehicles in an unsafe manner).

4. The Study Board identified health care providers as one group that would have some responsibility for contributing to support funding of the PICF, but the burden of funding should not necessarily fall exclusively on health care providers. Consideration could be given to spreading the funding requirements across a range of sources, some of which may be more responsible than others for the root cause of the problem that resulted in trauma treatment.

Every existing patient compensation fund is funded through a surcharge on insurance premiums or other type of fee or assessment imposed directly on health care providers. Many such funds serve as an excess layer of insurance coverage having a monetary limit per occurrence for which it will be responsible, as well as an aggregate annual limit for each participating provider. Assessing health care providers for the costs of funding the PICF may not alleviate concerns regarding the affordability of health care services.

The ten active Patient Compensation Funds throughout the country were examined for their sources of funding. In all states the primary source of funding relied on surcharges or assessments on the hospitals and physicians. In two of the states, Florida and Virginia, a specific Birth related injury fund was established and a fee of $50/live birth was assessed to the hospitals (in addition to physician assessments). Specifically, each state's funding is summarized as follows:

FUND	FUNDING SOURCE
Florida Birth Related Injury Compensation Fund	Hospitals pay $50 per live birth and OB Physicians pay $5,000 annually
Indiana PCF	Hospitals surcharged based on average occupancy. MD & DO's surcharge based on specialty. All others (nursing homes, dentists, etc pay 100% of underlying premium. Minimum of $100.
Kansas Health Care	Majority of funding based on assessment of underlying premium; although some classes pay specific values.
Louisiana PCF	Surcharge on underlying premiums of health care providers.
Nebraska Excess Liability Fund	50% of the underlying premium.

New Mexico	Annual surcharge based of ISO classification
Pennsylvania	Assessment on health care provider base on prevailing primary premium.
South Carolina	Charged to provider base on a percentage of the prevailing JUA rates.
Virginia Birth Related	Hospitals pay $50/live birth and OB Physicians Assessed $5,000.
Wisconsin PCF	Assessments on underlying premiums.

Alternative / Complementary Funding Sources

As an alternative, or as a complement, to a surcharge on medical liability insurance premiums, several alternative methods of raising revenue sufficient to adequately fund the PICF were considered. These methods include fees, assessments, fines and taxes. It is the recommendation of the Study Board that the Legislature consider the following funding sources:

Direct Beneficiaries of Subject Medical Liability Reforms

- Fee per each emergency room visit (e.g. $10 fee for each entry)
- Fee on hospitals per number of hospital beds
- Fee on each ambulance transport
- Fee per licensed health care provider (broadly defined under the MPLA)

Causes of Traumatic Injury[36]

- Motor Vehicle Accidents (e.g. fee added to each moving violation)
- All-terrain vehicles and other recreational vehicles (e.g., a special $10 tax per vehicle assessed at the point of retail sale of a new ATV or other recreational vehicle)
- Alcohol
- Firearms and ammunition

[36] According to data published in the National Trauma Bank Annual Report for 2003, motor vehicle crashes accounted for 39% of cases reported to the Data Bank. Gunshot wounds were the 3rd most common injury category. Violent injuries (gunshot, stab wounds, assault) utilize 13.4% of hospital days and 13.1% of ICU days.

Broader Based

- Surcharge on insurance policies (medical liability insurance, casualty policies and/or health insurance policies)
- Soft Drinks
- Fee on malpractice contingency fees
- Tobacco tax
- Lottery Proceeds

ELIGIBILITY

The Study Board considered the eligibility requirements for reimbursement of economic damages from the Fund. The Legislature prescribed specific limitations for who is eligible for reimbursement from the PICF:

> Eligibility for reimbursement from the patient injury compensation fund is limited to claimants who have been awarded damages in a medical malpractice action but have been certified by the board of risk and insurance management to be unable, after exhausting all reasonable means available by law of recovering the award, to collect all or part of the economic damages awarded due to limitations on awards established in sections nine [§ 55-7B-9] and nine-c [§ 55-7B-9c], article seven-b, chapter fifty-five of this code . . .[37]

Article 12C does not define "claimant." The MPLA also does not define "claimant," but does however define both "patient" and "plaintiff". "For purposes of the MPLA, the word "plaintiff" is defined as "a **patient or representative of a patient** who brings an action for medical professional liability under this article."[38] Patient" is defined in the MPLA as "a natural person who receives or should have received health care from a licensed health care provider under a contract, expressed or implied."[39]

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[37] W. Va. Code § 29-12C-2(c)(3).
[38] W. Va. Code § 55-7B-2(m) (Emphasis added). "Representative" is defined as "the spouse, parent, guardian, trustee, attorney or other legal agent of another."
[39] W. Va. Code § 55-7B-2(l).

The use of the undefined word "claimant" may create some ambiguity and have the unintended result in broadening the class of "eligible claimants." In *Osborne v. United States,* 211 W. Va. 667, 567 S.E.2d 677 (2002) the West Virginia Supreme Court of Appeals interpreted the "differentiation in terminology" between "person" and "patient" as used in the definition of "medical professional liability" contained in W. Va. Code § 55-7B-2(d). The Court held that the provisions of the MPLA permit a third party [i.e. a "non-patient"] to bring a cause of action against a health care provider for foreseeable injuries that were proximately caused by the health care provider's negligent treatment of a tortfeasor patient.

It is the recommendation of the PICF Study Board, that reimbursement of economic damages under the WV PICF be clarified to limit reimbursement only to persons satisfying both the definitions of "patient" and "plaintiff" under the MPLA and who have been unable, as certified by BRIM, after exhausting all reasonable means available by law of recovering an award, to collect all or part of the economic damages awarded due to limitations on awards established in Sections 9 and 9c of the MPLA.

Coverage Limits

Payments made by the Fund are limited to reimbursement to eligible claimants for "economic damages" only.[40] In the broadest sense, economic damages are compensation for objectively verifiable monetary loss such as past and future medical expenses, loss of past and future earnings, loss of use of property, cost of repair or replacement, and the economic value of domestic services, loss of employment or business opportunities. "'Noneconomic loss' means losses, including, but not limited to, pain, suffering, mental anguish and grief."[41] Although payouts from the Fund are limited to economic damages only, the Study Board identified areas of concern with respect to the total Fund payout for any single occurrence and the possibility of a

[40] W. Va. Code § 29-12C-1(c)(3);
[41] W. Va. Code § 55-7B-2(k).

large number of multiple payouts for any one particular health care provider in a short period of time.

In order for the fund to remain viable over the long-term, the total payout from the Fund for any single qualifying occurrence should be limited to an amount no greater than the Fund Limit of One Million Dollars ($1,000,000). Like the non-economic damage cap,[42] the maximum amount recoverable from the PICF should not exceed the Fund's per occurrence limit "regardless of the number of plaintiffs or the number of defendants or, in the case of wrongful death, regardless of the number of distributees. . ." Six of the eight states with active patient compensation plans, other than Pennsylvania and South Carolina, impose a cap on damages. Indiana and Nebraska cap total damages at $1.25 million for health care providers covered by the PCF. Louisiana and New Mexico cap total damages except for future medical care. Louisiana imposes a $500,000 cap and New Mexico imposes a $600,000 cap. Kansas and Wisconsin cap noneconomic damages. Kansas's noneconomic damage cap is $250,000 and Wisconsin's inflation-adjusted cap is about $425,000. Wisconsin further caps total damages for wrongful death ($500,000 for children and $350,000 for adults), Importantly, Indiana, Louisiana, New Mexico, and Wisconsin are among the six states identified by the American Medical Association as not exhibiting any problems with respect to the cost or availability of medical liability insurance. Pennsylvania's CAT Fund has an unfunded liability of over $2 Billion.

In addition, to avoid the Fund being depleted due to many negligent actions of an individual health care provider, consideration should be given to establishing an annual aggregate cap for any single health care provider especially for claims made due to the joint and several liability reforms. Currently, the Nebraska Patient Compensation Fund may be in an unsound financial condition or possibly insolvent because of approximately eighty (80) known

[42] W. Va. Code § 55-7B-8(a).

lawsuits filed against one doctor in connection with a hepatitis C outbreak allegedly caused by unsanitary office conditions. It is not difficult to envision a scenario where a physician's insurance coverage is canceled or non-renewed due to adverse claims history and the physician is unable or unwilling to purchase tail coverage or to obtain prior acts coverage. Plaintiffs filing claims after the expiration of the physician's claims made policy would look to the physicians' assets to satisfy any awards made against the physician and then, in appropriate cases, come to the PICF seeking payment for economic damages.

Finally, reimbursement from the PICF should not be required where there are other adequate and fair compensation programs in place. For instance, the PICF should not be required to supplement a medical liability claim that is covered under the West Virginia Insurance Guaranty Association Act.[43] In addition, consideration should also be given to limiting the total amount of economic damages payable by the PICF to $500,000 in the event of any civil action subject to the trauma cap against a state facility or state EMS provider or employee of a state EMS provider. This would serve to compensate the injured plaintiff up to the limit of the state's liability insurance policy. In both situations, the injured plaintiff would be in the same position both before and after the subject reforms of H.B. 2122.

PICF Operation and Administration

The Legislature established the guideline that BRIM would be responsible for implementing, administering, and operating the WV PICF, when and if established.[44] BRIM is governed by a five-member board.[45] The BRIM Board has general supervision and control over the insurance of all state property, activities and responsibilities.[46] In addition, to managing the state insurance program, BRIM currently administers the mine subsidence fund, the Senate Bill 3

[43] W. Va. Code §§ 33-26-1 et seq.
[44] W. Va. Code § 29-12C-(c) (1).
[45] W. Va. Code § 29-12-3.
[46] W. Va. Code § 2912-5.

insurance program, and the Preferred and High Risk health care professional liability programs for private physicians, hospitals, and health care facilities.

The West Virginia PICF is to be implemented, administered and operated by the West Virginia Board of Risk and Insurance Management.[47]

The Assets of the PICF Should be Protected

The PICF Study Board also recommends that the Legislature clarify that the fund itself be preserved for the benefit of those contemplated by the Legislature as needing access to the PICF, and that the fund can not be appropriated for any other use or purpose. A similar provision was passed by the State of Wisconsin earlier this year after the Governor suggested taking several hundred million dollars out of the Wisconsin PCF. Specifically, the Wisconsin law provided that "the fund is held in trust exclusively for the benefit of health care providers and proper claimants and may not be spent for any other purpose of the state." [48]

The West Virginia PICF should be established as a segregated fund and dedicated solely to reimbursement of economic damages to qualified patient-plaintiffs and the payment of administrative fund costs out of earnings. The assets of the WV PICF should not be used for any other purpose and may not be used to subsidize in any manner other state funds.

In addition, the PICF legislation should provide that if claims exceed reserves at the end of the calendar year, all claims should be prorated and satisfied to the extent of existing assets, so that Fund deficits are avoided. The Study Board would also recommend that the enabling legislation provide that the PICF shall not be considered a defendant in any medical liability action under the MPLA and that the Fund and its administrator shall not be considered an insurance company or insurer for any purpose under West Virginia law.

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[47] W. Va. Code § 29-12C-(c)(1).
[48] Wis. Stat. § 655.27(6).

Periodic Payments / Structured Settlements

Periodic payment of certain economic damages (i.e. future medicals and future lost earnings) would allow the PICF to divide the payment of an award over time instead of making one lump sum payment. This would lessen the immediate fiscal impact of an award and help to stabilize the operations of the Fund. Many states allow periodic payment of damages, including Alabama, Alaska, Arkansas, Arizona, California, Colorado, Delaware, Florida, Iowa, Idaho, Illinois, Indiana, Louisiana, Maryland, Maine, Michigan, Minnesota, Missouri, Montana, North Dakota, New Hampshire, New Mexico, New York, Ohio, South Dakota, Utah, Virginia, Washington and Wisconsin.

Critics of periodic payments argue that such payments are unfair to negligently injured persons because it removes the possibility for the investment of a large lump sum payment. Conversely, it could be argued that allowing for periodic payments or structured settlements for payment of future medicals and future lost earnings would prevent an injured party from using the proceeds from the Fund for unintended purposes. It would also help to ensure that an injured party would receive a periodic future stream of income to cover expenses for future medicals and future living expenses as those expenses are actually incurred.

Investment Management

For the existing PCFs, investment management is usually the responsibility of either the Board of Governors or the appropriate state agency in charge of investment strategies for other state funds. Invested assets of the WV PICF should be managed by the State Investment Management Board in the same manner as the other financial assets held by BRIM.

Annual Actuarial Review

Most existing PCFs require an annual review of the liabilities and reserves of the PCF. Many PCFs also use this review as an opportunity to review PCF assessment (surcharge) rates.

These actuarial services are either outsourced to independent qualified actuaries or provided by the actuarial staff of the state's Department of Insurance. In order to maintain the fiscal soundness of the WV PICF, it is the recommendation of the PICF Study Board to have an annual actuarial review of the liabilities and reserves of the WV PICF conducted by the outside actuary performing the actuarial review of BRIM's other programs.

The Legislature directed that the proposed emergency rules, in part, "[a]ssure the actuarial soundness the patient injury compensation fund and sufficient moneys to satisfy all foreseeable claims against the patient injury compensation fund, giving due consideration to relevant loss or claim experience or trend and normal costs of operation" and to "[p]rovide for a reasonable reserve fund for unexpected contingencies consistent, with generally accepted accounting principles"[49] In order to accomplish the aforementioned, it is proposed that an annual actuarial review should be performed by a qualified outside actuary. An independent actuary will also review the current case reserves and establish an IBNR (incurred but not reported reserve). GAAP financials will be prepared that include the IBNR liability, the cash on hand and any other related assets and liabilities of the Fund. On an annual basis, these financial statements will be audited as part of BRIM's overall financial statement audit, with the separate financial statements of the Fund broken out in the "Other Financial Information" Section of BRIM financial statements. The actuarial review can further be used to review the funding on an annual basis to review the current adequacy of the rates or charges assessed and to establish the rates to be charged [e.g. assessed on the members of the funding source(s)].

The effectiveness of any PICF legislation should be reviewed periodically, with special attention to the impact of the tort process, the ability of the Fund to satisfy claims, the review and assessment of all initial assumptions to confirm that the Fund is based upon actuarially sound

[49] W. Va. Code §§ 29-12C-2(a)(2) and (3).

and historically accurate information. The PICF Study Board recommends that such a study be conducted after three years with recommendations regarding revisions to the enabling legislation, including the legislative rules, to ensure the continued economic viability and stability of the Fund.

Reinsurance

BRIM, as the program administrator, should be authorized to cede to an authorized or approved reinsurer any or all of the PICF risk or to pursue other loss funding management to preserve the solvency and financial integrity of the fund. This would provide the Fund and BRIM with the flexibility to take advantage of market opportunities to transfer risk. Objective guidelines should be developed by BRIM for transferring the risk of the PICF program, including a minimum financial strength rating and company size and some regulatory approval requirements.

Other Issues and Recommendations

In addition to the foregoing recommendations, we would also recommend that due consideration be given to: (1) whether, and to what extent, the PICF be authorized to engage in settlements and make settlements payments in medical liability actions; (2) whether a review board should be established to act as a factfinder in certain cases; (3) whether health care providers should be required to carry medical liability insurance or to otherwise establish financial responsibility; (4) whether, and to what extent, should the State's liability for activities of the PICF be limited; (5) what are some ways for improving the information that is available regarding the outcomes of medical liability civil actions; and,.(6) whether attorney contingency fees paid out of the PICF should be limited.

Settlements

1. Would Limiting Access to the PICF to Claimants having Judgments Encourage Litigation?

Several issues are raised within the statutory guidelines relating to the Study Board's activities. For example, the Legislature has stated that the PICF is to be a source of funds for claimants who have been awarded damages in medical malpractice actions, meaning that by the time the PICF is reached there would already have been a judgment order entered. In addition, House Bill 2122 states that the PICF is for the collection of economic damages, as opposed to non-economic damages, that plaintiffs are otherwise unable to collect as a result of the two designated legal reforms. Finally, House Bill 2122 indicates that the PICF is to be reached only after all reasonable means available by law for recovering the award have been exhausted by the claimants.

The PICF Study Board has considered whether the fund should be reached pursuant to a settlement in addition to a completed trial with a jury verdict and a judgment order. Some states with patient compensation funds allow settlements to be paid from the fund as well as judgments. A concern was expressed that by limiting the ability to reach the fund to having first obtained a jury verdict and a judgment order, proceeding to trial in certain cases may actually be encouraged. For example, a claim that arises out of treatment of an emergency condition at a trauma center could, under easily conceived circumstances, be so severe that economic damages for the remaining life of the patient could exceed the five hundred thousand dollar cap imposed by West Virginia Code Section 55-7B-9c. In this case, the defendants or their insurers could be very willing to settle for the five hundred thousand dollar cap and avoid the trial altogether. The plaintiff, however, cannot reach the PICF without a judgment under the current law. For this reason, the Legislature may wish to consider allowing settlements as well as judgments to be paid from the PICF in certain limited situations. It's unlikely that the intent behind H.B. 2122 was to actually encourage litigation, although that could be the unintended consequence if the only way to reach the PICF is to proceed to trial and obtain a judgment.

Further, if a plaintiff must go to trial in order to eventually reach the PICF, in a case where economic damages could easily exceed the five hundred thousand dollar emergency condition cap, it would be advisable for the PICF to have notice and an opportunity to defend at trial. In such a case, the only entity with any genuine interest in preserving the assets of the PICF would be the PICF itself.

In addition to increasing costs of administration,[50] concern was also expressed that by permitting claimants to have access to the PICF when the underlying matter is settled, could have the effect of the parties (plaintiff and defendant health care providers) modifying their behavior to access the PICF. The consequence of making the PICF easily accessible could result in the PICF becoming financially unsound and result in additional cost shifting from health care providers and their insurers to the PICF.

Therefore, with regard to emergency condition cases that could be subject to the five hundred thousand dollar cap, the Legislature may wish to carefully consider allowing settlements in addition to judgments awarded, be paid out of the PICF. Often settlements are less than a jury may award as damages in civil litigation. Conversely, in medical liability actions, the defendants usually prevail in a majority of cases going to trial. Since 2001, the state-insured defendants under BRIM's liability policy have prevailed in 13 of 14 cases going to trial (93%). See Exhibits 3, 4, 5 and 6 for additional analysis of the issue with respect to authorizing the Fund to engage in settlements. In any event, it may be prudent to require notice of claims to the PICF that arise out of emergency treatment that could be subject to the five hundred thousand dollar cap so that the fund is able to protects its interests, whether they relate to a trial or a settlement.

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[50] Administrative costs of the PICF are to be paid out of the earnings of the Fund. W. Va. Code § 29-12-1(c)(4). If the PICF is involved in defending at trial, its administrative costs may likely exceed the amount available to pay such costs. If it is determined that the Fund is not limited to being a fund of last resort (e.g. exhaust all reasonable means to collect) then authorization to pay administrative costs, including the defense costs, should be permitted out of the principal of the Fund.

2. Should Settlements be Paid from PICF that are Based on Joint and Several Liability Reforms?

Allowance of settlements to be paid out of the PICF relating to claims that are uncollectible because of the joint and several liability reforms are admittedly more problematic. It could be more difficult through the settlement process to determine whether any of the defendants would bear some degree of liability and be uninsured or otherwise without sufficient assets to satisfy his or her percentage of liability.[51] It would be necessary through the settlement process to determine the ability to satisfy judgment, as well as determine the percentage of fault of multiple defendants. In addition, the issue relating to notice and an opportunity to defend that is mentioned in the section above would continue to apply, and would in fact be extended to any case in which any defendant is uninsured or otherwise unable to satisfy his or her potential liability. If settlements are allowed to be paid from the PICF there would need to be a mechanism within the settlement process to determine degree of liability and availability of insurance or personal assets to satisfy that degree of liability. A limited arbitration or other limited medical review panel could serve this purpose.

If settlements are authorized in any enabling legislation, another alternative would be to establish an administrative hearing procedure at the Board of Risk and Insurance Management or other designated review panel to take evidence and make administrative determinations of fact and law, subject to appropriate judicial appellate review, on behalf of the Fund regarding the eligibility, degree of liability of the respective health care providers and plaintiffs, and the availability of insurance or personal assets to satisfy any apportioned liability. The administrative hearing officer could serve as a fact-finder for a determination of eligibility and

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[51] As will be discussed later in this report, one way to avoid exposure of the fund due to uncollectibility resulting from the joint and several reforms would be to require all health care providers licensed in West Virginia to carry professional liability coverage. This requirement would greatly simplify the settlement process and limit the instances in which joint and several liability reforms trigger exposure of the PICF.

the amount of economic damages in cases subject to the trauma cap if the health care providers in the underlying medical liability action settle for the $500,000 cap.

3. Limiting Liability of PICF by Requiring Professional Liability Insurance of Health Care Providers

One way to address the potential difficulties relating to administration of the fund with regard to several liability is to limit as much as possible the instances in which any defendant would not have resources available to satisfy a potential claim. For example, the Legislature elected to make the non-economic damages cap pursuant to West Virginia Code Section 55-7B-8 available only to defendants with medical professional liability insurance in the amount of at least one million dollars per occurrence covering the medical injury, which is the subject of the action.[52] The Legislature could extend that insurance requirement to the joint and several liability reforms, so that any defendant not having coverage through an insurer approved by the Insurance Commissioner of at least one million dollars per occurrence could be liable from personal assets for any amount the plaintiff is entitled to collect, even if that amount exceeds the defendant's percentage of liability. An uninsured defendant's personal assets could be at risk and the PICF could only be liable after the uninsured defendant's personal assets had been exhausted. The five hundred thousand dollar cap on all damages arising from emergency care could also be made dependent upon the defendant being insured by an approved insurer. As an alternative to making these reforms available only for those having appropriate coverage, the Legislature could require that the maintenance of satisfactory professional liability insurance is a condition of obtaining and maintaining licensure as a health care provider in this State.

4. Notice and Opportunity to Defend

[52]In H.B. 2122, the Legislature conditioned certain reforms on the requirement that the health care provider have at least One Million Dollars of medical liability insurance. *See, e.g.,* W. Va. Code § 55-7B-8(d)(noneconomic loss cap); W. Va. Code § 55-7B-9(g)(eliminating ostensible agency liability unless the alleged agent does not have medical liability insurance of at least One Million Dollars); W. Va. Code § 38-10-4 (homestead exemption increased to $250,000 for a physician who has to declare bankruptcy because of a medical liability payment provided the physician maintains One Million Dollars in professional liability coverage.

The PICF Study Board's concern about notice and an opportunity to defend the fund arises out of a concern that the only party involved in a medical malpractice claim with any incentive or desire to limit the fund's exposure would be the PICF itself. If the Legislature determines that the PICF should have notice and an opportunity to defend whether in connection with settlement or trial, it may wish to make liability of the PICF contingent upon such notice. Notice of civil actions filed for injury or death arising out of medical malpractice could be given to the fund by requiring the plaintiff to serve a copy of the complaint upon the Fund within a brief period of time following the actual filing date. The Fund could have the option of employing independent counsel to represent the interests of the fund, or relying upon the defense provided by insurers involved in the civil action. With regard to settlements (if settlements are to be paid from the PICF), when insurers of health care providers have agreed to settle liability on claims against their insureds under circumstances in which it is reasonably likely that the PICF will be exposed, the PICF should be entitled to designate personnel with settlement authority who may negotiate an amount to be paid from the fund. The PICF should also be allowed to employ independent counsel to represent its interests in these negotiations. All of these defense related activities of the fund substantially increases the cost of administration.[53]

5. An Alternative to Allowing Settlements to be Paid from the PICF

As an alternative to allowing settlements to be paid from the fund, the Legislature could clarify the existing approach to payment from the PICF by stating that in any claim in which the insurer of a health care provider has agreed to settle its liability on a claim against its insured and the claimant's demand is in excess of the settlement amount, and in which circumstances exist that would indicate a likelihood that the PICF could be exposed, an action must be filed by the claimant against the health care provider in a court of appropriate jurisdiction for the alleged

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[53] Earnings from the Fund may not be sufficient to Fund these increased costs of administration.

damages. This would essentially force litigation to occur even though the defendants are willing and able to settle for the emergency care cap, or it becomes evident that the defendant with the majority of liability is without the financial wherewithal to satisfy his portion of liability. If an action is already pending against the health care provider at the time that settlement negotiations take place and the exposure of the fund becomes likely, the pending action would continue to be conducted in all respects as if the insurer had not agreed to settle. The Legislature could require that such actions be defended by the insurer in all respects as if the insurer had not agreed to settle its liability.

The insurer could be reimbursed from the PICF for the costs of the defense it provides that were incurred after the settlement agreement was reached with the insurer, including a reasonable attorney's fee not to exceed any limitation otherwise established by the PICF for attorney's fees. The PICF should nonetheless be authorized to employ independent counsel if it considers that necessary. These activities would increase cost of administering the PICF and potentially increase liability payouts since the defendant's insurer's contribution would be limited to the amount which it had agreed with the plaintiff to settle its liability. In a case with multiple defendants, for example, the plaintiff may agree to settle for a small amount of money with the defendant having the most liability. Other defendants in the case may not bear sufficient liability to fully compensate the plaintiff for his or her damages. The plaintiff, however, may decide to pursue the PICF as the primary target.

Limitation of State Liability

BRIM is a state agency charged with the administration of the PICF. Its board members are appointed by the Governor and its employees are state employees. Provided that the PICF receives no state appropriation, claims made against the Fund and the expenses of the Fund are paid from fees collected from assessments, surcharges or fees. Adding a provision to the PICF

enabling legislation addressing the state's liability would help ensure that the state is not responsible for the PICF's claims. The statute creating the Pennsylvania Medical Professional Liability Catastrophe Loss Fund contained language addressing the state's liability: "No claims or expenses against the fund shall be deemed to constitute a debt of the Commonwealth or a charge against the General Fund of the Commonwealth."[54]

Given that the Fund is to be actuarially sound and fully funded, it is recommended that the Legislature consider inserting a specific provision in enabling legislation specifying that the State is not liable for any claims subject to or against the West Virginia Patient Injury Compensation Fund.

Improved Data Reporting and Collection

The Study Board and its actuary had difficulty in obtaining reliable, relevant and credible data regarding trauma claims, joint and several liability information, detailed information breaking down damage awards by type of damages, the number of medical malpractice civil actions filed in West Virginia, and the number of health care providers in West Virginia.

Information is collected by various state and federal agencies. On medical malpractice claim payments, information is collected by the National Practitioner Data Bank, the West Virginia Board of Medicine and the West Virginia Insurance Commission. All such data has its inherent limitations and is not readily or easily comparable. In addition to individual claim payment information, insurance companies are required to file aggregate claim payment information as part of the financial statements filed with the State Insurance Commissioner.

The Insurance Commissioner is currently evaluating the kinds of additional data that would enable her to provide better information concerning medical malpractice and related insurance issues. The Commissioner is reviewing statutory and rule requirements for reporting

[54] 40 Pa. Cons. Stat. § 1307.701.

medical malpractice information to determine if they should be modified so that more detailed and specific information is obtained.

Limits on Payment of Attorney Fees from PICF

Traditionally, plaintiffs' attorneys are paid on a contingency fee basis in medical liability civil actions. They receive payment only if they win and, if they win, they receive a percentage (typically 33 1/3% or higher) of the award. Some argue that the contingency fee system results in excessive payouts for lawyers. Many states limit the total amount of an award that a lawyer may receive in contingency fees.

The purpose of the PICF is to reimburse plaintiff patients unable to collect all or part of the economic damages awarded to them in a medical liability action either due to limitations on awards for trauma care or the elimination of joint liability. Reasonable and fair limitations on attorneys' fees on payments made by the PICF would result in the injured plaintiff-patient receiving a larger share of the reimbursement of his or her economic damages without a corresponding increase in the loss costs of the PICF.

Another possible benefit of limiting or managing attorneys fees for malpractice cases might reduce the number (frequency) of medical liability claims, by making such actions less financially attractive to attorneys. However, an unintended consequence if the limitation was too great could possibly be a reduction of meritorious claims as well as non-meritorious claims. There are several possible alternatives exist for limiting or managing attorneys fees:

- **Sliding Scale** Limit the total amount of fees an attorney may receive based upon a statutory sliding scale. California, Connecticut, Delaware, Florida, Illinois, Indiana, Massachusetts, Maine, Michigan, New Jersey, New York, Oklahoma, Oregon, Tennessee, Utah, Wisconsin and Wyoming.

- **Subject Contingency Fees to Review.** A less restrictive alternative to placing limits in all attorney fees is to make large payouts subject to review by a court or screening panel. Arizona, Hawaii, Iowa, Maryland, Nebraska, New Hampshire, Nevada and Washington have passed such measures.

- **Fixed Fee.** Pay attorney representatives a fixed fee for assisting a patient-plaintiff in seeking reimbursement from the Fund.

- **Hourly Basis.** Reimburse attorneys on a set hourly fee, billed in tenths of hours, for representation of successful claimant before the Fund.

The PICF Study Board recommends payment of reasonable attorney fees from the total amount awarded by the PICF within coverage limits where necessary and related to the Fund, but also recommends limitations on such attorney fees. Such limitations could take the form of a reduced set hourly rate, billed in tenths of hours, with limits on litigation costs that may be passed on to the PICF, or a percentage of the amount paid from the fund, on a sliding scale basis depending upon the size of the amount paid by the fund. Because the emphasis of the PICF is on the patient, and insuring that the patient is able to recover any damages he or she may prove, it is recommended that attorney's fees payable from the fund be limited.

For example, the patient compensation fund feasibility study prepared by Pinnacle Actuarial Resources, Inc. for the Ohio Legislature recommends a sliding scale on contingency fees similar to California's MICRA: 40% on the first $50,000 of damages; 33% on the next $50,000; 25% on the next $500,000; and 15% of an amount exceeding $600,000. The Ohio study predicted that limiting contingency fees could increase payments to injured patients by 12% of total damages and would not add to costs of administering the system.

[55] 40 Pa. Cons. Stat. § 1307.701.

Exhibit 1 Patient Compensation Fund State Comparison

	Florida Birth-Related Neurological Injury Compensation Association	Florida Patient Compensation Fund	Indiana Patient Compensation Fund	Kansas Health Care Stabilization Fund	Louisiana Patient Compensation Fund	Nebraska Excess Liability Fund	New Mexico Patient Compensation Fund	Medical Care Availability and Reduction of Error (Mcare) (PA)	South Carolina Patients Compensation Fund	Virginia Birth-Related Injury Compensation Fund	Wisconsin Patient Compensation Fund
Goal of PCF	To provide an exclusive no-fault remedy for birth-related neurological injury claims	"paying out that portion of any claim arising out of the rendering of or failure to render medical care services…for health care providers…which is in excess of the fund entry level"	To provide a system of excess insurance for health care providers	"to provide excess professional liability coverage for defined health care providers"	"to guarantee that affordable medical malpractice coverage was available to all private providers"	"an alternate way to determine medical malpractice claims and to ensure that malpractice insurance coverage in Nebraska is available at reasonable rates."	"to promote the health and welfare of the people of New Mexico by making available professional liability insurance for health care providers in New Mexico"	"to pay claims against participating health care providers for losses or damages awarded in medical professional liability actions in excess of the basic insurance coverage required"	To pay that portion of a medical malpractice or general liability claim, settlement, or judgment against a licensed health care provider which is in excess of $100,000	The exclusive remedy for birth-related neurological injuries in Virginia	"(T)o provide excess medical malpractice coverage for health care providers."
Enabling Legislation	Florida Statute 766.303	Florida Statute 766.105	IC 34-18	K.S.A. 40-3401 K.S.A. 40-3419	R.S. 40:1299.41 R.S. 40:1299.48	Neb. Rev. Stat. 44-2801-2855	N.M.S.A. 41-5	MCARE Act	Code of Laws, Section 38, Chapter 79	V.C.A. 38.2-5000 V.C.A. 38.2-5021	W.S. 655.27
Creation Date	1988	1975	1975	1976	1975	1976	1978	2002	1976	1987	1975
Governance	5 Member Board of Directors	11 Member Board of Governors	Commissioner of Department of Insurance	10 Member Board of Governors	PCF Oversight Board	Director of Department of Insurance	Director of Department of Insurance	DOI Administers the Fund	13 Member Board of Governors	7 Member Board of Directors	13 Member Board of Governors
Participation	Voluntary	Hospitals Mandatory, Physicians Voluntary	Voluntary	Mandatory	Voluntary	Voluntary	Voluntary	Mandatory	Voluntary	Voluntary	Mandatory, with exemptions

	Florida Birth-Related Neurological Injury Compensation Association	Florida Patient Compensation Fund	Indiana Patient Compensation Fund	Kansas Health Care Stabilization Fund	Louisiana Patient Compensation Fund	Nebraska Excess Liability Fund	New Mexico Patient Compensation Fund	Medical Care Availability and Reduction of Error (Mcare) (PA)	South Carolina Patients Compensation Fund	Virginia Birth-Related Injury Compensation Fund	Wisconsin Patient Compensation Fund
Eligibility	Physicians	Physicians, Hospitals	Physicians, Hospitals	Physicians, Osteopaths, Chiropractors, Podiatrists, RNAs, Medical Care Facilities, Mental Health Clinics, Dentists, health Care LLCs Corps, etc.	Physicians, Hospitals	Physicians	Physicians, Hospitals	Physicians, Hospitals	Physicians, Hospitals	Physicians, Registered Nurses, Midwives, Hospitals	Physicians, Osteopaths, RNs, Nursing Homes, Hospitals, Ambulatory Surgery Centers, Cooperative sickness care associations
Required Primary Coverage (000)		$250/claim or $500/occurrence	Physicians $250/$750, Hospitals $250/$5,000,	$200/$600	$100/$300	Physicians $200/$600, Hospitals $200/$1,000	$200/$600	Physicians $500/$1.5M, Hospitals $500/$2.5M	$100/$300	Not applicable, exclusive remedy	$1,000/$3,000
Primary Coverage Options		Private Insurance or qualified Self-insurance (for Hospitals), of JUA	Private Insurance or Qualified Self-Insurance (for Hospitals)	Private Insurance or qualified Self-Insurance	Private Insurance or qualified Self-Insurance	Private Insurance or qualified Self-Insurance	Private Insurance	Private Insurance, JUA or qualified Self-Insurance	Private Insurance or qualified Self-Insurance	Not applicable, exclusive remedy	Private Insurance, WHCLIP, or qualified Self-Insurance
PCF Coverage Limits	Unlimited	Physicians either $1M/3/M or $2M/$M (including entry limits), Hospitals $2.5M per claim (no agg.)	$1.0M per occurrence in excess coverage	1) 100/300, 2) 300/900, #) 800/2.4M options available	$500K plus future medical expenses less primary coverage	$1.05M per occurrence in excess coverage	$600K non-economic, unlimited medical	$500/1.5M	Unlimited	Unlimited medical and ½ VA average weekly wage after age 18 for all birth-related neurological injuries	Unlimited

	Florida Birth-Related Neurological Injury Compensation Association	**Florida Patient Compensation Fund**	**Indiana Patient Compensation Fund**	**Kansas Health Care Stabilization Fund**	**Louisiana Patient Compensation Fund**	**Nebraska Excess Liability Fund**	**New Mexico Patient Compensation Fund**	**Medical Care Availability and Reduction of Error (Mcare) (PA)**	**South Carolina Patients Compensation Fund**	**Virginia Birth-Related Injury Compensation Fund**	**Wisconsin Patient Compensation Fund**
Funding Approach & Revenues	Hospitals ($50 per live birth) and physicians ($5K annually) are assessed by the Association	Annual, Semi-annual, or quarterly assessments	Assessments “on the same basis as premiums”	Assessments “on the same basis as premiums”	Assessments “on the same basis as premiums	Assessments as a percentage of underlying premiums	Assessments “on the same basis as premiums”	“rates shall be based on the prevailing primary premium”	Pay-As-You-Go Funding	Hospitals ($50 per live birth) and physicians ($5K annually) are assessed by the Fund	Administrative costs, operating costs, and claim payments are funded through assessments on participating health care providers.”
Funding Collection		Paid to Fund	Collected primary insurer or risk manager as “pass-through”	Collected by primary insurer as “pass-through”	Collected by primary Insurer as “pass-through”	Collected by primary Insurer as “pass-through”	Collected by primary Insurer as “pass-through”	Collected by primary insurer as “pass-through”	Annual payments to the Fund		Health Care providers are billed annually with lump sum or quarterly payments
Claims Administration	Administrative law judge determines coverage, Association staff administers		DOI Staff	Fund Staff monitors all Med Mal claims and suits in the state	Executive Director, Office of Risk Management	Director Administrative Services	DOI Staff	Outsourced	Agency Staff	VA Workers Compensation Commission, servicing carrier to administer payment of claims	Outsourced
Medical Review Board/Pretrial Screenings		Each Insurance company has a 90 day period to do an internal pretrial screening	Mandatory for Claims >$15K		Mandatory	Mandatory, unless waived	Mandatory		None	Review Panel set by Medical School Deans to determine Fund coverage	PCF Peer Review Council

	Florida Birth-Related Neurological Injury Compensation Association	**Florida Patient Compensation Fund**	**Indiana Patient Compensation Fund**	**Kansas Health Care Stabilization Fund**	**Louisiana Patient Compensation Fund**	**Nebraska Excess Liability Fund**	**New Mexico Patient Compensation Fund**	**Medical Care Availability and Reduction of Error (Mcare) (PA)**	**South Carolina Patients Compensation Fund**	**Virginia Birth-Related Injury Compensation Fund**	**Wisconsin Patient Compensation Fund**
Damage Caps	Punitives are limited to three times compensatory damages	Punitives are limited to three times compensatory damages	$250,000 per provider, $1.25M for all qualified providers and the Fund	$250K for non-economic, punitives limited to $5M or highest income in last 5 years	$500K plus future medical expenses	$1.25M per occurrence	$600K non-economic, unlimited medical	Punitives cannot exceed 200% of compensatory but cannot be <$100K	None	$1M cap on recoveries for bodily injury or death, $350K on punitives	Limits on non-economic damages
Attorneys' Fees	Sliding scale depending on recovery amount and type of judicial processes required	Sliding scale depending on recovery amount and type of judicial processes required	15% of PCF awards	Fees require judicial approval	None	No limits, fees are reviewable by judge	None	Unconstitutional	None	None	(a) 33 1/3% of first $1M, (b) 25% of first $1M if liability stipulated within 180 days, and (c) 20% of amount that exceeds $1M
Structured Settlements	Any party may request for future economic damages in excess of $250K	Any party may request for future economic damages in excess of $250K	Allowed, but not required	Not mandatory, but judges are authorized to require	PCF payments "paid as incurred"	Not required	Medical Payments must be paid as they are incurred	Allowed, but not Mandated	Allowed, but not Mandated	Allowed	Encouraged for payments > $100K
Arbitration; Alternative Dispute Resolution (ADR)	Judges can refer cases to nonbinding arbitration. Defendants who admit liability can enter binding arbitration to limit non-economic damages.	Judges can refer cases to nonbinding arbitration. Defendants who admit liability can enter binding arbitration to limit non-economic damages.	Mandatory Medical Review panel for Claims >$15K	Arbitration Option available	Allowed, but optional	Medical review Panel is a non-binding option	Medical Review Commission mandatory	Unconstitutional	None		Mediation System

WEST VIRGINIA - DESIGNATED TRAUMA CENTERS

HOSPITAL	ADDRESS	LEVEL
CAMC-General Division	PO Box 1547 Charleston, WV 25326	I
WVU Hospitals, Inc.	Medical Center Drive Morgantown, WV 26506	I
Tri-State Trauma Center - Cabell-Huntington Hospital	1340 Hal Greer Boulevard Huntington, WV 25701	II
Tri-State Trauma Center - St. Mary's Hospital	2900 1st Avenue Huntington, WV 25702	II
Weirton Medical Center	601 Colliers Way Weirton, WV 26062	III
Wetzel County Hospital	3 E. Benjamin Drive New Martinsville, WV 26155	III
Reynolds Memorial Hospital	800 Wheeling Drive Glen Dale, WV 26038	III
Grant Memorial Hospital	PO Box 1019 Petersburg, WV 26847	III
Jefferson Memorial Hospital	300 S. Preston Drive Ranson, WV 25438	III
Stonewall Jackson Memorial Hospital	230 Hospital Plaza Weston, WV 26452	III
Logan Regional Medical Center	20 Hospital Drive Logan, WV 25601	III
St. Joseph's Hospital	Amalia Drive Buckhannon, WV 26201	III
Raleigh General Hospital	1710 Harper Road Beckley, WV 25801	III

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P. O. Box 2501
Martinsburg, WV 25401
304-264-2111

Richard V. Todd
Salem Volunteer Fire Department
P. O. Box 126
Salem, WV 26426
304-782-3333

Gregory Harper
Schott Scientific Glass Inc. E.R.T.
1624 Staunton Avenue
Parkersburg, WV 26101
304-422-6531

Randall E. Cutright
Selbyville Volunteer Fire Department Inc.
H. C. 78 Box 31
Selbyville, WV 26236
304-924-6560

Drummond Figg
Shavers Fork Fire Rescue\Pocahontas Ski Medic
P.O. Box 16
Snowshoe, WV 26209
304-572-5683

Randy Prince
Sheltering Arms, Inc.
Box 37
Fayetteville, WV 25840
304-574-0540

Douglas Pittinger
Shepherdstown Volunteer Fire Department
PO Box F
Shepherdstown, WV 25443
304-876-2311

Matthew Sams
Short Gap Volunteer Fire Company
RT 2 Box 146
Keyser, WV 26726
304-726-4388

Harold Ellison
Sistersville General Hospital Ambulance Service
242 Oxford Street
Sistersville. WV 26175
304-652-2830

Randall Bailey
Sianesville Volunteer Ambulance Service
P.O. Box 6
Sianesville, WV 25444
304-496-8635

Gregory M. Thomas
Snowshoe Mountain Inc.
P.O. Box 10
Snowshoe, WV 26209
304-572-5683

Mark E. Porter
Special Metals
3200 Riverside Drive
Huntington, WV 25705
304-526-5780

Donna Steward
Springfield Area Rescue Squad Inc.
PO Box 370
Springfield, WV 26763
304-822-7594

Rusty Jeffrey
Spruce River Volunteer Fire Department
P.O. Box 99
Jeffrey, WV 25149
304-369-4761

Kendell A. Simpson
Stafford EMS, Inc.
P.O. Box 1098
Gilbert, WV 25621
304-664-2330

Rose Sims
STAT Ambulance Service Inc.
P.O. Box 393
Gilbert, WV 25621
304-664-6443

Butch O'Hara
Stone Church VFD
RD 2 Box 69 A
Wheeling, WV 26003
304-243-1571

Ray Crewey
Summers County EMS Inc.
P. O. Box 91
Pipestem, WV 25979
304-466-0312

Homer Wickline
Sweet Springs Valley Volunteer Rescue Squad
185 Sweet Springs Valley
Sweet Springs, WV 24941
304-536-3947

Kathy Lewis
Terra Alta Community Ambulance Squad
401 Aurora Avenue
Terra Alta, WV 26764
304-789-6566

Richard Glaw
Trap Hill Volunteer Fire And Rescue Inc.
P. O. Box 130
Glen Daniel, WV 25844
304-934-5843

Robert L. Ritner
Tri State Ambulance Inc.
P. O. Box 1131
Wheeling, WV 26003
304-233-2331 .

J. David Shields
Tucker County Emergency Ambulance Service Authority
P. O. Box 336
Parsons, WV 26287
304-478-2296

Clara Wells
Tyler County Emergency Squad Unit 1
P. O. Box 404
Middleboume, WV 26149
304-758-2235

Andrew Lett
Sunoco Chemical - Neal Plant
200 Big Sandy Road
Kenova, WV 25530
304-453-1371

Amy Summers
Taylor County Emergency Squad
P. O. Box 161
Grafton, WV 26354
304-265-0904

Robert Kirk
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1120 East State Street
Terra Alta, WV 26764
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Tri County Ambulance Service
P. O. Box 975
East Liverpool, OH 43920
330-385-4903

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Triadelphia Volunteer Fire Department
P. O. Box 15
Triadelphia, WV 26059
304-547-5010

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Tunnelton Community Ambulance Service
P. O. Box 544
Tunnelton, WV 26444
304-568-2533

Shannon M. Huffman
Tyler County EMS Unit 3/Alma EMS
P. O. Box 7
Alma, WV 26320
304-758-2455

Richard Brown
U.S. Dept. Of Interior - National Park Service
P. O. Box 246
Glen Jean, WV 25846
304-465-0508

Cindy Harsh
Union Ambulance Service, Inc.
Rt. 1 Box 4
Aurora, WV 26705
304-735-6881

Kenneth Nida
Union Carbide Corp./Dow Chemical Company
437 MacCorkle Avenue S.W.
South Charleston, WV 25303
304-747-4840

Jeanie Ratliff
Union Rescue / Monroe Transport
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Union, WV 24983
304-772-3383

Darren Stapleton
Upper Laurel Ambulance Service
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Glen Fork, WV 25845
304-294-4400

Shannon Whited
Upshur County Emergency Medical Services, Inc.
P. O. Box 124
Buckhannon, WV 26201
304-472-9640

William Lantz
Valley District Ambulance Service
P. O. Box 607
Masontown, WV 26542
304-864-5100

John Harto
Valley Grove VFD
P. O. Box 136
Valley Grove, WV 26060
304-547-0347

Terry O'Roark
Valley Medical Transport
295 Front Royal Pike
Winchester, VA 22602
540-536-2741

Blaine Howell
Van Volunteer Fire Department P.
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Van, WV 25206 304-245-8436

Ivan Strawderman
Wardens'lille Volunteer Rescue Squad
P. O. Box 2
Wardensville, WV 26851
304-874-3733

Gregory L. Eaton
Washington Bottom Volunteer Fire Department P.
O. Box 57
Washington, WV 26181
304-861-0145

Terry L. Hefner
Waverly Volunteer Fire Company
P. O. Box 96
Waverly, WV 25184
304-464-4320

Keith Richmond
Wayne Volunteer Fire Department P.
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Wayne, WV 25570 304-272-5656

Michael L. Hart
Webster County Memorial Hospital
P.O. Box 312
Webster Springs, WV 26288
304-847-5682

A.G. Lucas
Weirton Area Ambulance And Rescue
1305 Pennsylvania Avenue
Weirton, WV 26062
304-797-1233

Michael De Hamer
Weirton Steel Fire Department
400 Three Springs Drive
Weirton, WV 26062
304-797-4320

Albert W. Bond
West Liberty Volunteer Fire Department
P. O. Box 49
West Liberty, WV 26074
304-336-7500

Carla Morris
Wetzel County Ambulance Au1hority
P. O. Box 515
New Martinsville, WV 26155
304-455-5931

Stephen Johnston
Wheeling Fire Department
2126 Market Street
Wheeling, WV 26003
304-234-3776

Dan Hancock
Wheeling Island Gaming, Inc.
1 South Stone St.
Wheeling, WV 26003
304-232-5050

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White Sulphur Springs Emergency Medical Service
P. O. Box 129
White Sulphur Springs, WV 24986
304-536-4122

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Whitesville, WV 25209
304-854-1195

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Widener's Ambulance Service Inc.
P. O. Box 728
Northfork, WV 24868 304-862-2506

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P.O. Box 160
Williamsburg, WV 24991
304-647-1318

James Joseph Rut
Williamstown Volunteer Fire Company 411
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Williamstown, WV 26187 304-375-3960

Ronnie Somerville
Wirt County Emergency Squad
P. O. Box 448
Elizabeth, WV 26143
304-275-4219

Terry Brown
Wood County Emergency Services
911 Core Road
Parkersburg, WV 26101 304-485-7811

Jerry Rhodes
WV Office of EMS Emergency Response Team
350 Capitol Street, Room 515
Charteston, WV 25301-3716
304-558-3956

EXHIBIT 3
WV BOARD OF RISK AND INSURANCE MANAGEMENT
LITIGATION OUTCOME* BY CALENDAR YEAR

Calendar Year	Number of Cases to Trial	Plaintiff Verdicts	Defense Verdicts	Number of Medical Liability Cases Tried	Outcome of Medical Liability Trials
2001	16	5	11	2	Two Defense Verdicts
2002	23	7	16	6	Five Defense; One Plaintiff
2003**	28	11	17	6	Six Defense Verdicts

34% Plaintiff Verdicts
66% Defense Verdicts (no indemnity)
93% Medical Liability Defense Verdicts (no indemnity)

***Does not include BRIM II Health Care Provider Professional Liability Insurance Program**
**** As of September 30, 2003**

Patient Injury Compensation Fund

Exhibits 4, 5 and 6 examine medical professional liability claim payments reported to the West Virginia Board of Medicine with two objectives:

1. Examining judgments and settlements by frequency and severity, so as to provide insight into whether or not settlements should be encompassed by the PICF.
2. Examining the data to determine a reasonable loss limitation for the PICF.

Exhibits 4, 5 and 6 are compiled from data reported to the West Virginia Board of Medicine on medical liability (Medical Malpractice) claims after their disposition. The losses shown are indemnity amounts only and do not include amounts paid for adjusting and defending the claim. Limitations to the data are that it only includes physicians (M.D.s) and podiatrists; it does not include other health care providers, hospitals or doctors working within a corporate structure. The reported indemnity amounts do not break-out economic damages and non-economic damages.

Exhibit 4: This exhibit provides claim count information. From this exhibit, it appears that on average, judgments account for 9% and settlements 62% of the claims reported. Less than 3% of all reports filed with the Board of Medicine are judgments in an amount other than $0 (indemnity paid).

Exhibit 5: This exhibit provides a breakdown of reported judgments by size of loss. On average, 80% of all reported judgments have been under or equal to $1,000,000. Over the last 10 years only 17 judgments reported to the Board of Medicine have been in excess of $1,000,000. The average judgment over $1,000,000 has been somewhat less than $2,000,000. Specifically, individual judgments over $1M as reported to the Board of Medicine are as follows:

1993	$3.2M, $1.3M	(2)
1994	$0	(0)
1995	$1.3M, $2,7M	(2)
1996	$1.5M	(1)
1997	$3.7M	(1)

1998	$2.1M, 1.1M, 1.03M	(3)
1999	$1.02M, 1.5M, 1.006M	(3)
2000	$1.3M, $1.08M	(2)
2001	$2.3M, $1.6M	(2)
2002	$6.2M	(1)

If we assume that all of these judgments are non-trauma and the amounts reported are for economic damages only, and set a PICF cap of $1M, then all judgments up to $2M would be covered. This means that over the past 10 years, 93% of judgments would have been fully satisfied. Likewise, setting the cap at $1.5M means that 95% of all past judgments would have been satisfied. Taking this one step further, if we set the cap at $1.5M for judgments, and assume all of the judgments were trauma related and awards are for economic damages only, then 93% of all trauma judgments would have been satisfied.

Exhibit 6: This provides a size of loss distribution for settlements. Like judgments, settlements over $1M are rare. Out of 2,025 non-zero settlements reported to the Board of Medicine over the last 10 years, only 28 exceeded $1M. Put another way, over 98% of all reported settlements are below $1M. The average settlement over $1M has been just over $1.5M. *It is suggested that whatever cap is selected for judgments also be used for settlements (if it is determined that settlements be covered by the PICF).*

West Virginia Board of Medicine
Claim Count Review

Exhibit 4

Year	Number of Dismissals*	% of Total	Judgments Non Zero	Judgments Total	% of Total	Settlements Non Zero	Settlements Total	% of Total	All Total
1993	79	28%	8	18	6%	186	187	66%	284
1994	74	23%	10	36	11%	208	210	66%	320
1995	103	31%	14	38	11%	190	190	57%	331
1996	81	27%	5	20	7%	194	197	66%	298
1997	114	26%	9	28	6%	289	291	67%	433
1998	53	22%	9	27	11%	156	156	66%	236
1999	99	30%	15	28	8%	207	208	62%	335
2000	104	30%	7	37	11%	204	205	59%	346
2001	112	30%	9	37	10%	226	230	61%	379
2002	122	39%	7	25	8%	165	166	53%	313
Total	941	29%	93	294	9%	2,025	2,040	62%	3,275
Average	94		9	29		203	204		328

11/20/2003

* Effective April 1999 dismissals were no longer required to be reported to the Board.

West Virginia Board of Medicine

Size of Judgment Loss Distributions

Exhibit 5

Interval	1993 #	1993 $	1994 #	1994 $	1995 #	1995 $	1996 #	1996 $	1997 #	1997 $
Loss=$0	10	$0	26	$0	24	$0	15	$0	19	$0
$0<loss<=$100K	4	$64,931	0	$0	7	$301,907	1	$18,000	0	$0
$100K<loss<=$250K	0	$0	2	$320,000	2	$355,200	1	$130,337	5	$914,921
$250K<loss<=$500K	2	$720,616	5	$1,731,819	2	$647,127	1	$437,500	0	$0
$500K<loss<=$1M	0	$0	3	$1,894,600	1	$751,511	1	$1,000,000	3	$2,036,986
$1M<loss	2	$4,500,000	0	$0	2	$3,966,624	1	$1,500,000	1	$3,684,822
Total	18	$5,285,547	36	$3,946,419	38	$6,022,369	20	$3,085,837	28	$6,636,729
Total X Loss=$0	8	$5,285,547	10	$3,946,419	14	$6,022,369	5	$3,085,837	9	$6,636,729

Interval	1998 #	1998 $	1999 #	1999 $	2000 #	2000 $	2001 #	2001 $	2002 #	2002 $
Loss=$0	18	$0	13	$0	30	$0	28	$0	18	$0
$0<loss<=$100K	2	$132,514	6	$197,576	0	$0	3	$210,000	3	$175,073
$100K<loss<=$250K	2	$336,640	2	$371,829	0	$0	3	$440,557	0	$0
$250K<loss<=$500K	0	$0	0	$0	3	$1,157,054	0	$0	2	$680,150
$500K<loss<=$1M	2	$1,940,000	4	$2,997,264	2	$1,610,500	1	$528,733	1	$1,000,000
$1M<loss	3	$4,270,552	3	$3,527,451	2	$2,381,508	2	$3,612,000	1	$6,238,000
Total	27	$6,679,706	28	$7,094,120	37	$5,149,062	37	$4,791,290	25	$8,093,223
Total X Loss=$0	9	$6,679,706	15	$7,094,120	7	$5,149,062	9	$4,791,290	7	$8,093,223

11/20/2003

West Virginia Board of Medicine

Size of Paid Settlement Loss Distribution

	1993		1994		1995		1996		1997	
Interval	**#**	**$**	**#**	**$**	**#**	**$**	**#**	**$**	**#**	**$**
$0<loss<=$50K	79	$1,461,639	78	$1,704,102	79	$1,811,405	75	$1,718,264	177	$1,756,801
$50K<loss<=$100K	22	$1,735,833	40	$3,199,200	23	$1,892,250	33	$2,642,584	24	$2,040,933
$100K<loss<=$250K	47	$8,115,451	38	$6,665,678	44	$8,410,952	37	$6,786,025	33	$5,987,500
$250K<loss<=$500K	21	$7,301,798	32	$11,980,951	26	$10,015,000	33	$11,947,319	39	$14,664,111
$500K<loss<=$1M	14	$11,175,000	15	$11,694,010	15	$11,940,000	13	$8,560,000	13	$9,425,000
$1M<loss	3	$5,545,432	5	$9,175,000	3	$7,650,000	3	$4,159,000	3	$6,550,000
Total	186	$35,335,153	208	$44,418,941	190	$41,719,607	194	$35,813,192	289	$40,424,345
Total ex Losses=$0*	183	$35,335,153	203	$44,418,941	187	$41,719,607	191	$35,813,192	286	$40,424,345

	1998		1999		2000		2001		2002	
Interval	**#**	**$**	**#**	**$**	**#**	**$**	**#**	**$**	**#**	**$**
$0<loss=$50K	67	$1,152,744	87	$1,488,737	65	$1,633,255	84	$1,806,781	57	$1,229,665
$50<loss<=$100K	19	$1,612,092	28	$2,278,500	36	$2,892,600	37	$2,934,401	15	$1,214,000
$100K<loss<=$250K	28	$4,700,000	34	$5,936,000	45	$8,124,710	48	$8,350,814	49	$8,500,031
$250K<loss<=$500K	21	$7,188,000	42	$13,884,542	34	$12,753,796	29	$10,671,417	26	$10,065,000
$500K<loss<=$1M	18	$13,660,000	12	$9,615,000	19	$16,152,535	27	$21,817,833	18	$13,255,516
$1M<loss	3	$5,468,431	3	$10,995,605	4	$5,675,000	1	$1,250,000	0	$0
Total	156	$33,781,267	206	$44,198,384	203	$47,231,896	226	$46,831,246	165	$34,264,212
Total ex Losses=$0*	153	$33,781,267	203	$44,198,384	199	$47,231,896	225	$46,831,246	165	$34,264,212

*The second Total excludes losses which resulted in no indemnity payment.